CREATING COMMUNITY CARE: DECARCERATION STRATEGIES IN COMPETENCY LITIGATION

Rebecca Shaeffer*

INTRODUCTION

A disability justice approach to decarceration understands that jails and prisons exist on a spectrum of carcerality. This spectrum includes other forms of institutionalization, such that decarceration is one element of a larger effort to ensure that people with disabilities can live freely, with the necessary supports and accommodations for integration and autonomy in the community. Accordingly, efforts to reduce reliance on incarceration must extend beyond targeting jails and prisons and must answer the unmet needs of people with disabilities that have given rise to their criminalization. In addition, these efforts must engage with processes outside and adjacent to the criminal legal system through which criminalized people cycle.

Litigation challenging long waiting lists for admission to state psychiatric hospitals in order to obtain competency evaluations and restoration has sought to decarcerate people with mental health disabilities from jails in part through establishing community-based forensic evaluation and restoration systems, with wraparound services including housing. These wraparound services lay the groundwork for sustained liberation. Achieving these remedies requires the involvement of agencies outside of jails, including state departments of health, human services, and housing; prosecutors; defenders; and courts. It also requires an understanding of

* The author is a Staff Attorney for Criminal Systems at the National Disability Rights Network. Deep thanks to Simone Oberschmied for research assistance, and to Chloe Merino, Kim Mosloff, Chris Carney, Tom Stetson, and to the entire teams at Disability Rights Washington and Disability Rights Oregon for consultation.

the pressures on bed space at state hospitals created by excessive use of civil commitment and other failures of community care. This trans-institutional understanding of decarceration by disability rights organizations provides a pathway to reduction in incarceration and investment in community care. Mental health services have been historically diminished by years of austerity measures in successive legislative cycles, most prominently in the years following the 2008 financial crisis.[1] In more recent years, during and following the COVID-19 pandemic, workforce shortages in behavioral health, driven by both insufficient investment and increased demand,[2] have frustrated the effectiveness of some renewed investment initiatives.[3] As a result of these challenges to sustained investment in community mental health, the three largest providers of mental health services in the United States are not community centers or hospitals, but jails: Cook County Jail in Chicago, Los Angeles County Jail, and New York City's Rikers Island Jail.[4]

This Article attempts to illustrate the kinds of legal, policy, and budgetary shifts that are necessary in order to shift people in need of competency services out of jails and into community care. To lay the groundwork, this Article will explain the competency waitlist crisis, the legal order that attempts to regulate it, and the various pathways through which impacted people travel through incarceration, hospitalization, and community-based alternatives to these institutional responses. It will then examine two of the major permanent injunctions in competency waitlist litigation, *Oregon Advocacy Center v. Mink* and *A.B. ex rel. Trueblood v. Washington State Department of Social and Health Services*, that have resulted in significant decarceration of this population. Both lawsuits resulted in permanent injunctions limiting the number of days a state has to transfer a person from jail to a psychiatric facility for competency services. Enforcement of those timelines, however, has required years of litigation and innovation in service provision, including expansion of community-based competency programs, wraparound services, and housing. By exploring key and common features of the settlement enforcement efforts, this Article will attempt to identify key reforms necessary to ensure the liberty and due process interests of people criminalized with mental health disabilities.

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1. *See* NAT'L ALL. ON MENTAL ILLNESS, STATE MENTAL HEALTH CUTS: THE CONTINUING CRISIS 1 (2011), https://www.nami.org/wp-content/uploads/StateMentalHealthCuts2.pdf.

2. NAT'L CTR. FOR HEALTH WORKFORCE ANALYSIS, STATE OF THE BEHAVIORAL HEALTH WORKFORCE, 2024 (2024), https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-behavioral-health-workforce-report-2024.pdf.

3. *See* Mia Antezzo, *Investments in Behavioral Health Services: Top Three Emerging Themes from State Home and Community Based Services Spending Plans*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Oct. 18, 2021), https://nashp.org/investments-in-behavioral-health-service-systems-top-three-emerging-themes-from-state-home-and-community-based-services-spending-plans/.

4. Eric Westervelt & Liz Baker, *America's Mental Health Crisis Hidden Behind Bars*, NAT'L PUB. RADIO (Feb. 25, 2020, 5:01 AM), https://www.npr.org/2020/02/25/805469776/americas-mental-health-crisis-hidden-behind-bars.

I. THE INCOMPETENT TO STAND TRIAL (IST) CRISIS

People with intellectual, developmental,[5] and mental health disabilities[6] and traumatic brain injury (TBI)[7] make up a significant proportion of incarcerated people. Many of these individuals face criminal charges and incarceration for behavior that is regarded as criminal by law, but is rather a manifestation of their disability, exacerbated by failures in investment in community mental health and disability care services. This form of discrimination is intersected by societal and institutional racism that disproportionately exposes Black people with disabilities to higher rates of criminalization and police violence.[8] People with disabilities also face higher rates of victimization[9] and disciplinary sanctions[10] (like solitary confinement) when they are incarcerated. In the sustained national movement to decarcerate and to redirect public funds away from policing and incarceration to community investment, people with disabilities should be at the forefront of diversion and decriminalization efforts.

Many people with mental health, intellectual, and developmental disabilities move through the criminal and penal processes in the same way as individuals without disabilities. However, when a defendant is not able to effectively engage with the criminal legal process, they are understood to be incompetent to stand trial (IST) and cannot be prosecuted unless and until they become so competent. In *Dusky v. United States*, the Supreme Court set the standard for competency in criminal proceedings, holding that a defendant must possess "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."[11] Minimum standards that must be met for a person to be found competent to stand trial are: "a person whose mental condition is such that he lacks

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5. The prevalence of intellectual and developmental disabilities (I/DD) among incarcerated people is estimated at 7–10%. *See* Mike Hellenbach, Thanos Karatzias & Michael Brown, *Intellectual Disabilities Among Prisoners: Prevalence and Mental and Physical Health Comorbidities*, 30 J. APPLIED RSCH. INTELL. DISABILITIES 230, 230 (2017).

6. LAURA M. MARUSCHAK, JENNIFER BRONSON & MARIEL ALPER, U.S. DEP'T OF JUST., SURVEY OF PRISON INMATES, 2016: INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONERS 1 (2021), https://bjs.ojp.gov/library/publications/indicators-mental-health-problems-reported-prisoners-survey-prison-inmates.

7. The prevalence of TBI in the justice-involved population is estimated at sixty percent. *See* Eric J. Shiroma, Pamela L. Ferguson & E. Elisabeth Pickelsimer, *Prevalence of Traumatic Brain Injury in an Offender Population: A Meta-Analysis*, 27 J. HEAD TRAUMA REHAB., at E1, E1 (2012).

8. *See* Sirry Alang, Cortney VanHook, Jessica Judson, Adalia Ikiroma & Paris B. Adkins-Jackson, *Police Brutality, Heightened Vigilance, and the Mental Health of Black Adults*, 12 PSYCH. VIOLENCE 211, 217 (2022); Erin J. McCauley, *The Cumulative Probability of Arrest by Age 28 Years in the United States by Disability Status, Race/Ethnicity, and Gender*, 107 AM. J. PUB. HEALTH 1977, 1979 (2017).

9. Jessica M. Groscholz & Daniel C. Semenza, *Health Conditions and Victimization Among Incarcerated People in U.S. Jails*, 74 J. CRIM. JUST. 1, 5–6 (2021).

10. Brandy F.Henry, *Disparities in Use of Disciplinary Solitary Confinement by Mental Health Diagnosis, Race, Sexual Orientation, and Sex: Results from a National Survey in the United States of America*, 32 CRIM. BEHAV. & MENTAL HEALTH 114, 114 (2022).

11. Dusky v. United States, 362 U.S. 402, 402 (1960).

the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense."[12] The *Dusky* decision coincided with the beginning of the de-institutionalization movement[13] and the introduction of the use of the first psychiatric medication[14] to treat serious mental illness, making "restoration to competency" an imaginable concept for the judiciary.

The numbers of arrested people who are referred for competency evaluation and restoration have been steadily rising despite efforts in recent decades to scale up police training on mental health and de-escalation,[15] non-police emergency response,[16] and diversion,[17] which all seek to reduce the number of people who are criminalized for and with mental health disabilities. In a 2020 survey, eighty-two percent of state court authorities across all states reported that referrals to IST procedures were increasing.[18] While competency waitlists grew in many jurisdictions due to systematic impacts of the COVID-19 pandemic, this does not explain the entirety of the increase in referrals. Further, the growth in IST cases both predates and post-dates the pandemic. In Colorado, for example, requests for competency evaluations rose by 524% from 2000 to 2017.[19] In Los Angeles County, California, IST referrals grew 50% from 2014 to 2015.[20] In Connecticut, competency cases grew 20% even as overall criminal cases shrunk by 10%.[21] In Virginia,

12. Drope v. Missouri, 420 U.S. 162, 171 (1975).

13. Reductions in the use of long-term psychiatric hospitalization began in 1956. CHRIS KOYANAGI, KAISER COMM'N ON MEDICAID & THE UNINSURED, LEARNING FROM HISTORY: DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS AS PRECURSOR TO LONG-TERM CARE REFORM 4 (2007), https://www.kff.org/wp-content/uploads/2013/01/7684.pdf.

14. Thorazine, the first anti-psychotic medication, was introduced in the United States in 1954. Wes Lindamood, *Thorazine*, CHEM. & ENG'G NEWS (June 20, 2025), https://cen.acs.org/articles/83/i25/Thorazine.html.

15. *See* 34 U.S.C. § 10159.

16. *See* U.S. DEP'T OF JUST. & U.S. DEP'T OF HEALTH & HUM. SERVS., GUIDANCE FOR EMERGENCY RESPONSES TO PEOPLE WITH BEHAVIORAL HEALTH OR OTHER DISABILITIES 5 (2024), https://www.justice.gov/d9/2023-05/Sec.%2014%28a%29%20-%20DOJ%20and%20HHS%20Guidance%20on%20Emergency%20Responses%20to%20Individuals%20with%20Behavioral%20Health%20or%20Other%20Disabilities_FINAL.pdf.

17. *See* COUNCIL OF STATE GOV'TS JUST. CTR., BEHAVIORAL HEALTH DIVERSION INTERVENTIONS: MOVING FROM INDIVIDUAL PROGRAMS TO A SYSTEMS-WIDE STRATEGY 2 (2019), https://csgjusticecenter.org/wp-content/uploads/2020/02/Diversion-conecept-paper.pdf; LAUREN ALMQUIST & ELIZABETH DODD, COUNCIL OF STATE GOV'TS JUST. CTR. & MACARTHUR FOUND., MENTAL HEALTH COURTS: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE, at v (2009), https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG_MHC_Research.pdf.

18. Katherine Warburton, Barbara E. McDermott, Anthony Gale & Stephen M. Stahl, *A Survey of National Trends in Psychiatric Patients Found Incompetent to Stand Trial: Reasons for the Reinstitutionalization of People with Serious Mental Illness in the United States*, 25 CNS SPECTRUMS 245, 247 (2020).

19. *Id*. at 246.

20. Abby Sewell, *No One Knows What's Behind L.A. County's Rise in Mental Competency Cases*, L.A. TIMES (Feb. 28, 2016, 5:31 PM), https://www.latimes.com/local/california/la-me-mental-health-court-20160229-story.html.

