THE CLASS OF 1964 POLICY RESEARCH SHOP

Vermont Competency Restoration: Policy Landscape and Pathways

PRESENTED TO THE VERMONT HOUSE COMMITTEE ON JUDICIARY

Rep. Martin LaLonde, Chair

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Executive Summary

Those involved in criminal proceedings in the United States must be "competent to stand trial," meaning they must understand their charges, the consequences of the charges, legal processes and participants, and opportunities to participate in their own defense. Individuals deemed "incompetent" to stand trial have: 1) a potential mental disorder/cognitive impairment, and 2) a resulting deficit in their ability to participate in their case. In such cases, court proceedings are suspended. Some states have implemented formal competency restoration programs as targeted interventions for those deemed incompetent while other states have pursued more informal programming. This report explores the question: What policy and program options are available to Vermont to address competency-related issues in the criminal justice system that would effectively balance legal due process requirements, clinical treatment needs, stakeholder interests, and broader public health and safety concerns?

First, we discuss the context for competency restoration in Vermont, describing the current competency process and previous legislative action on competency. Next, we describe our research methodology for analysis: five case studies of forensic/competency programs utilizing comparative analyses, stakeholder interviews, and a review of public literature and data. We subsequently establish the policy landscape surrounding competency in our five case studies: New Hampshire, Massachusetts, Connecticut, Rhode Island, and Vermont. Finally, we provide 6 policy pathways for Vermont (see Figure 1), including both formal and informal competency restoration programs. Ultimately, this report describes the landscape and provides potential pathways for the Vermont House Committee on Judiciary to consider in implementing policies related to competency restoration.

Pathway 1:	Propose a bill to fund a formal competency restoration program.
Pathway 2:	Enhance community-based mental health and substance abuse care.
Pathway 3:	Incentivize expanding local crisis outreach and response teams.
Pathway 4:	Expand Vermont treatment courts.
Pathway 5:	Enhance parole/probation programs and officers.
Pathway 6:	Expand diversion programs.

Figure 1: *Overview of our proposed policy pathways. Created by authors.*

1. Introduction

When an individual is charged with a crime in the US, that person is guaranteed the right to understand the charges (accused crimes) against them, the potential consequences of those charges, the trial process, various participants in the trial, and how to participate in their own defense against those charges.[1] The ability to understand these aspects is called "competency to stand trial," (or, "competency"). Because of this, if an individual is determined to not be competent to stand trial, that individual has: 1) a potential mental disorder/cognitive impairment,[2] and 2) a resulting deficit in key abilities such as understanding, reasoning, or assisting their lawyers.[3]

Competency is a constitutional right guaranteed by the Sixth Amendment right to a fair trial and has been upheld in cases beginning with the landmark *Dusky v. United States* (1960). Importantly, however, not all cases receive a formal evaluation of competency. Instead, defendants are presumed competent. If someone (*e.g.,* a defendant, attorney, court, or someone acting on the individual's behalf) suspects that the defendant may be incompetent to stand trial, they will raise the issue of competency to the court.[4] Following this, based on the American Academy of Psychiatry and the Law's "AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial," a certified forensic examiner will perform an evidence-based evaluation of the 1) individual's mental health and cognitive ability, and 2) their resultant ability to understand the legal process. The forensic examiner (most often a psychiatrist) will determine whether the individual is competent or incompetent to stand trial and compile a report for the court and relevant parties to the case.[5]

If a defendant is found incompetent to stand trial, they usually are not acquitted of the charges. Instead, a determination of incompetency will place court proceedings on hold until a defendant's competency is restored, and they can fully participate in their defense. In *Jackson v. Indiana* (1972), the Supreme Court established that defendants be held for only as long as necessary to determine if competency can be restored, usually within six months to a year. If their competency cannot be restored within a reasonable timeframe, defendants who cannot be restored may be released, civilly committed,[6] or provided other forms of treatment.

With concern for limiting crime and supporting the mental health of constituents, competency restoration programs offer a way to ensure that individuals can advocate for themselves in court after treatment and legal education, with the aims to reduce recidivism and prevent a lengthy involuntary commitment process resulting from a misdemeanor charge.

Competency restoration programs therefore include two aspects: 1) treatment and/or rehabilitation programming, and 2) legal process education. A formal competency restoration program is a structured, court-approved treatment process (often involving hospitalization or certified outpatient services) designed to restore a defendant's mental fitness for trial, whereas an informal program typically lacks judicial oversight and may rely on ad hoc community-based services without standardized procedures or legal process education. These are not mutually exclusive. Out of 35 states operating community-based options, at least 16 of these states have implemented a formal competency restoration program.[7]

1.1 Vermont's Current Competency Process

Over 45,000 cases enter the Vermont legal system per year.[8] For these cases, 13 V.S.A. § 4817 governs the competency assessment process for criminal cases, requiring that the criminal defendant(s) be competent to stand trial. In Vermont, 1,842 psychiatric evaluations have occurred

since January 1st, 2023. Of those, 767 competency evaluations yielded a forensic finding, representing a 54.2 percent potential rate of incompetency determinations among cases evaluated.[9]

Vermont currently does not have a formal competency restoration system. The current process is shown in Figure 2. When the issue of competency is raised—either by the court, public defender, or state's attorney—the Department of Mental Health must complete a neutral evaluation of competency. The Department of Mental Health contracts with forensic psychologists and psychiatrists, some of whom may be out-of-state providers, who determine competency and, in some cases, give a reason for incompetency (*e.g.,* mental illness, dementia, traumatic brain injury, substance abuse). [10] If both the defense and prosecution agree, the Court proceeds according to the competency finding. If either party does not agree, the disagreeing party may request an independent evaluation, sourced and funded outside of the Department of Mental Health. These subsequent opinions can be agreed upon, or there may be a rare, contested competency hearing in which both the Department of Mental Health and the third-party experts testify on their findings. In such cases, the Court determines the final competency ruling. If at any point during the process both parties stipulate to the individual's competency, normal court proceedings continue.

If incompetency is determined, three primary pathways emerge, which indicate if the individual is subject to continued custody and if so, where such custody is based. These pathways are described here and are shown in Figure 2 as 1, 2, 3a, and 3b. In the first pathway (1), if incompetency is determined due to a traumatic brain injury within the last five years, under Act 248, the individual may be put in custody of the Department of Aging and Elder Services and provided community-based treatment.

The second pathway (2) involves those deemed incompetent for reasons unrelated to mental illness as well as those deemed incompetent for reasons related to mental illness who do not meet the civil legal standard for commitment. In both such cases, the individual is sent back into the community and charges may be dismissed or may remain. When incompetency is determined due to reasons outside of mental illness (such as developmental or intellectual disabilities, substance abuse, or dementia), there are limited options for restoration due to a lack of programming and, in some cases, the progressive nature of the condition. Though legal competency could be informally restored, there is no mandatory or formal programming for mental health/substance abuse in Vermont. When incompetency is determined due to reasons of mental illness not meeting the threshold for civil commitment as defined below, the state also has no pathway for mandated treatment or restoration.

The final pathway (3a and 3b) involves those who are deemed incompetent for reasons of mental illness and who do meet the civil legal standard for commitment. This standard is defined as having a major mental illness which directly causes the individual to be a danger to themselves or others. Importantly, this standard for commitment would apply regardless of status as a criminal defendant. For individuals who are deemed incompetent and do meet the civil legal standard, they are submitted into custody of Department of Mental Health, which functions separately from the Department of Corrections and the criminal justice system.

In these cases, two sub-pathways exist: orders of non-hospitalization (3a) and orders of hospitalization (3b), each discussed here in turn. An order of non-hospitalization (3a) refers individuals to community-based or outpatient treatment and is the default as the state must treat individuals in the least restrictive environment possible. Court orders for placement in Department of Mental Health custody still require voluntary engagement for treatment; while the custody is involuntary, the individual must voluntarily engage in treatment, and there is no consequence for non-compliance. Per Title 18: Health Chapter 181: Judicial Proceedings, § 7629 (d), this order will

last up to 90 days and can be renewed for up to one year. This pathway also involves no formal restoration programming although charges may be dismissed or kept pending until the statute of limitations expires in case individuals do regain competency. The individual may never have a competency reevaluation or may have a formal reevaluation if requested by one party (*i.e.,* in cases where the state's attorney or defender would like to proceed with the case). As of 2023, Vermont law states that "after an initial competency determination, a court may order subsequent evaluations of a defendant to be performed by the Department of Mental Health only upon a showing of changed circumstances."[11] In other words, the Department of Mental Health will only conduct reevaluations directly in cases where there is a clinical indication of change. In cases with no formal reevaluation, an individual charged with a subsequent crime and deemed competent could have their original charges stacked if still within the statute of limitations.

Finally, an order of hospitalization (3b) requires meeting both the civil legal standard for commitment and the medical threshold for hospitalization. This will be assessed by a provider at one of the seven hospitals with beds across the state, which are general service hospitals rather than separate facilities. The criminal court has the authority to authorize hospitalization orders for 90 days. If the Department of Mental Health sees a need to hold the individual for longer than 90 days, this matter will be adjudicated in family court. After this time, the individual will transition out of hospitalization and charges may be dismissed or held. Post-hospitalization, the Department of Mental Health will pay for requested reevaluations of competency. If an individual is deemed restored to competency, they may return to custody under the Department of Corrections (which in Vermont, also holds pre-trial detainees) or may be discharged back into the community pending any further legal processes.

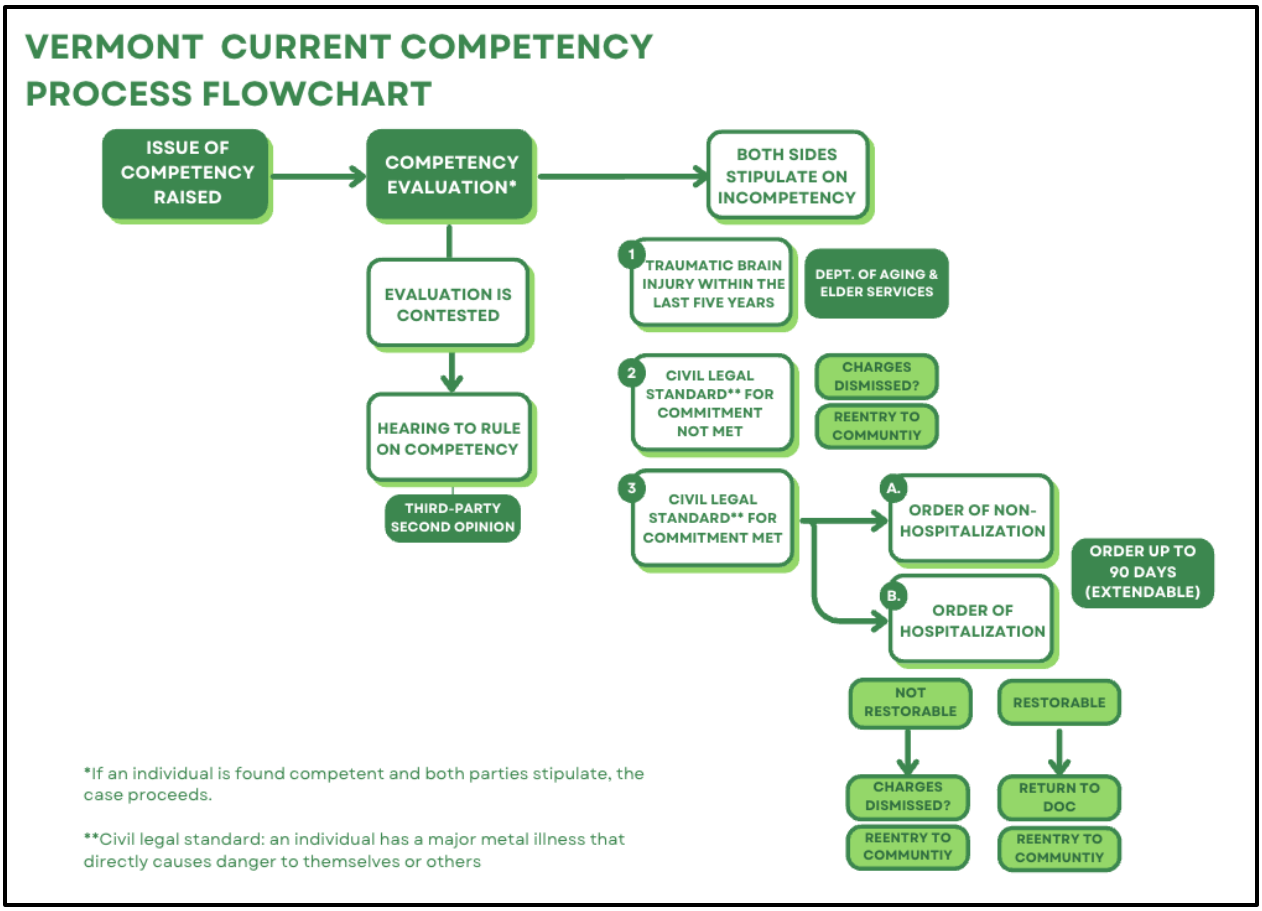

Figure 2: *Flowchart of Vermont's current competency assessment and informal competency restoration process. Created by authors based on stakeholder interviews and available documentation. This stylized representation simplifies selected pathways, which are delineated in full in the text. The discussion of Vermont's competency system represents our interpretation of the process as described by participants and should not be considered legal advice or definitive procedural guidance.*

