

**IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION**

DEBRA DARRINGTON, as next friend)	
for M.R., et al., <i>on behalf of themselves</i>)	
<i>and others similarly situated,</i>)	
)	
Plaintiffs,)	Case No. 2:25-cv-04268-MDH
)	
v.)	
)	
MISSOURI DEPARTMENT OF)	Hearing Requested
MENTAL HEALTH, et al.)	
)	
Defendants.)	

PLAINTIFF’S MOTION FOR PRELIMINARY INJUNCTION

COME NOW Plaintiffs, through their Court appointed Next Friends and undersigned counsel, and move this Court pursuant to Federal Rule of Civil Procedure 65(a) for entry of a preliminary injunction following an evidentiary hearing. In support of this motion, Plaintiffs state:

1. This case concerns the unconstitutionally prolonged pretrial detention of people suffering from serious mental health disorders or cognitive disabilities in Missouri’s jails. Plaintiffs and other similarly situated individuals¹ (collectively, “Plaintiffs”), who are either suspected of being or have already been deemed incompetent to stand trial (“IST”), are regularly housed in Missouri’s jails for months, and in some cases years, while they await their court-ordered competency treatment. These unreasonable wait times, caused by Defendants, deprive Plaintiffs of their due process rights protected by the Fourteenth Amendment.

2. Entry of a preliminary injunction is appropriate because Plaintiffs (i) are likely to succeed on the merits of their claims, (ii) face substantial risk of irreparable harm absent a

¹ At time of filing, the Court has yet to rule on Plaintiffs’ motion to certify the class. Doc. 5.

preliminary injunction, (iii) such harm to Plaintiffs absent an injunction far outweigh any harm in injunction would cause Defendants, and (iv) the issuance of an injunction is in the public interest.

3. For the reasons set forth here—and more fully set forth in the accompanying suggestions in support, which are fully incorporated herein—Plaintiffs are entitled to injunctive relief, and the Court should issue a preliminary injunction:

- a. Requiring Defendants to complete all currently pending capacity evaluations for all Plaintiffs still on the waitlist within 60 days of a judicial order directing such evaluations;
- b. Requiring Defendants to complete all future court-ordered capacity evaluations within 60 days of a judicial order directing such evaluations;
- c. Requiring Defendants to provide mental health services and competency restoration treatment to all Plaintiffs and class members within a constitutionally appropriate time, not to exceed 30 days, following a commitment order, said treatment to be provided either in a DMH facility or another suitable and the most integrated setting possible (e.g., in a hospital or community-based treatment center) and, in any event, not in a jail setting; and
- d. Requiring Defendants to file, within 21 days of the Court's order, a detailed proposal explaining how they will comply with the injunctive Order.

4. Because the Plaintiffs are indigent and because their fundamental constitutional rights are at stake, the bond requirement should be waived pursuant to Federal Rule Civil Procedure 65(c).

5. Plaintiffs request an evidentiary hearing on the relief sought herein.

WHEREFORE, Plaintiffs respectfully request that the Court grant their motion for a preliminary injunction requiring Defendants to create a detailed proposal for how they will ensure Plaintiffs are evaluated and provided with competency restoration services within a constitutionally permissible timeframe and grant such other relief which the Court deems just and proper.

Dated: March 9, 2026

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that a copy of the foregoing was filed electronically and served by operation of the CM/ECF system on all counsel of record on March 9, 2026.

/s/ Amy Malinowski

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**PLAINTIFFS' SUGGESTIONS IN SUPPORT OF
MOTION FOR PRELIMINARY INJUNCTION**

This case concerns the unconstitutionally prolonged pretrial detention of people suffering from serious mental health disorders or cognitive disabilities in Missouri's jails. Plaintiffs and other similarly situated individuals who are members of the putative class (collectively, "Plaintiffs") are either suspected of being or have already been deemed incompetent to stand trial ("IST") and are regularly housed in Missouri's jails for months, in some cases years, while they await their court-ordered competency treatment. These unreasonable wait times, caused by Defendants, deprive Plaintiffs of their due process rights protected by the Fourteenth Amendment and violate Title II of the Americans with Disabilities Act of 1990 ("ADA") and Section 504 of the Rehabilitation Act of 1973 ("RA").

Plaintiffs experience persistent, prolonged, and profound harm because of these unconstitutional delays, which are caused by Defendants. Plaintiffs—pre-trial detainees who suffer from mental health conditions or cognitive disabilities severe enough that they are suspected of or have been deemed IST—are forced to endure months of detention in facilities that are not equipped to treat or safely house them. This often results in Plaintiffs receiving inadequate (or no) medication to manage their conditions and being placed in solitary confinement or similarly isolating settings, causing additional harm. Plaintiffs' prolonged confinement—often in solitary cells—in inadequate facilities exacerbates their underlying mental conditions, unduly escalates the risk of harm to themselves and others, and undermines Missouri's interest in capacity restoration. These delays and their concomitant harms to Plaintiffs are a direct result of the Missouri Department of Mental Health's ("DMH") and Defendants' failure to provide prompt capacity evaluations and restoration treatment as required by law.

Pursuant to Rule 65 of the Federal Rules of Civil Procedure, Plaintiffs seek a preliminary injunction finding that they are likely to succeed on the merits and requiring Defendants, within twenty-one (21) days of the Court's order, to file a detailed proposal explaining how they will comply with the Court's order, and specifically addressing how they will:

- (1) ensure that Defendants complete all currently pending court-ordered capacity evaluations for all Plaintiffs still on the waitlist within 60 days of the order;
- (2) ensure that Defendants complete all future court-ordered capacity evaluations within 60 days of a judicial order directing such evaluations;
- (3) ensure that Defendants provide mental health services and competency restoration treatment to all Plaintiffs within a constitutionally appropriate time, not to exceed 30 days, following a commitment order, with said treatment to be provided either in a DMH facility or another suitable and most-integrated setting possible (e.g., in a hospital or community-based treatment center) and, in any event, not in a jail setting.

Such relief is necessary and narrowly tailored to remedy the ongoing violation of Plaintiffs' rights while more comprehensive and sustained solutions are developed in this litigation. At the time of filing, the Court has yet to rule in Plaintiffs' motion to certify the class. Doc. 5. Plaintiffs' arguments in these suggestions in support regarding Plaintiffs' entitlement to a preliminary injunction apply with equal force to all class members.

BACKGROUND

The criminal conviction of an accused deemed legally incompetent violates the Fourteenth Amendment's Due Process Clause, and states are obligated to ensure their procedures sufficiently protect this right. *Pate v. Robinson*, 383 U.S. 375, 378 (1966). The long-recognized test for a person's capacity to stand trial is "whether [the accused] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational

as well as factual understanding of the proceedings against him.” *Dusky v. United States*, 362 U.S. 402, 402 (1960). In *Jackson v. Indiana*, the Supreme Court held that “a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future.” 406 U.S. 715, 738 (1972). Therefore, if accused who have been judicially deemed IST are held in confinement at the hands of the state for more than such a reasonable period of time, the state violates their rights to due process.

While Chapter 522 of the Missouri Revised Statutes provides a process and some protections to an accused deemed IST, the system it contemplates is broken. Wait times to receive competency evaluations and competency restoration treatment in Missouri are unreasonably long under the *Jackson* standard. As a result, and absent intervention by this Court, Plaintiffs suffer and will continue to suffer irreparable harm.

A. Missouri’s Statutory Process

Missouri’s process starts with the presiding judge ordering a competency evaluation of a criminal defendant. Mo. Rev. Stat. § 552.020.2. This evaluation and an accompanying report “shall be completed and filed with the court within sixty days of the order unless the court for good cause orders otherwise.” *Id.*

The evaluation report must contain, in relevant part, recommendations as to: (1) “whether the accused should be held in custody in a suitable hospital facility for treatment pending determination” of competency to proceed; (2) “whether the accused, if found by the court to be mentally fit to proceed, should be detained in such hospital facility pending further proceedings”; (3) “whether the accused, if found by the court to lack the mental fitness to proceed, should be

committed to a suitable hospital facility for treatment to restore the mental fitness to proceed or if such treatment to restore the mental fitness to proceed can be provided in a county jail or other detention facility approved by the director or designee”; and (4) if not charged with a dangerous felony, murder in the first degree, or rape in the second degree, or attempts thereof, “whether the accused, if found by the court to lack the mental fitness to proceed . . . (a) [s]hould be committed to a suitable hospital facility; or (b) [m]ay be appropriately treated in the community” *Id.* at §§ 552.020.3(5)–(8). The evaluation’s central purpose is to recommend to the judge the appropriate next steps to either (1) begin civil commitment procedures for those deemed unlikely to obtain capacity, or (2) attempt to restore the accused’s capacity via mental health treatment.

Once the evaluation report is filed, the court “may order that the accused be committed to or held in a suitable hospital facility pending determination of the issue of mental fitness to proceed,” if the report makes such a recommendation and the accused is not released on bail or other conditions. *Id.* at § 552.020.6. And “[i]f the court determines that the accused lacks mental fitness to proceed, the criminal proceedings shall be suspended and the court shall commit him or her to the director . . . [who] shall notify the court and the parties of the location and conditions for treatment.” *Id.* at § 552.020.10. The statute is silent as to how quickly an accused who has been ordered committed must be placed in a DMH facility for treatment.

After an accused has been committed to DMH custody for a maximum of six months, the court must again order a competency evaluation “to ascertain whether the accused is mentally fit to proceed and if not, whether there is a substantial probability that the accused will attain the mental fitness to proceed to trial in the foreseeable future.” *Id.* at § 552.020.12(1). Once ordered, such an evaluation report must be filed with the court within thirty days. *Id.* If the accused is again found IST “but there is substantial probability the accused will be mentally fit to proceed in the

reasonably foreseeable future, the court shall continue such commitment for a period not longer than six months,” and then another evaluation is conducted. *Id.* at § 552.020.12(5). But if the accused is found to lack the mental fitness to proceed “and there is no substantial probability that the accused will be mentally fit to proceed in the reasonably foreseeable future, the court shall dismiss the charges without prejudice and the accused shall be discharged” pursuant to proper procedures. *Id.* at § 552.020.12(6).

B. Defendants’ Failure to Follow the Law

Defendants have been consistently dilatory in their statutory duties. Plaintiffs and hundreds of others languish in county jails for six months or more waiting for judicially ordered evaluations.¹ Once determined IST and ordered committed to DMH custody, Plaintiffs then wait an average of fifteen additional months, almost always while still being housed in local jails, to receive restoration treatment through DMH.²

These extended wait times are a direct result of Defendants’ failure to follow the law. Worse, the situation is rapidly deteriorating. Just three years ago in 2023, the average wait time for restoration treatment was eight months,³ nearly half of what it is now. Reports of longer than average wait times abound. An accused in the Clay County Detention Center has been waiting to receive court-ordered mental health services from DMH for over 469 days.⁴ Another Missouri jail

¹ Declaration of Annie Legomsky, Doc. 6-3 (“Legomsky Decl.”), ¶ 4.

² Expert Declaration of Lauren Kois, PhD; Neil Gowensmith, PhD; and Daniel Murrie, PhD, (“Groundswell Decl.”), attached hereto as **Exhibit 1**, ¶ 13.

³ Clara Bates, *Missourians wait an average of 8 months in jail for court-ordered mental health services*, ST. LOUIS PUB. RADIO (Sept. 20, 2025, at 10:26 a.m. CDT), <https://www.stlpr.org/government-politics-issues/2023-09-20/missourians-wait-an-average-of-8-months-in-jail-for-court-ordered-mental-health-services>.

⁴ Steph Quinn, *Nearly 500 Missourians awaiting court-ordered mental health services, an all-time high*, MO. INDEP. (Oct. 27, 2025, at 5:55 a.m.), <https://missouriindependent.com/2025/10/27/nearly-500-missourians-awaiting-court-ordered-mental-health-services-an-all-time-high/>.

reported an instance of an accused waiting over *three years* for an initial evaluation.⁵ In some instances, the wait times for treatment extend beyond the maximum sentences available for the crimes charged.^{6, 7}

While average wait times for evaluation and restoration treatment have ballooned, so have the waitlists for these services. In 2013, the waitlist to enter a facility for restorative treatment was ten names long.⁸ By July 2023, the number had risen to 252,⁹ a twenty-five-fold increase. By August 2025, the average number was 492,¹⁰ nearly doubling in a two-year span. By January 2026, the waitlist reached an all-time high of 528.¹¹ And there are currently about 200 accused simply waiting for initial evaluation.¹²

This waitlist was a predictable result of budget cuts and closures of facilities, which were directly tied to decisions made by Defendants.¹³ The Director of DMH, Valerie Huhn (the “Director”), has acknowledged that ten years ago, DMH had hundreds of additional beds and resources available.¹⁴ Yet, even as the waitlist rapidly grew, DMH decreased available forensic beds.

⁵ *Mental Health Needs in Missouri Jails Part I: Surveying County Sheriffs & Jail Administrators*, Missouri Appleseed (September 2025), at 15 (“Missouri Appleseed Report”) (Doc. 6-5).

⁶ Legomsky Decl., ¶ 5.

⁷ Ex. 1, Groundswell Decl., ¶ 13.

⁸ *Wait for Competency Restoration, Averages 14 Months in Missouri Jails*, PRISON LEGAL NEWS (May 1, 2025), <https://www.prisonlegalnews.org/news/2025/may/1/wait-competency-restoration-averages-14-months-missouri-jails/>.