21. Kelan Lyons, *Competency Exams are Being Used in More Criminal Cases, Even as Criminal Court Dockets Shrink*, CT MIRROR (Sept. 10, 2020, 5:00 AM), https://ctmirror.org/2020/09/10/competency-exams-increasing-number-of-criminal-cases-even-as-criminal-court-dockets-shrink/.

competency referrals increased 218% from 2007 to 2018.[22] "According to data from the Washington Department of Social and Health Services, competency evaluation referrals across the state doubled between 2013 and 2022 for felonies and misdemeanors."[23] "In some [Washington] counties, like Whatcom, the number of people with felony charges being referred to competency services has quadrupled over the last 10 years, even as Whatcom's population has only grown by about 11%."[24] In King County, Washington, "competency referrals for misdemeanor defendants have risen 108% over that same time, and in 2022 alone, 2,049 people were referred for an evaluation, most of them on nonfelony charges."[25]

The reasons for the increase in competency referrals are likely manifold, and not comprehensively understood. People with disabilities face a number of structural barriers to safe inclusion in the community, including underfunding for Medicaid waivers[26] that provide housing and community-based services that would allow them to live independently,[27] as well as a lack of affordable and supportive housing[28] leading to increased rates of homelessness[29] (and therefore vulnerability to arrest).[30] Michael Lawlor, former Undersecretary for Criminal Justice Policy and Planning in Connecticut, puts it plainly: "[I]t's simply because there's fewer services and supportive options available to them in the community."[31] Some point to the closure of psychiatric hospitals as a driver of this phenomenon, but long-term psychiatric hospitalization is associated more with poverty, social isolation, and lack of community services than with severity of illness.[32] At the same time,

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22. Daniel C. Murrie, Brett O. Gardner & Angela N. Torres, *The Impact of Misdemeanor Arrests on Forensic Mental Health Services: A State-Wide Review of Virginia Competence to Stand Trial Evaluations*, 28 PSYCH., PUB. POL'Y, & L. 53, 54 (2020).

23. Esmy Jimenez, *The Puzzling Rise of Defendants Too Sick to Stand Trial in WA*, SEATTLE TIMES (July 7, 2023, 6:00 AM), https://www.seattletimes.com/seattle-news/the-puzzling-rise-of-defendants-too-sick-to-stand-trial-in-wa/.

24. *Id.*

25. *Id.*

26. Adam Kemp, *The Wait for Government Disability Services Can Law Years. Some States are Trying to Change That*, PBS NEWS (May 15, 2023, 5:07 AM), https://www.pbs.org/newshour/nation/the-wait-for-government-disability-services-can-last-years-some-states-are-trying-to-change-that.

27. *Behavioral Health Services Covered Under HCBS Waivers and 1915(i) SPAs*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N (Mar. 3, 2020), https://www.macpac.gov/subtopic/behavioral-health-services-covered-under-hcbs-waivers-and-spas/.

28. Mia Chapman, *Exploring the Link Between Housing Stability and Mental Health*, NAT'L LEAGUE OF CITIES (May 28, 2024), https://www.nlc.org/article/2024/05/28/exploring-the-link-between-housing-stability-and-mental-health/.

29. Daniel Soucy, Makenna Janes & Andrew Hall, *State of Homelessness: 2024 Edition*, NAT'L ALL. TO END HOMELESSNESS (Aug. 5, 2024), https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness/.

30. MADELINE BAILEY, ERICA CREW & MADZ REEVE, VERA INST. OF JUST., NO ACCESS TO JUSTICE: BREAKING THE CYCLE OF HOMELESSNESS AND JAIL 1 (2020), https://vera-institute.files.svdcdn.com/production/downloads/publications/no-access-to-justice.pdf.

31. Lyons, *supra* note 21.

32. *See* Mysore N. Vranda, James P. Ranjith, Shivaleela Agadi, Cicil R. Vasanthra, Jagadisha Thirthalli, Channaveerachari Naveen Kumar, Ammapattian Thirumoorthy & Anekal C. Amaresha, *Psychosocial and Clinical Profile of Chronic Long-Stay Psychiatric Patients in Teaching Institution*, 12 J. FAM. MED. & PRIMARY CARE 2456 (2023).

psychiatric hospitals are costly.[33] Furthermore, pressure on state hospital beds in many states is driven by (1) court-ordered competency patients,[34] many of whom can be effectively restored without hospitalization, and by (2) extended institutionalization of people who qualify for Medicaid waivers but for whom these services have not been funded by states.[35] Yet there is never a waiting list for jail.

A referral for competency evaluation is not limited to cases of serious or violent crime. The more typical picture is a revolving door of homelessness, arrest for low-level infraction, involuntary commitment to psychiatric facilities, and jail (a cycle that is often produced repetitively). For example, in Colorado, authorities have estimated that only 25% of accused people on the IST waiting list were accused of serious felonies.[36] In Washington, D.C., 79% of IST defendants were charged with misdemeanors.[37] In Los Angeles, the primary drivers of IST referrals were minor charges like trespassing, drug crimes, simple battery, and vandalism.[38] In Pennsylvania, data similarly shows that the primary offences for which people end up in competency proceedings are low-level misdemeanors commonly associated with people experiencing mental health conditions, such as "resisting arrest," a charge which often attends people who are agitated as a result of psychiatric, cognitive, intellectual or developmental disability.[39]

Being referred for competency evaluation and restoration often extends the time a person with disabilities spends in jail for low-level offences, as waitlists for admittance to state hospitals can sometimes last for months. In Colorado, for example, prior to reforms pursuant to litigation, waitlists were as long as a year for a class one misdemeanor.[40] In the seminal case *Jackson v. Indiana*, the Supreme Court ruled that states cannot indefinitely confine criminal defendants who are

33. Alex Clarke & Ira D. Glick, *The Crisis in Psychiatric Hospital Care: Changing the Model to Continuous, Integrative Behavioral Health Case*, 71 PSYCHIATRIC SERVS. 165, 166 (2020).

34. NRI, USE OF STATE PSYCHIATRIC HOSPITALS, 2023, at 3 (2024), https://www.nri-inc.org/media/is0dobjz/smha-use-of-state-psychiatric-hospitals-may-2024-final-w-out-tables.pdf.

35. Alice Burns, Abby Wolk, Molly O'Malley Watts, Maiss Mohamed & Maria T. Pena, *A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024*, KAISER FAM. FOUND. (Oct. 31, 2024), https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2024/.

36. Shelly Bradbury, *How Jails and Courtrooms Became Colorado's Mental Health Safety Net—and Why That Isn't Working*, DENVER POST (Dec. 17, 2023, 1:46 PM), https://www.denverpost.com/2023/12/13/competency-colorado-mental-health-illness-jail-court-systems/.

37. Reston N. Bell, Philip J. Candilis & Nicole R. Johnson, *An Update on Outpatient Competence Restoration Outcomes: The Washington DC Model*, 5 J. FORENSIC SCI. & RSCH. 1, 3 (2021).

38. Sewell, *supra* note 20.

39. Danielle Ohl & Brittany Hailer, *Competency Proceedings in Pa. Typically Involve Minor Crimes*, SPOTLIGHT PA (Mar. 9, 2023), https://www.spotlightpa.org/news/2023/03/pa-common-criminal-charges-competency-mental-health/.

40. Tatiana Flowers, *"Competency Dockets" at Colorado Courts Are Linking People with Mental Illness to Community-Based Services*, COLO. SUN (Apr. 29, 2024, 3:02 AM), https://coloradosun.com/2024/04/29/competency-dockets-colorado/.

found incompetent to stand trial.[41] The Court found that the length of time of confinement must be no more than "the reasonable period of time necessary to determine whether there is a substantial probability that [the individual] will attain . . . capacity in the foreseeable future."[42] However, the Court stopped short of providing specific guidance on what length of time might be considered reasonable. Following *Jackson*, many states have statutorily limited the maximum amount of time a person can be detained for competency restoration to the maximum sentence for their offence.[43] However, this limited maximum is still usually much longer than the individual would have been sentenced to should their case have proceeded without a competency evaluation. Additionally, it ignores the fact that people undergoing competency evaluations are legally innocent as pre-trial detainees. Furthermore, the "reasonable period of time" required by *Jackson*[44] is usually counted only from the time restoration is ordered, and does not count the innumerable delays that can occur in the process of referring and evaluating people for competency.[45] In 2015, the ACLU of Pennsylvania challenged Pennsylvania's IST waiting times, which regularly stretched past a year.[46] In that case, one of the class members had been waiting for 486 days in jail for competency services, another waited over 340 days for stealing three peppermint patty candies, and two individuals died while awaiting transfer to the hospital.[47]

Jailtime for people with disabilities is exceedingly dangerous. Mental health and other disability screening in jails is often perfunctory or absent,[48] as is effective treatment.[49] A swiftly rotating jail population and severely understaffed facilities makes adequate supervision, program engagement, treatment, and accommodation almost impossible in many facilities.[50] Suicide is the leading cause of death in jails nationwide.[51] Beyond suicide, conditions for people with serious mental illnesses

41. Jackson v. Indiana, 406 U.S. 715, 738 (1972).

42. *Id.*

43. Andrew R. Kaufman, Bruce B. Way & Enrico Suardi, *Forty Years after* Jackson v. Indiana*: States' Compliance with "Reasonable Period of Time" Ruling*, 40 J. AM. ACAD. PSYCHIATRY L. 261, 261–64 (2012).

44. *Jackson*, 406 U.S. at 738.

45. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., FOUNDATION WORK FOR EXPLORING INCOMPETENCE TO STAND TRIAL AND COMPETENCE RESTORATION FOR PEOPLE WITH SERIOUS MENTAL ILLNESS/SERIOUS EMOTIONAL DISTURBANCE 6 (2023), https://library.samhsa.gov/sites/default/files/pep23-01-00-005.pdf.

46. *Lawsuit Alleges Many Defendants with Mental Illness Jailed for Well Over a Year Awaiting Mental Health Treatment*, AM. C.L. UNION PA. (Oct. 22, 2015), https://www.aclupa.org/en/press-releases/lawsuit-alleges-many-defendants-mental-illness-jailed-well-over-year-awaiting-mental.

47. *Id.*

48. *See* ELENA DIROSA, TONYA VAN DEINSE, GARY CUDDEBACK, ANDREA MURRAY-LICHTMAN, JESICA CARDA-AUTEN & DAVID ROSEN, MENTAL HEALTHCARE PRACTICES FROM ENTRY TO RELEASE ACROSS SOUTHEASTERN JAILS (2024).

49. National Alliance for the Mentally Ill reports that two-thirds of incarcerated people with mental health conditions do not receive treatment for them. *See Mental Health Treatment While Incarcerated*, NAT'L ALL. FOR THE MENTALLY ILL, https://www.nami.org/advocacy/policy-priorities/improving-health/mental-health-treatment-while-incarcerated/ (last visited Apr. 21, 2025).