Thus, the current model in Vermont constitutes an *informal* competency restoration system. Although defendants may receive treatment and potentially regain competency after being declared incompetent, Vermont's process lacks the formal legal education and structured programming that characterizes a formal competency restoration program. Vermont stakeholders have emphasized that orders of hospitalization mainly consider mental health treatment needs rather than criminal risk. In fact, "danger" for hospitalization orders is not defined in a criminal sense (*i.e.,* risk of recidivism), but rather, as danger of self-harm in most cases. Finally, in Vermont's current system, an individual may request another competency evaluation "at any time before final judgment."[12]

1.2 Vermont Population Dynamics

Vermont's specific population dynamics may affect decision making surrounding implementing a competency restoration program. The main areas of analysis related to competency issues that we

address are: 1) mental health/substance use disorder prevalence statewide, 2) mental health/substance use disorder prevalence in prisons, and 3) Vermont healthcare systems.

First, Vermont has a slightly higher prevalence of mental illness compared to the US at large. In 2024, 27 percent of Vermont adults had any mental illness, compared with 23 percent nationally.[13] Across the state in 2023, 14 percent of Vermonters met the federal serious mental health condition definition, and 22 percent of Vermonters had a co-occurring mental health and substance use disorder.[14] Drug overdose deaths in the state are also greater than the US, with a 42.3 per 100,000 rate of drug overdose deaths, compared with 32.4 per 100,000 nationwide. Numerous Vermont stakeholders indicated in our interviews that the rural opioid epidemic remains particularly acute in Vermont. The state has a 37 per 100,000 rate of opioid-involved accidental or undetermined drug overdose deaths.[15] More broadly, 22 percent of Vermont adults had a substance use disorder in the past year, compared with 18 percent nationally.[16]

Second, the high frequency of mental health and substance use disorders translates into the Vermont prison population. Stakeholders reported that two-thirds of the Vermont 1,400 incarcerated individuals have a diagnosed opioid use disorder, and that 70 percent of Vermont's incarcerated people are on a psychotropic medication to treat a mental health issue. It is currently unclear whether these statistics have recently increased or remained steady over time.

Finally, the Department of Mental Health and Department of Corrections attempt to treat Vermonters when possible. As explained in an interview with a Department of Corrections official, Vermont holds a treatment-first approach. For example, in the justice system, cases may generally be dismissed or referred to family court to determine if state-mandated mental health treatment is required. Importantly, mental healthcare in Vermont was ranked #1 in Mental Health America's Access to Care ranking, a metric which "indicates how much access to mental health care exists within a state [by measuring] access to insurance, access to treatment, quality and cost of insurance, access to special education, and mental health workforce availability."[17] This quality of care stands in contrast to the prevalence of mental health and substance use disorders in Vermont, suggesting that current healthcare capacity may not be enough to adequately treat all Vermonters who could need it.

1.3 Vermont's Competency-Related Legislative History

Vermont's overall crime rate has remained relatively low compared to the national average but slightly increased by 4 between 2022 to 2023.[18] Further, interactions between law enforcement and residents may be putting a strain on government resources. One 2024 study discovered that 18 Vermont residents encountered police 2,543 times between 2018-2022.[19] Because of these factors, competency restoration programming could be one avenue for Vermont to improve both public health and public safety outcomes by reducing the strain on government resources during defendant's trials.

Pursuant to these goals, in 2022, the Vermont Supreme Court officially established the Judiciary Commission on Mental Health and the Courts, which worked with the Vermont Senate to pass S.91. This law addressed issues surrounding competency evaluations, such as: "expediting evaluations by way of adding qualified psychologists as evaluators; adding a clearer burden on counsel to explain the need for evaluations; bifurcating insanity and competency evaluations; ensuring timely records availability; and consolidating repeat requests where one person is the subject of multiple cases."[20] This bill was also passed against the backdrop of legal action against the state for backlogged competency evaluations and wait time.[21]

In addition, S.91 also required examining whether a plan for a competency restoration program should be adopted in Vermont.[22] Thus, against the backdrop of the goal to improve both public health and public safety, Vermont legislators wish to examine whether a formal competency restoration program should be implemented in Vermont.

2. Purpose Statement

This research explored the question: What policy and program options are available to Vermont to address competency-related issues in the criminal justice system that would effectively balance legal due process requirements, clinical treatment needs, stakeholder interests, and broader public health and safety concerns? The research was mainly motivated by public safety, public health, resource, and accountability concerns.

The current Vermont justice landscape is challenged in several ways. First, Vermont lawmakers seek judiciary system solutions that will enhance community public safety. Second, public health concerns exist. Around 80 percent of Vermont's court cases now involve individuals who have been diagnosed with mental health or substance use disorders.[23] This prevalence suggests that there is significant need for mental health treatment options. Lawmakers across the political spectrum agree that prisons should not be where mental health is treated. Competency restoration, however, provides a particularly unique intersection between criminal justice and mental health treatment. While research demonstrates that competency restoration programs are critical in addressing public health and safety by ensuring those facing criminal charges have the cognitive capacity to participate in their legal proceedings, substantive concerns exist about whether and how to create an effective, ethical and sustainable competency and treatment system.

Third, although formal competency restoration programs remain effective, they may face resource constraints. Available research on competency programs indicates that the vast majority (80-90 percent) of defendants who go through such restoration programs are successfully restored to competency within six months.[24] Yet, states currently face budget constraints,[25] which could affect whether they can support the healthcare capacity necessary for formal competency programs. Competency restoration programs expend resources across mental healthcare, correctional systems and the judiciary, at the potential expense of expanding preventative community mental healthcare or proper justice for criminal cases. At its extreme, resource constraints could lead to breaches of required timelines for competency restoration. Most notably, *Trueblood et al. v. Washington State Department of Social and Health* (2014) challenged unconstitutional delays in competency evaluation and restoration services. As a result of this case, Washington state has been ordered to provide court-ordered competency evaluations within 14 days and competency restoration services within seven days. Colorado,[26] Oregon,[27] and Oklahoma[28] have also faced lawsuits over competency services, resulting in settlements that required states to address competency evaluation and restoration delays. These resource constraints pose challenges to both the individuals who may not receive care, and the state providers who could violate statutory mandates. Further, some argue that competency restoration leads to greater criminalization and pathways to incarceration in ways that impact both individuals and court system capacity, especially for more minor crimes.

Finally, accountability concerns may exist. Some posit that the existence of formal competency restoration programs could create a loophole for lawyers to secure a lower sentence for their client through the program. For example, if an individual is found incompetent to stand

trial there remains a possibility that the defendant will be assigned to treatment rather than jail time. This course of action may not align with some group's definition of justice.

With these motivations as context, in February 2025, Vermont State Representative Martin LaLonde introduced two bills related to competency restoration. First, H.251 is an act relating to establishing a competency restoration process that at the time of this report's publication is only a short form bill. Second, H.405 is an act relating to competency to stand trial, specifically adding statutory language for case dismissal for incompetent defendants after the statute of limitations for the offense for as long as their incompetent status remains. While this research does not explicitly comment on these two bills, they (and the four other bills relating to competency in the 2024-2025 session) indicate a wider trend of interest in competency and restoration programs for Vermont lawmakers. This research thereby utilizes these motivations to establish the policy landscape and potential policy pathways of formal and informal competency restoration programs.

3. Methodology

To assess informal and formal competency restoration programs, we conducted a case study analysis between five states (including Vermont) involving stakeholder interviews as well as a review of existing data and literature. These methods assessed the efficacy, limitations, and programming framework of competency restoration programs and alternative forensic mental healthcare, ultimately providing the foundation for our Policy Landscape and Policy Pathways discussed in Section 5 and 6. In this section, we first explain the five case studies, then outline the process for stakeholder interviews within those states, and finally provide the existing literature and data reviewed.

3.1 Case Study Analysis Overview

This research was guided by a state-by-state case study analysis of five states with and without formal competency restoration programs (see Figure 3). In addition to Vermont, we evaluated programs in Connecticut and Rhode Island, both of which have formal competency evaluation and restoration programs in their courts, and New Hampshire and Massachusetts, which both have alternative forensic mental health services instead of competency restoration programs. The states we have chosen to include for our case study analysis are all within the New England region, sharing a similar geographic location to Vermont. By looking at states with both formal and informal competency restoration programs, we strived to understand the necessary considerations Vermont stakeholders should have in determining if the implementation of a competency restoration program would address concerns for public health and safety.

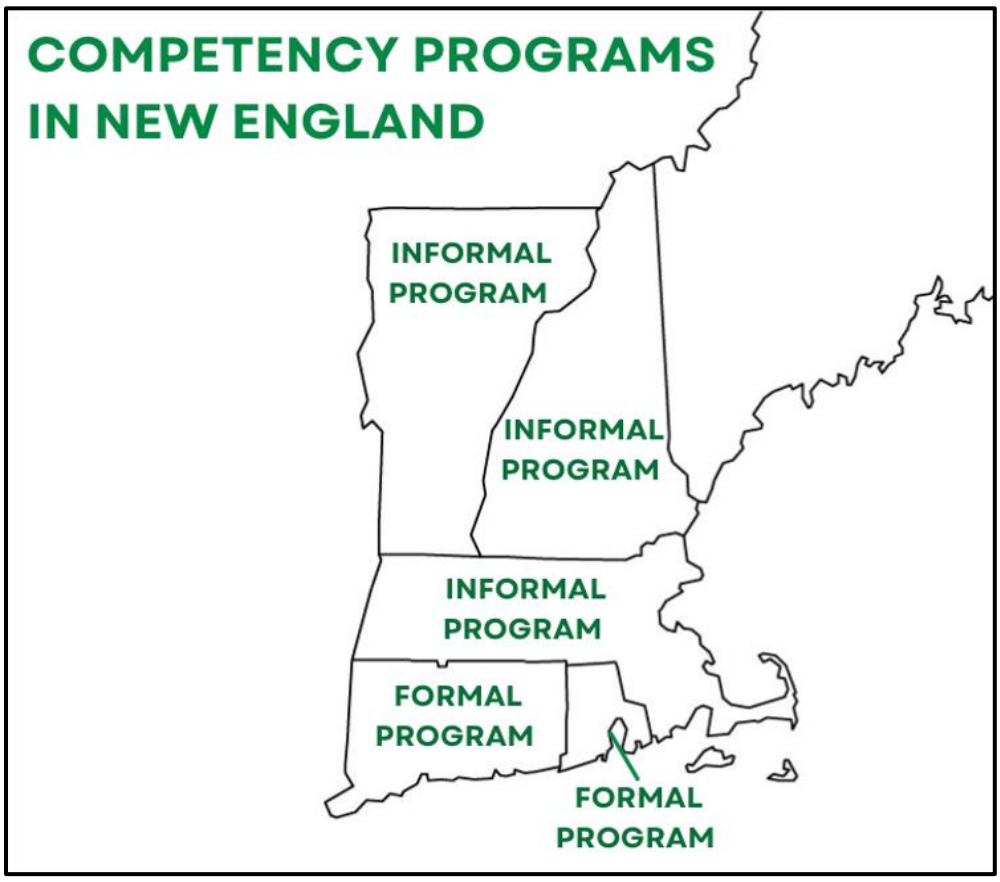

Figure 3: *Map of states used for this report's case studies. Created by authors.*

3.2 Stakeholder Interviews

To help perform an analysis of each state, we conducted expert interviews with knowledge of competency processes and programming. To integrate varying perspectives, we interviewed lawmakers, forensic clinical psychologists, and government officials selected through snowball and purposive sampling, selecting our sources based on the relevance of their expertise to competency restoration programming and through referrals made to us by other stakeholder interviewees. The thirteen individual and small group interviews we conducted included members of the Council of State Governments Justice Center, Vermont state officials, attorneys from the Vermont Legal Aid Mental Health Law Project, members of the Connecticut Department of Mental Health and Addictive Services, a Massachusetts court clinician with the Recovery with Justice Program, a New Hampshire statewide Mental Health Court Coordinator, and forensic psychologists across states.