⁹ *House May Mental Health Committee Hearing*, Mo. Dep’t of Mental Health (May 5, 2025), at 6, <https://www.documentcloud.org/documents/25931693-house-may-health-mental-health-committee-hearing-may-5-final/> (hereafter, “May 2025 Mental Health Committee Meeting”).

¹⁰ *Nearly 500 Missourians*, *supra* n.4.

¹¹ Ex. 1, Groundswell Decl., ¶ 11.

¹² *Id.* (noting 186 individual awaiting evaluations as of January 2026).

¹³ *Id.* ¶ 21.a.

¹⁴ *Id.* ¶ 21.a. & n.28, n.30 (citing the DMH report on facility closures over time); *see also* Hearing Before the Comm. on Corr. and Public Institutions, 2025 Leg. 103, Statements of Huhn and Simmons on behalf of DMH, [https://sg001-harmony.sliq.net/00325/Harmony/en/PowerBrowser/PowerBrowserV2/20200831/-](https://sg001-harmony.sliq.net/00325/Harmony/en/PowerBrowser/PowerBrowserV2/20200831/)

As early as 2022, DMH was aware that the waitlist was growing and that the State was appropriating insufficient resources to reverse the wait times.¹⁵ But the Defendants are only implementing limited solutions that cannot solve the problem. In late 2025, at a time where there were over 538 persons on the waitlist, DMH made one supplemental appropriation request for the 2026 fiscal year (“FY26”) that related to the waitlist: to serve an additional 25 individuals for outpatient competency restoration.¹⁶ Similarly, DMH sought only one increase in its proposed FY27 budget that related to the waitlist: for 50 individuals to be treated in community-based programs.¹⁷ While in theory this would provide some limited relief, the Director, also acknowledged in her testimony to the Missouri House Budget Committee that, although the department was requesting funding for 50 persons, it only had service providers ready for 8 persons.¹⁸ DMH is not seeking any funding for an immediate increase in available beds and has stated the soonest it plans to have additional beds is 2030.¹⁹

It is simple math: additional resources for 25 or 50 people will not solve a waitlist that has grown by over 5000% since 2013. Moreover, while the Governor states that timely treatment is a priority, he also recommended a cut of \$42.8 million from DMH’s overall budget request for

1/13438?mediaStartTime=20250908101656&mediaEndTime=20250908103324&viewMode=3&globalStreamId=4, at 10:33:00 (receiving questions about closed and reduced-capacity facilities).

¹⁵ See *May 2025 Mental Health Committee Hearing*, *supra* n.9, at 6.

¹⁶ *Supplemental New Decision Item: Utilization Cost Increase*, FY 2026 Supplemental Appropriations Department Request, at 127, <https://budplan.ia.mo.gov/media/pdf/fy26-supplemental-appropriation-department-requests>.

¹⁷ *FY 2027 Budget Request with Governor’s Recommendations Appropriations Book*, Mo. Dep’t of Mental Health, at 5 (Jan. 2026), <https://budplan.ia.mo.gov/media/pdf/fy27-dmh-appropriation-book-governor-recommendations>.

¹⁸ House Budget Committee Hearing, Mo. Dep’t of Mental Health at 8:34:28–8:35:09 (Feb. 10, 2026), <https://sg001-harmony.sliq.net/00325/Harmony/en/PowerBrowser/PowerBrowserV2/20260210/-1/14268?mediaStartTime=20260210082830&mediaEndTime=20260210084500&viewMode=3&globalStreamId=4>.

¹⁹ *Id.* at 8:41:50–8:42:30.

FY27,²⁰ meaning that if the budget passes in a substantially similar form, DMH will be stretched even thinner next year than it is now due to the State's overall budget priorities.

The problem has been so apparent and dramatic that the legislature has demanded information from DMH, and, in 2023, the legislature amended Section 552.020 to allow for additional solutions to address the increasing wait times.²¹ Unfortunately, DMH's implementation of those solutions has been poor, slow, and/or non-existent. For example, the revised law permits individuals charged with a crime and found IST to receive competency restoration treatment in the community (like an outpatient facility or in their family home). Mo. Rev. Stat. § 552.020.3(8)(b). However, as of September 2025, only six accused had participated in community-based restoration programs.²² Unfortunately, the amendments have not resulted in decreased wait times, and instead the situation has only worsened.²³

Simply put: Defendants have not addressed the issues leading to unreasonable delays in competency treatment. This is evident because the problems have only grown.

C. Conditions of Plaintiffs' Confinement and Ongoing Harms

Defendants' failures cause significant, ongoing harms to Plaintiffs, who have been and continue to be improperly housed in jails ill-equipped to handle the mental health needs of this vulnerable population. Plaintiffs experience or are imminently at risk of experiencing several forms of irreparable harm due to Defendants' delay in providing Plaintiffs with adequate evaluation and treatment. *First*, correctional staff in local jails lack adequate training and resources to care for and protect individuals with mental illness and often resort to using restraints, solitary

²⁰ *2026 Legislative and Budget Priorities: A Foundation for Growth*, Missouri Governor Mike Kehoe, at 5, <https://budplan.oa.mo.gov/media/pdf/fy2027-budget-and-legislative-priorities>.

²¹ Ex. 1, Groundswell Decl., ¶ 19.

²² *Id.* ¶ 26.c.iii.

²³ *Id.* ¶ 19.d.

confinement/room restriction, or even physical abuse in attempting to control Plaintiffs. *Second*, Plaintiffs’ confinement in jails alone exacerbates symptoms and results in worse prognoses. But solitary confinement—which untrained staff regularly use to control Plaintiffs—causes even greater harm. *Third*, Plaintiffs confined in jails across the State lack access to prescribed medication or other needed therapies, further compounding the problem.²⁴ Subject to the control of staff unequipped to handle mental health crises, isolated from others, and lacking access to necessary care, Plaintiffs are at increased risk of decompensation, making later capacity restoration more difficult or even impossible.²⁵ The cause of these harms is Defendants’ failures, and Plaintiffs suffer and will continue to suffer them absent the Court’s intervention.

Persons suffering from serious mental illness (“SMI”), like Plaintiffs, disproportionately suffer harms at the hands of other inmates or correctional staff.²⁶ A preliminary report by Dr. Terry Kupers, a clinical psychiatrist retained as an expert for Plaintiffs, describes why jail environments are harmful to people like the Plaintiffs.²⁷ Because Plaintiffs struggle to understand and follow a jail’s strict rules, correctional staff resort to use of chemical sprays, electric shock from stun devices, physical restraint in chairs or beds that can sometimes last days, and other serious harms resulting from physical assaults perpetrated by jail staff in pursuit of control.²⁸ In contrast, these abuses are often entirely absent when an accused designated IST receives restoration services in

²⁴ Legomsky Decl., ¶ 7.

²⁵ *Id.* ¶¶ 7–8.

²⁶ Preliminary Expert Report of Dr. Terry A. Kupers, M.D., M.S.P., (hereinafter “Kupers Prelim. Report”), attached hereto as **Exhibit 2**, at 14–16.

²⁷ Dr. Kupers is nationally recognized expert on carceral mental health issues, including solitary confinement. He is a board-certified psychiatrist, Institute Professor Emeritus at the Wright Institute, and a Distinguished Life Fellow of the American Psychiatric Association. His other education, training, and experience is detailed in his preliminary report and CV. Ex. 2, Kupers Prelim. Report at 1–2.

²⁸ *Id.* at 14.

State-run psychiatric hospitals, which, unlike local jails, are equipped to treat Plaintiffs' mental health needs.²⁹

Plaintiffs, like most incarcerated individuals suffering from SMI, are often isolated, either intentionally by jail staff or by choice.³⁰ Generally, in larger, more crowded jails, individuals suffering from SMI are placed in solitary confinement because the staff is untrained in dealing with mental health crises or otherwise cannot control them.³¹ Individuals with SMI who are placed in solitary confinement or other isolation do not receive mental health treatment.³² And the longer they are isolated, the worse their eventual prognoses.³³ “Indeed, when individuals deemed IST wait long periods in jail for assessment and then for competency restoration treatment, because of harsh and punitive jail conditions and the delay in instituting adequate treatment, they become more disturbed and more difficult to restore to competency.”³⁴ The Director has acknowledged as much.³⁵ And Defendants' failures have not only increased Plaintiffs' risks of decompensation, but suicide risk also increases in direct proportion to wait times in jails without adequate restorative treatment.³⁶ Again, these risks can be greatly mitigated or entirely eliminated if DMH provided Plaintiffs with proper restorative treatment in an appropriate environment.³⁷

Generally, jails do not provide mental health treatment that is remotely equivalent to what Plaintiffs would receive in community-based care or at DMH-run inpatient treatment facilities.³⁸

²⁹ *Id.* at 21–23.

³⁰ *Id.* at 16.

³¹ *Id.* at 16–17.

³² *Id.* at 16.

³³ *See id.* at 11–12.

³⁴ *Id.* at 11.

³⁵ *Id.* at 11–12.

³⁶ *Id.* at 12, 19–20, 24.

³⁷ *Id.* at 20–24 (contrasting jail settings with state-run hospitals providing restoration services).

³⁸ *See id.*

Typically, jails cannot offer individual therapy or group-based therapeutic activities. Many individuals found to be IST, including Plaintiffs, require assistance with activities of daily living such as basic hygiene or using the restroom. For example, when in the community, Plaintiff D.W. had a case worker visit him daily to assist him in eating and using the toilet.³⁹ Since D.W. has been incarcerated, he has lost a great deal of weight.⁴⁰ And, due to his SMI, he is fully incontinent at the age of thirty and constantly urinates and defecates in his cell.⁴¹ Understandably, this causes tension and puts a burden on the correctional staff.

Jails, in many cases, do not or cannot provide Plaintiffs with adequate medication.⁴² This is either because of limited availability, the lack of connection between the in-jail psychiatrist and the experienced care teams outside of jails, or because jails cannot force individuals to take medication.⁴³ And even if Plaintiffs are getting medications in jail, medication alone does not make for effective restorative treatment.^{44, 45} As explained by Dr. Kupers:

Mental health treatment involves a lot more than meeting a few times per week with the DMH forensic mobile team at the jail and the prescription of psychotropic medications. The brief time an IST jail detainee sees mobile team members each week does not nearly compensate for the seven days a week the individual remains in jail subject to a harsh disciplinary system with punishments meted by custody staff, use of force and restraint by custody staff, victimization by other prisoners who stigmatize mental illness, and the large proportion of the IST detainee's time spent alone and mainly idle in a jail cell, if not in Administrative Segregation or Protective Custody – the two official forms of solitary confinement.⁴⁶

³⁹ Declaration of Delicia Walker, Next Friend to Plaintiff D.W. (“Walker Decl.”), attached hereto as **Exhibit 3**, ¶¶ 4, 9.

⁴⁰ *Id.* ¶ 8.

⁴¹ *Id.* ¶ 9.

⁴² Ex. 2, Kupers Prelim. Report at 7.

⁴³ *See id.* at 7–8, 10–11.

⁴⁴ *Id.* at 30.

⁴⁵ Ex. 1, Groundswell Decl., ¶ 26.f.

⁴⁶ Ex. 2, Kupers Prelim. Report at 30.

Without sufficient access to medications or mental health treatment while housed in jail, Plaintiffs suffer ongoing harms.⁴⁷ DMH has attempted to alleviate these harms by launching limited mobile treatment teams, but these attempts have failed.⁴⁸ In theory, these teams conduct medical and psychiatric assessments, offer supportive psychotherapy, provide case management, and prescribe medication.⁴⁹ However, in reality, the few mobile teams operate with a medication-focused approach that prioritizes symptom management.⁵⁰ The teams do not provide the kinds of comprehensive restoration services that are available in DMH treatment facilities, increasing Plaintiffs' risks of decompensation.⁵¹ These methods pale in comparison to the implementation of comprehensive restoration services, which, when properly implemented, provide an increased capacity for that type of restoration treatment.⁵²

1. Plaintiff C.T.

These risks are not hypothetical. For many Plaintiffs, they are already a reality. For instance, Plaintiff C.T. has decompensated so severely that since being jailed in January 2024, he has been placed on suicide watch on at least three separate occasions.⁵³ Immediately following his incarceration in January 2024, intake and receiving screening records reflect significant mental-health concerns that resulted in his placement on suicide and detox watch, followed by full suicide precautions.⁵⁴ C.T.'s condition only continues to deteriorate in jail. On April 2, 2025, he reported feeling actively suicidal, and jail staff, acting on a psychologist's recommendation,

⁴⁷ *Id.* at 32–33 (Opinions 9 and 10).

⁴⁸ Ex. 1, Groundswell Decl., ¶ 20.

⁴⁹ *Id.* ¶ 20.a.

⁵⁰ *Id.* ¶¶ 20.a–b.

⁵¹ *Id.* ¶ 20.

⁵² *Id.* ¶ 26.e.

⁵³ Ex. 2, Kupers Prelim. Report at 25–26.