50. DIROSA ET AL., *supra* note 48.

51. E. ANN CARSON, U.S. DEP'T OF JUST., MORTALITY IN LOCAL JAILS, 2000–2019–STATISTICAL TABLES 8 (2021), https://bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf.

as well as people experiencing intellectual and other cognitive disabilities are often worse than those for other jail residents.[52] Individuals with mental health, intellectual, and developmental disabilities are particularly vulnerable to victimization by assault, sexual abuse, exploitation and extortion, and they face higher rates of disciplinary sanctions due to the behavioral manifestations of their disabilities in a stressful environment.[53] A New York Times investigation uncovered that seventy-seven percent of the people who were seriously injured by staff assaults at Rikers Island Jail, for example, had mental health diagnoses.[54]

Jail conditions are often worse than federal prison conditions,[55] due to their local governance, patchwork of funding, and inability to control population. Overcrowded conditions, present in many jails particularly since the end of the pandemic,[56] have a deleterious effect on mental health and are linked with increased incidences of suicide.[57] Jails are often dangerous and in poor condition[58] and may lack even basic sanitation.[59] Jails are also often permeated with chaotic sounds, harsh lighting, and are "an atmosphere of threat and violence,"[60] all of which are external factors that can exacerbate mental illness. Increasing staffing shortages also results in incarcerated individuals being locked in cells for longer periods of time and having less monitoring,[61] increasing the possibility of a prisoner experiencing a mental health crisis and not receiving prompt care and intervention. Additionally, inadequate training and understaffing worsens mental health and suicide risk during incarceration.[62]

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52. *See, e.g.*, DISABILITY RTS. WASH., LOST AND FORGOTTEN: CONDITIONS OF CONFINEMENT WHILE WAITING FOR COMPETENCY EVALUATION AND RESTORATION 8 (2013), https://disabilityrightswa.org/wp-content/uploads/2017/12/LostandForgotten_January2013.pdf.

53. *See Callous and Cruel: Use of Force Against Inmates with Mental Disabilities in US Jails and Prisons*, HUM. RTS. WATCH (May 12, 2015), https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and ("Nationwide, among state prisoners, 58 percent of those who had a mental health problem had been charged with rule violations, compared to 43 percent of those without such problems.").

54. Michael Winerip & Michael Schwirtz, *Rikers: Where Mental Illness Meets Brutality in Jail*, N.Y. TIMES (July 14, 2014), https://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html.

55. *See, e.g.*, Christopher Blackwell, *Two Decades of Prison Did Not Prepare Me for the Horrors of County Jail*, N.Y. TIMES (May 16, 2023), https://www.nytimes.com/2023/05/16/opinion/sunday/abuse-jail-prison.html.

56. Keri Blakinger, *Why So Many Jails Are in a 'State of Complete Meltdown*,' MARSHALL PROJECT (Nov. 4, 2022), https://www.themarshallproject.org/2022/11/04/why-so-many-jails-are-in-a-state-of-complete-meltdown.

57. Meredith P. Huey & Thomas L. Mcnulty, *Institutional Conditions and Prison Suicide: Conditional Effects of Deprivation and Overcrowding*, 85 PRISON J. 490, 490 (2005).

58. *See, e.g.*, Michael Seiden, *Almost 100 Shanks Made from Crumbling Pieces of Fulton County Jail Seized from Inmates*, WSB-TV ATLANTA (Apr. 20, 2022, 11:45 PM), https://www.wsbtv.com/news/local/fulton-county/almost-100-knives-made-pieces-deteriorating-fulton-county-jail-seized/VL7NLLQN2ZDT3DNX5KR3DOOMRI/.

59. *See, e.g.*, Erica C. Barnett, *In a Sign of Worsening Conditions, Understaffed King County Jail Has Lacked Water for a Week*, PUBLICOLA (Oct. 6, 2022), https://publicola.com/2022/10/06/in-a-sign-of-worsening-conditions-understaffed-king-county-jail-has-lacked-water-for-a-week/.

60. Josephine Wonsun Hahn, *How to Lower the High Level of Jail Suicides*, BRENNAN CTR. FOR JUST. (Aug. 17, 2022), https://www.brennancenter.org/our-work/analysis-opinion/how-lower-high-level-jail-suicides.

61. Jo Nurse, Paul Woodcock & Jim Ormsby, *Influence of Environmental Factors on Mental Health Within Prisons: Focus Group Study*, BRIT. MED. J. 480, 480 (2003).

62. Hahn, *supra* note 60.

In such an environment, incarcerated people learn to "become hypervigilant and ever-alert for signs of threat or personal risk," making it difficult to establish conditions, such as trust and vulnerability, which can be key for managing mental health.[63] Just witnessing such violence can "exacerbate existing mental health disorders or even lead to the development of post-traumatic stress symptoms like anxiety, depression, avoidance, hypersensitivity, hypervigilance, suicidality, flashbacks, and difficulty with emotional regulation."[64] Crowding, an atmosphere of harm, and solitary confinement in prisons have all been linked to self-harm.[65]

In light of the overwhelmingly risky environment of jail for people with mental health conditions, judges adjudicating cases involving people on IST waitlists in jail have recognized explicitly that:

> Our jails are not suitable places for the mentally ill to be warehoused while they wait for services. Jails are not hospitals, they are not designed as therapeutic environments, and they are not equipped to manage mental illness or keep those with mental illness from being victimized by the general population of inmates. Punitive settings and isolation for twenty-three hours each day exacerbate mental illness and increase the likelihood that the individual will never recover.[66]

Perversely, a competency referral often disrupts, rather than facilitates, swift access to diversion, treatment, and stabilization for arrested people with serious mental illness.[67] Individuals subjected to these proceedings often become ineligible for other forms of diversion to community-based programs and can be stuck in a limbo between criminal and civil mental health processes for weeks, months, or longer while they often decompensate in jail. Such individuals can fall through the cracks between the behavioral health court and jail systems and may suffer from lack of advocacy as the criminal process is paused for the competency evaluation followed by a wait for restoration services.

Furthermore, the goal of competency services is to restore the individual's ability to participate in the court process—a "successful" restoration simply restores a person to jail to face prosecution, where they may again be subjected to poor conditions and treatment. Those who are least likely to be restored, including those with non-treatable disabilities like intellectual and developmental disabilities, dementia, and TBI, are often subjected to a repeated cycle of competency proceedings as

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63. CRAIG HANEY, THE PSYCHOLOGICAL IMPACT OF INCARCERATION: IMPLICATIONS FOR POST-PRISON ADJUSTMENT 77, 81 (2001), https://www.urban.org/research/publication/psychological-impact-incarceration.

64. Katie Rose Quandt & Alexi Jones, *Research Roundup: Incarceration Can Cause Lasting Damage to Mental Health*, PRISON POL'Y INITIATIVE (May 13, 2021), https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/.

65. Jennifer M. Reingle Gonzalez & Nadine M. Connell, *Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity*, 104 AM. J. PUB. HEALTH 2328, 2329 (2014).

66. Trueblood v. Wash. State Dep't of Soc. and Health Servs., 101 F. Supp. 3d 1010, 1013 (W.D. Wash. 2015).

67. Debra A. Pinals & Lisa Callahan, *Evaluation and Restoration of Competence to Stand Trial: Intercepting the Forensic System Using the Sequential Intercept Model*, 71 PSYCHIATRIC SERVS. 698, 699 (2020).

rearrests occur in the absence of effective community treatment and housing, and they may never be prosecuted and sentenced, or effectively treated. Notably, a higher proportion of people accused of low-level misdemeanors are found to be unrestorable.[68] Nor are these individuals likely to meet the standard of dangerousness necessary for civil commitment, leading to a senseless cycle of confinement that does not result in recovery. Dr. Katherine Warburton, Medical Director of the California State Hospital system, has said:

> The most tragic aspect of this crisis is that the massive efforts to admit and restore patients are ultimately a waste of expensive clinical resources without improving the trajectory of a person's life. After returning to jail and standing trial, they are most likely worse off: either released without resources to the same circumstances that precipitated arrest or incarcerated.[69]

Case study: Alan Thibodeaux, Bamberg County Jail, South Carolina

Alan Thibodeaux's case exemplifies the tragic outcomes of the competency crisis. Alan was a Virginia resident with a long-standing schizophrenia diagnosis that was generally well-managed with medication.[70] Following a disruption to his treatment, Alan went missing from a Virginia hospital and was reported missing by his brother.[71] Later that month, he was arrested sleeping in an abandoned home in South Carolina, telling officers he had entered in order to find a warm place to sleep.[72] Officers arrested him and charged him with "burglary," after which he was found incompetent to stand trial and ordered to a state hospital for restoration.[73] However, he was never transferred from Bamberg County Jail, where he never received treatment for his mental health conditions or his diabetes.[74] Rather, jail officers regularly subjected him to brutal cell extractions and tasered him while he decompensated.[75] In the course of his five-month stay in jail, he lost seventy-seven pounds and eventually died of multi-organ failure, starvation, and dehydration.[76]

68. Douglas Mossman, *Predicting Restorability of Incompetent Criminal Defendants*, 35 J. AM. ACAD. PSYCHIATRY L. 34, 41 (2007).

69. HALLIE FADER-TOWE & ETHAN KELLY, COUNCIL OF STATE GOV'TS JUST. CTR., JUST AND WELL: RETHINKING HOW STATES APPROACH COMPETENCY TO STAND TRIAL, at viii (2020), https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf (quoting Dr. Warburton).

70. Julia Marnin, *Man Tased and Starved in SC Jail Before Death Was Supposed To Be in Hospital, Suit Says*, STATE (Nov. 16, 2023, 12:20 PM), https://www.thestate.com/news/state/south-carolina/article281853263.html.

71. *Id.*

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*; *see also* Evans Moore, LLC, *Arrest, Detention, and Death of Alan Thibodeau at Bamberg County Detention Center | Evans Moore, LLC*, YOUTUBE (Oct. 24, 2023), https://www.youtube.com/watch?v=NXQaifp810k.

The competency waitlist crisis is the most acute manifestation of the much-discussed link[77] between the de-institutionalization movement and the growth of mass incarceration. National, state, and local governments failed to create the community-based mental health care system promised by the Community Mental Health Act of 1963.[78] Subsequent and repeated austerity measures have reduced investment in health, welfare, and housing, and the increased criminalization of homelessness, drug use, and other social phenomena produced by the carceral policies of the 1980s, 1990s, and 2000s[79] has given rise to the mass incarceration of people with disabilities. The criminalization of disability is the result of a complex set of intersecting political and social conditions that will not be fully discussed here. Nonetheless, it is clear that efforts to ameliorate the crisis of jails and prisons as "the new asylums" will only be as successful as are efforts to build this missing investment by creating systems of community-based mental health care, housing, and material support for people with disabilities.

II. UNDERSTANDING COMPETENCY PROCESSES

State statutes and practices vary, but, generally, questions of competency can be raised by any party—defense, prosecutor, judge, and sometimes even jail staff—at any stage in the proceedings.[80] If a court determines that a "bona fide doubt" exists as to a defendant's competency, it must consider this issue formally,[81] usually after a forensic evaluation, which can take place in the jail, an outpatient facility, or in an institutional setting. Criminal proceedings pause at this point, although an individual will often remain in custody.[82] Following the forensic finding of IST, the court will order the individual for restoration to competency, a process which usually combines medication (which can be provided on a voluntary or involuntary[83] basis) and legal education with the goal of orienting the individual as to the criminal proceedings that will likely take place.[84] Forensic professionals provide regular

77. *See generally* Corinna Barett Lain, *The Road to Hell is Paved with Good Intentions: Deinstitutionalization and Mass Incarceration Nation*, 65 WM. & MARY L. REV. 893 (2024) (arguing that mental health and mass incarceration crises are interconnected and that lessons from deinstitutionalization's failures can inform the decarceration process).

78. *See* Community Mental Health Act of 1963, Pub. L. No. 88-164, 77 Stat. 282.