The focus of the interviews varied by the expertise and background of the interviewee but each interview informed our understanding within one or more of these categories: 1) the program structures in place and their effectiveness, 2) areas for improvement in accessibility or accountability of mental healthcare, 3) alternative approaches to competency restoration programs that could be considered, 4) what data is being collected and data sharing practices, 5) the responsibilities of stakeholders involved in the state's services, and 6) key considerations for potential implementation. The general framework for our interview questions within these six main areas can be found in Appendix A.

3.3 Review of Published Efficacy Literature

To provide background on competency restoration program methods, Vermont's population and system specific challenges, and nationwide trends in mental health and substance use, we conducted an analysis of existing literature of published data reports. These sources helped inform analyses of the efficacy of the programs discussed in the case studies. The scholarship included data from a variety of sources, with the study and the purpose of its use cited as follows:

- **Data from the Vermont Department of Mental Health:** Contextualized the services provided by the Department of Mental Health and the number of forensic evaluations.[29]
- **Data from the Washington State Institute for Public Policy:** Provided a comprehensive overview of competency restoration practices, timelines, and efficacy broken down by method.[30]
- **Data from Journal of the American Academy of Psychiatry and the Law:** Reviewed competency restoration best practices in different treatment environments, with findings related to restoration location and length of stay necessary.[31]
- **Data from the Substance Abuse and Mental Health Services Administration:** Documented a holistic literature review of competency restoration, including the Sequential Intercept Model, legal foundations for restoration, and best practices.[32]
- **Data from the Vermont Crime Research Group:** Contextualized the prevalence and severity of current mental health encounters with police in Vermont.[33]
- **Data from the Kaiser Family Foundation[34] and Mental Health America:**[35] Illuminated the state of Vermont's mental health and substance use disorder prevalence, and the state of Vermont's healthcare system, both compared to national trends.

Through the combination of these methods, our findings fall into three categories, which are expanded upon in the following sections. The brief first provides contextual information about the history of health and justice in the US, ultimately explaining the goals of competency restoration that are evaluated by the research. Next, we present the five case studies, utilizing as common points of analysis the goals of competency restoration, to establish profiles for each state and their program. Finally, the paper outlines potential policy pathways for Vermont policymakers, including both formal and informal competency restoration program options.

4. Historical Context and Goals of Competency Restoration in the Justice System

The relationship between the health and justice systems is critical to understand in the context of competency-related issues. In this section, we will first outline a brief history of health and justice in the US, demonstrating how the US deinstitutionalized individuals with mental health issues, leading to the justice system increasingly handling health challenges. As part of this increasing interaction between health and the justice system, we then describe the Sequential Intercept Model, a model that represents how criminal justice and treatment systems interact. Finally, we list the specific goals of competency restoration as conveyed through the five case studies.

4.1 History of Health and Justice in the US

Deinstitutionalization in the United States, including Vermont, refers to the process of people with mental health and substance use disorders transferring out of large state-run institutions and into community-based care settings. This movement began in the 1950s and has continued to evolve over the decades. The US experienced two waves of deinstitutionalization. In the 1950s and early 1960s, deinstitutionalization efforts focused on people with mental illness, whereas such efforts began targeting individuals with developmental disabilities in the mid-1960s.[36] Importantly, these two groups are largely prone to competency-related issues.

The population of individuals in public mental hospitals fell most acutely since its peak of 559,000 in 1955 to 215,500 in 1974.[37] Further, since the late 1960s, the average daily population of state-operated intellectual or developmental disability facilities serving 16 or more people has decreased from nearly 200,000 to less than 40,000 by 2014.[38] While deinstitutionalization coincided with the increase of medical treatment for mental health and substance use disorders,[39] the rapid closure of institutions without sufficient community-based support services contributed to homelessness, emergency room overcrowding, and increased criminal justice involvement. Research has demonstrated that many of the community treatment alternatives were underfunded or inadequate, leading to "trans-institutionalization"—where individuals previously institutionalized in psychiatric hospitals ended up in prisons or jails instead. Scholars argue that trans-institutionalization led to prisons and jails arising as a surrogate for psychiatric treatment.[40]

In Vermont specifically, government officials described that over the past fifty years there has been a trans-institutionalization of people from mental institutions into Vermont correctional facilities. For example, the officials cited that 70 percent of the state's 1,400 currently incarcerated people are on psychotropic medication. These officials identified that contemporary Vermont prisons are not therapeutic environments, and that prisons should not be a mental health/substance use care provider in place of specific government treatment support.

Today, incarceration disproportionately affects individuals with a mental health/substance use disorder, as 40 percent of those diagnosed with serious psychiatric disabilities face arrest at some point in their lifetime.[41] Further, up to 44 percent of those in jails/prions have a mental health disorder, and up to 63 percent of people in jails/prisons have a substance use disorder.[42]

Based on the institutional shifts discussed here, in the early 1990s, researchers in Colorado began to realize that individuals with mental illnesses were overrepresented in the criminal justice system, with limited resources to help them. As a result of this observation, a consulting agency created the Sequential Intercept Model, which is a nationally utilized framework for conceptualizing how individuals with mental health issues interact with the criminal justice system. According to a co-creator, the model "should be used as a basis for future information sharing and collaboration between mental health, substance use, and criminal justice staff. This mapping helps everyone understand how the local criminal justice and treatment systems work, describes local resources, and identifies how each participant fits in the larger picture [and] to identify the gaps between the current resources and the unmet needs of the criminal justice-involved population."[43]

The Sequential Intercept Model promotes early intervention across the criminal justice timeline to divert cases before they proceed further into the criminal justice process, aligning with Vermont's treatment-based approach. At each of the six intercepts (numbered 0 through 5), the Model provides interventions that can prevent further criminal justice involvement. The original intercept model is shown in Figure 4, and consists of:

- **Intercept 0 (Mobilizing Community Resources)**: Deploy mobile crisis teams, peer crisis services, and emergency hotlines to provide mental health support before law enforcement becomes involved.
- **Intercept 1 (Redirecting at First Contact)**: Train law enforcement in Crisis Intervention Team (CIT) models and implement co-responder approaches to divert individuals to treatment rather than arrest.
- **Intercept 2 (Screening at Initial Detention)**: Conduct mental health and substance use assessments at booking or initial hearings to identify treatment needs and diversion opportunities.
- **Intercept 3 (Treating Within Specialized Courts)**: Establish mental health courts, drug courts, and veterans' courts that provide structured supervision and treatment alternatives to traditional prosecution.
- **Intercept 4 (Transitioning from Custody to Community)**: Develop comprehensive reentry planning that connects individuals to community-based services, medication, housing, and benefits before release.
- **Intercept 5 (Supporting During Community Supervision)**: Implement specialized probation and parole processes for populations with mental health conditions and facilitate ongoing treatment engagement through coordinated supervision.

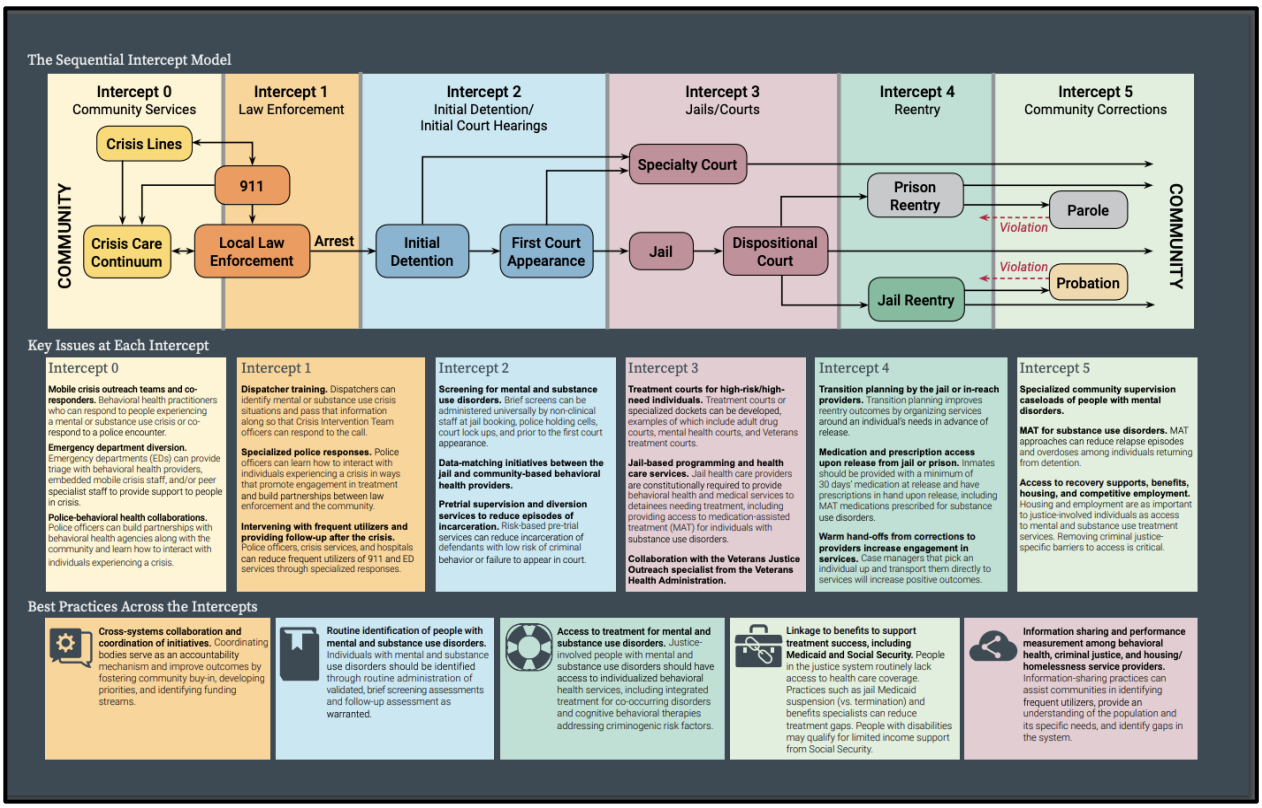

Figure 4: *Overview of the Sequential Intercept Model. Created by the Substance Abuse and Mental Health Services Administration.*[44]

Each of these intercepts provides an opportunity to support individuals' health, while attempting to improve public safety by addressing the root causes of crime. Competency to stand trial occurs between Intercept 2 (mental health/drug use assessments) and Intercept 3 (court-sponsored treatment), as exemplified below in Figure 5.

