OCBHJI Fitness to Proceed/Aid and Assist Frequently Asked Questions
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What process are the terms Competency Restoration, Fitness to Proceed, or Aid & Assist referring to?

Before or during the trial in a criminal case, when a court has a reason to doubt a person's capacity to (a) understand the nature of proceedings, (b) assist with counsel, or (c) participate in their own defense due to a "qualifying mental disorder (ORS 161.360(2))" (i.e., qualifying psychiatric diagnosis, intellectual or developmental disability, and/or neurocognitive condition), the court may order an examination by a Certified Forensic Evaluator to determine if a person is currently fit to stand trial (ORS 161.365) - in colloquial terms, "able", "not able", or "never able." This process, as well as the resulting competency restoration process (ORS 161.370) following the determination of "not able" is known as the Fitness to Proceed or Aid and Assist process.

What is competency restoration?

Competency restoration is a process to facilitate a person's ability to understand the criminal proceedings, assist their counsel, or participate in their own defense after being found "not able." While the nuances of competency restoration may look different based upon the needs of the person, public safety concerns, and availability of services and supports, the basic concept of restoration looks the same - providing the standard suite of supports and services one would provide to stabilize and/or accommodate a person who is not involved in a criminal case with the addition of coordination with the court (case management). The Community Mental Health Program would also be responsible for providing consultations to the court when ordered. In some cases, legal skills training *could* be helpful.

A word on legal skills training: Providing education on processes and concepts around the court system could be helpful in some cases. However, if someone is presenting with acute psychiatric symptoms, such as psychosis or mania, attempting to teach them what the judge does is unlikely to significantly contribute to psychiatric stabilization. A practical description of restoration would include "behavioral health treatment; case management; incidental supports; legal skills training; linkages to benefits; medical treatment related to capacity; medication management; peer-delivered services; and vocational services" (OAR 309-088-0115). In cases wherein the person is presenting with competency issues in connection with a neurocognitive condition (e.g., dementia, head trauma) or an intellectual or developmental disability, accommodations and coordination with other agencies (e.g., Aging and People with Disabilities, a division under the Department of Human Services and services at the county level) would be utilized within the suite of accommodations and services.

Where should competency restoration take place?

Once a person is found "not able," it is considered a matter of due process that restoration must occur for the court process to continue. Thus, the question is not *if* restoration should be attempted, but *where* should the person be placed during the restoration process. This is determined in partnership with the court and the Community Mental Health Program (CMHP) balancing the person's needs; the public safety concerns; and the services, supports, and placements available. Restoration services cannot

currently be provided in jail in Oregon in keeping with the Mink decision (Oregon Advocacy Center v. MINK, March 6, 2003 https://caselaw.findlaw.com/us-9th-circuit/1253234.html).

Three factors need to be taken into account when determining placement for competency restoration: (a) Acuity of symptoms/need for accommodations; (b) Safety concerns; and (c) Available placement options. Balancing these factors is crucial when determining placement, as considering only one or two alone could result in inappropriate placement that could have significant personal liberty, public safety, and/or fiscal ramifications.

Acuity of symptoms/need for accommodations: The presence of a psychiatric diagnosis, intellectual or developmental disability, or neurocognitive condition is not sufficient within itself for a person to be found incapacitated (ORS 161.360 & 161.365). Likewise, a finding of incapacitation ("not able") is also not sufficient to warrant hospitalization - the most structured and expensive level of care (as of this writing, one person for one day costs approximately $1,500). The recommended level of care should be congruent with the level of treatment, services, and supports necessary for the person's acuity of symptoms and/or need for accommodations or services - this is known as medical necessity.

Public safety concerns: The public safety concerns posed by individuals may or may not correlate with the acuity of symptoms/need for accommodations, nor the classification of the charges (i.e., felony vs misdemeanor). In other words, the presence of a psychiatric disorder, intellectual or developmental disability, or neurocognitive concern does not within itself increase the probability that a person poses an increased risk to public safety - conversely, it can actually increase the risk of a person being the victim of a crime (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1389236/). That being said, the nature of a person's symptoms might increase public safety concerns (e.g., a fixed delusion about a stalking victim). Public safety concerns are currently defined in statute as "the defendant presents a risk to self or to the public if not hospitalized or in custody (Enrolled Senate Bill 295 (2021) Section 2(4))."