79. Liat Ben-Moshe, *Why Prisons Are Not "The New Asylums*," 19 PUNISHMENT & SOC'Y 272, 278 (2017).

80. RONALD ROESCH, PATRICIA A. ZAPF, STEPHEN L. GOLDING & JENNIFER L. SKEEM, U.S. DEP'T OF JUST., DEFINING AND ASSESSING COMPETENCY TO STAND TRIAL 6 (2014), https://www.justice.gov/sites/default/files/eoir/legacy/2014/08/15/Defining_and_Assessing_Competency_to_Stand_Trial.pdf.

81. Drope v. Missouri, 420 U.S. 162, 173 (1975); Pate v. Robinson, 383 U.S. 375, 385 (1966).

82. *See* Lisa Callahan & Debra A. Pinals, *Challenges to Reforming the Competence to Stand Trial and Competence Restoration System*, 71 PSYCHIATRIC SERVS. 691, 691 (2020), https://psychiatryonline.org/doi/10.1176/appi.ps.201900483.

83. Sell v. United States, 539 U.S. 166, 177–81 (2003) (setting out the criteria for imposition of involuntary medication to attempt to restore a defendant to competency).

84. *See generally* Debra A. Pinals & Lisa Callahan, *Evaluation and Restoration of Competence to Stand Trial: Intercepting the Forensic System Using the Sequential Intercept Model*, 71 PSYCHIATRIC SERVS. 698 (2020), https://psychiatryonline.org/doi/epdf/10.1176/appi.ps.201900484.

(although variable by jurisdiction and statute) updates to the court as to the individual's progress in restoration to competency.[85] Traditionally, evaluation and restoration happen in a state psychiatric hospital. Restoration can be lengthy and is not always successful.

Twelve years after *Dusky* in 1972, the Supreme Court ruled in *Jackson v. Indiana* that states may not indefinitely confine people based on IST.[86] It further ruled that the length of time of confinement must be limited on the basis of likelihood of restorability but declined to provide detailed guidance on what that timeline might be.[87] States have responded to that ruling in widely heterogeneous ways, some imposing limits of one year, others allowing confinement up to the maximum length of the possible sentence imposed (without any finding of guilt and frequently without even a finding of probable cause for arrest), and others imposing no statutory limit at all.[88] Some jurisdictions continue to resist the full force of *Jackson*, leading to excessively long periods of involuntary confinement in psychiatric hospitals for many people who, despite being criminally accused, do not meet the standards of dangerousness necessary for civil commitment, thus placing unnecessary pressure on state hospitals.[89]

If the individual is restored to competency while hospitalized, they are usually returned to jail to continue criminal proceedings.[90] If they are found unable to be restored, the criminal charges are often dismissed.[91] If the individual meets the criteria for civil commitment (dangerousness to self or others, in general), they may be committed to the state hospital thereafter.[92] Those who do not meet the standard should be released. In practice, many such people are released to the same situation which gave rise to their criminalization in the first place—a lack of secure housing and community-based mental health services. These pathways often create a "churn" in which people who are persistently mentally ill are repeatedly subject to arrest, detention, evaluation, and release without ever receiving meaningful treatment.[93]

There is substantial variation between jurisdictions as to the availability of services and sites at which these steps can occur, some of which will be discussed in detail later in this Article. Delays can and do occur, such as: (1) waiting for an

85. *See generally* Paul S. Appelbaum & Loren H. Roth, *Clinical Issues in the Assessment of Competency*, 21 FOCUS 106 (2023), https://psychiatryonline.org/doi/epdf/10.1176/appi.focus.23022006.

86. 406 U.S. 715, 738 (1972).

87. *Id.* at 732.

88. *See generally* Andrew R. Kaufman, Bruce B. Way & Enrico Suardi, *Forty Years After* Jackson v. Indiana*: States' Compliance With "Reasonable Period of Time" Ruling*, 40 J. AM. ACAD. PSYCHIATRY L. 261, 261–62 (2012).

89. Steven K. Hoge, *Commentary: Resistance to* Jackson v. Indiana*—Civil Commitment of Defendants Who Cannot be Restored to Competence*, 38 J. AM. ACAD. PSYCHIATRY L. 359, 362–63 (2010).

90. *See generally* Alexandria Boutros, Seung Suk Kang & Nash N. Boutros, *A Cyclical Path to Recovery: Calling into Question the Wisdom of Incarceration After Restoration*, 57 INT. J.L. PSYCHIATRY 100 (2018), https://doi.org/10.1016/j.ijlp.2018.01.007.

91. *See* George F. Parker, *The Quandary of Unrestorability*, 40 J. AM. ACAD. PSYCHIATRY L. 171, 172 (2012).

92. *Id.* at 171–75.

93. *See, e.g.*, George Joseph & Simon Davis-Cohen, *Locked Up for Three Decades Without a Trial*, THE APPEAL (June 21, 2018), https://theappeal.org/locked-up-for-three-decades-without-a-trial/.

evaluation after competence is raised; (2) waiting for the evaluation report and for a hearing on the findings of that report; (3) waiting for a judicial decision after that hearing; (4) waiting for a restoration slot after incompetence is determined; (5) waiting for restoration status reports and hearings on those reports; or (6) waiting for a final legal determination of restoration. A separate issue arises when a defendant is deemed unrestorable. Once a person is found incompetent, the *Jackson* considerations come into play, and the obligation to initiate restoration service promptly begins.[94] Courts have ruled that patients cannot be held in competency restoration treatment after clinicians determine they are unlikely to have competency restored or they are no longer making progress towards that goal. Yet many states continue to house patients in forensic units, in some cases for years, after such a determination has been made, instead of moving them to more appropriate state hospital civil units or community placements.[95]

Historically, competency evaluation and restoration occurred exclusively in state psychiatric hospitals, and still does in some states, and by statute in the federal system.[96] Even now, most people who are referred for competency evaluations are institutionalized in one way or another, whether it be in jail or in a state hospital bed.[97] In response to the IST "bed" crisis, however, many states are innovating with new and additional sites in which competency evaluation and restoration can occur—primarily in jail or in community mental health settings.

A. Jail-Based Competency Restoration

Jail-based competency restoration (JBCR) has proliferated in recent years as a way to restore individuals found IST without a lengthy wait for scarce hospital beds. Its appeal is understandable—since many IST individuals are waiting in jail anyway, it makes a certain sense to attempt to restore them immediately rather than stacking hospital time on top of jail time, particularly for low-acuity patients. These programs are highly controversial given the widespread agreement that jail is not, and can never be, a therapeutic environment. JBCR first appeared in Virginia in 1997[98] and has grown steadily over the past decade, driven primarily by cost and the practicality of not having to transfer people off-site.[99] However, notwithstanding this growth, there are no established standards for what constitutes

94. NAT'L JUD. TASK FORCE TO EXAMINE STATE CTS.' RESPONSE TO MENTAL ILLNESS, LEADING REFORM: COMPETENCE TO STAND TRIAL SYSTEM 1 (2021), https://www.ncsc.org/__data/assets/pdf_file/0019/66304/Leading_Reform-Competence_to_Stand_Trial.pdf.

95. *See* Complaint at 24–28, J.H. v. Dallas, No. 1:15-cv-2057, ¶¶ 24–28 (Md. Pa. Oct. 22, 2015).

96. 18 U.S.C. § 4241(d).

97. *See supra* text accompanying notes 90–92.

98. Douglas Lewis Jr., Peter Ash, Victoria C. Roberts, Tomina J. Schwenke, Melvin Pagán-González & Glenn J. Egan, *Jail-Based Competency Restoration Services in the United States: The Need, the Controversy, the Impact of COVID-19, and Implications for Future Treatment Delivery*, 50 CRIM. JUST. BEHAV. 216, 218 (2023).

99. *See generally* H. Richard Lamb & Linda E. Weinberger, *The Shift of Psychiatric Inpatient Care from Hospitals to Jails and Prisons*, 33 J. AM. ACAD. PSYCHIATRY L. 529, 529 (2005).

an effective JBCR program.[100] The nature of the program varies depending on its jurisdiction; for example, the program could consist of a separate housing unit that looks like a jail but that operates like an inpatient facility, or the individual remains in general population and receives services through the jail's existing mental health program.[101]

Many scholars and practitioners have criticized the use of JBCR for many of the same issues that plague the carceral environment generally, which range from harsh to inhumane.[102] JBCR concerns include the lack of authority in jail settings to administer involuntary medication,[103] the conflicts of interest between maintaining security,[104] restoring competency, and evaluating competency, and the delay in treatment for individuals who do not respond to JBCR and subsequently require inpatient services.[105] For example, in Arizona, the JBCR program offered little assistance beyond normal jail conditions. A former staff psychologist described how conducting interviews with individuals was difficult, as he was required to talk through grates in cell doors or thick windows, or even in common areas without privacy. The psychologist said that "there is no in-patient mental health care . . . only varying degrees of confinement."[106] Further, harm from jail experiences, including JBCR, extend to collateral matters for IST patients like individuals losing benefits, housing, access to regular medical providers, or custody of their children.[107]

Defenders of JBCR tout its benefits as a stop-gap measure preferable to waiting in jail for a hospital bed without treatment and saving costs by streamlining

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100. Alan R. Felthous & Joseph D. Bloom, *Jail-Based Competency Restoration*, 46 J. AM. ACAD. PSYCHIATRY L. 364, 370 (2018); *see also* Jerry L. Jennings & Kevin Rice, *Future of Jail-Based Competency Treatment: Commentary from 30,000 Feet*, 1 ARCHIVES PSYCHIATRY 1, 4 (2022) (explaining that "there is no clear 'original protocol' for JBCT, and its historical development is an example of what *not* to do in terms of the following ideals of implementation science," namely, the "research evidence should be strong before implementation is justified," and there should be "careful planning and 'deliberate and purposive actions' to implement a new treatment").

101. Daniel C. Murrie, W. Neil Gowensmith, Lauren E. Kois & Ira K. Packer, *Evaluations of Competence to Stand Trial Are Evolving Amid a National "Competency Crisis,"* 41 BEHAV. SCI. L. 310, 315 (2023).

102. Felthous & Bloom, *supra* note 100, at 365–67; Reena Kapoor, *Commentary: Jail-Based Competency Restoration*, 39 J. AM. ACAD. PSYCHIATRY L. 311, 313 (2011).

103. Joseph D. Bloom & Scott E. Kirkorsky, *Treatment Refusal in Arizona's Jail-Based Competency to Stand Trial Restoration Programs*, 47 J. AM. ACAD. PSYCHIATRY L. ONLINE 233, 237 (2019).

104. *See generally* Jerry L. Jennings, Kevin Rice & Christopher Baglio, *Jail-Based Competency Treatment Comes of Age: Multi-Site Outcomes and Challenges to the Implementation of an Evidence-Based Forensic Continuum*, 39 BEHAV. SCI. L. 83 (2020), https://onlinelibrary.wiley.com/doi/epdf/10.1002/bsl.2501; Reena Kapoor, *A Continuum of Competency Restoration Services Need Not Include Jail*, 48 J. AM. ACAD. PSYCHIATRY L. 52, 55 (2020).

105. Peter Ash, Victoria C. Roberts, Glenn J. Egan, Kelly L. Coffman, Tomina J. Schwenke & Karen Bailey, *A Jail-Based Competency Restoration Unit as a Component of a Continuum of Restoration Services*, 48 J. AM. ACAD. PSYCHIATRY L. 43, 44 (2020).