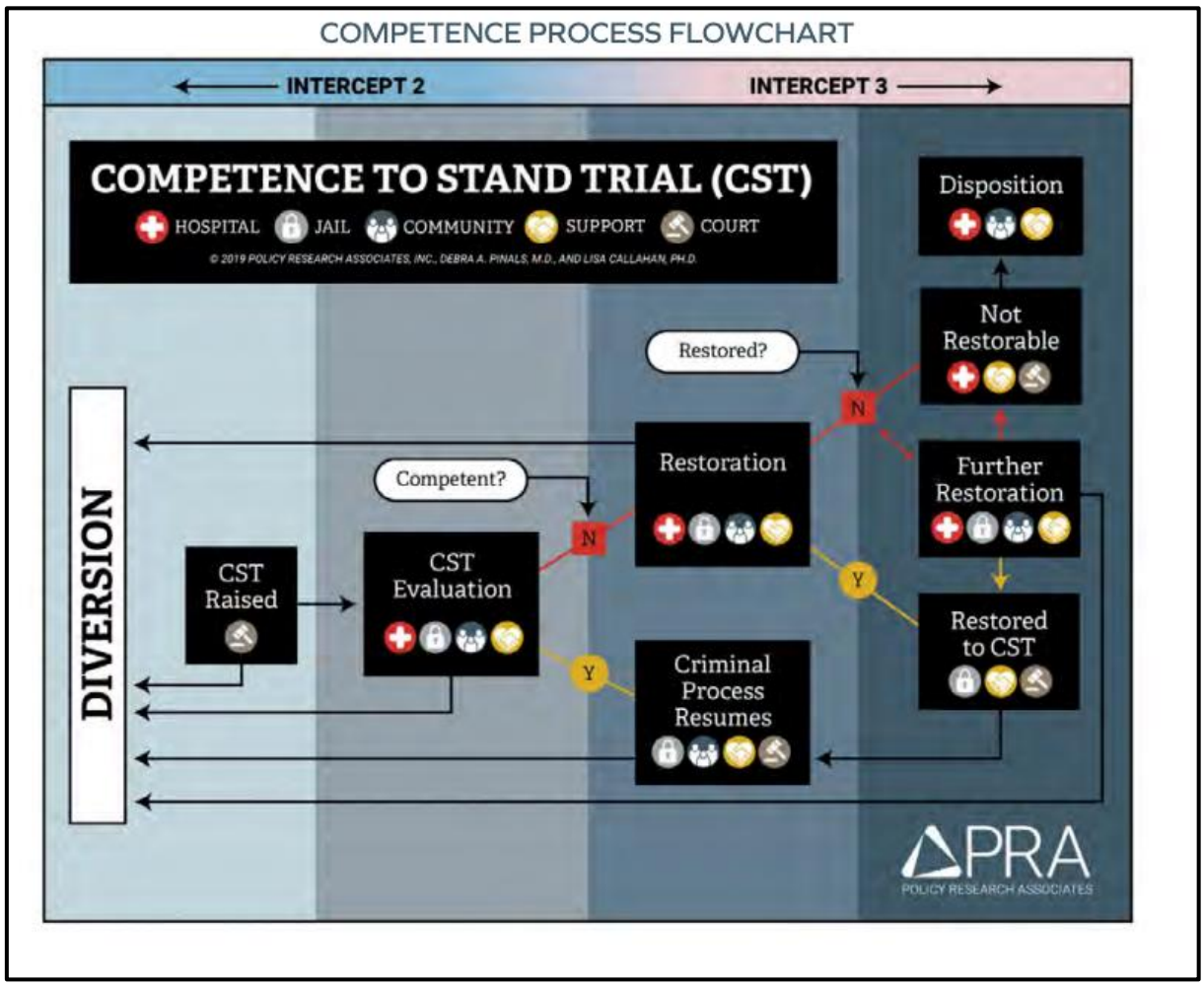

Figure 5: *Competence Process Flowchart as related to the Sequential Intercept Model. Created by Policy Research Associates.*[45]

4.2 Goals of Competency Restoration

Across expert interviews, various legal and clinical stakeholders proposed goals for competency restoration. These goals focus on addressing: 1) diagnosed mental disorder/cognitive impairments, and 2) resulting individual deficits in key legal abilities such as understanding, reasoning, or assisting their lawyers. Different stakeholders across states attributed different priority levels to these goals, since each program differed in its approach. This exhaustive list of goals does not appear in a specific order of importance:

- **Ensure due process rights:** Uphold defendants' Sixth Amendment rights by ensuring they can meaningfully participate in their defense.
- **Enable legal proceedings to continue**: Help individuals understand their case, work with their attorney, and understand court proceedings.
- **Provide education about court processes:** Integrate knowledge-building about court system in addition to legal strategies such as plea deals.
- **Improve functional abilities**: Focus on both factual understanding and rational abilities to work with attorneys.

- **Address underlying mental health issues**: Provide therapy and medication as part of the restoration plan.
- **Balance public safety concerns**: Address criminalized behaviors and uphold the law through accountability.
- **Coordinate care transitions**: Ensure defendants have a plan in place for service before they leave the carceral/restoration treatment facility.
- **Reduce recidivism**: Aim for individuals to commit fewer repeat crimes, less frequently and support low crime rates.
- **Improve quality of life**: Increase quality of life for participants through appropriate treatment.
- **Spread out resources:** Coordinate urban and rural resources to connect individuals with care in an accessible manner.

5. Policy Landscape (Case Studies)

To best evaluate Vermont's current system and future options, we conducted case studies of competency restoration landscapes in four other US states. These cases spanned across the Northeastern US and included states with formal competency restoration programs and informal competency restoration programs. Each state held different metrics for success, program specifics, and stakeholders. To reconcile these differences across programs, we utilized the goals outlined in Section 4.2 to compare various aspects of the programs. In this section, we will first provide a broad side-by-side comparison of the state competency systems, and then explain each individual program (New Hampshire, Connecticut, Rhode Island, Massachusetts) in detail. Finally, in this section, we review the case study of Vermont's current competency process.

5.1 State Profiles

The four cases we chose for analysis were New Hampshire, Connecticut, Rhode Island, and Massachusetts. Each case study focused on their current forensic system and competency programming, ultimately aiming to compare the states in relation to Vermont. Each state profile outlines the state's approach to competency restoration and the services provided, limitations in their system, and recommendations for future development made by stakeholders. A comparative table of key program aspects can be seen in Figure 6 below.

State	New Hampshire	Massachusetts	Connecticut	Rhode Island	Vermont
Formal Competency Restoration	No	No	Yes	Yes	No
Inpatient forensic treatment	Yes	Yes	Yes	Yes	Yes
Outpatient forensic treatment	No	No	Yes	Yes	No
Qualifications for competency restoration	N/A	N/A	High-Risk Felonies & Low-Risk Misdemeanors	High-Risk Felonies	N/A
Restoration Timeline	12 months	6 months	18 months	6 months	90 days

Figure 6: *Overview of competency programming across case studies, including Vermont. Created by authors.*

5.1.2 New Hampshire

Information about New Hampshire's informal competency restoration process largely runs through the Department of Health and Human Services (DHHS) clinical forensic psychologists. Competency orders are often requested by the defense counsel and rarely by the court or state. Once a competency evaluation is requested, a referral is made to DHHS, and forensic clinicians and psychologists collect background information, discovery material, and history on the defendant. Then, a meeting is set with the defendant and defense attorney to conduct a full clinical interview. The state utilizes the Competency Assessment Instrument tool for evaluation. If the individual is found restorable to competency, a plan for future treatment is made and provided by DHHS. The majority of New Hampshire's forensic clinical care uses the Ohio Risk Assessment System to inform evaluation and treatment options, but treatment approaches and services are very individualized to the person's needs. If the individual is not restorable and considered high-risk, a decision must be made on whether involuntary hospitalization is needed. Inpatient psychiatric care occurs at the New Hampshire State Hospital which holds 24 forensic beds. The New Hampshire statute outlines a 12-month time frame for restoration; if the individual is unrestorable by the 12-month mark, the defendant's charges are dismissed.

In addition to informal forensic treatment and restoration, New Hampshire provides the option to recommend the defendant to mental health court. New Hampshire's mental health courts and their capacity differ vastly from county to county and, despite efforts within the Judicial Branch to seek funding for mental health courts, there is no standard funding structure. New

Hampshire drug courts, however, do have structured funding. Individuals who are recommended for mental health courts must be competent. Once in a mental health court, some defendants may plead guilty in exchange for receiving suspended sentences or have their charges dropped, depending on the charge and status of the defendant. Most mental health court treatment programs are around one year long, depending on the defendant completing the treatment plan.

Stakeholders reported that the main challenge faced in expanding New Hampshire mental health courts is the lack of centralized data and funding, making it difficult for these locally organized courts to have consistent and standardized practices. The challenge of effective data sharing also affects New Hampshire forensic mental healthcare services at large. For competency restoration in particular, further challenges exist with legal restrictions on what can be discussed with the patient before adjudication to protect the defendant from revealing relevant information to their case. This factor could limit the level of treatment that can be provided while someone is detained but not adjudicated because the defendant may not share all relevant aspects. Strict legal timelines also lead to even high-risk individuals being released if certain evaluations are not completed on time. Stakeholders indicated that restoration and treatment are often delayed far after initial evaluation due to delays in hearings and court proceedings. Delays leading to long periods of time between treatment and reevaluation also increases chances of regression for individuals. Ultimately, treatment timelines depend on patient progress, which may conflict with statutory definitive restoration timelines. Necessary improvements in forensic mental healthcare that experts cite include: the need for reentry planning services, the overall lack of medication and services, and long waitlists for resources. New Hampshire stakeholders suggest that treatment should be infused into the system, investing in secure treatment facilities rather than detention centers and decreasing recidivism by following through on treatment in community-based services.

5.1.3 Massachusetts

Massachusetts also currently does not have a formal competency restoration program. When the issue of competency is raised, court clinicians perform competency evaluations and provide recommendations to the judge and lawyers. If incompetency is determined and there is no need for hospitalization, treatment is conducted on an outpatient basis and court clinicians can recommend a therapist or psychiatrist to the court. Inpatient treatment is largely conducted at the Bridgewater State Hospital that provides civil commitment to male patients without criminal charges and competency restoration to pretrial detainees. Other Department of Mental Health facilities that provide competency restoration services include the Worcester Recovery Center and Hospital and the Taunton State Hospital. Commitment orders at these facilities are valid for six months, according to the state statute. For individuals with cognitive disabilities, they may be recommended to outpatient neuropsychological testing to determine competency and potential restoration. For those who do not meet the criteria for inpatient treatment, the defense attorney must provide legal education to their clients before trial rather than a restoration program.

Massachusetts stakeholders emphasized that mental illness and substance use disorders do not have inherent ties to an individual's competency, which enhances the need for more integrated and community-based mental healthcare resources. Stakeholders noted that competency can also fluctuate within different intervals of time, especially if someone with mental illness is inconsistent with medication. Some individuals may be actively symptomatic and can have a mental health disorder but still be considered competent.

Stakeholders report the biggest issue in Massachusetts' informal competency restoration programming surrounds people who do not meet the criteria for inpatient evaluation and treatment.

In such cases, there is no other structured outpatient programming for restoration. Some additional barriers in Massachusetts forensic healthcare include: challenges streamlining data between court and community providers, a lack of programming for those who are not proficient in the English language, long waitlists for services especially in Boston, and the decentralization of resources. Stakeholder recommendations also emphasize the need for measures to keep individuals accountable with treatment, for example through personnel such as case managers or social workers. They suggest that parole and probation departments should also receive essential training in handling mental health cases as they are an often overlooked yet key part of restoration efforts. This suggestion demonstrates that issues related to competency restoration can emerge throughout a defendant's criminal justice process, rather than only pre-trial.