Whether a person is facing felony versus misdemeanor charges does not necessarily correlate with public safety risk. There are domestic violence charges that are misdemeanors and theft charges, based upon the amount of what was stolen, that are felonies. Thus, the risk to others does not necessarily fall in line with if a person is charged with a felony or a misdemeanor.

Possible placement options: Both acuity of symptoms/need for accommodations *and* public safety concerns must be taken into consideration regarding where a person is placed for restoration services. Medical necessity (i.e., the level of a person's symptoms and need for services) dictates the level of treatment that Medicaid will reimburse. However, there are times when the public safety concerns a person poses require a more secure setting than would be covered by medical necessity. Currently, in those cases, if the person is placed outside of Oregon State Hospital, the cost of that gap is covered by the county.

Per statute, individuals whose most serious offense is a violation cannot be committed to Oregon State Hospital (ORS 161.370(5)). Placement at Oregon State Hospital for defendants whose most serious offense is a misdemeanor, must have a Certified Forensic Evaluator determine that a hospital level of care is required due to the the acuity if symptoms of the person's qualifying condition and the CMHP recommends that the appropriate community restoration services are not present and available in the community (ORS 161.370(4)(a)(A)). Or the court determines the defendant needs a hospital level of care,

due to the acuity of symptoms, the presence of public safety concerns, and the lack of present and available appropriate community restorations services (ORS 161.370(4)(a)(B)).

In addition to placement at Oregon State Hospital, placement options for community restoration include outpatient restoration in a person's home, hotel, or other placement, as well as placement within the following levels of care if there is medical necessity:

Mental Health Residential Treatment

Facility Type	Capacity	Staffing	Description
Adult Foster Home (AFH)	Up to 5	24 hour care with provider awake until 11pm Minimum Staff Required*: Provider and an approved caregiver for occasional respite.	Adult Foster Homes are licensed by the Health Systems Division, or by the Aging and People with Disabilities. Services provided include training or assistance with personal care and activities of daily living, supervision of medications and/or behavior, crisis prevention, and management of diet and health care. Adult Foster Homes testing and Certification of Completion is required for staff.
Residential Treatment Home (RTH)	Up to 5	24 Hour Awake Staff Minimum Staff Required*: .5 Administrator with 1 Direct Care Staff per 8 hour shift.	An unlocked residential treatment home licensed by the Health Systems Division to serve 5 or fewer adults with mental illness. Services include medication monitoring, daily living skill training, and supportive services. Staff are required to complete 16 hours of pre-service training and 8 hours annually.
Residential Treatment Facility (RTF)	6 to16	24 Hour Awake Staff Minimum Staff Required*: .5 Administrator with 1 Direct Care Staff per 8 hour shift.	An unlocked residential treatment facility licensed by the Health Systems Division to serve 6 or more adults with mental illness. Services include support for daily living, medication monitoring and crisis intervention. Staff are required to complete 16 hours of pre-service training and 8 hours annually.
Secure Residential Facility (SRTF)	6 to 16	24 Hour Awake Staff Minimum Staff Required*: .5 Administrator with 2 Direct Care Staff and 1 RN per 8 hour shift	A locked residential treatment facility licensed by the Health Systems Division to serve 6 or more adults with mental illness. Services include support for daily living, medication monitoring, and crisis intervention. Staff are required to complete 16 hours of pre-service training and 8 hours annually.
* More staff may be required to insure safety for clients and staff. This is negotiated at the time of program development and is facility specific.			

How long can someone be in restoration services?

The length of time someone can be in restoration services when they are found to be "not able" is dependent on where they are housed.