106. Michael Kiefer, *This Program for Mentally Ill Defendants Mostly Focuses on Getting Them Fit for Trial*, AZ CENTR. (Dec. 11, 2018), https://www.azcentral.com/in-depth/news/local/arizona-investigations/2018/12/11/restoration-competency-jail-program-defendants-mental-illness-maricopa-county-superior-court/712133002/.

107. DISABILITY RTS. WASH., *supra* note 52, at 17.

services. At best, it has been described as a possible option on the "continuum of restoration services."[108] Although there are no established standards for JBCR programs, doctors have opined on some best practices, including more freedom of movement than usually permitted in jail, large communal areas that are "aesthetically discernible from standard jail housing units," and a quiet and relaxed environment.[109] Restoration rates in JBCR vary, and in some jurisdictions are comparable to inpatient restoration, although many people in JBCR may have lower acuity illnesses than those in-patient.[110] Other data seems to indicate that jail may be sufficient for some IST patients, but likely not for most patients.[111]

However, these reported benefits fail to consider non-carceral alternatives (which may be particularly effective for the same low-acuity patients who are likely to be restorable in JBCR) and the long-term effects of incarceration, as well as the ethical[112] and legal[113] concerns of jail-based services.[114] The resources necessary to establish JBCR programs flow mainly to for-profit correctional behavioral health companies, whose standards of care and oversight are generally lower than Medicaid-based programs. For example, many JBCR programs are run by correctional healthcare company Wellpath,[115] which has been investigated by Congress for deaths and other harms caused by chronic understaffing due to cost-cutting[116] and has recently declared bankruptcy.[117] They may also be incentivized to keep individuals in JCBR longer than necessary due to income incentives.[118] Funneling money into correctional healthcare also frustrates the larger goal of decarceration

108. Ash et al., *supra* note 105, at 51.

109. Scott E. Kirkorsky, Mary Gable & Katherine Warburton, *An Overview of Jail-Based Competency Restoration*, 25 CNS SPECTRUMS 624, 627 (2020).

110. Murrie et al., *supra* note 101, at 315, 317.

111. W. Neil Gowensmith, *Resolution or Resignation: The Role of Forensic Mental Health Professionals Amidst the Competency Services Crisis*, 25 PSYCH. PUB. POL'Y & L. 1, 9 (2019).

112. Kapoor, *supra* note 104, at 312.

113. *Id.*; *see also* Joseph D. Bloom & Scott E. Kirkorsky, *The Ninth Circuit Court of Appeals and Jail-Based Competency Evaluation and Restoration,* 49 J. AM. ACAD. PSYCHIATRY L. 415, 420 (2020) ("We hypothesize, however, that for jail-based competency restoration programs to pass the Ninth Circuit's scrutiny, Arizona would have to commit to statewide program elements including staffing, funding, public reporting of program data, and routine program evaluation.").

114. *See* Amber Beard, *Competency Restoration in Texas Prisons: A Look at Why Jail-Based Restoration Is a Temporary Fix to a Growing Problem*, 16 TEX. TECH ADMIN. L. J. 179, 187 (2014) ("The Journal believes that long-term jail-based competency restoration programs offer a temporary compromise and it is too early to determine long-term effectiveness.").

115. WELLPATH, https://wellpathcare.com/the-rise-restoring-individuals-safely-and-effectively-program/(last visited Mar. 18, 2025).

116. Blake Ellis & Melanie Hicken, *Senators Raise Alarm About Nation's Largest Prison Healthcare Provider*, CNN (Dec. 19, 2023), https://www.cnn.com/2023/12/19/us/wellpath-senators-investigation-invs/index.html.

117. Dietrich Knauth, *Wellpath Spins off Behavioral Health Unit in Bankruptcy*, REUTERS (Jan. 8, 2025, 6:00 PM), https://www.reuters.com/legal/government/wellpath-spins-off-behavioral-health-unit-bankruptcy-sale-2025-01-08/.

118. COLLEEN HORTON, HOGG FOUND. FOR MENTAL HEALTH, RESTORATION OF COMPETENCY TO STAND TRIAL (2013), https://hogg.utexas.edu/project/competency-restoration-policy-brief.

and resource shifting from incarceration to community investment and pursuing decriminalization of people with disabilities.[119]

B. Community-Based Competency Restoration

More promisingly, some states are innovating systems of community-based competency services, which may keep people free in the community and increase the likelihood of sustained recovery through continuity of care. Even state psychiatric hospitals are not necessarily sites of effective psychiatric recovery and are themselves frequently subjected to lawsuits challenging poor conditions, lack of effective treatment, abuse, and neglect.[120] Furthermore, the goal of "restoration" treatment is not the same as therapeutic recovery. Indeed, "successful" restoration merely returns an individual to the criminal and carceral systems from which they were referred. Comprehensive community-based mental health care and housing is needed to off-ramp criminalized people with disabilities at every stage of the competency process—diversion from arrest, from prosecution, from hospitalization, and re-entry from hospitalization following psychiatric stabilization. Furthermore, as the settlements examined here will demonstrate, in order to successfully keep waiting lists to constitutional levels, policy and treatment reform must also flow to patients in state hospital care who are not IST, but whose prolonged hospitalization puts pressure on state hospital beds.

Given that the drivers of the competency waitlist crisis—a failure to adequately fund mental health care and supportive housing in the community—are technically exogenous to the criminal legal system itself, the remedies needed are also largely outside it. The major cases motivating competency reform take aim not primarily at court or corrections systems (although coordination and capacity building are needed from these actors) but rather seek to force the hand of state health agencies to create the care systems whose absence leads to criminalization of mental illness.

There have been a number of litigation challenges to long IST waiting lists in multiple states, including (but not limited to) Oregon, Washington, Pennsylvania,[121] Colorado,[122] Louisiana,[123] Utah,[124] and Texas.[125] Comprehensive and functional settlement agreements or remedial orders have been reached, some following trial, in at

119. Lamb & Weinberger, *supra* note 99, at 529.

120. For example, the Oregon State Hospital, which is the primary facility providing competency restoration services for the state of Oregon, was found by the DOJ in violation of the Civil Rights of Institutionalized Persons Act by a number of measures, including failure to provide adequate care, overuse of restraint, and insufficient protection from harm. These findings were made four years after a court order mandating reforms to Oregon's IST waiting list. *See generally* Letter from Grace Chung Becker, Acting Assistant Att'y Gen., Off. Assistant Att'y Gen., to Theodore R. Kulongoski, Governor of Oregon (Jan. 9, 2008), https://www.justice.gov/sites/default/files/crt/legacy/2011/04/14/oregon_state_hospital_findlet_01-09-08.pdf.

121. Settlement Agreement at 4, J.H. v. Dallas, No. 1:15-cv-02057-SHR (M.D. Pa. Jan. 31, 2016).

122. Amended and Restated Settlement Agreement at 1, Ctr. for Legal Advoc. v. Barnes, No. 1:11-cv-02285-NYW (D. Colo. July 28, 2016).

123. Consent Decree at 7, La. Advoc. Ctr. v. La. Dep't of Health and Hosps., No. 2:10-cv-01088-SSV-JCW (E.D. La. Apr. 13, 2011).

124. Complaint at 3, Disability L. Ctr. v. Utah, No. 2:15-cv-00645-RJS (D. Utah Sept. 27, 2016).

125. Order on Plaintiffs' Motion for Class Certification at 2, Ward v. Young, No. 1:16-cv-00917 (W.D. Tex. Mar. 29, 2022).

least Oregon,[126] Washington,[127] Utah,[128] Colorado,[129] California,[130] and Pennsylvania.[131] Each of these agreements contain significant investments in community restoration programs, which allow IST patients to be evaluated and treated outside of confinement in either jail or a hospital. Most agreements also provide for increased hospital beds and some include jail-based restoration. As of 2020, thirty-five states permit out-patient restoration, but only sixteen have implemented formal community-based restoration programs.[132] Unfortunately, that number has stayed more or less stagnant in recent years, while JCBR programs continue to rise.

Community-based competency restoration programs have demonstrated notable success. For example, in 2021, due to its introduction of "competency dockets" in a number of criminal courts, 63% of Colorado's initial competency evaluations happened in jail, while 37% were conducted in community settings. By December 2023, the percentages almost reversed, with 67% of evaluations occurring in the community and only 33% in jail.[133] 51% of people were ordered to receive restoration services in the community.[134] Studies have found that people in community-based restoration services are restored to competency in 70% of cases, competitive with other settings, for less than half the cost of hospital care.[135]

III. FOUNDATIONAL CASES ESTABLISHING COMMUNITY BASED CARE

Given the constitutional repugnance of long periods of confinement either in jail or in state psychiatric hospitals for IST patients, it is worth exploring in detail settlements in lawsuits that have instead expanded community care and housing options in controlling IST waiting lists—namely, *Oregon Advocacy Center v. Mink*[136] and *A.B. ex rel. Trueblood v. Washington State Department of Social and Health Services*.[137] These two cases are not comprehensive of all such settlements—cases in other states including Pennsylvania[138] and Colorado[139] have also resulted in

126. Plaintiffs' Unopposed Motion for Order to Implement Neutral Expert's Recommendations at 6, Or. Advoc. Ctr. v. Mink, No. 3:02-cv-00339-MO (D. Or. Aug. 15, 2022).

127. *See generally* Defendant's Long-Term Plan, Trueblood v. Wash. State Dep't of Soc. and Health Servs., No. 2:14-cv-01178-MJP (W.D. Wash. July 2, 2015).

128. Joint Motion for (1) Approval of Settlement Agreement and Class Notices, (2) Appointment of Monitor, and (3) Stay of Proceedings, Disability L. Ctr. v. Utah, No. 2:15-cv-00645-RJS (D. Utah Sept. 27, 2016).

129. Amended and Restated Settlement Agreement, *supra* note 122, at 1.

130. Stiavetti v. Clendenin, 280 Cal. App. 5th 691, 737–38 (Cal. Ct. App. 2021).

131. Settlement Agreement, *supra* note 121, at 3.

132. Bell et al., *supra* note 37, at 2.

133. Flowers, *supra* note 40.

134. *Id.*

135. Graham S. Danzer, Elizabeth M.A. Wheeler, Apryl A. Alexander & Tobias D. Wasser, *Competency Restoration for Adults in Different Treatment Environments*, 47 J. AM. ACAD. PSYCHIATRY L. ONLINE 1, 9–10 (Feb. 8, 2019), https://jaapl.org/content/jaapl/early/2019/02/08/JAAPL.003819-19.full.pdf.

136. *See generally* Plaintiffs' Unopposed Motion for Order to Implement Neutral Expert's Recommendations, *supra* note 126.

137. *See generally* Defendant's Long-Term Plan, *supra* note 127.

138. Settlement Agreement, *supra* note 121, at 3.

139. Amended and Restated Settlement Agreement, *supra* note 122, at 5.

court-ordered expansion of community-based services and supportive housing options. It is also worth recognizing that JBCR remains an option on the so-called "continuum of care" in many systems (e.g. California[140]), which also use community-based restoration and housing models. Others (e.g. Washington[141] and Pennsylvania[142]) have prohibited use of JBCR as an acceptable strategy to reduce waitlists in the context of such litigation. However, the lengthy periods of settlement, enforcement, and implementation in these leading cases demonstrate both the complexity and the necessity of moving beyond a jail-hospital "bed space" paradigm to one that recognizes and seeks to holistically remedy the systemic and trans-institutional drivers of the criminalization of mental health disability.