⁵⁴ Ex. 4, C.T. Medical Records at 231–32, 266–73.

again placed him on full suicide watch with constant monitoring.⁵⁵ Throughout the first half of April 2025, C.T. remained on continuous suicide watch for approximately ten days, with repeated crisis-monitoring and mental-health records documenting that he was maintained on full suicide precautions due to persistent risk of self-harm and severe psychiatric decompensation, including observations that he was speaking incoherently and talking to himself.⁵⁶ And in August 2025, amid ongoing psychosis, C.T. was again placed on suicide watch.⁵⁷

These repeated suicide-watch placements demonstrate the profound psychological harm C.T. has suffered during his jail confinement. In each instance, rather than receiving therapeutic intervention at the hands of dedicated mental health staff (as would be available if treated in a DMH-run facility), C.T.'s mental-health crises were addressed through isolation and observation status alone. While these measures may reduce the immediate risk of self-harm, they do nothing to treat his underlying SMI, which is necessary to restore him to competency. Indeed, after reviewing medical records from C.T.'s detention at the St. Louis City Justice Center, Dr. Kupers concluded:

I can confidently say, to a reasonable degree of medical certainty, that had [C.T.] been transferred to a state hospital timely, instead of waiting so long in the jail, his psychiatric condition would not have deteriorated, and his repeated suicide crises would have been met with more intensive crisis intervention, the result likely being much less inclination to harm himself.⁵⁸

2. Plaintiff M.R.

Plaintiff M.R. has likewise endured grievous harm while waiting for DMH treatment. M.R. entered jail on April 11, 2024. During his prolonged incarceration without treatment, his mental

⁵⁵ *Id.* at 231–32, 380–410.

⁵⁶ *Id.* at 374–79, 380–410.

⁵⁷ *Id.* at 231–34, 380–450.

⁵⁸ Ex. 2, Kupers Prelim. Report at 26.

health deteriorated.⁵⁹ His jail medical records not only confirmed his diagnosis of schizophrenia and other serious mental illnesses, but prior treatment for schizophrenia.⁶⁰ Notably, while M.R. denied experiencing hallucinations at the time of his initial intake, by April 2025 he was reporting active visual and auditory hallucinations—seeing people “that quickly disappear” and conversing with voices only he can hear.⁶¹ Jail mental health staff have observed M.R. exhibiting disorganized, delusional speech and bizarre behavior indicative of uncontrolled psychosis.⁶² During phone calls with his grandmother, M.R. expressed deep concerns that people were out to kill him, and he feared for his safety.⁶³ His paranoia resulted in him believing that five inmates were “going to get me,” and he feared that he would be beaten.⁶⁴ M.R. also would tell his grandmother that he couldn’t wait to get home to his wife and kids, despite not being married or having children.⁶⁵ Yet M.R. waited fifteen months to receive mental health restoration treatment at the hands of DMH.⁶⁶ As noted in Dr. Kupers’ preliminary report, during M.R.’s time in the jail, he met with a psychiatrist once every four months and his medical records show that he had only a few sessions with mental health providers during his entire fifteen month wait.⁶⁷

Possibly most troubling, M.R. grew increasingly desperate about the indefinite nature of his confinement. On multiple occasions, he asked jail staff about when DMH will transfer him for treatment, only to learn that he simply remained on the waitlist. For example, during a mental health visit on December 15, 2024, M.R. asked “where on the list” he was for a state hospital bed;

⁵⁹ *Id.* at 26; Ex. 7, Second Declaration of Debra Darrington (“Darrington Decl.”), ¶ 14.

⁶⁰ Ex. 2, Kupers Prelim. Report at 26.

⁶¹ Ex. 5, M.R. Medical Records at 18.

⁶² *Id.* at 118, 195.

⁶³ Ex. 7, Darrington Decl., ¶ 15.

⁶⁴ *Id.*

⁶⁵ *Id.* ¶ 14.

⁶⁶ Ex. 2, Kupers Prelim. Report at 26.

⁶⁷ *Id.*

the jail's Qualified Mental Health Professional ("QMHP") could only advise M.R. to be patient and wait because no bed was yet available.⁶⁸ A full year later, M.R. again pleaded for information about the "DMH program," and the treating nurse consulted with the jail's mental health staff only to confirm that M.R. was still "on the list" for DMH services.⁶⁹

3. Plaintiff O.J.

Plaintiff O.J. was detained at the Greene County Jail between October 2023 and January 21, 2026, and spent **530** days in jail on a waitlist for competency restoration services.⁷⁰ When O.J. was admitted to the jail, he reported he had been diagnosed with schizophrenia and depression and was taking Trazadone (an antidepressant with sedative side effect).⁷¹ In the jail he was prescribed two strong anti-psychotic medications at therapeutic dosages, as well as Trazadone.⁷² At times at the jail he was reported to have descended into an acute psychotic decompensation.⁷³ O.J. was prescribed anti-psychotic medications throughout his stay at the jail, with psychotherapy sessions lasting approximately 15 minutes a few times per month through 2025 noted in the chart.⁷⁴ He was typically described as "lethargic with blunted affect," speech noted to be "pressured" on multiple occasions, he was occasionally described as "paranoid" and "manic" and his reported "distressing" auditory and visual hallucinations continued throughout his stay in the jail.⁷⁵ His medications were adjusted periodically, but he was prescribed strong anti-psychotic medications throughout his stay.⁷⁶

⁶⁸ Ex. 5, M.R. Medical Records at 202.

⁶⁹ *Id.* at 129.

⁷⁰ Ex. 2, Kupers Prelim. Report at 27.

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*; see also Ex. 6, O.J. Medical Records.

As summarized by Dr. Kupers, “Mr. O.J. was suffering chronic Schizophrenia and Depression, with occasional acute psychotic episodes, which were managed at the jail with psychotropic medications and some individual psychotherapy. He took part in no other treatment or rehabilitation programs and seems to have spent most of his time in his cell.”⁷⁷

4. Plaintiff K.M.

K.M., a 64-year-old Black man, has been detained at the Buchanan County Jail since June 2024. He has been on a DMH waitlist for restoration services since January 24, 2025: 409 days. At the time of his arrest, K.M. was living on his own and supporting himself financially.⁷⁸ Before his detention at the Buchanan County Jail, K.M.’s brother Eric says they were able to talk every week, either by phone or in person.⁷⁹ For many months, Eric and K.M.’s other family members were denied visits due to concerns with K.M.’s mental health, but Eric visits K.M. regularly now and reports observing that K.M. lost weight and that his continued detention is negatively affecting his mental health.⁸⁰ K.M. does not have a typical cell at the jail (with bunk, toilet, sink), but is kept in the booking area.⁸¹ He is only allowed out of his cell for showers and visitors; he spends almost all of his time by himself in his cell.⁸²

LEGAL STANDARD

District courts consider four factors when deciding to grant a preliminary injunction: “(1) the threat of irreparable harm to the movant; (2) the state of the balance between this harm and the injury that granting the injunction will inflict on other parties litigant; (3) the probability that the movant will succeed on the merits; and (4) the public interest.” *CEZ Prior, LLC v. 755 N Prior*

⁷⁷ *Id.*

⁷⁸ Ex. 8, Second Declaration of Eric Massey, ¶ 3.

⁷⁹ *Id.* ¶ 4.

⁸⁰ *Id.* ¶¶ 5–7, 10–12.

⁸¹ *Id.* ¶ 8.

⁸² *Id.* ¶¶ 8, 9.

Ave. LLC, 126 F.4th 1353, 1358 (8th Cir. 2025) (quoting *Dataphase Sys., Inc. v. C L Sys., Inc.*, 640 F.2d 109, 113 (8th Cir. 1981) (en banc)); see also *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008) (“A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of the equities tips in his favor, and that an injunction is in the public interest.”). While no single factor is determinative, the probability of success is the most significant. *Sleep No. Corp. v. Young*, 33 F.4th 1012, 1016 (8th Cir. 2022). To succeed on a motion for preliminary injunction in this case, the movants need not show that they are more likely than not to succeed but instead need only to show that they have a “fair chance” of prevailing on the merits of their claim. *Id.* at 1017–18 (explaining that the fair-chance standard does not require a claimant to show that the claims have a likelihood of success that is greater than fifty percent); see also *D.M. ex rel. Xiong v. Minn. State High Sch. League*, 917 F.3d 994, 999–1000 (8th Cir. 2019) (acknowledging that the fair-chance standard is a less rigorous standard and explaining that it applies to cases in which the Plaintiffs are *not* seeking to enjoin a “duly enacted state statute”) (quoting *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 732 (8th Cir. 2008)).

ARGUMENT

A. **Plaintiffs are Likely to Succeed on the Merits of Their Due Process Claims**

Defendants’ failure to provide timely evaluations and restorative treatment to those suspected to be or already deemed IST violates Plaintiffs’ rights under the Fourteenth Amendment’s Due Process Clause, the ADA, and the RA. For purposes of this Motion, Plaintiffs seek preliminary injunctive relief on the Due Process claims (Counts I and II).

Plaintiffs are likely to prevail on their claims for violations of their Fourteenth Amendment right to due process because Plaintiffs routinely sit in jail for months or even years awaiting their court-ordered evaluations and restoration treatment that Defendants are legally obligated and

mandated to provide. The excessive wait times Plaintiffs experience violate *Jackson*'s mandate that the pre-trial detention of a defendant deemed IST be limited to a "reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future." 406 U.S. at 738. Defendants' delays are systemic and extend well beyond any reasonable time necessary to make these mandated determinations.

The prolonged pre-trial detention Plaintiffs experience violates their substantive due process rights for three reasons: (1) the nature and duration of their confinement is not reasonably related to capacity restoration, and instead undermines their chances for restoration; (2) such long periods of confinement constitute de facto punishment without Plaintiffs' being convicted of a crime; and (3) Defendants' denial of prompt evaluations and restoration services deprives Plaintiffs of their liberty interests in health and safety.

1. Plaintiffs' Prolonged Confinement in Jails is Not Reasonably Related to Capacity Assessment or Restoration

Plaintiffs languish in jails waiting for judicially ordered and statutorily mandated evaluations and restorative treatment only because of Defendants' consistent failure to provide timely services. These excessive wait times unreasonably deprive Plaintiffs of liberty and violate due process.

In *Jackson*, the Supreme Court examined the case of an intellectually disabled, deaf, and mute man who was unable to "read, write, or otherwise communicate except through limited sign language." 406 U.S. at 717. Mr. Jackson was charged with robbery, and the state court initiated Indiana's then-existing process for determining his competency to stand trial. *Id.* As required by Indiana law, Mr. Jackson was examined by two psychiatrists, who both concluded that Mr. Jackson was unable to understand the charges against him or participate in his defense. *Id.* at 718. Both doctors testified that it was unlikely Mr. Jackson would ever gain competency to stand trial. *Id.* at

718–19. The Indiana court then ordered that Mr. Jackson be committed “to the Indiana Department of Mental Health until such time as that Department should certify to the court that the defendant is sane.” *Id.* at 719 (internal quotation marks omitted). Mr. Jackson appealed this order arguing that his due process rights were violated by the court’s imposition of what amounted to indefinite commitment without having first found him criminally liable. *Id.*

The Supreme Court agreed, stating that “[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.” *Id.* at 738. Thus, a criminal defendant “committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future.” *Id.* If capacity restoration is not substantially likely, “the State must either institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant.” *Id.* The Court’s central legal holding—that the nature and duration of pretrial detention must bear some reasonable relation to the purpose for which the individual is committed—applies equally here.

Following *Jackson*, courts have held that IST pre-trial detainees’ due process rights are violated (or are likely violated) when they are detained in jails for long periods awaiting evaluation or treatment services. *See United States v. Pano-Flores*, 784 F. Supp. 3d 960, 967–67 (W.D. Tex. 2025) (finding that the criminal defendant’s nine-month wait in jail to receive restoration treatment was “undoubtedly unreasonable” and violative of his due process rights, warranting dismissal of the indictment with prejudice); *United States v. McCarthy*, 703 F. Supp. 3d 1377, 1381 (M.D. Fla. 2023) (finding a five-month detention awaiting placement in a hospital treatment facility unconstitutional for violation of due process and not excusable because of lack of available bed

space; finding that, “[t]he constitutional injury of indefinitely depriving a presumptively innocent defendant of his liberty should be readily apparent to the Government”); *United States v. Reeves*, 690 F. Supp. 3d 531, 535 (W.D.N.C. 2023) (finding that a nine-month pre-hospitalization detention “simply cannot be squared with” *Jackson’s* “reasonable relation” requirement (internal quotation marks omitted)); *United States v. Donnelly*, 41 F.4th 1102, 1106 (9th Cir. 2022) (finding six-month detention awaiting inpatient restoration treatment impermissible); *Trueblood v. Wash. State Dep’t of Soc. & Health Servs.*, No. C14-1178, 2016 WL 4268933, at *16–17 (W.D. Wash. Aug. 15, 2016) (entering permanent injunction ordering state department to conduct competency evaluation within fourteen days of court order for evaluation); *United States v. Smith*, 764 F. Supp. 2d 541, 545 (W.D.N.Y. 2011) (holding that defendant’s due process rights were likely violated by ten-week pre-hospitalization detention in county jail); *Advoc. Ctr. for Elderly & Disabled v. La. Dep’t of Health & Hosps.*, 731 F. Supp. 2d 603, 620–21 (E.D. La. 2010) (finding wait times of six to nine months for restoration treatment likely violated due process); *Or. Advoc. Ctr. v. Mink*, 322 F.3d 1101, 1106, 1121–23 (9th Cir. 2003) (affirming injunction requiring detainees be admitted to state hospital within seven days of a court finding incapacity to proceed and deeming wait times of one to five months impermissible); *Terry ex rel. Terry v. Hill*, 232 F. Supp. 2d 934, 938, 944 (E.D. Ark. 2002) (finding wait times of eight months for evaluation and over six months for restoration treatment violated due process); *see also Disability L. Ctr. v. Utah*, 180 F. Supp. 3d 998, 1004 (D. Utah 2016) (denying motion to dismiss due process claims brought by pretrial detainees awaiting competency restoration services where “[i]t is not uncommon for these individuals to remain incarcerated in county jails for six months or more after a court orders them transferred to [Utah State Hospital] for treatment” and “in some cases, incompetent defendants are held in jail awaiting transfer to [Utah State Hospital] for periods longer than the length of the

sentence they would serve if found guilty of the crime with which they are charged”). So too should this Court rule.