5.1.4 Connecticut

Connecticut has formal competency restoration programming, which strictly focuses on restoring individuals to competency under legal terms rather than providing comprehensive mental health treatment. In Connecticut, competency orders can be made regardless of the level of offense and are not limited to high-risk or violent felonies. When evaluating competency, forensic psychologists determine specific deficits in cognitive functioning and symptoms of mental health/substance use disorders. Connecticut law does not require a specific diagnosis for competency determination as some other states do. Connecticut officials instead explained that because there is no perfect correlation between diagnosis of a disorder and competency, some defendants with no diagnosis can still be deemed incompetent. The restoration programming in Connecticut is team oriented: the process of forensic evaluation is done by a team composed of a psychiatrist, psychologist, and social worker. Each forensic team is assigned three defendants at a time and manages collateral data, writes a report, and testifies in court. Forensic monitors are responsible for overseeing the case and the restoration process, working closely with a treatment team. There is an 18-month maximum timeframe for restoration, but defendants usually complete the programming after six to nine months. Inpatient treatment can occur at the public Connecticut Valley or Whiting Forensic hospitals.

In contrast to New Hampshire, Connecticut officials indicated that they currently have adequate access to and supply of resources, programming, and training. The state thus typically does not have a waitlist for inpatient treatment nor concerns about limited resources. Stakeholders still stressed that proper training is needed across all settings and that consistent large stakeholder meetings are necessary to streamline communication. Officials particularly emphasize the need for all parties to understand the purpose of restoration in the state and to differentiate the process from general mental health treatment. They also noted that data sharing is often the biggest challenge: Connecticut departments collect a significant amount of data, but a data analyst is needed to aggregate information, especially when streamlining inpatient and outpatient care.

Finally, the Enhanced Forensic Respite Bed model was implemented in Connecticut to address the large amount of competency orders in the state which are disproportionately made up of misdemeanor cases. Stakeholders noted that judges often order competency simply because they do not want individuals facing homeless released from custody without housing. By increasing outpatient restoration options for individuals facing low level charges, the goal of this model is to avoid the costs of people being hospitalized or being in custody for longer than necessary. Competency restoration programming is often very disruptive for individuals as most people who cannot go into community-based services then must wait for restoration. Connecticut stakeholders are working towards bolstering outpatient treatment in addition to their pre-existing community-

based forensic programs that cover pretrial jail diversion towards treatment and targeted case management post-release.

5.1.5 Rhode Island

Rhode Island also has a formal competency restoration program overseen by the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH). There are no distinctions within hospital admittance to BHDDH based on mental health, substance abuse, or other conditions. Because Rhode Island is geographically consolidated, most competency-related operations are centralized to BHDDH. Within the formal competency restoration, BHDDH administers all competency evaluations, risk assessments for incompetent individuals, and management/risk assessments for insanity plea programming. BHDDH also manages inmates deemed too ill to be treated in a correctional facility during their period of incarceration who are transferred from the Department of Corrections to BHDDH forensic hospitals. When a competency evaluation is ordered, the individual could post bail and subsequently be transferred to the centralized jail. No bail individuals are assessed in custody by BHDDH, though sometimes the judge will send individuals directly to a community facility to be evaluated.

Rhode Island's competency evaluation reports are divided into three parts: a 1) clinical evaluation, 2) competency evaluation, and 3) a psychiatric risk assessment (if deemed not competent). The clinical evaluation consists of a review of the individual's personal medical, substance use, and legal history, to determine whether they are actively ill and their current treatment or medication upkeep. Within the competency evaluation, a copy of the police report and defendant's account are included. Forensic examiners also review the charges and potential consequences to understand the defendant's ability to understand court processes and their relationship with their attorney. Individuals must be determined as not competent and violent or high-risk to be admitted for competency restoration programming. Low-risk misdemeanors are diverted from jail and recommended for community treatment. Higher risk individuals are considered for outpatient care in court and high-risk individuals are cared for in inpatient facilities. Rhode Island has two inpatient psychiatric hospitals. First, Eleanor Slater Hospital is a civil hospital that holds 52 forensic beds out of 70 total psychiatric beds and is 50 percent federally funded. Second, the Rhode Island Psychiatric Hospital is funded only by state taxpayers. High-risk cases have a six-month time frame for restoration and reassessment, although timelines can be lengthened in Rhode Island and adjusted based on legal and patient-specific time frames.

The goal of competency restoration in Rhode Island is to move towards decriminalization and treatment. Rhode Island stakeholders emphasize that the success of a program is determined by access to community-based services for continued treatment and diversion to outpatient facilities or processing through a mental health court. Stakeholders report that it is very rare for defendants who completed competency restoration programming to later return to corrections. Alternatively, stakeholders indicated that incompetent defendants often have anosognosia (*i.e.,* the patient is unaware of their significant health issue), thereby necessitating court-mandated treatment. In their recommendations for potential new competency restoration programs, stakeholders noted the importance of considering litigation surrounding long wait times for competency assessment and hospital beds as well as variations in determining misdemeanors and felonies by state.

5.1.6 Vermont

Vermont does not have a formal competency restoration program. Instead, Vermont's policy landscape reflects some of the national criminal justice system trends. As previously mentioned in Section 4.1, deinstitutionalization in Vermont has transitioned individuals with mental health and substance use disorders from state-run institutions to community-based care. Since many community alternatives closed due to a lack of funding, individuals have faced criminalized behavior leading to being treated in prisons rather than previous psychiatric hospitals.

Currently, about 80 percent of Vermont court cases involve an individual with a mental health or substance abuse issue. With Vermont's prevalence of opioid use disorders among the incarcerated population, many existing programs are focused on addressing substance use disorders. To address the growing demand for mental health-related cases, Vermont has necessarily outsourced out-of-state psychologists and psychiatrists to provide sufficient competency restoration treatment for defendants.

Vermont currently operates without a formal competency restoration program. When defendants are found incompetent to stand trial, the state follows one of several pathways depending on the underlying cause of incompetency and whether the individual meets civil commitment standards (see Section 1.1 for detailed process). For those deemed incompetent due to mental illness who meet the civil legal standard for commitment—defined as having a major mental illness that directly causes them to be a danger to themselves or others—the court may order hospitalization or community-based treatment through the Department of Mental Health. Importantly, the primary goal of this intervention is treatment and public safety rather than competency restoration. While some individuals may regain competency because of treatment, there is no formal programming specifically designed to restore defendants to competency, and charges may be dismissed or remain pending depending on the circumstances and severity of the offense.

While Vermont lacks a formal competency restoration program, the state has various community-run programs dedicated to reintegration and recovery in its criminal justice system. Turning Point Vermont operates centers statewide that are dedicated to help individuals with substance abuse recovery by providing peer-based recovery methods. There are 12 recovery centers across Vermont that facilitate recovery groups to help individuals post-incarceration. Another program, Jenna's Promise, is dedicated to helping formerly incarcerated women who suffer from substance use disorders. They assist in providing transitional housing and rehabilitation services. These programs target different elements and populations in the criminal justice system and are part of the state's relevant justice and treatment infrastructure. Finally, Vermont's Department of Corrections also funds restorative justice programs through the Community Justice Centers.

Stakeholders indicated that the largest challenges to implementing a formal competency restoration program in Vermont are staff shortages and costs. One stakeholder from the Department of Corrections indicated that implementing a formal program through a three-year contract with healthcare providers would cost an estimated $130M, which would be triple the cost of a publicly run formal program. Notably, the current budget for the Department of Corrections is $230M. Stakeholders also had concerns about staffing shortages, since creating a formal program could worsen the strain on the already very limited provider pool. These experts noted that mental health support is currently inadequate in Vermont with very few counselors who are difficult to reach, which has led to outsourcing care. One challenge is that Vermont is one of the few states without a general fund hospital, which closed in 2011 after Tropical Storm Irene.[46]

Lastly, stakeholders emphasized the lack of communication between treatment providers and legal teams with significant misunderstandings across groups on how competency procedures work in the state currently. Many also highlight the inability to release information from mental agencies as a related challenge to communication.

6. Vermont Policy Pathways

From the case studies, we generated distinct profiles of how competency-related programming works in different contexts as well as broader uniting principles for designing and implementing such initiatives. In this section, we first outline concrete principles for analyzing potential competency-related programming options within Vermont. Next, we explain how a formal competency program could be implemented in Vermont, and considerations necessary for such a program (Pathway 1). We then present various pathways Vermont could pursue regarding informal competency restoration programs (Pathways 2-6). Each pathway is outlined with considerations raised by stakeholders from across our case studies. The sections include discussion of concerns, improvements, and positive feedback from stakeholders who have relevant knowledge and experience. These pathways offer flexible implementation options, allowing the Legislature to adopt them individually or in combination based on available resources and policy priorities.

6.1 Principles for Analysis

First, considering the differing interests and opinions on whether/how to implement a formal competency restoration program in Vermont, we highlight three main principles to consider when evaluating competency-related policy options and implementation strategies: 1) Access to Justice, 2) Individual/Community Outcomes, and 3) System Durability. These three principles emerged throughout our work and were consolidated from expert interviews and published policy briefs on policy implementation. When considering whether to implement competency restoration programming and, if so, which type, these principles could be utilized to assess the potential efficacy of any policy.

Access to Justice

Access to Justice represents the fundamental principle that individuals involved in the criminal justice system should have their cases assessed fairly on their merits, without procedural or practical barriers preventing meaningful participation. This principle encompasses both constitutional rights and ethical considerations regarding how the state treats individuals with mental health challenges who become justice-involved. Thus, Access to Justice includes the following considerations for Vermont competency issues:

- **Accountability**: Ensuring that the criminal justice system holds individuals accountable for their actions in a manner to decrease further criminal activity.
- **Victim's Rights:** Reducing potential danger to victims, promote their perception that justice has been served, and uphold the Victim's Rights Statute in Vermont whose stated purpose "seeks to ensure that crime victims are treated with the dignity and respect they deserve while functioning in a system in which they find themselves through no fault of their own."[47]
- **Equal justice:** Upholding Chapter 165 of Title 13, which seeks to balance crime victims' and criminal defendants' rights through victim advocacy.[48]
- **Procedural fairness**: Ensuring that individuals with competency-related issues have the maximum opportunity to fully participate in their defense.
- **Prevention of strategic incompetency claims**: Creating a system where an incompetent determination is not an incentivized defense tool to avoid prosecution, while still protecting truly incompetent defendants.
- **Purpose alignment**: Clearly defining whether competency restoration aims solely to prepare individuals for legal proceedings or serves broader public health and safety outcomes.
- **Appropriate treatment duration**: Minimizing the length of stay in restoration programs to balance intensive treatment needs and statutory timelines.
- **Proportional treatment to legal timelines**: Ensuring that legal timelines for evaluation and restoration do not lead to disproportionate detention periods, particularly for non-violent and low-level offenses.
- **Ethical treatment selection**: Appropriately selecting individuals for involuntary treatment based on clinical necessity, with robust procedural protections.
- **Care continuity**: Providing seamless transitions between different systems (criminal justice, mental health, community) to prevent individuals from experiencing abrupt termination of services.
- **Equitable access**: Ensuring that competency-related services are accessible regardless of geographic location, socioeconomic status, or other demographic factors within Vermont.
- **Legal protections**: Establishing appropriate statutory timelines and procedural safeguards for competency evaluation and restoration that protect defendants' rights.

