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Lynda M. Connolly
Chief Justice

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President and Chief Executive Officer
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James T. Brett
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BY FACSIMILE

Dear Co-Chairs Sudders and Brett:

I write to share with the members of the Department of Mental Health Inpatient Study Commission that you co-chair my thoughts about some of the issues that you will need to examine in considering the appropriate balance of inpatient and outpatient forensic evaluation services under G.L. c. 123, §§ 15-18.

The Department of Mental Health has long been a partner with the courts in providing quality mental health services for those who appear before us, whether as respondents in civil commitment proceedings or as criminal defendants in need of forensic evaluations. We are all aware that budgetary factors beyond DMH's control are now placing that system of diagnosis, treatment and long term care under great strain resulting in the reduction in inpatient beds and contracted outpatient services, and the reduced staffing of the court clinics. I greatly appreciate DMH's continued commitment to the mentally ill despite very real and growing budget pressures.

You are doubtless familiar with the statutory provisions requiring forensic evaluations of criminal defendants. When a judge doubts whether a criminal defendant is competent to stand trial or is criminally responsible (G.L. c. 123, § 15[a]), or seeks a mental health assessment in aid

of sentencing (§ 15[e]), an initial mental health assessment is performed by a forensic psychologist from the court clinic. In the District Court, this usually involves an examination by the court clinician, who by statute is required to be a forensic psychologist, followed by the forensic examiner testifying in a court hearing. After reviewing that assessment, if the judge has reason to believe that additional observation and examination is necessary, the defendant is hospitalized either in a mental health facility or, in the case of male defendants for whom strict security is needed, at Bridgewater State Hospital (BSH), for up to 20 days (unless an additional 20-day extension is requested as necessary) (§§ 15[b] or [e]).

Similarly, under G.L. c. 123, § 18, when a jail or house of correction questions whether a prisoner is in need of hospitalization because of mental illness, the prisoner is examined at the place of detention by a forensic psychologist or psychiatrist and that report is then filed with the court, along with a petition for up to 30 days of inpatient examination and observation. In the case of a pretrial detainee, by statute the petition must be filed in the court where the criminal case is pending; in the case of a sentenced prisoner, it is filed in the local district court for that place of detention.

Three-quarters of § 15 forensic evaluations are already being done on an outpatient basis. The latest numbers I have indicate that 2,576 such forensic evaluations of criminal defendants were conducted in FY2006. 1,982 (76.9%) were done on an outpatient basis, including 1,539 § 15(a) evaluations by the court clinics, and another 594 extended § 15(a) outpatient evaluations, mostly in community settings. 594 forensic evaluations (23%) were done on an inpatient basis, including 499 hospitalizations under § 15(b) and 95 under § 15(e). In calendar year 2008, only 6.8% of DMH's average daily inpatient census (57 of the average 833 patients) were committed for purposes of forensic evaluation under § 15.

In considering whether any changes should be undertaken to increase still further the percentage of such examinations that are done on an outpatient basis, it is important to keep two considerations in mind.

The first is that all of the patients who require forensic evaluation are also criminal defendants, and many (not all) of them are facing significant criminal charges. (It is commonly known that, early in the criminal process, police and prosecutors often exercise their discretion not to prosecute minor criminal charges when appropriate mental health or addiction treatment services are an available alternative.) A significant number of those who do face criminal charges require secure pretrial detention under normal bail (G.L. c. 276, §§ 57-58) and dangerousness (§ 58A) laws, both for flight-avoidance and public safety reasons. If a wholesale de-institutionalization of most § 15(b) assessments from mental health facilities and BSH is undertaken without addressing these public safety issues, the reality is that often it may not be to an outpatient setting but to a jail. That suggests that any such decision should not be driven by DMH's census or departmental budget concerns alone, but needs to be thought out in the context

of the entire criminal justice system. It is, of course, possible to envision a system in which quality inpatient mental health evaluations for pretrial defendants are done in a jail rather than a hospital setting, but it is doubtful whether that would result in any significant short-term cost savings, given the significant increase in the correctional mental health budget that it would require.