Lengthy detentions awaiting evaluation and restoration treatment are constitutionally impermissible because they are not reasonably related to the goal of capacity restoration and the state’s interest in bringing defendants to trial. For example, in *Mink*, the Ninth Circuit could not identify any “legitimate state interest in keeping mentally incapacitated criminal defendants locked up in county jails for weeks or months.” 322 F.3d at 1121. The court pointed to evidence showing that Oregon’s jails were largely unequipped to meet the needs of detainees with severe mental health disabilities and that lengthy exposure to typical jail conditions might cause detainees to decompensate, posing a danger to themselves and others. *Id.* at 1106–07. Further, the court found that the Oregon State Hospital’s (“OSH”) failure to promptly admit IST defendants “not only contravenes the legislature’s statutory mandate that OSH provide them with restorative treatment, it also undermines the state’s fundamental interest in bringing the accused to trial” by depriving them of care that might restore capacity. *Id.* at 1121.

The district court for the Eastern District of Arkansas came to a similar conclusion in *Terry*, 232 F. Supp. 2d at 943–45. In that case, the court certified a class of all persons who had been ordered by Arkansas state courts to undergo inpatient forensic mental evaluations or to be committed to the Arkansas State Hospital (“ASH”) for treatment. *Id.* at 935. The class in *Terry* alleged harms similar to those alleged by Plaintiffs and the putative class here regarding the unconstitutionally long wait times the *Terry* class members experienced awaiting transfer to ASH for court-ordered evaluation and competency restoration treatment. *Id.* at 938 (“The average wait is over eight months for inpatient evaluations and over six months for inmates awaiting treatment.”). Based on testimony from both lay and expert witnesses regarding the harms class

members experienced during their extended wait times in county jails—including instances of class members harming themselves or others, being treated with medication in jails unfit to treat individuals with SMI, and otherwise decompensating due to extended wait times without proper mental health treatment—the court found that the class members’ constitutional rights had been violated and noted that, “[t]he lack of inpatient mental health treatment, combined with the prolonged wait in confinement, transgresses the constitution.” *Id.* at 940–41, 943.

This case requires a similar result. In Missouri, IST pre-trial detainees’ average wait time for an initial evaluation is six to eleven *months*, far longer than the sixty days contemplated in Missouri’s statute. The average wait time for admission to a DMH hospital for restoration treatment is 1.5 to 2.8 *years*.⁸³ Some wait far longer. These average wait times are similar to—and, in nearly every instance, exceed—periods courts have deemed unconstitutional.⁸⁴ Worse, in Missouri, as has been the case in other states, some individuals are held in pre-trial detention awaiting these services for as long as or longer than they would be incarcerated if they were convicted and sentenced to the maximum statutory sentence for all of their pending charges.⁸⁵ Defendants simply cannot justify these delays as being reasonably related to the goal of restoration or the initiation of civil commitment hearings, as is required by *Jackson* and Missouri law.

Nothing about these wait times is rehabilitative, nor are the impacts on Plaintiffs negligible. To the contrary, long jail stays without treatment cause significant harm to persons with serious mental illnesses, who are at high risk of psychiatric decompensation in jail.⁸⁶ The lack of appropriate care combined with the stress of the carceral environment often leads to the re-

⁸³ Ex. 1, Groundswell Dec., ¶13.

⁸⁴ See string citation, *supra* at 19–21.

⁸⁵ Legomsky Decl., ¶ 5.

⁸⁶ Ex. 2, Kupers Prelim. Report at 23–24.

emergence of psychiatric symptoms and an increase in self-injury and suicide attempts.⁸⁷ People with SMI are more vulnerable to harm from others while incarcerated and often have difficulty following rules, resulting in disciplinary actions and segregation, which in turn further increases the risk of physical and psychological harms.⁸⁸ Timely assessment and treatment of Plaintiffs are crucial to prevent these harms. As noted above, Defendants have made budgetary and operational choices that limit the number of individuals who can be treated at any given time in DMH facilities. This is a system that Defendants are uniquely positioned to fix, yet they continue to make decisions that exacerbate the problem and cause the waitlist and wait times to grow.

2. Plaintiffs' Unnecessarily Long Pre-Trial Detentions Constitute Punishment Without Conviction

Plaintiffs are not yet convicted of the charges against them, and they therefore have a liberty interest in freedom from punishment. *Bell v. Wolfish*, 441 U.S. 520, 535 (1979) (holding that certain conditions of confinement may violate a pretrial detainee's due process rights when those conditions amount to punishment); *accord Terry*, 232 F. Supp. 2d at 943–44 (“[T]he Court finds that the delay in transferring court ordered detainees to the ASH for evaluation or treatment, amounts to punishment of the detainees. . . . [T]he length of the wait experienced by inmates today is far beyond any constitutional boundary.”). Plaintiffs’ prolonged detention in Missouri’s jails violates due process because it does not bear the requisite “reasonable relation” to the purpose of their detention, which is to restore their capacity to stand trial. *See Jackson*, 406 U.S. at 738 (“[E]ven if it is determined that the defendant probably soon will be able to stand trial, his continued commitment must be justified by progress toward that goal.”).

⁸⁷ *Id.*

⁸⁸ *Id.* at 12–20, 23–24.

Here, the time spent waiting for evaluation and/or restoration treatment is not restorative and, instead, undermines progress towards the goal of competency restoration. Missouri’s jails either do not provide restoration services or provide constitutionally inadequate restoration services.⁸⁹ Most struggle to provide even basic mental health care, let alone the intensive mental health care Plaintiffs require.⁹⁰ Lacking adequate or even basic care, Plaintiffs suffer needlessly from prolonged detention, amplifying its punitive nature. This is not surprising; jails are not mental health facilities. Nor are they meant to be. That is why both Missouri courts and the state’s statutory scheme mandate that DMH treat these individuals.

Without a reasonable relationship between the detention and the goal of detention, “a court may permissibly infer that the purpose of the governmental action is punishment that may not constitutionally be inflicted upon detainees *qua* detainees.” *Bell*, 441 U.S. at 539; *see also Stearns v. Inmate Servs. Corp.*, 957 F.3d 902, 907 (8th Cir. 2020) (applying the *Bell* standard and stating that “[i]f conditions are found to be arbitrary or excessive, it is permissible to ‘infer that the purpose of the governmental action is punishment’” (quoting *Bell*, 441 U.S. at 539)); *Disability L. Ctr.*, 180 F. Supp. 3d at 1012 (noting that plaintiffs’ alleged conditions of detention “amount to punishment” where “[t]he State detains incompetent defendants for months without adequate mental health treatment after a court has ordered them committed to [the state’s] custody to receive restorative treatment[,]” and where “[t]he State imposes these conditions on incompetent criminal defendants simply because there is no room at [the state hospital]”); *Terry*, 232 F. Supp. 2d at 942–43 (finding that prolonged detention of individuals awaiting treatment at the state psychiatric hospital amounted to punishment because it was not related to any legitimate state goal).

⁸⁹ Ex. 1, Groundswell Decl., ¶¶ 19–21.

⁹⁰ *See* Background Section C, *supra*.

Here, Plaintiffs are being unconstitutionally punished with long detentions in Missouri's jails without ever having been convicted of a crime and without any reasonable relationship between the long incarceration and the goal of determining their fitness to stand trial. This improper punishment provides an independent reason that Plaintiffs will succeed on the merits of their constitutional claims.

3. Plaintiffs' Prolonged Detention Deprives Them of Their Liberty Interest in Restorative Treatment

Plaintiffs also “have a liberty interest in receiving restorative treatment” while they are detained. *Mink*, 322 F.3d at 1121. A “lack of inpatient mental health treatment, combined with the prolonged wait in confinement, transgresses the constitution.” *Terry*, 232 F. Supp. 2d at 943.

Missouri's jails provide neither the quantity nor quality of care necessary to afford Plaintiffs any meaningful opportunity to regain competency. *See Mink*, 322 F.3d at 1122.⁹¹ Most county jails offer only minimal psychiatric services—often limited to distributing medication—and do not have the capacity for the structured, therapeutic interventions (e.g., counseling, cognitive rehabilitation, daily treatment programming) that are fundamental to competency restoration.⁹² As a result, every day that Plaintiffs remain in jail without access to proper court-ordered and statutorily required treatment is a day that their constitutional and statutory right to restorative care is denied.

Extended jail waits cause substantial clinical harm: longer wait times correlate with greater psychiatric deterioration and diminished likelihood of regaining competency.⁹³ For example, Plaintiff M.R.'s mental status declined significantly during his prolonged wait for treatment, with jail clinicians documenting worsening psychosis after months of detention marked by only

⁹¹ *See generally* Legomsky Decl.

⁹² Ex. 2, Kupers Prelim. Report at 10–11.

⁹³ *Id.* at 11–12.

sporadic medication adjustments. Although M.R. initially denied hallucinations at intake in April 2024, by April 2025 he was reporting active visual and auditory hallucinations and exhibiting increasingly disorganized thought processes.⁹⁴ His condition continued to deteriorate over the ensuing months. By late 2025, jail staff documented repeated medication refusals and periods of non-compliance with prescribed antipsychotic treatment.⁹⁵ During a mental-health contact in late 2025, a jail QMHP specifically noted that M.R. had been off his antipsychotic medication for approximately a month and was expressing grandiose and delusional beliefs—claiming to be a police officer and a doctor—while discussing the possibility of entering DMH’s competency-restoration program.⁹⁶ These records illustrate that Defendants’ failure to provide timely inpatient care not only inflicts ongoing psychological harm on M.R. but also undermines the very goal of competency restoration by allowing his psychosis to worsen to the point that he was unable to participate in his treatment. This effect is not isolated to Plaintiff M.R. or even the named Plaintiffs in this matter.⁹⁷ Similarly, M.T.’s mother reports that while in jail his hygiene has worsened, he has lost teeth and weight, and is not receiving the care he needs.⁹⁸ She attests: “I look at my son and I think, “He is completely gone.””⁹⁹ Defendants’ inaction deprives all Plaintiffs, including the putative class members, of their liberty interest in treatment and violates due process for this reason as well.

B. Plaintiffs Will Suffer Irreparable Harm Absent a Preliminary Injunction

Plaintiffs will suffer irreparable harm without immediate injunctive relief limiting their time spent in Missouri jails waiting for evaluations and restorative treatment. As set out above,

⁹⁴ Ex. 5, M.R. Medical Records at 18, 118, 195.

⁹⁵ *Id.* at 28, 48–82, 199–200.

⁹⁶ *Id.* at 194.

⁹⁷ *See generally* Background Section C, *supra*.

⁹⁸ Ex. 9, Second Declaration of Anita Tabb.

⁹⁹ *Id.*, ¶23

Plaintiffs' rights to due process have been and will continue to be violated by Defendants' failures to act. "[T]he denial of a constitutional right is a cognizable injury and an irreparable harm." *Ng v. Bd. of Regents of Univ. of Minn.*, 64 F4th 992, 998 (8th Cir. 2023) (internal quotation marks and citation omitted). The growing waitlist has been an issue for years. Defendants are well aware of the problem and the role they play in this court-ordered treatment.

But Plaintiffs will suffer irreparable harm in this case independent of the harm's constitutional character. Plaintiffs have suffered and will continue to suffer various severe consequences because of their prolonged detention, including: prolonged mental pain and suffering; an increased risk of decompensation and isolation; greater risk of physical harm to themselves and others; and increased severity of psychological symptoms and decreased capacity for eventual restoration.^{100, 101} These consequences constitute irreparable harm as they may permanently exacerbate Plaintiffs' conditions and result in irreversible physical and mental harms. *See Advoc. Ctr. for Elderly and Disabled*, 731 F. Supp. 2d at 625 (finding irreparable harm where "continued incarceration could exacerbate the Incompetent Detainees' mental conditions").

C. The Balance of the Equities Weighs Strongly in Favor of Injunctive Relief

As detailed above, Defendants' denial of timely evaluations and restoration treatment violates Plaintiffs' rights protected by the Fourteenth Amendment. Additionally, "keeping mentally incapacitated criminal defendants locked up in county jails for weeks or months . . . undermines the state's fundamental interest in bringing the accused to trial." *Mink*, 322 F.3d at 1121. These ongoing violations of Plaintiffs' rights far outweigh any harm Defendants might incur from a preliminary injunction requiring them to create a plan of action to treat IST defendants within a constitutionally appropriate time period.

¹⁰⁰ Ex. 1, Groundswell Decl., ¶ 15.

¹⁰¹ Ex. 2, Kupers Prelim. Report at 33 (Opinion 10).