A. Mink

Mink is the foundational case establishing that the Department of Human Services and the Oregon State Hospital (OSH) violated due process by failing to transfer defendants to an appropriate state hospital in a timely manner. The district court added teeth to the *Jackson* decision by granting an injunction finding that people found incompetent to stand trial were entitled to prompt treatment, which it defined as admission to a state hospital within seven days of a finding of incapacity. The Ninth Circuit upheld the district court's injunction over the defendant's appeal.[143]

Notably, the Oregon Advocacy Center (now called Disability Rights Oregon[144]), the protection and advocacy agency for the state of Oregon, filed *Mink*. Protection and Advocacy agencies are uniquely positioned to challenge IST waiting lists. The Protection and Advocacy (P&A) System is a nationwide network of congressionally-mandated disability rights agencies in each state and territory. They have the authority to provide legal representation and advocacy under the Developmental Disabilities Assistance and Bill of Rights Act (the DD Act) and related statutes[145] to all people with disabilities.[146] Crucially, their implementing regulations provide for the right of access to "service providers, individuals with developmental disabilities, and records . . . that are necessary for a P&A system to make a determination about whether alleged or suspected instances of abuse and neglect are taking place or have taken

140. CAL. PENAL CODE § 1369(a) (West 2009).

141. Trueblood v. Wash. State Dep't of Soc. & Health Servs., 101 F. Supp. 3d 1010, 1023–24 (W.D. Wash. 2015).

142. Jail-based competency restoration is permitted in Pennsylvania. *See* OFF. MENTAL HEALTH SUBSTANCE ABUSE SERVS., DEP'T HUM. SERVS., COMMONWEALTH OF PA.,PROCEDURE 5 – JAIL-BASED COMPETENCY RESTORATION (2019), https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/services/assistance/documents/individual-pages/forensic-wait-list/Foresic%20Wait%20List%20-%20Procedures.pdf. However, per the terms of the settlement agreement in *J.H. v Dallas*, no jail-based competency placements can count toward the additional treatment slots ordered by that settlement. Settlement Agreement, *supra* note 121, at 4.

143. Or. Advoc. Ctr. v. Mink, 322 F.3d 1101, 1122–23 (9th Cir. 2003).

144. *About Us*, DISABILITY RTS. OR., https://www.droregon.org/about (last visited Feb. 22, 2025).

145. 42 U.S.C. §§ 15041–45; 45 C.F.R § 1326.19–24; 42 U.S.C. §§ 10801–07, 10821–27; 29 U.S.C. § 794e; 29 U.S.C. § 3004; 42 U.S.C. § 1320b-21; 42 U.S.C. § 300d-53; 52 U.S.C §§ 21061–62.

146. *See About,* NAT'L DISABILITY RTS. NETWORK, https://www.ndrn.org/about/(last visited Feb. 22, 2025).

place."[147] The statute further clarifies that the facilities to which P&As have access "may include, but need not be limited to, hospitals, nursing homes, community facilities for individuals with mental illness, board and care homes, homeless shelters, and jails and prisons."[148] This means that P&As have unparallelled ability to enter into, monitor, and investigate jails, psychiatric facilities, and community service providers alike, giving them an unusually expansive understanding of the multiple systems implicated in the competency process. The multiplicity of state agencies and legal processes involved in the process creates fissures in oversight, information and authority which tend to exacerbate delays and bottlenecks in the system.

For example, once a competency evaluation has been ordered, the criminal process pauses. Public defenders have little access to their clients while they await and during the evaluation and restoration process, and additionally have no role in those decisions. Absent specific statutory authority, judges tend to defer to health agencies and their representations in relation to bed space, appropriate length of time needed for restoration, etc. P&As, with their trans-institutional oversight powers, are ideally situated to identify rights violations and remedies that occur across behavioral health and criminal legal facilities and legal, regulatory, and service systems.

As a procedural matter, P&As also possess standing rights to act as plaintiffs in federal litigation on behalf of people with disabilities. The Oregon P&A did so in the *Mink* case,[149] thereby avoiding common problems of mootness for plaintiffs who are likely to be moved in and out of jails and hospitals as the competency process unfolds. The P&As' power to assert organizational and associational standing also helps to avoid any potential issues related to the strict pleading requirements of the Prison Litigation Reform Act[150] that might arise in cases where plaintiffs are held in jail, as they were in this case.

Mink is the first case to insist not only on a specific timeline for IST services, but also that "[l]ack of funds, staff or facilities cannot justify"[151] delays in treatment. This finding opened up a field for greater investment in the provision of these services. The simplicity of the court's order—that state hospitals must accept IST referred people within seven days of a finding of incapacity—belies the enormous transformation in the delivery of forensic mental health services that are necessary to comply with this order and to effectively decarcerate people with disabilities from jail.

The complexity and difficulty of sustaining the seven-day maximum period came to a head more than a decade after the *Mink* order when plaintiffs filed for

147. 45 C.F.R § 1326.19.

148. 42 U.S.C. § 10802.

149. Or. Advoc. Ctr. v. Mink, 322 F.3d 1101, 1110 (9th Cir. 2003) (finding Oregon P & A had standing to bring case on behalf of individuals detained in jail awaiting competency evaluations and treatment at the state hospital).

150. 42 U.S.C § 1997e.

151. *Mink*, 322 F.3d at 1121 (quoting Ohlinger v. Watson, 653 F.2d 775, 779 (9th Cir. 1980)).

sanctions after the Oregon Health Authority fell out of compliance with the 2002 injunction.[152] In 2019, patients were waiting on average twenty-six days in jail for transfer to a state psychiatric facility.[153] In June of that year, the court ordered the state to comply within ninety days.[154] In response to the order, the Oregon Health Authority sought legislative assistance for what it called a "dramatic increase" in competency orders, which it attributed to rising homelessness and increased criminalization of people experiencing homelessness.[155] It further requested expanded community restoration placements, in which a patient could receive competency treatment outside a hospital or jail setting, and better transition planning for hospitalized IST patients who no longer required hospitalization.[156] The Oregon Health Department's request for increased investment in community health and housing in order to reduce the jail IST waitlist was a recognition that the liberty interests at the heart of the Fourteenth Amendment are not realizable in practice without the rights to health and housing that are still under-legislated.

The Oregon legislature responded to the 2019 litigation and the Oregon Health Authority's requests by passing Senate Bill 24. That law prohibits IST individuals charged with misdemeanors from being committed to the hospital except in cases of a finding of dangerousness or extreme acuity of symptoms that can only be managed in the hospital.[157] People charged with felonies are also subject to a higher level of scrutiny before hospitalization, such that the least restrictive option is imposed, with regular reviews of available community resources and assessments to determine whether their needs could be met in the community.[158]

Passing IST individuals from jail to the hospital created unconstitutionally long confinement times[159]—either in jail awaiting treatment, or in the hospital awaiting release—as a result of the state's failure to provide affordable housing and robust community mental health treatments. Furthermore, the influx of IST cases created conflicts over bed space in the state psychiatric hospitals between people requiring court-ordered hospitalization due to civil commitment processes[160] and criminal defendants requiring commitment after being found "guilty except for insanity"

152. *See Lawsuit: Providing Restorative Treatment When Unable to Aid and Assist in Defense*, DISABILITY RTS. OR., https://www.droregon.org/litigation-resources/oregon-advocacy-center-v-mink (last visited Mar. 10, 2025).

153. *Id.*

154. *Id.*

155. *See* Memorandum from Oregon Health Auth. to Governor Kate Brown (June 7, 2019), https://www.oregon.gov/oha/Documents/Memo-Actions-to-address-capacity-crisis-at-the-Oregon-State-Hospital.pdf (stating that sixty percent of its "aid and assist" (IST) patients were homeless).

156. *Id.*

157. OR. HEALTH AUTH., SENATE BILL 24–WHAT YOU NEED TO KNOW 2, https://www.oregon.gov/oha/OSH/LEGAL/Documents/2019-SB-24-FAQ.pdf.

158. *Id.*

159. *See* Jackson v. Indiana, 406 U.S. 715 (1972).

160. *See* Jayati Ramakrishnan, *Hospitals Sue Oregon Health Authority Over Failure to Provide Mental Health Facilities for Patients*, OREGONIAN (Sept. 7 2023, 1:01 PM), https://www.oregonlive.com/health/2022/09/hospitals-sue-oregon-health-authority-over-failure-to-provide-mental-health-facilities-for-patients.html.

(GEI).[161] Oregon psychiatrists commenting on the crisis in 2023 stated that the crisis demonstrated that "civil and criminal commitment should be viewed as parts of a single underfunded mental health system when it comes to the psychiatric treatment of these legally derived patient groups."[162] The Metropolitan Public Defender Services (Portland's public defender organization) joined Disability Rights Oregon's 2019 lawsuit, combining a separate case about waitlists for the GEI population,[163] and confirming the linked destinies of these two populations subject to court-ordered hospitalization.[164]

An interim settlement in the consolidated cases was reached in 2021, appointing a neutral expert to make recommendations for resolving the IST crisis.[165] The court has ordered implementation of the expert's (Dr. Debra Pinals) recommendations, which include limitations on which patients can be admitted to OSH, a decreased period of time in which people can be held at the hospital based on the seriousness of the accusation, and discharge of at least one hundred patients who had been committed for longer than the newly established maximum of three years. The expert's periodic reports[166] and regular meetings of all the parties (which now include District Attorneys and state hospital systems who have sought to intervene in the proceedings) are still ongoing. As of April 2024, the parties filed a joint status report[167] noting a marked improvement in wait times. However, Disability Rights Oregon filed a contempt motion in January 2025[168] alleging that the state was again out of compliance with regard to wait times, leading to the death of at least two people on the waitlist in jail.[169]

The contempt filing emphasizes that the elements of the neutral expert's improvement plan that the state has failed to implement include the failure to timely discharge long-term patients at the state hospital, which would make beds available for new competency patients.[170] This sticking point makes clear that it is not possible to effectively pursue the decarceration of people criminalized for disability without also expanding protection of the liberty interests of disabled people who are confined for non-criminal purposes. The contempt filing points out, for

161. *See* OR. REV. STAT. § 161.325 (2025).

162. Thomas E. Hansen, Amela Blekic & Joseph D. Bloom, *COVID-19,* Mink-Bowman*, and Court Ordered Psychiatric Services in Oregon,* 51 J. AM. ACAD. PSYCHIATRY & L. ONLINE 411, 411 (2023), https://jaapl.org/content/jaapl/51/3/411.full.pdf.

163. Bowman v. Matteucci, No. 21-cv-01637, 2021 WL 5316440, at *3 (D. Or. Nov. 15, 2021).

164. Disability Rts. Or. v. Allen, No. 02-cv-00339, 2023 WL 144159, at *1 (D. Or. Jan. 9, 2023).

165. Interim Agreement at 1, Or. Advoc. Ctr. v. Mink, No. 02-cv-00339 (D. Or. Dec. 17, 2021), ECF No. 238-1 (consolidating *Mink* and *Bowman*).

166. *See, e.g.*, June 3, 2024 Progress Report to Neutral Expert, Or. Advoc. Ctr. v. Mink, No. 02-cv-00339 (D. Or. June 3, 2024).

167. *See* April 3, 2024, Progress Report to Neutral Expert, Or. Advoc. Ctr. v. Mink, No. 02-cv-00339 (D. Or. Apr. 3, 2024).