The same shift from mental health facilities to jails could result if the legal standard for ordering an inpatient § 15(b) assessment is amended without considering the effect on criminal defendants who require pretrial detention for public safety reasons – if, for example, inpatient assessment were authorized only if the defendant meets the mental-illness and likelihood-of-harm criteria for a G.L. c. 123, §§ 7-8 commitment. Incompetence to stand trial is, of course, a functional rather than a clinical diagnosis, and it can be raised not only by lesser degrees of mental illness or dangerousness than would support a §§ 7-8 commitment, but also by significant substance abuse, head trauma or even mental retardation. Our laws must reflect a commitment of resources and an appropriate forum for these competency evaluations as well. If, apart from competency issues, a defendant must be detained while awaiting trial, then the issue is not whether any § 15(b) evaluation is going to be done on an inpatient basis, but *where.*

Conducting evaluations in the least-restrictive appropriate setting is an appropriate goal that has my full support. I would welcome your further discussions with the courts and other parts of the criminal justice system as to how some increase in outpatient § 15(b) evaluations could be achieved. Particularly in current budget conditions, however, it is essential to recognize that any changes you propose may affect other budgets in addition to DMH's budget. Providing the appropriate "observation and further examination" required by § 15(b) without relying on a secure hospital setting – whether in a jail setting or an outpatient setting – will require a further commitment of resources, many of which are not currently available. Specifically, it would require:

- The availability of additional qualified mental health clinicians to perform such § 15(b) evaluations in the courthouse or correctional facilities. As you know, some courts are serviced directly by DMH psychologists, while others rely on DMH-contracted vendors to provide these services. These same clinicians must additionally provide evaluations in § 12 emergency mental health matters (there were 603 such evaluations in FY 2006) and in § 35 alcohol or drug cases (which numbered 4440 in FY 2006). Certainly there is currently no excess of clinicians available.

- The availability of appropriate space in both courthouses and correctional facilities for these ongoing evaluations. Any space dedicated for this purpose will have to provide privacy for the parties and be large enough to not only accommodate the clinician and the defendant but also family members and others with relevant information to provide to the clinician, and appropriate waiting areas. Finding such

space in many of our already overcrowded courthouses may not be easy.

- Security for defendants and related individuals who may become disruptive or disorderly during their post-arraignment visits to our already overcrowded courthouses. The potential for conduct resulting in disruption of courthouse business or danger to clinicians or others must be a consideration. It is particularly important that clinical interviews not simply be transferred from a hospital setting to a court cellblock, which would hardly facilitate the kind of "observation and further examination" intended by § 15(b).

- Resources such as scheduling, reception and other administrative support, telephone and computer access for mental health clinicians who essentially will be working out of courthouses or jails.

Unfortunately these issues, and the overall budget challenges facing DMH's inpatient system, arise in a context in which the outpatient picture, and in particular the court clinics, are already under great strain. Since any solution is budget-driven, and all of state government is facing very serious budget challenges, it is not yet clear what sort of changes would be realistic at the moment.

I believe that without keeping in mind these resource issues – in the court and correctional budgets, as well as DMH's – any attempt at this time to create an outpatient alternative to a 20 day hospital setting for mental health assessments for those accused of criminal activity is problematic. The resource issue is crucial here, since resources in this area are already scarce.

I welcome your continued discussion of these issues with the courts and with DMH's other partners involved with mental health issues in the criminal justice system. With the appropriate resources identified and in place, I would certainly endorse any effort to support a least restrictive alternative for mental health examinations and treatment.

Sincerely,

Lynda M. Connolly
Chief Justice of the District Court

cc:
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Honorable Harriette L. Chandler
Honorable Jennifer Flanagan
Honorable Elizabeth A. Malia
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