Individual/Community Outcomes

Individual/Community Outcomes focuses on measurable results for both individual defendants and the broader community. This principle recognizes that competency restoration exists within a larger context of recovery-oriented justice (a rehabilitation-focused approach addressing underlying causes of criminal behavior), where success is measured not just by legal case resolution but by meaningful improvement in public health and public safety indicators. Dimensions related to Individual/Community Outcomes include:

- **Public health improvement**: Measuring success by improvements in individuals' mental health stability, reduced symptom severity, and increased functioning.
- **Public safety enhancement**: Tracking reductions in recidivism, decreased criminal justice system involvement, and improved community safety.
- **Accountability**: Promoting justice outcomes that emphasize modes of accountability that shape positive future actions.
- **Evidence-based approaches**: Implementing restoration techniques with proven effectiveness, prioritizing interventions supported by research to maximize success rates.
- **Reduced system interactions**: Decreasing the frequency and intensity of interactions with the criminal justice system without compromising public safety.
- **Person-centered recovery**: Tailoring treatment approaches to individual needs, embracing diverse modalities including medication management, psychotherapy, peer support, and educational components.
- **Accountability balance**: Creating mechanisms that hold individuals accountable for criminal behavior while simultaneously addressing underlying mental health and substance use factors.
- **Symptom stability**: Achieving sustainable symptom management beyond immediate legal needs, reducing the likelihood of decompensation after program completion.
- **Life skill development**: Enhancing defendants' practical abilities to navigate daily life, maintain housing, and function in community settings.
- **Restoration success rates**: Tracking the percentage of defendants successfully restored to competency within reasonable timeframes, with analyses of factors associated with success or failure.
- **Cross-system coordination**: Measuring how effectively mental health, substance use, and criminal justice systems collaborate to produce positive outcomes.

System Durability

System Durability emphasizes the practical sustainability of any potential policy pathway Vermont adopts. This principle recognizes that even the most well-designed program will fail if it cannot function effectively within Vermont's resource constraints and institutional landscape. System Durability considers both short-term operational efficiency and long-term sustainability. Key considerations for System Durability include:

- **Procedural efficiency**: Preventing unnecessary delays between legal proceedings and treatment interventions through streamlined administrative processes.
- **Fiscal sustainability**: Developing a stable, long-term funding structure that efficiently uses state resources and appropriately balances institutional care with community-based approaches.
- **System interactions**: Considering that given the intertwined nature of justice and health systems, addressing health considerations in the shorter term may impact the justice system's long term sustainability and vice versa.
- **Resource optimization**: Identifying existing system bottlenecks and resource constraints, then developing targeted solutions to address these limitations.
- **Stakeholder collaboration**: Establishing formal mechanisms for ongoing coordination between legal, clinical, correctional, and community providers throughout the competency process.
- **Clear protocols**: Implementing detailed communication channels and decision-making frameworks that clarify roles and responsibilities across participating agencies.
- **Community integration**: Coordinating with Vermont's existing community mental health infrastructure to ensure services align with the state's decentralized care model.
- **Workforce capacity**: Addressing staffing needs for forensic evaluation and treatment, including recruitment, retention, and specialized training.
- **Scalability**: Creating a system that can adjust to fluctuating demands and caseloads without compromising quality or timeliness.
- **Data infrastructure**: Developing robust tracking systems to monitor performance indicators, support quality improvement, and inform policy refinements.
- **Legislative alignment**: Ensuring that statutory frameworks support rather than hinder efficient operation of the competency restoration process.

6.2 Formal Competency Program

6.2.1. Pathway 1: Propose A Bill to Fund a Formal Competency Program

Based on our state profiles and expert interviews, we present a flowchart of the potential formal competency restoration program pathways to guide decision-making if Vermont were to propose implementation. These pathways are shown in Figure 7 below. The flowchart goes through restoration programming in five stages indicated by letters A through E: A) Competency Orders, B) Competency Evaluation, C) Competency Determination, D) Restoration Programming, and E) Post-Restoration.

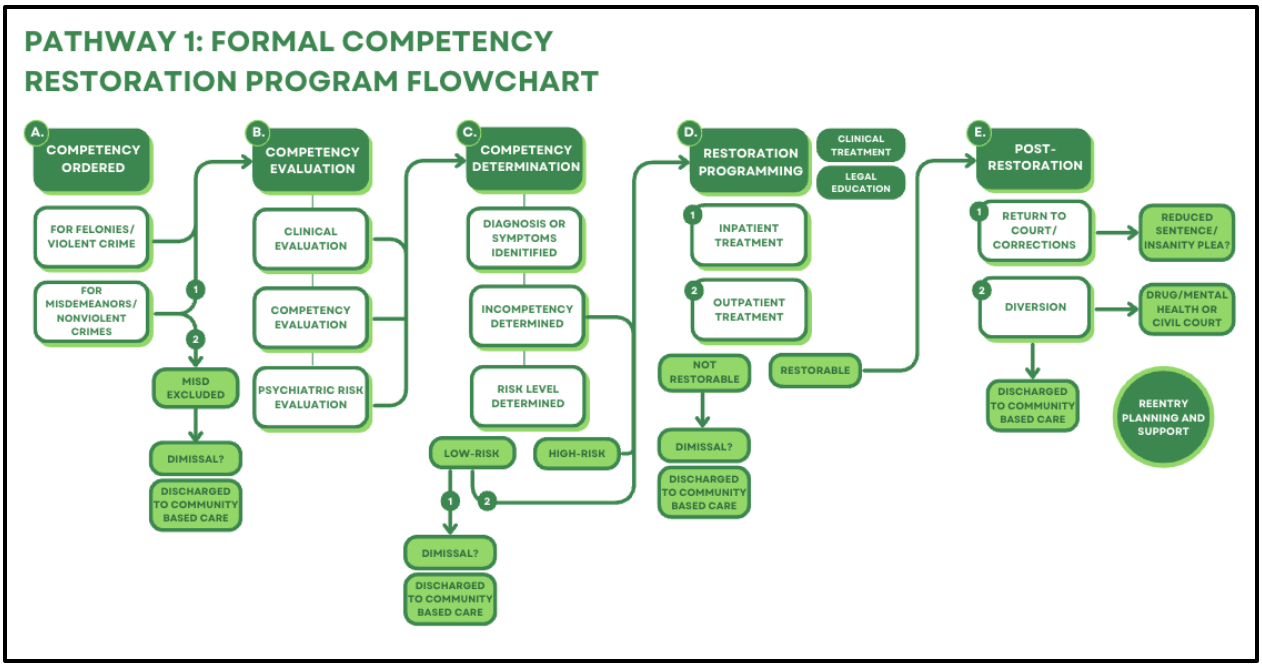

Figure 7: *Flowchart representing the process of a potential formal competency restoration program in Vermont. Created by authors based on our synthesis of available competency restoration program components and stakeholder feedback about each component's efficacy.*

The first step of a potential formal competency restoration program is the issue of competency being raised in court. When **competency is raised**, courts must determine whether and how to distinguish between processing violent felonies versus nonviolent misdemeanors. Some states, especially those with no formal competency programming and those that have scarce resources, limit expenditures on forensic treatment to felonies or violent crimes. For individuals charged with misdemeanors whose competency is questioned, formal programming could either: 1) include these cases in the full competency evaluation and restoration process, or 2) statutorily exclude misdemeanor cases from competency proceedings entirely, allowing charges to be dismissed and individuals to be referred to community-based mental health services. Rhode Island's competency restoration program determines qualification for restoration programming after evaluation based on a psychiatric risk evaluation, which we will further expand upon later in this section. Connecticut does not distinguish between misdemeanors and felonies or risk level because they have the inpatient and treatment capacity to take all competency cases through the restoration process. This approach may not work for Vermont, however, as represented by Connecticut stakeholders expressing concerns about competency restoration programs being used to provide resources to defendants (*e.g.,* housing) for those with misdemeanor cases. Considering this concern within the context of Vermont's current homelessness crisis and growing unhoused population, expanding competency restoration to misdemeanors may overburden the system and deter concrete long-term solutions for housing. This decision between whether a formal program includes misdemeanor charges or are limited to high-risk felony charges holds implications for charging and sentencing (*i.e.,* defendants assigned to a competency restoration program rather than case dismissal). For example, one stakeholder provided a hypothetical example that a shoplifting case worth less than $100 would not be a wise use of state resources for a formal competency program.

Once competency is raised, the individual will undergo a **competency evaluation**. In this flowchart, we modeled this step based off Rhode Island's three-part evaluation process consisting

of a clinical evaluation, competency evaluation and psychiatric risk evaluation. A formal program could include any combination of the evaluation types, depending on what needs fit the program. The evaluation process in Rhode Island encompasses all aspects of the individual's needs, considering both the individual's clinical background as well as their legally defined competency status. Under these three categories for evaluation, a framework would be developed either by the state or following existing evaluation frameworks such as the Competency Assessment Instrument or the Ohio Risk Assessment System, as seen in New Hampshire. Who and under what department this evaluation would be conducted is a decision-making factor that Vermont stakeholders must consider based on the state's capacity. In Connecticut, evaluation is carried out in teams made up of a psychiatrist, psychologist, and social worker under the Department of Mental Health and Addiction Services—which holds similar responsibilities to Rhode Island's BHDDH Department—while Massachusetts has court clinicians conduct evaluations through the court. Considering that Vermont currently outsources to out-of-state psychiatric professionals through telehealth and virtual services, if the state were to consider implementing a competency restoration program, finding funding and developing a robust staff might be a challenge.

Based on the information gathered during an evaluation, a **determination of competency** must be made. The Vermont statute for a competency restoration program should first determine whether a formal diagnosis is required. Connecticut does not require a formal diagnosis and rather identifies symptoms that signify an individual's competency level. Stakeholders across states emphasized that having a mental health disorder is not inherently correlated with being not competent; often, individuals with mental health-related considerations may also have a substance use disorders or intellectual disability, and individuals can still struggle with competency even though they do not have a formal diagnosis. Once incompetency is determined, a risk level for the individual may also be determined. Vermont already considers whether an individual poses a risk "to themselves or others" in decision-making surrounding the civil legal standard for commitment. In a formal program, those who are low risk could be either 1) discharged and have their charges dismissed or 2) continue into restoration programming. Rhode Island makes the distinction between different levels of charges at this stage of the program, diverting low-level cases towards community-based care while moving high-level cases through the restoration process.

The central part of a formal program is the **restoration programming** itself. Restoration could take place in two areas: clinical treatment and legal education. In Connecticut, the weight of competency restoration programming mostly leans on competency under legal terms. Treatment providers in their program understand that their work within competency restoration has a different justice-oriented goal than general mental health care. Restoration programming can take place in either 1) inpatient treatment, such as through involuntary hospitalization at a state or forensic hospital, or 2) outpatient treatment through community healthcare partners. While most states determine placement for restoration and treatment based on the individual's needs and risk level, Connecticut makes no distinction because they are not limited by the number of beds or treatment infrastructure. However, this design may not be as portable to the Vermont context. The decommissioning of the Vermont General Hospital may hinder Vermont's ability to develop an adequate inpatient treatment option unless funding is granted for new hospitalization infrastructure or unless other preexisting infrastructure can be built upon. Some other considerations include determining whether there would be programming other languages for those whose first language is not English and whether Vermont would keep the current 12-month time frame for restoration if a formal program were to be implemented.

After the 12-month mark or another appropriate timeframe, reevaluation is needed to determine whether the individual is restorable. If they are not restorable, the individual may be discharged for community-based care and potentially have their charges dismissed. If the individual is restorable, **post-restoration** may include either 1) returning to court and/or corrections or 2) diversion away from the criminal justice system. If an individual proceeds through trial, if found guilty, they could be given some reduced sentence. Some individuals in such a position might also plead not guilty by reason of insanity. Within Connecticut's formal programming framework, competency restoration programming functions to move individuals through corrections. After restoration for Rhode Island defendants, however, individuals are rarely returned to the Department of Corrections; rather, they are diverted to a drug, mental health, or civil court where they are provided options for continued treatment or discharged and recommended treatment through community services. Rhode Island gears their restoration programming towards decriminalizing and diverting individuals for further rehabilitation and treatment. Regardless of the approach taken, reentry planning and support is necessary to decrease chances of recidivism and allow individuals the opportunity to contribute as members of their communities.