If they are committed to the Oregon State Hospital, "[r]egardless of the number of charges against an individual, in no event shall the defendant be committed for longer than whichever of the following, measured from the defendant's initial custody date, is shorter: (A) Three years; or (B) A period of time equal to the maximum sentence the court could have imposed if the defendant had been convicted (Enrolled Senate Bill 295 (2021) Section 5(5)(a))." This is called end of jurisdiction (EOJ). If the person is charged with a misdemeanor, the EOJ can occur rapidly: 30 days for a Class C misdemeanor, 6 months for a Class B misdemeanor, or 12 months for a Class A misdemeanor.

If they are not committed and are placed on community restoration, EOJ does not occur - "the court shall release the defendant, pursuant to an order that the defendant engage in community restoration services, until the defendant has gained or regained fitness to proceed, or until the court finds there is

no substantial probability that the defendant will, within the foreseeable future, gain or regain fitness to proceed (ORS 161.370(6)(a))" regardless of the level of crime the person is charged with.

What is the difference between a Community Consultation and a Certified Forensic Evaluation?

A Community Consultation is performed by the Community Mental Health Program (CMHP) to provide recommendations to the court regarding "…if the defendant were to be released in the community, to determine appropriate community restoration services are present and available in the community" (ORS 161.365(1)(a). This recommendation to the court occurs at the beginning of the fitness to proceed process to help determine initial placement for restoration, as well as later on in the process if there are questions around placement (e.g., exploring the later possibility of community restoration for a defendant who was initially placed at the Oregon State Hospital or movement to Oregon State Hospital if a person is becoming more acute while participating in community restoration).

CMHPs are required to use a standard consultation template for the process (https://www.oregon.gov/oha/OSH/LEGAL/Pages/information-mental-health-providers.aspx). Within the template, CMHPs provide basic information, including court and charging information, as well as their contact information. CMHPs recommend services for community restoration and if they are present and available in the community; recommend release conditions/requirements and a risk mitigation plan; as well as a summary of the interview with the defendant (OAR 309-088-0125).

Are CMHP consultations required for all cases? The court SHALL order a CMHP consultation, except if the defendant is charged with certain serious Measure 11 crimes and Aggravated Murder (please see below). In those cases, the court has the discretion to order the consultation, but is not required to order it (ORS 161.365(1)(a)).

"If the defendant is charged with one or more of the following offenses the court is not required to, but may in its discretion, order the consultation described in paragraph (a) of this subsection:

(A) Aggravated murder; (B) Murder in any degree; (C) Attempted aggravated murder; (D) Attempted murder in any degree; (E) Manslaughter in any degree; (E) Aggravated vehicular homicide; (F) Arson in the first degree when classified as crime category 10 of the sentencing guidelines grid of the Oregon Criminal Justice Commission; (G) Assault in the first degree; Enrolled Senate Bill 295 (SB 295-B) Page 6 (H) Assault in the second degree; (I) Kidnapping in the first degree; (J) Kidnapping in the second degree; (K) Rape in the first degree; (L) Sodomy in the first degree; (M) Unlawful sexual penetration in the first degree; (N) Robbery in the first degree; or (O) Robbery in the second degree (ORS 161.365(1)(b))."

A Certified Forensic Evaluator (CFE), either based in the community or at the Oregon State Hospital, evaluates the defendant and prepares a report for the court regarding if the defendant is "…incapacitated if, as a result of a qualifying mental disorder, the defendant is unable: (a) To understand the nature of the proceedings against the defendant; or (b) To assist and cooperate with the counsel of the defendant; or (c) To participate in the defense of the defendant" (ORS 161.360(2)). The CFE also recommends if "that a defendant requires a hospital level of care due to the acuity of the defendant's

symptoms must be based upon the defendant's current diagnosis and symptomology, the defendant's current ability to engage in treatment, present safety concerns relating to the defendant and any other pertinent information known to the evaluator. If the defendant is in a placement in a facility, the evaluator may defer to the treatment provider's recommendation regarding whether a hospital level of care is needed (Enrolled Senate Bill 295 (2021) Section 3(1))." Only a CFE, not the CMHP, can determine if a defendant has a qualifying mental disorder and if the defendant is currently "able" (possesses capacity), "not able" (does not currently possess capacity), or is "never able" (it is highly unlikely that the defendant will gain or regain capacity in the foreseeable future). The CFE evaluation is considered confidential and the relevant CMHP is to be provided a copy of the report (Enrolled Senate Bill 295 (2021) Section 3(3)(a)).