This is a problem of Defendants' own making. The harms Plaintiffs experience on a daily basis are inexcusable and readily outweigh any burdens Defendants may experience to ensure compliance with the Constitution and Missouri law. However, recognizing the enormity of the problem that Defendants have created by failing to take sufficient measures to resolve this growing problem, Plaintiffs make a modest request that even further supports granting injunctive relief. The burdens on Defendants to create an achievable plan for the reduction and eventual end to the waitlist fiasco pale in comparison to the harms Plaintiffs experience each day. This factor weighs overwhelmingly in Plaintiffs' favor.

D. A Preliminary Injunction Serves the Public Interest

Preliminary injunctive relief will uphold the rights of Missourians who languish in county jails awaiting court-ordered capacity evaluations and restoration treatment. It is in the public interest to ensure that Plaintiffs receive treatment to prevent decompensation and to enable the expedient resolution of their criminal cases. *See Advoc. Ctr. for Elderly and Disabled*, 731 F. Supp. 2d at 626 (finding strong public interests in protecting the Fourteenth Amendment rights of pretrial detainees and in criminal defendants proceeding speedily to trial). Additionally, "it is always in the public interest to protect constitutional rights." *Schmitt v. Rebertus*, 148 F.4th 958, 970 (8th Cir. 2025) (internal quotation marks and citation omitted).

E. The Court Should Waive Rule 65(c)'s Security Requirement

Federal Rule of Civil Procedure 65(c) provides that a "court may issue a preliminary injunction . . . only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." However, the district court retains discretion to set the bond amount as it sees fit or waive the security requirement. *See Richland/Wilkin Joint Powers Auth. v. U.S. Army Corps of*

Eng'rs, 826 F.3d 1030, 1043 (8th Cir. 2016) (finding permissible district court's waiver of bond requirement in issuing preliminary injunction in case implicating the public interest).

Here, waiver is appropriate because Plaintiffs' fundamental rights are at stake, Plaintiffs are all indigent and IST or presumed IST, and Defendants have no legitimate interest in continuing to subject Plaintiffs to prolonged detention.

CONCLUSION

For the reasons set forth above, Plaintiffs respectfully request that the Court schedule a hearing on Plaintiffs' motion for preliminary injunction, grant the motion for preliminary injunction, and enter an order as follows:

- (1) Requiring Defendants to complete all currently pending court-ordered capacity evaluations for all Plaintiffs still on the waitlist within 60 days of the order;
- (2) Requiring Defendants to complete all future court-ordered capacity evaluations within 60 days of a judicial order directing such evaluations;
- (3) Requiring Defendants to provide mental health services and competency restoration treatment to all Plaintiffs and class members within a constitutionally appropriate time, not to exceed 30 days, following a commitment order, with said treatment to be provided either in a DMH facility or another suitable and most-integrated setting possible (e.g., in a hospital or community-based treatment center) and, in any event, not in a jail setting;
- (4) Requiring Defendants to file, within 21 days of the Court's order, a detailed proposal explaining how they will comply with this injunctive Order; and
- (5) Granting other such relief as is just and appropriate under the circumstances.

Dated: March 9, 2026

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that a copy of the foregoing was filed electronically and served by operation of the CM/ECF system on all counsel of record on March 9, 2026.

/s/ Amy Malinowski

Exhibit 1

to

**PLAINTIFFS' SUGGESTIONS IN SUPPORT OF
MOTION FOR PRELIMINARY INJUNCTION**

**IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION**

DEBRA DARRINGTON, as next friend)
for M.R., et al., *on behalf of themselves*)
and others similarly situated,)
)
Plaintiffs,)
)
v.)
)
MISSOURI DEPARTMENT OF)
MENTAL HEALTH, et al.)
)
Defendants.)

Case No. 2:25-cv-04268-MDH

**EXPERT DECLARATION OF LAUREN KOIS, PhD;
NEIL GOWENSMITH, PhD; and DANIEL MURRIE, PhD**

I. SUMMARY OF EDUCATION AND PROFESSIONAL EXPERIENCE

1. We provide this declaration regarding the current state of competency to stand trial (CST) evaluation and restoration systems in Missouri, including practices attempted and general best practices for managing such systems, with particular attention to timelines for service delivery.
2. Dr. Kois is a licensed forensic psychologist and Instructional Faculty at the University of Virginia School of Medicine’s Institute of Law, Psychiatry, and Public Policy. Her clinical, research, and consulting work focus on enhancing the quality, efficiency, and implementation of forensic mental health services, specifically CST evaluation and restoration practices. She has implemented forensic programs in inpatient, jail, and community settings, including in rural areas lacking infrastructure and resources. She is nationally recognized for her research and consulting activities and has assisted many state systems in addressing competence restoration demands. Previously, she served as core faculty of the University of Alabama’s Clinical Psychology-Law doctoral program,

where she trained undergraduate and graduate students in forensic psychology and assisted the Alabama Department of Mental Health in its efforts to improve forensic services. Dr. Kois has taught Criminal Forensic Assessment courses and seminars to doctoral, postdoctoral, and professional trainees. She has trained thousands of mental health and legal professionals in matters of competence evaluation and restoration standards and practices throughout the country.

3. Dr. Gowensmith is a licensed forensic psychologist and the president of Groundswell Services, Inc. (“Groundswell”), a consulting service dedicated to reviewing, coordinating, and improving public forensic mental health systems across the United States. He is also a full professor at the University of Denver and directs a forensic psychology training clinic. His main focus in forensic psychology is CST. To this end, he conducts CST evaluations, investigates CST practices and standards, writes articles and books on CST, trains graduate students and postdoctoral fellows to conduct high-quality CST evaluations, and provides consultation to state forensic mental health systems regarding CST services and standards. Previously he served as the Chief of Forensic Services for the State of Hawaii’s Department of Health, overseeing all forensic evaluations, programs, staff, and legislation—which ultimately resulted in termination of their federal oversight.
4. Dr. Daniel Murrie works as a forensic-clinical psychologist, university professor, and national expert in forensic mental health services, with expertise including competence evaluation and restoration treatment. He serves as Director of the University of Virginia's Institute of Law, Psychiatry, and Public Policy and as a Professor of Psychiatry and Neurobehavioral Sciences in the UVA School of Medicine. In these roles, he oversees

Virginia's state-wide training program for forensic evaluators, directs a forensic training clinic, performs forensic evaluations (including adjudicative competence), and consults with state forensic mental health systems regarding forensic services. Along with Groundswell colleagues, he has provided formal consultation to many state forensic systems on competence evaluation and restoration. As a scholar, his research and teaching focus on reliability, bias, and quality improvement in forensic evaluation. He has authored over 100 peer-reviewed scientific publications and dozens of book chapters on forensic mental health evaluations and services.

5. Groundswell Services works in many states addressing the challenges in CST service systems. Presently, Groundswell is working in the states of California, Colorado, New York, and Oklahoma addressing wait times and other challenges associated with competence services. We have also worked with Alabama, Alaska, Georgia, Hawaii, Minnesota, Nevada, and Washington. In Colorado, Drs. Gowensmith and Murrie serve as Special Masters overseeing a Consent Decree designed to improve Colorado's competence services system. Dr. Gowensmith serves as a court-appointed expert for similar services in Oklahoma.
6. Groundswell has provided consultation to states facing litigation that addresses forensic services, as well as states not facing litigation. In litigation, Groundswell has been retained by both plaintiffs and defendants to address solutions to the challenges facing forensic mental health services, including delays in competence-related services. While Groundswell's recommendations are tailored to specific state realities, they do not change substantially whether we are retained by plaintiffs or defendants.

II. QUESTIONS ASKED OF GROUNDSWELL SERVICES, INC.

7. This Declaration is submitted in response to Plaintiffs' requests for Groundswell's response to the following questions that relate to people with serious mental illness (SMI) awaiting capacity to proceed to trial services in Missouri jails:
- a. What is the current state of Missouri's competence evaluation and restoration system?
 - b. What competence service initiatives has the Missouri Department of Mental Health implemented in its attempts to resolve the state's demand for competence services, and what has been their effectiveness?
 - c. Why is it critical to provide competence services promptly?
 - d. What best practices could the Missouri Department of Mental Health take to reduce waiting periods for competence evaluation and restoration for all or nearly all detainees? These could include:
 - i. The utility and potential effectiveness of jail-based CST restoration
 - ii. Best practices for managing CST-related services, including reasonable time frames for evaluation and restoration treatment
 - iii. Suggested actions that may alleviate the long wait times for CST related services in Missouri.
8. Plaintiffs raised these questions given the long delays in accessing CST evaluations and restoration services in Missouri.

III. MISSOURI'S COMPETENCY SYSTEM: CURRENT STATE

9. *Competence to stand trial* (CST) refers to a defendant's present mental capacity to meaningfully participate in their criminal proceedings. To be competent, individuals must

possess sufficient ability to understand the nature and purpose of legal proceedings against them and to assist their attorney in their defense. A *CST evaluation* is a forensic assessment conducted by a mental health professional (typically a psychologist or psychiatrist) to examine whether a defendant meets the legal standard for competence. Evaluators assess the defendant's understanding of court procedures, ability to communicate with counsel, and capacity to make informed decisions about their case. They submit their forensic opinion to the court, and the judge rules whether the defendant is competent or incompetent to stand trial (IST).

10. If the court finds the defendant competent, criminal proceedings continue. If the court finds the defendant IST, the court typically commits the defendant to the jurisdiction's mental health authority for *competence restoration services*. Most often, restoration aims to restore competence through psychiatric treatment and education regarding legal processes, roles of court personnel, and trial procedures. The goal is to help defendants regain (or attain) the functional abilities necessary to participate meaningfully in their legal proceedings.
11. Most defendants awaiting CST evaluations are housed in county jails, and those found IST continue to wait in those same jails until restoration begins. At times, waits for evaluations and/or restoration services are very long—sometimes even longer than the time defendants would have served if sentenced. Missouri's CST evaluation and restoration system has faced significant challenges providing timely services. As of January 2026, approximately 186 individuals awaited CST evaluations from Missouri jails.¹ Another 528 individuals awaited restoration while detained. This marks an all-time

¹ Simmons, J. (2026, January 30). *Competence to Stand Trial Update* [Presentation]. Missouri State Public Defender.

high for individuals needing restoration, a nearly five-fold increase from September 2021.²

12. The demand for CST services is statewide. According to a comprehensive survey conducted by Missouri Appleseed in 2025, 92.5% of Missouri's jail facilities indicated they held individuals awaiting evaluations.³

13. In 2023, Missouri defendants referred for CST evaluations waited approximately 8 months for their evaluations to occur.⁴ Individuals now wait between 6 and 11 months for their initial CST evaluations.⁵ In 2025, wait times for transfer to an appropriate mental health facility for restoration ranged between 1.5 and 2.8 years, with an average wait time of 14 months.^{6,7} Indeed, at least 12 people were incarcerated beyond the maximum possible sentence for their charges while awaiting restoration in 2025.⁸ The most recent data provided by DMH indicated that in January 2026, the restoration wait time averaged 15 months.⁹

14. These waitlist delays far exceed what Missouri law allows. Missouri statute explicitly requires DMH to conduct and file CST evaluations with the court within 60 days of a

² Quinn, S. (2025, October 27). Nearly 500 Missourians awaiting court-ordered mental health services, an all-time high. Missouri Independent. <https://missouriindependent.com/2025/10/27/nearly-500-missourians-awaiting-court-ordered-mental-health-services-an-all-time-high/>

³ Annor, E., & Quinn, K. (2025, September). Mental health needs in Missouri jails Part I: Surveying county sheriffs & jail administrators. Missouri Appleseed.

⁴ Bates, C. (2023, September 20). Missourians wait an average of 8 months in jail for court-ordered mental health services. Missouri Independent. <https://www.stlpr.org/government-politics-issues/2023-09-20/missourians-wait-an-average-of-8-months-in-jail-for-court-ordered-mental-health-services>

⁵ Annor, E., & Quinn, K. (2025, September). Mental health needs in Missouri jails Part I: Surveying county sheriffs & jail administrators. Missouri Appleseed.

⁶ Annor, E., & Quinn, K. (2025, September). Mental health needs in Missouri jails Part I: Surveying county sheriffs & jail administrators. Missouri Appleseed.

⁷ Prison Legal News. (2025, May 1). Wait for competency restoration averages 14 months in Missouri jails. <https://www.prisonlegalnews.org/news/2025/may/1/wait-competency-restoration-averages-14-months-missouri-jails/>

⁸ Annor, E., & Quinn, K. (2025). Mental health needs in Missouri jails Part I: Surveying county sheriffs & jail administrators. Missouri Appleseed. <https://www.missouriappleseed.org>

⁹ Simmons, J. (2026, January 30). *Competence to Stand Trial Update* [Presentation]. Missouri State Public Defender.

request unless there is good cause, as ordered by a court, to delay the evaluation.¹⁰

Additionally, Missouri law requires DMH to take custody of individuals into an inpatient mental health facility¹¹ *immediately* following an IST¹² finding. The current wait times clearly exceed statutory timeframes, and they continue to grow.¹³ Subsequently, the waitlists of people waiting for evaluations and restoration also continue to grow.

15. Most defendants on CST waitlists have SMI, so extended detention in county jails while awaiting evaluation or restoration can have dire consequences.¹⁴ Jails are not hospitals; they are not designed to provide intensive psychiatric treatment. Jails typically lack the resources, trained staff, and medications necessary to address serious mental health needs. Simply put, individuals with SMI are at high risk for deteriorating mental health while awaiting mental health services.