One main consideration for deciding whether to implement a formal restoration program is the Access to Justice principle as part of purpose alignment: whether restoration aims to address solely the defendant's competency status, or also broader public health and safety outcomes. There needs to be a strong understanding, among all stakeholders, of program goals whether it be an archetypal restoration program with the goal of basic legal understanding, such as in Connecticut, or function with the goal of decriminalization and access to community-based treatment, such as in Rhode Island. Almost all stages of the program flowchart require significant financial support for infrastructure development and staffing. Currently, Vermont is facing a staffing crisis especially in the state's mental health facilities, resulting in the need to outsource to psychiatrists and providers in other states. The Vermont Department of Corrections, Department of Mental Health, and other forensic behavioral health institutions would need to coordinate their staffing capacities and determine where funding is needed to develop a sustainable competency restoration program. One consistently recurring challenge among all four states we examined is the need for data sharing and standardization. Stakeholders in all states stressed the need for centralizing and streamlining data through all levels to ensure effective data collection and output, helping to identify the highest population needs and improve the program's operations.

While these factors may directly impact the decision of whether to implement a formal restoration program, broader statewide trends may also impact that decision. As previously mentioned, Vermont currently faces a housing crisis across the state. In mental health cases and issues of competency, ensuring that individuals follow through with treatment and medication after release is dependent on whether they have a stable living environment upon reentering the community. In the statute for a formal program, sentencing guidelines must also be considered as most charges for repeat offenders in Vermont are for violations of conditions of release. In addition, stakeholders have stressed the need for understanding that a competency restoration program cannot function as a tool for treatment or replace other mental health services as correctional facilities and other coercive settings fundamentally cannot act as therapeutic environments. Because of this, stakeholders recommended that a competency restoration program develop concurrently with substantial community care investment. Further, since most Vermont cases are non-violent, most individuals who go through corrections will return to society. Whether or not a formal competency restoration program is implemented, bolstering reentry planning,

public mental health services, and diversion pathways are necessary steps to promote safer communities and help individuals become productive members of society.

6.3 Informal Competency Restoration Programs

Given the complex interplay of health and justice issues as described above in Pathway 1 (a formal competency restoration program), we now utilize the Sequential Intercept Model presented in Section 4.1 to consider informal competency restoration program options. At the varying stages of the Sequential Intercept Model, opportunities may exist to address competency-related issues without a formal competency restoration program. This section identifies policies and programs at varying stages of the Model, first explaining the program or policy, and then identifying various considerations for implementation according to the principles delineated in Section 6.1 (*i.e.,* Access to Justice, Individual/Community Outcomes, System Durability). We order our presentation of these policy pathways according to the Sequential Intercept Model's chronological staging of the justice system.

6.3.1 Community Partners

Intercept 0 of the Sequential Intercept Model centers around community services. Currently, Vermont utilizes numerous community partners in conjunction with the Department of Mental Health and the Department of Corrections to provide treatment and support to individuals involved in the criminal justice system. These partners could be critical for any expansion of competency-related programming in Vermont. The following partners were highlighted in expert interviews, but likely do not encompass the full range of partners and services:

- **Community Justice Centers:** Vermont holds a unique restorative practice called Circles of Support and Accountability (CoSA). CoSA programs operate all 17 Community Justice Centers run across the state, supported by funding from the Department of Corrections.[49] The CoSA program is a community-based, volunteer-driven model for post-incarceration re-entry. As such, the aim is to enhance community safety through supporting high-risk offenders returning to their communities post-incarceration. Legislators and community partners both indicated the success of this program.[50]
- **Turning Point Vermont**: Turning Point has 12 peer recovery centers in Vermont, employing individuals with previous addictions to run peer-recovery groups. In these spaces, Turning Point runs peer-support groups and drop-in sessions. While not exclusively reserved for formerly imprisoned individuals, Department of Corrections officials indicated that this is an important program for formerly incarcerated people. The stakeholders reported that many individuals view the program as critical to post-release success because the groups allowed people to see themselves not as a prisoner, but as someone with a drug addiction that needs recovery support.[51]
- **Pathways Vermont**: This organization hosts a "Housing First" program, providing independent housing and community-based support for individuals experiencing homelessness who have a history of mental health or other challenges. Pathways Vermont also operates the Forensic Assertive Community Treatment program, supporting 40-60 individuals under the supervision of the Department of Corrections and in collaboration with Probation and Parole through a substance use risk reduction program.[52]
- **Vermont Care Partners:** Vermont has "a statewide network of sixteen non-profit community-based agencies providing mental health, substance use, and intellectual and

developmental disability services and supports."[53] Vermont Care Partners is also a trade association, advocating for increased funding for community-based mental health services.[54]

- **Montpelier Police Department:** The Montpelier Police Department has implemented diversionary programs to assist individuals with substance use or mental health disorders. For example, the Project Safe Catch Program aims to connect individuals with drug addiction to treatment providers, directing them into treatment rather than arrest for drug crimes. The Crisis Intervention Team (discussed in Pathway 3) aims to divert individuals with mental illnesses to de-escalate situations and emphasize community options and resources rather than the police as a primary response. [55]

6.3.2 Pathway 2: Enhance Community-Based Mental Health and Substance Abuse Care

Vermont could enhance its approach to competency-related issues by strengthening community-based mental health and substance abuse resources. This strategy aligns with the Sequential Intercept Model by intervening at Intercept 0 to prevent criminal justice involvement before law enforcement contact occurs. By investing in community resources that address the underlying causes of crime, Vermont could reduce the number of individuals who later face competency challenges in the criminal justice system. Stakeholders emphasized that community-based rehabilitation programs that help individuals develop coping strategies and prevent reoffending represent the "optimum" approach to addressing mental health and substance abuse issues that contribute to criminal behavior.

Key Components: While this policy pathway does not specifically aim to restore competency, community-based treatment centers help serve two goals. First, community centers treatment may reduce the likelihood of individuals interaction with the criminal justice system for a mental health or substance abuse-related issue. Second, the centers can provide effective re-entry programming for individuals exiting prison. Stakeholders with knowledge of these centers indicated that programs such as CoSA and Turning Point build healthy behaviors and connections on a community level, thereby easing the transition for individuals exiting the Department of Corrections and re-entering society. As the Center for State Government explains: "Because people with behavioral health needs are often those who become involved in the [competency] process, providing services in the community can limit the number of people entering the [competency] process in the first place."[56] Lawmakers may consider establishing or enhancing treatment/rehabilitation programs in the following areas:

- Mental health or substance use disorder treatment, including crisis services;
- Educational and vocational programs;
- Pro-social activities that support recovery;
- Department of Corrections-funded Transitional Housing;[57]
- Community Justice Centers/CoSAs.[58]

Implementation Benefits: Since most individuals incarcerated in Vermont are likely to return to the community, this policy solution helps individuals re-entering society and provides programming that could help individuals be restored to competency. Stakeholders with knowledge of the Vermont prison environment highlighted that prison is not a therapeutic environment. Thus, by bolstering support for community-based systems, individuals will be treated in a conducive

environment for their recovery and rehabilitation, while keeping them in their own community. Further, the availability of community-based care can help counter any legal system incentives for the competency process as a means for an individual to receive treatment. As Connecticut stakeholders observed, competency restoration programs sometimes become a replacement for other social service programs (*e.g.,* housing or treatment).

Treating substance use disorders could particularly impact public safety outcomes. Research from the US Sentencing Commission observed a 27 percent decrease in the likelihood of recidivating compared to individuals who completed a drug abuse treatment program.[59] Importantly, the National Institute of Health has demonstrated that inmates with opioid use disorders—who make up a substantial proportion of Vermont's incarcerated population—are at a higher risk for overdose post-release without treatment.[60] Thus, supporting these treatment programs could help improve public safety and public health outcomes in the long term.

Expected Outcomes: Expanding community-based care addresses multiple dimensions of the three evaluations principles. For Access to Justice, this approach promotes equitable access by making services available regardless of geographic location or involvement with the criminal justice system. It creates a proportional response to competency issues by allowing individuals to receive the appropriate level of care in the least restrictive environment possible, while maintaining accountability through community treatment.

For Individual/Community Outcomes, the public health benefits are substantial. Community-based care provides continuous treatment rather than intervening in episodic crises, addressing underlying conditions that contribute to criminal justice involvement. Research demonstrates that community treatment is a key aspect to improving clinical outcomes.[61] Public safety is enhanced through reduced recidivism rates when individuals receive appropriate treatment, particularly for those with substance use disorders who face high overdose risks post-release without intervention.

System Durability is particularly strong with this approach. By leveraging Vermont's existing network of community providers, the policy builds on established infrastructure rather than creating entirely new systems. This approach allows for scalability as programs can expand incrementally based on need and funding availability. Community-based care promotes cross-system coordination, creating natural partnerships between courts, corrections, and treatment providers. While requiring financial investment, community-based treatment has demonstrated cost-effectiveness compared to hospitalization or incarceration.

Implementation Considerations: The main consideration for this policy is that it is not cost neutral. If the state seeks to invest such that demand for community care can be met, this policy would require investment at a time when there is not currently a large budget surplus nor increased federal funding for these types of programs. Further, the specific amount of funding needed is unclear as different programs would benefit from different amounts/types of funding (*i.e.* utilizing funding for staffing positions versus treatment supplies).

6.3.3 Pathway 3: Incentivize Expanding Local Crisis Outreach and Response Teams Programs

Intercept 1 of the Sequential Intercept Model encompasses law enforcement, including specialized police resources. The Montpelier Police Department (MPD) provides one such specialized resource. The MPD has developed an effective "Crisis Intervention Team" Program for Montpelier

and Washington County to respond to mental health and drug abuse issues. This type of police response handles mental health related issues to prevent further involvement in the justice system. Thus, Vermont could incentive expanding the number of these programs across jurisdictions. The main consideration for expanding these programs is that it requires the legislature to partner with municipalities where implementation would occur.

Key Components: According to the MPD, "A Crisis Intervention Team program is more than first responder training. It is a community partnership of law enforcement, mental health, medical and addiction professionals, individuals who live with mental illness (and/or their families), and other advocates who forge a response model that promotes access to treatment rather than entry into the criminal justice system." The goals of a Crisis Intervention Team are to:

1. Improve the safety of officers and the person in crisis, thereby enhancing public safety; and
2. Help persons with mental disorders and/or addictions access medical treatment rather than place them in the criminal justice system due to illness related behaviors.

Implementation Benefits: According to the MPD, internal research has identified four main benefits to their CIT: 1) efficient crisis response times, 2) an increase in jail diversion for those with mental illness, 3) continuity with community providers, and 4) a significantly decreased occurrence of injuries among police officers.

Vermont stakeholders familiar with these teams identified that often, individuals evaluated for competency with low-level criminal charges might benefit more from support and resources than interactions with the criminal justice system. For example, one stakeholder indicated that a defendant charged with less than $100 in theft received more than five competency evaluations over the course of their case. These evaluations pose a burden on both the defendant and the legal/mental health systems, delaying timelines and imposing a high cost on the state. Those evaluations may have been prevented through the situation being handled by a Crisis Intervention Team.

Evidence: Over 2,700 communities nationwide have implemented Crisis Intervention Team programs.[62] Results of studies evaluating these programs include:

- Across the nation, Crisis Intervention programs reduce arrests of people with mental illness[63] while simultaneously increasing the likelihood that individuals will receive necessary mental health services.[64]
- In Memphis, a Crisis Intervention Team resulted in an 80 percent reduction of officer injuries.[65]
- In Detroit, replacing imprisonment with community-based mental health treatment saved $21,000 per individual per year.[66]
- In eight different programs across the nation, a Crisis Intervention Team resulted in a higher 12-month utilization rate for mental health services.[67]

Expected Outcomes: Incentivizing an expansion of Crisis Intervention Teams in Vermont could strengthen all three principles we consider for policy evaluation. For Access to Justice, these teams could enhance procedural fairness by facilitating appropriate diversion before formal legal proceedings begin, ensuring individuals with competency-related issues receive proper assessment and support rather than inappropriate criminal processing. Victim perspectives would also be addressed as communities would likely see increased stability and reduced public disturbances/victimization when individuals receive proper treatment.