168. Plaintiff Motion for Contempt & Remedial Order, Or. Advoc. Ctr v. Mink, No. 02-cv-00339 (D. Or. Jan. 7, 2025).

169. *Id.* at 3.

170. *See id.* at 15–16.

example, that the Oregon Legislative Fiscal Office noted that "Oregon ranks 48th in the nation for mental health services . . . [and] scored particularly bad in terms of prevalence of mental illness and adults with any mental illness reporting unmet needs."[171] There is a direct line of causality between this failure to invest in comprehensive community mental health services, and the excessive criminalization and incarceration of people with mental health disabilities.

Even psychiatrists who favor hospital-based (as opposed to community-based) restoration have acknowledged that Oregon's state hospitals alone "will never have the requisite number of beds to meaningfully serve the needs of the civil and criminal courts. OSH . . . will need to continue to provide services to the courts . . . but the real long-term answer is now to be found in the community."[172] Services "in the community" mean not only an increase in the availability of outpatient restoration services, but also, as *Mink* reveals, sufficient services to allow already hospitalized people to leave institutions and live freely, integrated into public life with adequate supports and accommodations. This linkage of broader investment in community mental health systems as a comprehensive remedy to the IST waitlist crisis is one of the enduring lessons of the *Mink* case, and the primary reason why the 2003 injunction is still in active enforcement litigation. While the road to state compliance with the due process guarantees of people subjected to competency proceedings is far from easy, the way forward is clear.

B. Trueblood

A.B. ex rel. *Trueblood v. Washington State Department of Social and Health Services*[173] was also filed by a P&A, Disability Rights Washington,[174] along with partner organizations in a class action against Washington State Department of Social and Health Services (DSHS) for failing to provide timely competency evaluation and restoration services to the class members, violating their due process rights. Following a bench trial, in 2015, the court issued a permanent injunction requiring that defendants cease violating the constitutional rights of class members by providing competency services in a timely manner.[175] The permanent injunction followed *Mink* by (1) declaring that incarcerating class members for more than seven days while they wait for defendants to provide competency restoration services violates the Due Process Clause of the Fourteenth Amendment, and (2) requiring competency evaluations within seven days of a court order to do so.[176] It also

171. *Id.* at 13 (alteration in original) (quoting LEGIS. FISCAL OFF., 2021-23 BUDGET REVIEW 7 (2021), https://olis.oregonlegislature.gov/liz/2021R1/Downloads/CommitteeMeetingDocument/230880).

172. Hansen et al., *supra* note 162, at 418.

173. 101 F. Supp. 3d 1010 (W.D. Wash. 2015).

174. DISABILITY RTS. WASH., www.disabilityrightswa.org (last visited Feb. 19, 2025).

175. *Trueblood*, 101 F. Supp. 3d at 1023–24.

176. *Id.* This was later amended to fourteen days after the Ninth Circuit reversed, saying the time period was too short. *See* A.B. *ex rel.* Trueblood v. Wash. State Dep't of Soc. & Health Servs., 822 F.3d 1037, 1046 (9th Cir. 2016).

ordered that defendants must prepare a long-term plan on how they would continue to provide services within these time frames, despite growing demand for services.[177] The court additionally appointed a monitor to oversee implementation and provide regular reporting.[178]

In providing for long-term planning, monitoring, and reporting from the outset of the injunction, *Trueblood* anticipated some of the long-term implementation challenges that took nearly two decades to be hammered out in Oregon. Perhaps predictably, on February 8, 2016, the court granted an order modifying its permanent injunction after finding that DSHS was not complying with the timing requirement.[179] Because the court observed that allowing DSHS to create its own schedule resulted in an *increase* in wait times since the trial, the modified injunction set a series of interim deadlines for the completion of specific actions.[180] The modified injunction also ordered defendants to submit a revised long-term plan and increased oversight by the court monitor.[181] In July 2016, the court held defendants in contempt for failing to take the necessary steps to provide timely inpatient competency restoration services and imposed monetary sanctions to compel compliance.[182] The court again held defendants in contempt in October 2017 and imposed sanctions, this time because defendants were failing to provide in-jail competency evaluations in a timely fashion.[183]

The parties negotiated a broad settlement agreement in respect of the contempt orders, which was approved in 2018.[184] The agreement focused on improving services and options to divert individuals out of criminal prosecution and the competency restoration system.[185] The settlement was implemented in phases, allowing for improvements to programs depending on the success of each phase. It had a number of requirements and specific timelines for evaluation, admission, and restoration, and required that the state make significant and specific investments in achieving these, including:

177. *Trueblood*, 101 F. Supp. 3d at 1024.

178. *Id.*

179. Order Modifying Permanent Injunction, A.B. *ex rel.* Trueblood v. Wash. State Dep't of Soc. & Health Servs., No. 14-cv-01178, 2016 WL 4533611 (W.D. Wash. Feb. 8, 2016).

180. *Id.*

181. *Id.*

182. Order of Civil Contempt, A.B. *ex rel.* Trueblood v. Washington State Dep't of Soc. & Health Servs., No. 14-cv-01178 (W.D. Wash. July 7, 2016), ECF No. 289.

183. Order on Plaintiffs' Second Motion for Civil Contempt: Jail-Based Evaluations, Trueblood v. Wash. State Dep't of Soc. & Health Servs., No. 14-cv-01178, 2017 WL 4700326 (W.D. Wash. Oct. 18, 2017).

184. Order Granting Final Approval of Amended Settlement Agreement, A.B. *ex rel.* Trueblood v. Washington State Dep't of Soc. & Health Servs., No. 14-cv-01178 (W.D. Wash. Dec. 11, 2018), ECF No. 623.

185. *See* Amended Joint Motion for Preliminary Approval of Settlement Agreement Attachment A, A.B. *ex rel.* Trueblood v. Wash. State Dep't of Soc. & Health Servs., No. 2:14-cv-01178 (W.D. Wash. Oct. 25, 2018), ECF No. 599-1.

- Seeking funding in order to hire additional forensic evaluators and forensic navigators and implement a data system to anticipate future demand.[186]
- Supporting legislative amendments to reduce the number of people ordered into competency evaluation and restoration and to seek funding to roll out community outpatient restoration services, including residential support for unhoused people.[187]
- Opening additional forensic beds at state hospitals.[188]
- Seeking funding to increase mobile crisis response services, build new crisis stabilization facilities, and to provide law enforcement with qualified mental health professionals to promote diversion from arrest and enhanced behavioral health crisis training.[189]
- Developing an enhanced peer support program.[190]
- Developing significant intensive case management and housing support services for class members.[191]

These requirements reflect a holistic and preventative approach to both anticipating and reducing the IST waitlist, with attention not only to capacity of mental health services but also to diversion from criminalization by attempting to reduce arrests through interventions in policing and mental health emergency response.

On June 27, 2019, DSHS submitted its implementation plan,[192] and submitted quarterly implementation status reports through 2021.[193] However, in December 2022, plaintiffs moved for contempt and material breach of settlement.[194] The basis of the motion was the state's dedication of inpatient competency restoration beds to long term civil commitment patients instead of class members increasing projected wait times for inpatient restoration to over ten months. In July 2023, the court found that DSHS had breached a portion of the 2018 settlement agreement by failing to provide the negotiated-for bed space for class members in state hospitals.[195] The court also found DSHS in contempt of the permanent injunction by denying class members timely services. The court made additional orders to protect forensic beds from being occupied by long term civil commitment patients, enforced by significant fines, totaling $100,318,000.[196] This conflict mirrors the

186. *Id*. at 8, 13.

187. *Id*. at 9–10.

188. *Id*. at 19.

189. *Id*. *passim*.

190. *Id*. at 32–33.

191. *Id*. at 28.

192. Declaration of Nicholas Williamson, Attachment A, A.B. *ex rel*. Trueblood v. Wash. State Dep't of Soc. & Health Servs., No. 2:14-cv-01178 (W.D. Wash. June 27, 2019), ECF No. 679-1.

193. AB v DSHS (Trueblood): *Reforming Washington's Forensic Mental Health System*, DISABILITY RTS. WASH., https://disabilityrightswa.org/cases/trueblood/(last visited Apr. 19, 2025) (collecting reports).

194. Plaintiff's Motion for Material Breach of Contempt Settlement Agreement and Motion for Civil Contempt, A.B. *ex rel*. Trueblood v. Wash. State Dep't of Soc. & Health Servs., No. 14-cv-01178 (W.D. Wash. Dec. 22, 2022), ECF No. 938.

195. A.B. *ex rel*. Trueblood v. Wash. State Dep't of Soc. and Health Servs., 681 F. Supp. 3d 1149, 1176 (W.D. Wash. 2023).

196. *Id*. at 1179–80.

friction over bed space as between civil commitment and IST patients seen in the *Mink* implementation.

As in Oregon, implementation of the injunction and settlement necessitated multiple legislative amendments. In 2019, pursuant to the agreement, the governor signed SB 5444.[197] Previously, "an individual charged with a misdemeanor could be ordered into competency restoration with the same process as someone charged with a felony."[198] But after the changes enacted in SB 5444, "an individual charged with a misdemeanor crime cannot be ordered into competency restoration unless the prosecuting attorney first establishes that there is a 'compelling state interest' to order competency restoration treatment for that individual."[199] This reform goes farther than the limitations on in-patient restoration in the Oregon legislation, with the aim of diverting most misdemeanor defendants away from competency proceedings altogether. Furthermore, DSHS engages in active outreach to the courts "that refer the highest number of misdemeanor restoration orders and remains engaged in ongoing discussions with the Court Monitor and Plaintiff's counsel about how to reduce these referrals."[200] In 2023, this law was further amended to require courts to consider "all available and appropriate alternatives" to inpatient competency restoration, including developing diversion programs for defendants charged with non-felony crimes.[201] Unfortunately, despite these interventions, misdemeanor competency rates have not reduced but have, in fact, increased as of September 2024.[202]

Implementation of the injunction has taken place in multi-year phases, with extensive data reporting showing class member data more or less in real time.[203] As of April 2025, DSHS's *Trueblood* website states that, after more than $2 billion invested, it completed in-jail competency evaluations within fourteen days 83.3% of the time in 2024 and that it "consistently offers" *Trueblood* class members beds in inpatient facilities within seven days.[204] Contempt fines have been reinvested

197. *Trueblood Bill, SB 5444, Signed by Governor*, DISABILITY RTS. WASH. (May 16, 2019), https://disabilityrightswa.org/trueblood-bill-sb-5444-passes-in-house-and-senate/.

198. *Misdemeanor Competency Restoration*, WASH. STATE DEP'T OF SOC. & HEALTH SERVS., https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/misdemeanor-competency-restoration (last visited Apr. 19, 2025).

199. *Id.*

200. *Id.*

201. S.B. 5440, 68th Leg., Reg. Sess. (Wash. 2023).

202. *See Misdemeanor Competency Restoration*, WASH. STATE DEP'T OF SOC. & HEALTH SERVS, https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/misdemeanor-competency-restoration (last visited May 25, 2025).

203. *See Court Monitor Reports*, WASH. STATE DEP'T OF SOC. & HEALTH SERVS, https://www.dshs.wa.gov/bha/court-monitor-reports (last visited Apr. 20, 2025) (database of monthly progress reports for court monitor).