16. DMH leadership has identified several factors contributing to delays in providing competence-related treatment.¹⁵ Like many jurisdictions across the country, limited bed capacity in state forensic hospitals certainly limits restoration capacity. Missouri's current inpatient forensic capacity includes approximately 898 beds across six facilities, the largest being Fulton State Hospital (300 beds¹⁶). However, only three of these facilities

¹⁰ Mo. Rev. Stat. § 552.020.2

¹¹ Community-based treatment is an option for those who can comply with bond and treatment conditions, and who are not charged with violent felonies, murder, or certain sexual offenses.

¹² Mo. Rev. Stat. § 552.020.10

¹³ Missouri Department of Mental Health. (2025, May 5). *House Health and Mental Health Committee Hearing* [PowerPoint presentation]

¹⁴ Favril, L., Yu, R., Hawton, K., & Fazel, S. (2020). Risk factors for self-harm in prison: a systematic review and meta-analysis. *The Lancet Psychiatry*, 7(8), 682-691.

¹⁵ Missouri Department of Mental Health. (2025, May 5). *House Health and Mental Health Committee Hearing* [PowerPoint presentation], slides 6, 11-14.

¹⁶ Missouri Department of Mental Health. (2025, May 5). DMH presentation to House Health and Mental Health Committee [PowerPoint slides]. <https://legacy.www.documentcloud.org/documents/25931693-house-may-health-mental-health-committee-hearing-may-5-final/>

provide restoration. Missouri has approximately 14.4 beds per 100,000 people, which is less than 30% of the capacity that authorities recommend (50 beds per 100,000).¹⁷

17. DMH faces workforce challenges that hinder efforts to expand capacity. DMH Director Huhn reported high turnover rates which constrain current bed utilization but also the feasibility of staffing newly constructed facilities.

18. Finally, the number of pretrial evaluations that Missouri courts request has increased by nearly 50% over the past five years.¹⁸ This increase is not unique to Missouri. A recent survey found that 82% of state mental health administrators estimated increased CST evaluation referrals within their state, while 78% estimated increased need for restoration services.¹⁹ Nationally, the number of CST evaluations ordered annually has risen from approximately 60,000 to more than 140,000, according to the most rigorous estimates.²⁰

IV. PRACTICES ATTEMPTED IN MISSOURI THUS FAR

19. Legislative Changes Through Senate Bill 106

- a. In 2023, Missouri enacted Senate Bill 106 to decrease CST wait times and decrease the number of people on the waitlist through three primary initiatives.²¹ However, implementation has been slow, and the waitlist has continued to grow.
- b. First, SB106 added language requiring evaluators to assess during the initial evaluation "whether there is a substantial probability that the accused will be

¹⁷ Silver, S., & Hancq, E. S. (2024). Finding the right balance of civil and forensic state psychiatric hospital beds. Treatment Advocacy Center. <https://www.treatmentadvocacycenter.org/wp-content/uploads/2024/02/Prevention-Over-Punishment-Full-Report.pdf>

¹⁸ Missouri Department of Mental Health. (2025, May 5). *House Health and Mental Health Committee Hearing* [PowerPoint presentation], slide 6

¹⁹ Warburton, K., McDermott, B. E., Gale, A., & Stahl, S. M. (2020). A survey of national trends in psychiatric patients found incompetent to stand trial: Reasons for the reinstitutionalization of people with serious mental illness in the United States. *CNS Spectrums*, 25(2), 245-251.

²⁰ Kois, L. E., Potts, H., Cox, J., & Zapf, P. (2024). Court-reported competence to proceed data across the United States. *Law and Human Behavior*, 48(3), 182.

²¹ Mo. Rev. Stat. § 552.020

mentally fit to proceed in the reasonably foreseeable future."²² The rationale is straightforward: defendants with conditions rendering restoration futile—such as advanced dementia or severe developmental disabilities²³—should be identified early and removed from the restoration waitlist, with appropriate civil commitment proceedings initiated instead.

- c. Second, SB 106 introduced the possibility of community-based restoration. When providing their opinion upon a defendant's first competence evaluation, evaluators are required to opine whether the defendant "may be appropriately treated in the community."
- d. Third, SB 106 required evaluators to assess whether defendants may receive restoration treatment in a county jail or other detention facility.²⁴ Missouri implemented jail-based restoration programs at four facilities in 2025, with a total capacity of approximately 40 individuals.²⁵ However, these programs provide limited services and cannot accommodate defendants with acute psychiatric needs requiring hospital-level care, thereby limiting their impact on the broader population of individuals found IST. In short, we have seen no evidence that SB 106 has significantly reduced Missouri's delays in providing competence-related services. Rather, the situation has only worsened since SB 106 was enacted.

20. Mobile Treatment Teams and Jail-Based Services

²² Mo. Rev. Stat. § 552.020.3(4)

²³ Staats, M. L. P., Kivisto, A. J., & Connell, R. E. (2021). The role of cognitive functioning in predicting restoration among criminal defendants committed for inpatient restoration of competence to stand trial. *International Journal of Law and Psychiatry*, 74, 101654.

²⁴ Mo. Rev. Stat. § 552.020.3(7)

²⁵ Huhn, V. (2025, May 5). *DMH presentation to House Health and Mental Health Committee* [PowerPoint slides]. Missouri Department of Mental Health.

- a. DMH launched mobile teams to provide treatment and support for individuals in jails awaiting CST services.^{26, 27} By 2022 DMH established two teams—one serving jails in the eastern region of the state and one serving the western region. According to DMH presentations, these teams conduct medical and psychiatric assessments, offer supportive psychotherapy, provide case management, and prescribe medication. They typically coordinate with jail staff or local providers to administer medications for individuals who elect to take them.
- b. While these mobile teams represent an effort to address service gaps, their capacity to provide comprehensive restoration remains limited. The medication-focused approach, while valuable for symptom management, does not address the comprehensive restoration services that research and clinical practice suggest are necessary for effective CST restoration. Further, many defendants decline medication that is necessary for psychiatric stability.
- c. The mobile team model may therefore provide better care than most jails could offer independently, but it does not replace the intensity, comprehensiveness, or therapeutic environment of specialized inpatient restoration programs required to stabilize and treat many IST defendants. The value this program provides may be meaningful, but it has not been sufficient to reduce Missouri’s competence waitlist, which has only increased (along with wait times) since the program.

21. Expanding Inpatient Bed Capacity

²⁶ Simmons, J. M. (2021, September 29). *DMH forensic mobile teams* [PowerPoint slides]. Missouri Department of Mental Health.

²⁷ Legomsky, A. (2026, January 30). *DMH Update provided to Darrington Plaintiff*. Missouri State Public Defender.

- a. Between 2010 and 2011, DMH permanently closed 223 acute psychiatric inpatient beds.²⁸ In 2021, as the waitlist continued to increase, DMH demolished a hospital without immediately replacing that hospital's capacity.²⁹ Six state psychiatric hospitals now offer a total system capacity of approximately 898 forensic beds, but only three facilities provide restoration services: Center for Behavioral Medicine (65 beds), Forensic Treatment Center-North (75 beds), and the Nixon Forensic Center at Fulton State Hospital (300 forensic beds).³⁰ This represents a current forensic restoration capacity of 440 beds.
- b. DMH plans to expand its current inpatient bed capacity through two initiatives: increasing the Center for Behavioral Medicine (CBM) facility from 65 to 115 beds³¹ and constructing a new Kansas City facility that will add 150 beds to the system (200 new beds in total).³² The timeframe for the 50 additional beds at CBM depends on many other factors, so these beds will not become available until 2028 at the earliest.³³ The new Kansas City hospital beds are estimated to open in 2030.³⁴
- c. The planned addition of 200 beds would increase restoration capacity to 640 beds, representing a 45% increase over current capacity. While this expansion is

²⁸ Missouri Department of Mental Health. (2025, May 5). *Presentation to House Health and Mental Health Committee* [PowerPoint slides].

²⁹ *Darrington v. Department of Health and Human Services*, No. 2:25-cv-04268-WJE (W.D. Mo. filed Nov. 24, 2025).

³⁰ Missouri Department of Mental Health. (2025, May 5). *Presentation to House Health and Mental Health Committee* [PowerPoint slides].

³¹ DMH Presentation to House Health and Mental Health Committee (May 5, 2025) at 11 (Exhibit 2 to Complaint)

³² DMH Presentation to House Health and Mental Health Committee (May 5, 2025) at 7 (Exhibit 2 to Complaint)

³³ *Darrington v. Huhn*, No. 2:25-cv-04268-WJE, Complaint ¶ 88 (W.D. Mo. filed Nov. 24, 2025).

³⁴ U.S. House Committee on Corrections and Public Institutions. (2025, September 7). *Committee hearing on corrections and public institutions* [Video]. Retrieved from <https://sg001-harmony.sliq.net/00325/Harmony/en/PowerBrowser/PowerBrowserV2/20200831/-1/13438>

substantial, it arrives after years of declining capacity and amid accelerating demand. If court-ordered CST referrals continue their recent growth trajectory, the system will continue generating more demand than the additional beds can accommodate. In short, the demand for restoration beds will continue growing faster than the supply, leaving the crisis unresolved.

- d. Finally, expanding capacity remains difficult amid the workforce challenges that DMH faces. Struggling to retain staff makes it difficult to fully use the available capacity, let alone staff new facilities. The CBM expansion alone will require 90 additional full-time equivalent positions at a cost of \$6 million annually.³⁵ Recruiting and retaining qualified forensic mental health professionals will likely be difficult even without the added pressure of staffing new facilities. These workforce limitations mean that even when physical bed capacity increases, operational capacity may lag if DMH cannot maintain adequate staffing levels.
- e. Although these expansion plans represent progress in acknowledging the system's inadequate capacity, they do not address the immediate crisis facing the hundreds of individuals currently detained in jails while awaiting services. The current waitlist exceeds the projected increased bed capacity. Even with additional beds and full staffing, the system will struggle to keep pace with accelerating demand.
- f. Inpatient capacity expansion alone cannot resolve a crisis rooted in insufficient community-based alternatives, workforce instability, and court referral patterns that continue to climb. Without fundamental systemic changes—including robust outpatient restoration programs, community mental health diversion, and statutory

³⁵ Missouri Department of Mental Health. (2025, May 5). *Presentation to House Health and Mental Health Committee* [PowerPoint slides].

reforms—increased inpatient beds will simply accommodate more people waiting longer. Without immediate changes, Missouri’s CST crisis will continue to worsen before it improves.

V. THE NEED TO PROVIDE COMPETENCY SERVICES PROMPTLY

22. Timely CST Evaluations

- a. CST evaluations should be conducted promptly after a court order. Most states require evaluations to be completed within several weeks’ time. A review of state statutes in 2015 revealed a national average requirement of 30 days.³⁶ The American Bar Association Criminal Justice Mental Health standards recommend, “Each jurisdiction should establish time periods by which the evaluation should be concluded and a report returned to the court. Such periods normally should not exceed fourteen days...”³⁷
- b. Lengthy evaluation delays extend incarceration unnecessarily, subsequently increasing the risks for deterioration and other harms among people awaiting those evaluations. Long delays are problematic even for defendants who are found competent upon evaluation (not just those found IST who then must wait further for restoration services) or who are otherwise appropriate for jail diversion services. Missouri’s statutory timeline of 60 days is already more than double what authorities recommend and most other states allow, and the actual wait times far exceed these. Again, defendants on DMH waitlists in October 2025 waited up to 11 months for their initial CST evaluation. Clearly, wait times in Missouri

³⁶ Gowensmith, W. N., Murrie, D. C., & Packer, I. K. (2017). *Analysis of current Washington competency restoration services* (Contract No. 1532-37719).

³⁷ American Bar Association. (2016). *Criminal justice standards on mental health*. American Bar Association.

significantly and unnecessarily exceed both statutory requirements and common timelines.

23. Timely Restoration Services

- a. For individuals found incompetent, restoration services should begin quickly, given that the forensic evaluator and the court have agreed that the person needs urgent mental health care. There is never any *clinical* reason to delay the start of restoration treatment. Rather, states must strike a balance between clinical need and logistic realities. Efficient systems can usually process these transfers within days.
- b. Very few states specify a statutory limit to begin restoration services after a finding of incompetence. Washington statute specifies 7 days, and Virginia specifies 10 days, but most other state statutes are silent on this issue. This is because these cases are now largely driven by clinical priorities rather than judicial ones. Essentially, once a person has been evaluated for competency, been diagnosed with a major mental illness, opined incompetent by the evaluator as a result of that illness, and then adjudicated incompetent by the court, there is little debate about the person's urgent need for restoration. Clinically, there is no good reason to wait to provide treatment to a person in need of it. However, the logistical issues involved in accessing treatment across settings can cause some reasonable delays (e.g., medical clearance from jails to hospitals, transportation schedules, transferring paperwork). Given the reality and impact of these nuanced details, states to date have rarely specified a time frame for restoration in statute.

- c. However, states that have experienced litigation addressing the matter are typically mandated to admission timelines between a few days to a few weeks. For example, Hawaii’s permanent injunction allowed a maximum of 3 days to admit an incompetent defendant to their state hospital. Oregon’s *Mink* decision mandates transfer within 7 days, Oklahoma’s consent decree allows 21 days, California’s order allows 28 days (though they currently admit IST defendants within less than one week), and Colorado’s consent decree allows either 7 or 28 days (depending on the defendant’s clinical condition). Most states with court-mandated time frames operate within those ranges. We know of no state that has identified a time limit beyond 30 days. Missouri’s average wait time of about 14 *months* is far beyond these other time frames and vastly exceeds any reasonable clinical time frame for access to court-ordered hospital treatment.
- d. Additionally, research indicates that most IST defendants undergoing restoration services are restored within 180 days.³⁸ Thus IST defendants in Missouri, on average, spend far more time in county jails waiting for restoration to *begin* than they would be expected to spend in the restoration treatment itself.