In terms of Individual/Community Outcomes, Crisis Intervention Teams could directly improve public health by connecting individuals to treatment at the earliest possible stage, often before arrest, preventing the traumatic experience of incarceration which can exacerbate mental health conditions. Public safety would be enhanced through de-escalation techniques that reduce the risk of violent encounters between police and individuals in crisis. This approach also promotes evidence-based practices as Crisis Intervention Team models have demonstrated effectiveness in communities nationwide.

For System Durability, Crisis Intervention Teams promote procedural efficiency by reducing unnecessary arrests and court proceedings. Resources are optimized as expensive jail beds and court time are preserved for cases that cannot be diverted. The approach aligns with Vermont's existing community-based care model, leveraging local resources and partnerships rather than requiring massive new infrastructure. While implementation requires investment in training and staffing, the long-term fiscal impact could be positive as expensive hospitalizations and incarcerations could be reduced.

Implementation Considerations: Mental health encounters occur more frequently with local law enforcement rather than Vermont State Police. Thus, the Vermont Legislature could provide incentives for local police forces to create Crisis Intervention Teams, but a state-run program may not be feasible.

6.3.4 Pathway 4: Expand Vermont Treatment Courts

While a formal competency program largely operates at Intercept 2, subsequent options to address competency-related issues exist in Intercept 3 in jails/courts. Nationwide, as part of the national problem-solving court ecosystem, states have established more than 4,148 treatment courts.[68] These courts combine community-based treatment programs with strict court supervision and progressive incentives and sanctions. Individuals are referred to treatment courts based on eligibility criteria such as type of crime and criminal background.[69]

Key Components: Currently, the Vermont Judiciary determines the court that a case will proceed through based on the case type. The Vermont Judiciary currently operates treatment dockets in the following locations: 1) Chittenden Adult Drug Treatment Court Docket and Adult Mental Health Treatment Docket, 2) Chittenden Family Treatment Docket, 3) Rutland Adult Drug Treatment Court Docket, 4) Washington Adult Drug Treatment Court Docket, and 5) Windsor DUI Treatment Docket. The Vermont Constitution grants the authority to the General Assembly to establish new courts in Chapter II.[70] Vermont could explore the possibility of establishing treatment courts statewide.

Implementation Benefits: According to the National Center for State Courts, drug courts lower recidivism, save money, free jail beds, and treat substance abuse problems by promoting collaboration among treatment providers, local governments, law enforcement, prosecution, defense, and state agencies/courts.[71] Participants in these programs are held accountable while receiving treatment to address potential root causes of crime. Individuals involved in drug courts tend to report less drug use and are less likely to test positive for drug use than individuals going through traditional court processes,[72] coinciding with less criminal activity and fewer arrests.[73]

Similarly, mental health courts respond to individual needs related to mental health, but also often treat co-occurring disorders. The Council of State Governments reports a lower rate of new criminal charges for individuals, coinciding with lower one-year recidivism rates.[74] Further, mental health courts can help enable better collaboration between the court system and community partners to connect individuals with treatment services.

Expected Outcomes: Treatment courts would enhance Access to Justice by creating a specialized forum designed specifically for defendants that could address underlying competency-related issues (*e.g.,* drug use and mental health disorders). These courts establish clear procedural protections while balancing accountability with treatment needs. For victims, treatment courts offer a structured approach that may provide more meaningful resolution than either incarceration or case dismissal, as they focus on addressing underlying problems that lead to criminal behavior.

The Individual/Community Outcomes principle is well-served by treatment courts, as they combine judicial oversight with therapeutic interventions. The public health impact includes improved treatment adherence and completion rates compared to traditional court processing. Public safety is enhanced through intensive supervision combined with treatment, which research shows that treatment courts reduce recidivism more effectively than either strategy alone.[75] The person-centered recovery approach of treatment courts allows for individualized intervention plans that address specific needs rather than applying one-size-fits-all solutions.

For System Durability, treatment courts create formal coordination mechanisms between legal, mental health, and substance use services—addressing a key gap identified by stakeholders. Although establishing treatment courts requires initial investment in training, staffing, and coordination, the approach promotes fiscal sustainability through reduced recidivism and avoided incarceration costs. The model is scalable, allowing Vermont to start with new pilot courts in high-need areas before expanding statewide. Treatment courts also provide a framework for data collection and outcome tracking, enabling continuous quality improvement.

Implementation Considerations: While the benefits of treatment courts are widespread, establishing treatment courts is a long-term solution that would require collaboration between the Legislature, the Judiciary, and the Departments of Mental Health and Corrections. To pursue this policy, the Legislature could establish a working group to provide recommendations on how treatment courts could be established statewide to help limit the strain on court organization, administration, and resources. New Hampshire has also outlined mental health court guidelines, which could be adopted.[76]

6.3.5 Pathway 5: Enhance Parole/Probation Programs and Officers

Issues underlying competency may be ongoing depending on the individual. At Intercept 4 of reentry, Vermont could therefore enhance support for these individuals to prevent repeat involvement in the criminal justice system after their release from incarceration.

Key Components: Individuals with competency-related issues may face ongoing issues related to the underlying causes of their competency-related issues. The individuals could benefit from expanded opportunities for parole (conditional release after one's initial incarceration) and probation (serving one's sentence in the community) alongside increased training for officers, as proposed by Massachusetts stakeholders. One stakeholder highlighted the need for expanded parole and probation options, explaining that some older individuals in the Vermont Department

of Corrections who have been incarcerated and later released on medical furlough were not taken by any nursing home based on their violent criminal history (*i.e.,* homicide). This exemplifies how some incarcerated individuals who require hospice care can die in prison settings without the correctional infrastructure, legal processes, and community resources to receive end of life care outside correctional facilities.

Implementation Benefits: Expanding parole and probation opportunities for individuals with mental health and/or substance use disorders may enhance public health and public safety. By allowing low-risk individuals to enter parole/probation, the court can connect them to specific treatment programs. Within the Parole and Probation Offices, stakeholders indicated a desire to hire individuals with backgrounds in psychology when possible and to provide specific training for parole and probation officers. This training could enhance the officials' working relationships with the individuals they supervise and help to reduce burnout.

Expected Outcomes: Enhanced parole and probation programs could strengthen Access to Justice by creating proportional oversight mechanisms tailored to individual risk and need factors. For individuals with competency-related issues, specialized supervision can ensure they receive necessary treatment while maintaining appropriate accountability. This approach also provides care continuity by spanning the transition from institutional to community settings.

For Individual/Community Outcomes, specialized parole and probation programs offer public health benefits by facilitating ongoing treatment engagement and medication adherence. Public safety is enhanced through structured supervision combined with targeted interventions addressing criminogenic needs. The approach promotes cross-system coordination, ensuring that clinical and correctional systems work together rather than at cross-purposes. Enhanced training for officers improves their ability to recognize and respond appropriately to mental health symptoms, reducing unnecessary violations and revocations.

System Durability could be supported through the efficient use of existing resources. Vermont already has a probation and parole infrastructure; enhancing it with specialized training for these specialized cases requires less investment than creating entirely new programs. This approach promotes workforce capacity by developing specialized skills among existing staff. The policy is also scalable, allowing for gradual implementation as training resources become available. By focusing on transitional support, this approach addresses a critical gap in the current system where individuals often lose treatment connections when moving between systems.

Implementation Considerations: While the Vermont Legislature has a certain role in changing legal requirements for probation and parole, the Vermont Department of Corrections would be responsible for implementing better training for probation and parole officers.

6.3.6 Pathway 6: Expand Diversion Programs

The final informal competency restoration pathway is a broad pathway that includes options at each stage of the Sequential Intercept Model. Diversion programs systematically identify justice-involved individuals early and redirect them to appropriate services to prevent deeper penetration into the criminal justice system. If the Vermont Legislature seeks to implement diversion programs, specific programs would need to be chosen for exploration based on the Legislature's goals. Thus, the following are five main opportunities for diversion based on the Sequential

Intercept Model's stages that could specifically be explored further for implementation in Vermont:[77]

- **Pre-Arrest Diversion (Intercepts 0/1):** Complete diversion from the criminal justice system. Some programs may include:
  - Expanding Crisis Response Teams;
  - Providing public education about the 988 crisis line.
- **Pre-Charge Diversion (Intercept 2):** Diversion from traditional case processing. These programs may include:
  - Conducting mental health screenings upon arrest;
  - Completing pre-trial risk assessments;
  - Connecting individuals to community resources;
  - Diverting cases into civil/treatment courts;
  - Creating a separate jail system for individuals with mental health/substance use disorders.
- **Post-Charge Diversion (Intercept 3):** Diversion from traditional case processing. These programs may include:
  - Tying release and transition to individuals completing their treatment program;
  - Expanding pre-trial release options;
  - Ensuring that the competency process is only for serious crimes, and relevant misdemeanor cases are diverted to treatment;
  - Utilizing treatment courts for diversion.
- **Pre-Conviction Diversion (Intercept 3):** Diversion from traditional case processing. These programs may include:
  - Standardizing treatment best practices to utilize in sentencing policy that highlights community treatment providers for probation and parole.
- **Post-Conviction Diversion and Re-Entry (Intercepts 4/5):** Programs that aim to help individuals re-integrate into their community.
  - Increase opportunities for jail-based restoration/treatment;
  - Expand community-based treatment options in re-entry programs, with Department of Corrections staff connecting individuals to treatment providers;
  - Connect individuals with housing and employment/education options.

7. Conclusion

This research evaluated the landscape of competency restoration programs to help the Vermont House Committee on Judiciary consider changes to the state's current competency process. We collected data through case studies of four states of comparison and Vermont, utilizing comparative analyses, stakeholder interviews, and a review of published data. The results reveal best practices and considerations for competency related programs.

The policy landscapes ultimately inform the potential pathways for Vermont that emerged throughout our research. Stakeholders help inform three principles for evaluating potential policy pathways to implement: 1) Access to Justice, 2) Individual/Community Outcomes, and 3) System Durability. Through the lens of these principles, Vermont stakeholders can consider whether and how to implement a formal or informal competency restoration program. Pathway 1—a formal competency program—could require state-intensive resources for a small population but has the potential to create high competency restoration rates based on the efficacy of other such

programs.[78] Alternatively, policies exist for informal competency restoration programs including Pathways involving: 2) community-based mental health and substance abuse treatment, 3) local crisis outreach and response teams, 4) treatment courts, 5) parole/probation programs and officers, and 6) diversion programs. Each formal and informal pathway holds different strengths related to the principles for analysis.

Given the complexity of the historical and current interactions between health and the justice system, improving competency restoration outcomes may require one or many approaches. Our different pathways achieve different goals for the Vermont Legislature to consider implementing. With this research, we believe that the Legislature can effectively consider the path forward for competency restoration in Vermont.

Appendix A: Expert Interview Guide Overview

Background

- Establish an understanding of the interviewee's position and previous roles;
- Understand the interviewee's connection to competency restoration and forensic healthcare.

System Structure

- Identify the type of programming in place for the interviewee's state;
- Identify competency evaluation methods and standards for reevaluation;
- Define the purpose of competency restoration and program goals;
- Identify existing alternative diversion or forensic treatment programs in lieu or in addition to competency restoration.

System Evaluation

- Reflect on balancing legal timelines and requirements with clinical needs;
- Define measures of program success and restoration;
- Reflect on what resources could better help program participants;
- Identify what data collection is needed;
- Identify the population needs of the state and where programming may face limitations in accessibility.

Integration and Future Development

- Highlight main stakeholders and partnerships in forensic healthcare programming;
- Reflect on what other jurisdictions should consider when implementing similar programs;
- Identify any alternative approaches to competency restoration that should be considered.

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