204. Trueblood, et al. v. Washington State DSHS, WASH. STATE DEP'T OF SOC. & HEALTH SERVS., https://www.dshs.wa.gov/bha/trueblood-et-al-v-washington-state-dshs (last visited Apr. 20, 2025).

into mental health and housing services not already provided by the state or required by the settlement.[205]

The contempt and enforcement proceedings in *Trueblood*, more so than any other state litigation on these matters, has resulted in material budgetary investment, in the form of contempt fines administered in part by the plaintiff, Disability Rights Washington, into community-based alternatives to incarceration and institutionalization.[206] This outcome demonstrates that, where the state legislature's failures to invest in community mental health programs are insufficient to secure the due process rights of criminalized people with mental health disabilities, such investment can and must be made directly by court order.

IV. ELEMENTS OF A SUCCESSFUL IST WAITLIST SETTLEMENT

A review of the *Mink* and *Trueblood* settlement agreements and multi-year implementation begin to provide an outline of the necessary elements of a constitutionally viable IST system. They mark a significant departure from the *Jackson* days, in which courts took a hands-off approach to competency procedures, deferring to the decisions, timelines, and confinement standards of Departments of Health. They instead recognize that courts, legislatures, departments of health, jails, and community service providers must each be active participants in establishing sufficient capacity across the system to avoid over-confinement of people with mental health disabilities throughout the system. Statutory,[207] regulatory, and budgetary changes are necessary to implement court orders. Touchstones of these effective settlements include:

- Firm and enforced timelines: Ongoing enforcement measures in *Mink* and *Trueblood* demonstrate that competency system bottlenecks occur at more than one temporal location. It is not enough to place time limits on the waiting period between a court order to competency restoration and transfer to services. Rather, limits need to be placed at every stage of proceedings, including: (1) time from referral to evaluation to evaluation itself; (2) time spent in restoration treatment itself, (3) transition from forensic to civil treatment status and (4) transition from confinement to the community.
- Data Reporting and Transparency: Both the *Mink* and *Trueblood* settlements have produced regular, accurate, and public data dashboards[208] showing occupancy levels, waiting times, and progress against settlement objectives. This transparency allows for ongoing adjustments, recognition

205. *See, e.g.*, S.B. 5693, 67th Leg., Reg. Sess. (Wash. 2022); WASH. STATE HEALTH CARE AUTH., TRUEBLOOD DIVERSION PROGRAM 2–9, (June 30, 2023), https://www.hca.wa.gov/assets/program/leg-report-trueblood-diversion-program-20230612.pdf.

206. *See supra* note 205.

207. *See generally* Susan McMahon, *Reforming Competency Statutes: An Outpatient Model*, 107 GEO. L.J. 601 (2019) (discussing proposed statutory reforms).

208. *See Court Monitor Reports*, *supra* note 203; *Oregon State Hospital* Mink-Bowman *Order Compliance*, OR. HEALTH AUTH., https://www.oregon.gov/oha/osh/pages/mink-bowman.aspx.

of system weaknesses, and accountability. This is a far cry from the pre-lawsuit days when IST patients, public defenders, and judges were at the mercy of state health department representations about capacity and waiting times.

- Diversion from criminalization: Both the *Mink* and *Trueblood* settlements eventually recognized the need for front-end decriminalization efforts, making both legislative changes and budgetary investments to provide for alternatives to police emergency response, police and prosecutor-led diversion from arrest and prosecution for people with mental health and other cognitive disabilities into appropriate supportive community programs.
- Major investment in community placements: Community care is the primary mechanism by which decarceration and deinstitutionalization of people with disabilities occurs. Its absence is the primary driver of their criminalization. States must work to repair comprehensive mental health systems that have been ravaged by austerity measures. Ideally, this investment should go beyond temporary placements for IST patients and should recognize that their widespread availability and full funding are necessary to prevent future arrests and hospitalizations.[209]
- Supportive housing investments: Community placements are often unsuccessful in situations where the individual is unhoused.[210] States that have successfully moved individuals out of the jail and hospital context must invest in supportive housing for at least the duration of the competency process and ideally open up a pathway to permanent supportive housing in order to prevent future cycling through jail and hospital. Housing is essential for recovery and public safety.
- Better transition planning: Off-ramps from institutionalization to community integration are essential at multiple touchpoints of hospitalization, and must apply to civil as well as criminal placements. Its success depends, of course, on the existence of community placements to which to discharge people,[211] making these two elements of a settlement deeply interdependent.
- Workforce development: The *Mink* and *Trueblood* courts have made clear that they will not accept lack of resources or staffing to act as a defense against unconstitutionally long periods of confinement. Increases in forensic personnel must be budgeted for, as well as incentives to recruit and retain qualified staff.

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209. Recent research confirms that Medicaid expansion reduces arrest rates. *See* Jessica T. Simes & Jaquelyn L. Jahn, *The Consequences of Medicaid Expansion Under the Affordable Care Act for Police Arrests*, PLOS ONE (Jan. 12, 2022), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0261512.

210. *See* HALLIE FADER-TOWE & ETHAN KELLY, COUNCIL OF STATE GOV'TS JUST. CTR., JUST AND WELL: RETHINKING HOW STATES APPROACH COMPETENCY TO STAND TRIAL *passim* (2020), https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf.

211. *See* WASH. STATE DEP'T OF SOC. & HEALTH SERVS., STATE HOSPITAL WARD SIZES, DISCHARGE PRACTICES, AND COMMUNITY PLACEMENT ISSUES 4 (2009), https://www.dshs.wa.gov/sites/default/files/legislative/documents/StateHospitalSizes.pdf.

V. ONGOING CHALLENGES

Beyond the policy advances in these settlements, there are other issues that must be addressed in order to reduce the criminalization of disability. The criminalization of homelessness and the state of mental health care provision in jails are two notable challenges that should be addressed in order to more sufficiently effect decarceration within a disability framework.

A. Criminalization of Homelessness

Primary among these challenges is homelessness and its criminalization, an area of significant constitutional backsliding which threatens to undermine much of the progress made under *Mink*, *Trueblood*, and their ilk. The Supreme Court's recent decision in *City of Grants Pass v. Johnson* found a city ordinance that effectively criminalized homelessness to be constitutional.[212] Notably, the ordinance in question was enacted in Oregon, the same state as *Mink*, and in the same circuit of the case *Grants Pass* overturned, *Martin v. City of Boise*[213] (which had previously held at bay such ordinances in the Ninth Circuit). This means that *Grants Pass* now invites increased criminalization of homelessness in the very same communities in Oregon, Washington, and California in which IST-waiting-list litigation has occurred. Given the strong intersections between homelessness and mental health disability, the increased criminalization of homelessness that is now constitutionally permissible is likely to put new and additional pressure on competency systems in those states and others.

B. Mental Health Care in Jails

The rise of jail-based competency restoration in some ways complicates and obscures the urgent need for improved mental health care in jails and the ways in which jail conditions produce distress and disability. Ultimately, restoration services are not coterminous with comprehensive mental health treatment. While jail can never be a therapeutic environment, and the decriminalization and decarceration of people with disabilities must be a primary intervention, as long as people with mental health needs are jailed, a constitutionally sufficient level of care must be provided. This is true not only for people referred for competency evaluation and restoration, but also for non-IST individuals who reside in jails and for those who have been restored and are transitioning back into a jail environment. At the same time, the rise of jail-based mental health programs[214] and jail mental units in general risk reinforcing the role of jails as appropriate settings for people with

212. 603 U.S. 520, 521 (2024).

213. 920 F.3d 584 (9th Cir. 2019) (abrogated by *Grants Pass*, 603 U.S. at 521).

214. *See, e.g.*, *Wellpath and the California Department of State Hospitals Work Together to Implement Early Access and Stabilization Services for Incarcerated Patients*, WELLPATH (Nov. 22, 2022), https://wellpathcare.com/2022/11/22/wellpath-and-the-california-department-of-state-hospitals-work-together-to-implement-early-access-and-stabilization-services-for-incarcerated-patients/.

mental health disabilities. This may result in acceptance of a degraded quality of care and confinement for IST patients who would be better served in the community. This is the central tension present for all who seek to improve outcomes for criminalized people with mental health conditions but is one which cannot currently be avoided. Somehow our movements must both ensure adequate treatment in jail, while decentering incarceration as an appropriate setting, even temporarily, for people within this class of disability and need.

CONCLUSION

The *Mink* and *Trueblood* cases and their long, complicated road to implementation are in many ways a final reckoning with the unfinished promise of the deinstitutionalization movement. They make plain the impossibility of ever building enough beds, either in hospitals or in jails, to house all people criminalized for disability and who are IST, without a return to the unconstitutional liberty violations associated with the long-term warehousing of disabled people from centuries past.

As the complex, multi-year, multi-agency settlement implementation processes in Oregon and Washington demonstrate, it is not easy to build a statewide mental health system where there once existed only a binary choice between jail and involuntary hospitalization. Surely, the *Jackson* court could not have anticipated that its insistence on the unconstitutionality of indefinite confinement of the IST population required a wholesale reinvestment and reorganization of health systems, greater provision of community-based services, and diversion from the criminal legal system. Yet, for many states, that is exactly what it takes to avoid unconstitutional confinement of people with disabilities. It is also exactly what the disability justice movement has demanded since the mid-twentieth century to end the warehousing of disabled people into institutions. Competency is the hardest edge of widespread failures to provide comprehensive mental health care systems and supportive and affordable housing. It is in the bowels of jails that we find the consequences of those failures, and it is in that confinement that the Constitution finally finds these failures intolerable. Can states build comprehensive mental health systems out of a single lawsuit against one small aspect of these underfunded systems? It seems that they must.

Angela Davis has said, "[a]bolition is not primarily a negative strategy. It's not primarily about dismantling, getting rid of, but it's about re-envisioning. It's about building anew."[215] In this light, cases challenging IST waiting lists are a kind of abolitionist praxis. They recognize that simply closing jails or psychiatric hospitals may not in itself produce liberation, without simultaneously building material care for each individual in need of it. They force siloed state authorities to collaborate and shift resources from carcerality to housing and comprehensive mental health treatment in the community. It was never enough for any court to simply place a

215. *Angela Davis on Abolition, Calls to Defund Police, Toppled Racist Statues & Voting in 2020 Election*, DEMOCRACY NOW! (June 12, 2020), https://www.democracynow.org/2020/6/12/angela_davis_on_abolition_calls_to (video interview and transcript).

time limit on an IST waiting list. Each limitation on confinement is only realizable through building a place of belonging and recovery outside of facility walls.

Reform is not easy or simple work for states accustomed to warehousing people with disabilities in one institution or another, cutting public funding and outsourcing "care" to for-profit private jail health contractors. The expansiveness of the work needed to achieve constitutional lengths of confinement for people incompetent to stand trial may seem daunting. But the lawsuits, sanctions, settlements, and painstaking creation of new programs to meet the needs of criminalized people with disabilities are some of what Mariame Kaba calls "one million experiments"[216] that messily make the way to freedom. They also yoke together explicitly the fates of people with disabilities both inside and outside of carceral facilities, demonstrating that a comprehensive health and housing system is a necessary precursor to both liberty and public safety. They are the material manifestation of the insight that decarceration is not possible without disability justice, and disability justice is not possible without decarceration.

216. *See* One Million Experiments Podcast, *The Hypothesis with Mariame Kaba*, ONE MILLION EXPERIMENTS (Oct. 28, 2021), https://millionexperiments.com/podcast/season-1/podcast-episode-1 (discussing Kaba's concept of "one million experiments").