**VI. BEST PRACTICES FOR MANAGING COMPETENCY EVALUATION
AND RESTORATION SYSTEMS**

24. Based on research and our collective experience with forensic systems across jurisdictions, we have identified several practices that appear most promising for the effective management of evaluation and restoration systems while also protecting the constitutional rights of individuals with mental illness in the criminal legal system. To be

³⁸ Pirelli, G., & Zapf, P. A. (2020). An attempted meta-analysis of the competency restoration research: Important findings for future directions. *Journal of Forensic Psychology Research and Practice*, 20(2), 134-162.

clear, not all practices will work in all jurisdictions, and even successful strategies from other states may require adjustments for Missouri's system.

25. Adequate System Capacity

- a. States must maintain adequate capacity to meet demand. This requires enough qualified forensic evaluators, adequate inpatient beds for individuals requiring inpatient level of care (for both civil and forensic populations), robust outpatient programs, and trained staff.
- b. Policymakers should support budgets that allow for competitive compensation and retention of public sector forensic mental health practitioners. Even for states not facing litigation, CST services consume tremendous resources, but “savings” that compromise the quality of staff and services are often more costly in the long term.³⁹
- c. Simply put, states need an adequate number of hospital beds to manage the acute psychiatric needs of their populations. Psychiatric hospitals provide a fundamental systemic backbone around which the rest of the civil and forensic mental health system can be built. Even with the most robust and effective community options and diversion programs in place, some people need inpatient services from a psychiatric hospital. However, as was indicated earlier, Missouri's net loss of inpatient psychiatric beds since 2011 corresponds with the massive increase in wait times and the number of people waiting for inpatient competency services. Missouri, like all states, needs enough inpatient psychiatric beds to manage both

³⁹ Wik, A., Hollen, V., & Fisher, W. H. (2020). Forensic patients in state psychiatric hospitals: 1999–2016. *CNS Spectrums*, 25(2), 196-206.

their civil and forensic populations, but currently Missouri's capacity is inadequate.

26. Other Best Practices and Initiatives to Alleviate Competency Service Delays

- a. There is no one magic solution to eliminate delays in a state's CST service system. However, combinations of various practices and initiatives have reduced wait times and waitlists in other states. We provide a brief overview of those here; in-depth information about these topics will be discussed in our expert report.
- b. Front-End Diversion and Prevention
 - i. Many individuals with mental illness who enter the criminal legal system do so because of a lack of community mental health services, housing instability, or other social determinants of health rather than serious criminal behavior requiring prosecution. Early interventions are critical in reducing the number of people ordered to CST services: they connect people with care *before* the individual encounters law enforcement. These include crisis intervention training for law enforcement, mobile crisis response teams, and deflection programs to reduce unnecessary flow into CST services. In addition, for those individuals who are arrested and charged, many jurisdictions have employed early screening procedures to assess defendant's suitability and eligibility for diversion programs or specialized mental health dockets and courts; these screens and programs are designed to move appropriate cases out of the competency system and into closely monitored community-based mental health services and programs, even while charges remain pending.

c. Community-Based Restoration

- i. Not all individuals found incompetent require inpatient hospitalization.

Many, especially those facing low-level charges, can and should be restored in community-based services. Outpatient restoration is consistent with both clinical best practices and legal requirements under the Americans with Disabilities Act and the *Olmstead v. L.C.*, 527 U.S. 581 (1999) decision, which requires that services be provided in the most integrated and least restrictive setting appropriate to individuals' needs.⁴⁰

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- ii. Systems should develop robust screening procedures to identify appropriate candidates for outpatient restoration versus those requiring inpatient services. Screening procedures involve forensic evaluators systematically assessing an IST defendant's psychiatric stability, safety and security risks (such as injury to oneself or others), and treatment compliance to opine whether a defendant can safely receive restoration in the community rather than hospitalization. The most robust procedures use multidisciplinary teams to develop individualized placement recommendations and incorporate community-based supports (e.g., housing, transportation, treatment access, social support).
- iii. Given that approximately 70% of individuals awaiting restoration in Missouri are charged with low-level, non-dangerous offenses, it seems likely that a substantial number could potentially be treated on an

⁴⁰ Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101 et seq. (1990).

⁴¹ *Olmstead v. L.C.*, 527 U.S. 581 (1999).

outpatient basis.⁴² However, as of September 2025, only 6 individuals had participated in outpatient restoration⁴³—a stark underutilization despite statutory authorization and program availability.

d. Triage

- i. Some mental health conditions are more urgent than others. People who are suicidal, gravely disabled, or otherwise especially vulnerable to harms and risks should be admitted to hospitals more quickly than those who are not. Rather than “first-come-first-served,” triage systems prioritize individuals based on clinical acuity and safety risks to ensure the most critical cases get immediate care. When applied to CST waitlists, individuals with acute mental health crises are prioritized for inpatient admission even before others who have been waiting longer.
- ii. Currently, Missouri’s inpatient admission pattern does not follow any specific protocol. It should employ a formal, statewide, uniform triage system for inpatient restoration in which:
 1. Initial CST evaluations can be “fast-tracked” through coordination between local courts and evaluators.
 2. Admissions of the most acutely ill defendants should occur within a few days.
 3. The triage system should be implemented statewide and should be centrally managed.

⁴² Legomsky, A. (2024). *Declaration of Annie Legomsky* [Exhibit 3]. *DRNC v. North Carolina Department of Health and Human Services*, Case No. 1:24-cv-00335 (M.D.N.C. filed May 13, 2024).

⁴³ Missouri Legislature. (2025, September 7). *Committee hearing on corrections and public institutions* [Video testimony].

4. Jails should provide weekly updates regarding every pretrial detainee on the waitlist so that the priority admission list can be adjusted as determined by detainees' changing acuity levels.
5. Clinical progress should guide when to re-evaluate CST.

e. Jail-Based Competency Restoration

- i. Jail Based Competence Restoration (JBCR) treatment programs have emerged in several states as a strategy to help meet the demand for restoration services. Growing research tends to support the efficacy and effectiveness of JBCR programs, with good restoration outcomes,⁴⁴ relatively short lengths of stay,⁴⁵ and significant cost savings.⁴⁶
- ii. JBCR is not simply a matter of receiving standard or enhanced mental health services available in jail. Rather, JBCR increases capacity for restoration treatment by providing robust, structured, and targeted programming in a dedicated space within a jail.
- iii. JBCR programs are particularly appropriate for those defendants who do not necessitate inpatient hospitalization, but whose charges or behavioral risks make them unsuitable for community-based restoration. Take, for example, an IST defendant who is stable on medication, has a violence history, and no reliable community supports. An individual such as this

⁴⁴ Danzer, G. S., Wheeler, E., Alexander, A. A., & Wasser, T. D. (2019). Competency restoration for adult defendants in different treatment environment. *The Journal of the American Academy of Psychiatry and the Law*, 47(1), 43-52.

⁴⁵ Ash, P., Roberts, V. C., Egan, G. J., Coffman, K. L., Schwenke, T. J., & Bailey, K. (2020). A jail-based competency restoration unit as a component of a continuum of restoration services. *Journal of the American Academy of Psychiatry and the Law*, 48(1), 43-52.

⁴⁶ Danzer, G. S., Wheeler, E., Alexander, A. A., & Wasser, T. D. (2019). Competency restoration for adult defendants in different treatment environment. *The Journal of the American Academy of Psychiatry and the Law*, 47(1), 43-52.

would require structured restoration services but does not need hospital-level psychiatric monitoring. Conversely, a defendant who is acutely psychotic, poses significant violence risk, and has moderate-to-severe cognitive impairment requires constant medical monitoring and maximum security that only inpatient hospitalization can provide. JBCR fills the critical middle ground between these extremes. Ultimately, JBCR programs help reserve inpatient hospital beds for more acutely ill clients whose symptoms require inpatient hospitalization.

iv. The best JBCR programs are hospital-like treatment units separated from the rest of the jail. According to the National Judicial College and other sources,⁴⁷ best practices and components of successful JBCR programs include:

1. Partnership with a jail that supports the mission and values of the program and that provides proper mental health treatment generally.
2. Physical space (i.e. housing and treatment space) that is separated from other areas of the jail and other inmates/defendants.
3. Small to moderate milieu sizes (e.g., unit sizes of 15-25 patients) sufficient to provide individualized and tailored care.
4. Dedicated treatment staff, with sufficient expertise, assigned to the program.

⁴⁷ Roberson, A., & Vitacco, M. J. (2022). Jail-based competency restoration: What's out there and what's missing. *Journal of Correctional Health Care*, 28(4), 230-235

5. Dedicated jail staff—who have completed a rigorous screening process and enhanced mental health training—assigned to the program.
 6. Collaboration between treatment staff and jail staff.
 7. Intensive day treatment programming (i.e., a schedule with ample treatment and enrichment activities).
 8. Rigorous admission screening to ensure participants are appropriate for a JBCR program.
- v. JBCR is not:
1. General jail mental health services. JBCR requires dedicated restoration programming, not simply standard psychiatric care or medication management available to all incarcerated individuals.
 2. Administrative segregation or punitive isolation. JBCR units must be therapeutic environments designed for treatment, not used as disciplinary placements or to remove disruptive inmates from general population.
 3. Appropriate for all IST defendants. JBCR is unsuitable for defendants with acute psychosis requiring 24/7 medical monitoring or severe cognitive impairment unlikely to improve with treatment.
 4. A substitute for adequate inpatient capacity. JBCR serves a specific middle tier; insufficient inpatient beds should not drive inappropriate JBCR placements for defendants who truly need hospitalization.

vi. In summary, high quality JBCR programs are dedicated, therapeutic environments separate from other units in the jail, staffed by dedicated restoration treatment providers and offering robust treatment. Based on our review, what is currently being called JBCR in Missouri county jails does not meet the standard for safe or effective JBCR.

f. Evidence-Based Restoration Interventions

i. Restoration programs should employ evidence-based interventions rather than relying on medication stabilization alone. While medication management is often necessary, it is typically insufficient by itself.

Research indicates that the most effective programs incorporate:

1. Structured competency restoration curricula delivered through individual or group sessions teaching defendants about courtroom procedures, legal roles, plea processes, and communication with attorneys.
2. Integrated treatment, for example, combining medication management with substance use treatment or other clinical services based on individual need.
3. Case management that connects individuals enrolled in outpatient restoration to community supports such as housing, transportation, and aftercare.

ii. Interventions such as these are well-supported in the SMI, criminal legal, and forensic behavioral health research literature. Evidence-based

strategies such as these directly address waitlist backlogs by shortening inpatient admissions and freeing hospital beds for higher-need individuals.

g. Data Infrastructure and Cross-System Collaboration

- i. There is much to do regarding data infrastructure to fully understand system-wide CST issues. Systems should collect and analyze data on service demand, capacity, wait times, and outcomes to inform resource allocation and planning. Collaboration between courts and mental health authorities is critical to collecting accurate data.

h. Program Evaluation and Quality Improvement

- i. Many jurisdictions under legal oversight feel pressured to resolve CST crises quickly; they may implement new programs without adequate data to guide them or evaluate effectiveness. However, systematic data collection is critical because it allows administrators to identify which strategies work, detect gaps in service delivery, and demonstrate whether programs are achieving attended outcomes—rather than relying on assumptions or anecdotal evidence.
- ii. For example, a new community-based restoration program’s data indicates lower restoration rates than would be expected. By analyzing program data, administrators find that enrollees with substance use disorders have much lower restoration rates and are more likely to miss sessions than their counterparts. Instead of deeming the program a failure, administrators create a substance use treatment track and find that this group’s restoration rates increase.

- iii. Data-driven adjustments such as this reduce waitlist length by identifying underlying barriers rather than relying on first impressions about where the system is failing. The capacity for program evaluation research allows administrators to identify successes and needs for improvement, respond accordingly, and push for evidence-based reform. We urge system administrators and policymakers to collect program outcome data and use these data to assess program process and impact.
- i. Resolution for Defendants found Incompetent and Unrestorable
 - i. Systems should quickly identify defendants who are permanently incompetent, for example, defendants with chronic irremediable conditions such as dementia. Early identification can prevent unnecessary detention and allow for appropriate civil commitment or community placement when appropriate.
 - ii. Evaluators should receive training and clear guidance on assessing likelihood of restoration. Missouri's SB 106 provision allowing unrestorable findings at the initial evaluation is consistent with this best practice. The challenge is providing alternative treatment settings for those individuals found unrestorable that does not further constrain the already limited forensic capacity.
- j. Statutory Change
 - i. Many states have employed statutory changes to address CST waitlists. While Missouri attempted some changes with SB 106, additional changes may be worth considering.