What is the difference between a Competency Docket and Mental Health Court?

Mental Health Courts are a type of specialty court (also called treatment court) that focus on engaging individuals that possess high treatment needs, as well as a high risk of committing another offense (http://www.ocbhji.org/training/treatment-court-toolkit/). Studies show participants assessed as having high treatment needs/high risk to re-offend show improved results with the combined treatment and supervision provided within treatment courts rather than with traditional supervision alone.

Due to Mental Health Court being part of the plea bargaining agreement process, it is important for an individual to be competent in order to give informed consent regarding entry to the program. If someone is unfit to proceed, it is a violation of due process rights for them to participate in the court process, even if the result is Mental Health Court. Thus, use of Competency Dockets are on the rise in Oregon - they allow for specialized supervision during the Fitness to Proceed (FTP) process and entry does not require the competency constraints of a Mental Health Court.

And yet, both Competency Dockets and Mental Health Courts both require intense communication and collaboration from diverse stakeholders within the criminal justice and treatment realms - usually the same or similar players. Thus, a Competency Docket just focusing on FTP concerns can be run with the same team, which increases the effectiveness and efficiency of the process, as the members are familiar with the issues surrounding the FTP population, in addition to becoming knowledgeable about FTP procedure. Competency Dockets can also serve as a way for the team to become familiar with defendants, who then can be screened for participation into the Mental Health Court after they are found to be able.

What is a rapid evaluation process?

The first rapid process started the conversation within the Multnomah County Mental Health Local Public Safety Coordinating Council (LPSCC) regarding who the prosecution and the defense could agree on for Certified Forensic Evaluators (CFE). Due to the difficulty of obtaining CFE evaluations quickly in some areas, courts with a dedicated competency docket have started contracting private CFEs that both the prosecutor and defense can agree upon to conduct evaluations for the docket. Initially, the evaluators were chosen as part of a pilot project, but at the conclusion of the pilot, the contract for evaluators will be going out to Request For Proposal (RFP). A dedicated Competency Docket is needed to

organize the staffings to get a better picture of who is within the process in order to rapidly serve them. Furthermore, it is helpful to have all Fitness to Proceed cases go through one judge who is familiar with the process and with behavioral health concerns.

During staffing for a dedicated competency docket, behavioral health, the judge, prosecution, defense, and evaluators go through the docket's roster to identify who needs evaluations and who should be prioritized into the rapid process (typically those in custody). There are dedicated slots each week for the rapid process, however, in Multnomah County, if the evaluators have the bandwidth, they may do more. If the judge issues a court order for the jail and the hospital to quickly release records, it allows the evaluators to complete the evaluations in a timely and accurate manner. If a defendant is too symptomatic for a full evaluation, the evaluators will conduct an abbreviated evaluation. The parties use this abbreviated evaluation to determine next steps (e.g., Oregon State Hospital, dropping charges, etc).

How do we improve the Fitness to Proceed (Aid and Assist) process in our jurisdiction?

Most importantly, reach out to your stakeholders in the process, may they be judicial, behavioral health, or peers, versus waiting for them to reach out to you. Coming together to collaborate and find solutions in a non-adversarial manner will strengthen your county's ability to more effectively and efficiently process cases and find solutions to systemic barriers. While most of the time, the judge, prosecutor, defense, and behavioral health are brought to the table - some important stakeholders that are easy to overlook are the trial court administrator, police, parole and probation, judicial assistant, intellectual and developmental disability professionals, housing, and peers - all who can help you have a more systematically based solution. If you reach out through your Local Public Safety Coordinating Councils (LPSCC), you will find many of the stakeholders represented at the meeting. LPSCCs are required by statute (ORS 423.560), however they vary in how they function across the State.

Training on issues around working with the forensic population can be found in communicating with your law enforcement and parole and probation officers. There is training available through the Oregon Center of Behavioral Health and Justice Integration on working with law enforcement partners.