- ii. Some states have restricted restoration to persons facing felony charges, while others have restricted *inpatient* restoration to persons facing felony charges. For many practical and principled reasons, there is often less governmental interest in delivering restoration services to defendants facing only misdemeanor charges.
- iii. Some states have altered statutes to allow for—or even mandate—consideration of civil commitment in lieu of restoration among defendants facing misdemeanor or low-level charges. By diverting misdemeanor defendants to civil commitment or case dismissal pathways, these jurisdictions reduce the flow of individuals into restoration services, preserving limited inpatient beds for defendants charged with serious felonies that the state intends to prosecute. This statutory approach has demonstrably reduced waitlist backlogs in states that have adopted it.

VII. CONCLUSION

27. Missouri faces substantial challenges in its CST system. Hundreds of individuals with SMI remain detained in jails for extended periods—often far exceeding statutory timelines—while awaiting evaluation or restoration services. While the state has attempted various reforms, implementation has been insufficient to address the scale of the problem.
28. The practices outlined in this declaration provide a framework for effective system management. These include timely service delivery (30 days for evaluations; 7-21 days for restoration admission), alternative restoration settings (including high quality community-based and jail-based restoration), evidence-based restoration interventions,

front-end diversion, adequate inpatient capacity, robust data infrastructure, ongoing quality improvement, statutory change, and improved access to civil mental health services.

29. These strategies vary greatly. Some can be implemented rapidly, while others require more time, resources, and formal legislative changes. Many require collaboration across systems and stakeholders to do well. All will require careful consideration of Missouri's specific context and idiosyncrasies. Even strategies that have been clearly successful in other states may require adjustments.

30. Nevertheless, there is reason for optimism. There are many validated steps Missouri can begin promptly to make meaningful system changes and improve conditions for individuals with SMI and profound cognitive deficits ordered to receive CST-related services.

We declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of our knowledge and belief.

Executed on March 5, 2026.



Lauren Kois, Ph.D.



Neil Gowensmith, Ph.D.



Daniel Murrie, Ph.D.

Exhibit 2

to

**PLAINTIFFS' SUGGESTIONS IN SUPPORT OF
MOTION FOR PRELIMINARY INJUNCTION**

Preliminary Expert Report of Terry A. Kupers, M.D., M.S.P.

Re: *Darrington vs. Missouri Department of Mental Health*

Case No. 2:25-cv-04268

I. Background and Qualifications

I am a board-certified psychiatrist, Institute Professor Emeritus at the Wright Institute, Distinguished Life Fellow of the American Psychiatric Association, and an expert on correctional mental health issues. I have testified more than thirty times in state and federal courts about the psychiatric effects of jail and prison conditions, the quality of correctional management and mental health treatment, and prison sexual assaults. I have served as a consultant to the U.S. Department of Justice and Human Rights Watch.

I am author of Solitary: The Inside Story of Supermax Isolation and How We Can Abolish It (University of California Press, 2017) and Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It (Jossey-Bass/Wiley, 1998), co-author of Ending Isolation: The Case Against Solitary Confinement (Pluto Press, 2025), co-editor of Prison Masculinities (Temple University Press, 2001), and a Contributing Editor of Correctional Mental Health Report. I have authored and co-authored dozens of professional articles and book chapters, including “Schizophrenia, its Treatment and Prison Adjustment,” in Managing Special Populations in Jails and Prisons (Editor Stan Stojkovic, Kingston, NJ: Civic Research Institute, 2005).

I served as consultant to the Connections Program in San Francisco, California, a collaboration between San Francisco Court Case Managers, San Francisco Jail Mental Health Services and Community Mental Health agencies designed to provide alternatives to jail for mentally ill and substance-abusing offenders. I was a member of the California Department of Health Task Force to write “Health Standards for Local Detention Facilities” in 1976-77. I have served as consultant and staff trainer in several other jail departments of mental health, and in the course of my professional work I have inspected dozens of jails in urban centers as well as small, mainly rural counties in several states.

I served as monitor of the *Presley v. Epps* consent decree (federal court) in Mississippi,

involving prisoners with mental illness in isolated confinement at Mississippi State Penitentiary.¹ I served as psychiatric expert witness and testified in *Trueblood v. Washington*,² about the effects of long wait periods for prisoners deemed incompetent being transferred from jail to state hospitals in Washington.

I was the recipient of the Exemplary Psychiatrist Award presented by the National Alliance on Mental Illness (NAMI) at the 2005 annual meeting of the American Psychiatric Association, the William Rossiter Award for "global contributions made to the field of forensic mental health" from The Forensic Mental Health Association of California in 2009, the Gloria Huntley Award from the National Alliance on Mental Illness (NAMI) in 2020, and the Judge Stephen S. Goss Lifetime Achievement Award from Judges and Psychiatrists Leadership Initiative (JPLI), The Council of State Governments & American Psychiatric Foundation in 2024. My *curriculum vitae* and a list of cases in which I have served as an expert in the past four years are attached to this report as Exhibits A & B.

I have been retained by Plaintiffs' counsel to offer opinions about the likely psychiatric effects of delays in providing pre-trial jail detainees with competency assessments, and delays in transferring pre-trial detainees determined to be Incompetent to Stand Trial (IST) to a State Hospital in Missouri for competency restoration treatment. My fees are \$350/hour for all work and travel time except testimony, and \$500/hour for testimony at deposition and trial. The payment of my fee is not dependent on the content of my testimony.

This is a preliminary report which I intend to supplement after discovery has been conducted in the case, in compliance with the case's scheduling order and the applicable rules.

II. Preparation

In preparation for rendering opinions in this matter, at this time, I have reviewed the following:

- Complaint, *Darrington v. Missouri Department of Mental Health*, No. 2:25-cv-04268-MDH (W.D. Mo. Nov. 24, 2025).
- Suggestions in Supp. of Mot. for Class Cert. Ex. 5, Evelyn Annor & Katie Quinn, *Mental Health Needs in Missouri Jails, Part I: Surveying County Sheriffs & Jail Administrators*, Missouri Appleseed, (Sept. 2025), <https://missouriappleseed.org/wp-content/uploads/2025/09/FINAL-Mental-Health-in-Jails-Report-9.23.25-1.pdf>,

¹ No. 4:05-CV-00148-JAD (N.D. Mississippi, 2005 & 2007).

² *A.B. v. WA DSHS*, Case 2:14-cv-01178-MJP

- Darrington v. Missouri Department of Mental Health*, No. 2:25-cv-04268-MDH (W.D. Mo. Nov. 24, 2025), Doc. 6-5.
- Declaration of Annie Legomsky, JD/MSW, *Darrington v. Mental Health Department*, No. 2:25-cv-04268-MDH (W.D. Mo. Nov. 24, 2025) U.S. Dep’t of Justice, C.R. Div., *Investigation of Missouri’s Use of Nursing Facilities and Guardianship for Adults with Mental Health Disabilities*, (June 18, 2024), <https://www.justice.gov/crt/media/1356331/dl>.
 - Doug Burris, *Operational Review of the St. Louis Justice Center*, (2025).
 - Suggestions in Supp. of Mot. for Class Cert. *Darrington v. Missouri Department of Mental Health*, No. 2:25-cv-04268-MDH (W.D. Mo. Nov. 24, 2025).
 - Clara Bates, *Hundreds of Missourians Continue to Languish in Jail Waiting for Mental Health Services*, Mo. Indep. (May 7, 2025), <https://missouriindependent.com/2025/05/07/hundreds-of-missourians-continue-to-languish-in-jail-waiting-for-mental-health-services/>.
 - Commission on Accreditation for Corrections, *Standards Compliance Reaccreditation Audit*, Buzz Westfall Justice Center/St. Louis County Jail, Clayton, Missouri, (Sept. 8, 2025).
 - Suggestions in Supp. of Mot. For Class Cert., Ex. 1 (Timothy Wilson and Jeanette Simmons, *Pretrial Evaluations & Competency Restoration*, Mo. Dep’t of Mental Health), *Darrington v. Missouri Department of Mental Health*, No. 2:25-cv-04268-MDH (W.D. Mo. Nov. 24, 2025) Doc.6-1.
 - Suggestions in Supp. of Mot. for Class Cert., Ex. 2 (May 5 Presentation by Mo. Dep. of Mental Health), *Darrington v. Missouri Department of Mental Health*, No. 2:25-cv-04268-MDH (W.D. Mo. Nov. 24, 2025) Doc. 6-2.
 - Steph Quinn, *Missouri Lawmakers Vow to Tackle Mental Health Backlog as Hundreds Languish in Jails*, Mo. Indep. (Dec. 16, 2025), <https://missouriindependent.com/2025/12/16/missouri-lawmakers-vow-to-tackle-mental-health-backlog-as-hundreds-languish-in-jails/>.
 - 2023 SAMHSA Uniform Reporting System (URS), Missouri 2023 Mental Health National Outcome Measures (NOMS) (2023), <https://www.samhsa.gov/data/sites/default/files/reports/rpt53128/Missouri.pdf>.
 - *Map of Certified Community Behavioral Health Organizations*, Mo. Dep’t of Mental Health (Feb. 18, 2025), <https://dmh.mo.gov/media/pdf/map-certified-community-behavioral-health-organizations>.
 - *DMH Facilities, Planning for the Future*, Mo. Dep’t of Mental Health (January 9, 2024). Shannon Bader & Lisa Callahan on Missouri Summit on Competence to Stand Trial (Apr. 9, 2024).
 - Suggestions in Supp. of Mot. for Class Cert., Ex. 4 (Jeanette Simmons, Mo. De’t of Mental Health Deputy Dir., Chapter 552: Competency Challenges, Mo. Dep’t of Mental Health), *Darrington v. Missouri Department of Mental Health*, No. 2:25-cv-

04268-MDH (W.D. Mo. Nov. 24, 2025) Doc.6-4. PMedical Records from St. Louis City Just. Ctr. for Mr. T.C.

- Medical Records from Greene Cnty. Jail for Mr. O.J.
- Medical Records from Jackon Cnty. Jail for Mr. M.R.
- Tony Messenger, *Restraint Chair No Longer Being Used at St. Louis Jail*, St. Louis Post-Dispatch (Dec. 23, 2025), https://www.stltoday.com/news/local/column/tony-messenger/article_3a112308-2f57-4d06-b21b-5153f9e25f0e.html?utm_medium=social&utm_source=twitter&utm_campaign=user-share.
- Lacreteria Wimbley, *Woman Dies in Custody of St. Louis City Jail, Marking 22 Deaths Since 2020*, St. Louis Pub. Radio (Feb. 1, 2026), <https://www.stlpr.org/government-politics-issues/2026-02-01/woman-detainee-dies-custody-st-louis-jail-city-justice-center>.
- Steph Quinn, *Missouri Lawmakers Vow to Tackle Mental Health Backlog as Hundreds Languish in Jails*, Mo. Indep. (Dec. 16, 2025), <https://missouriindependent.com/2025/12/16/missouri-lawmakers-vow-to-tackle-mental-health-backlog-as-hundreds-languish-in-jails/>.
- Steph Quinn, *'It sure looks like a crisis': Lawmakers confront mental health backlog in Missouri jails*, Mo. Indep., (Feb. 11, 2026), <https://missouriindependent.com/2026/02/11/it-sure-looks-like-a-crisis-lawmakers-confront-mental-health-backlog-in-missouri-jails/>.

In addition, I conducted the following interviews:

- On December 22, 2025, I interviewed Mr. Doug Burris, former administrator of both the St. Louis City and St. Louis County jails, by Zoom for approximately 35 minutes. Zoom Interview with Doug Burris, former administrator of St. Louis City and St. Louis County Jails (Dec. 22, 2025).
- On January 7, 2026, I interviewed Ms. Annie Legomsky, Director of Client Advocacy at Missouri State Public Defender, by Zoom for approximately an hour and a half. Zoom Interview with Annie Legomsky, Dir. of Client Advocacy at Mo. State Pub. Def. (Jan. 7, 2026).
- On January 8, 2026, I interviewed Ms. Mary Fox, former Director of the Missouri State Public Defender, by Zoom for approximately 40 minutes. Zoom Interview with Mary Fox, former. Dir. of the Mo. State Pub. Def. (Jan. 8, 2026).
- On January 15, 2026, I interviewed Mr. David Wiegert, a Public Defender in Jackson County, for 40 minutes on the phone. Phone Interview with David Wiegert, Pub. Def. In Jackson County (Jan. 15, 2026).

- On January 10, 2026, I interviewed Mr. J.W., an impacted person who wishes to remain anonymous, for approximately 30 minutes on the phone. Phone Interview with J.W., anonymous impacted person (Jan. 10, 2026).
- On January 11, 2026, I interviewed Ms. S.A., an impacted person who wishes to remain anonymous, for approximately 45 minutes on the phone. Phone Interview with S.A., anonymous impacted person (Jan. 11, 2026).

III. Summary of the Case

The Missouri Department of Mental Health (DMH) is responsible for pre-trial mental health assessments regarding competency to stand trial, and a Missouri State Hospital is, by state law, the main site of treatment (competency restoration treatment) of individuals accused of a crime who are determined by assessment and court adjudication to be incompetent to stand trial (IST). I am asked to opine about the effects of delays in performing assessments of pre-trial jail detainees' competency as well as long delays transferring defendants deemed IST to a state hospital or other setting for competency restoration services while the defendant waits in jail for the assessment and transfer.

As of the writing of this preliminary report, there are 524 people who have been declared by the court IST and are on the waitlist for transfer to a state hospital to receive competency restoration services, and 446 of those individuals are waiting in a county jail to be transferred to a state hospital for competency restoration treatment; in 186 additional criminal cases, the court has ordered an evaluation for competence and the individual is waiting in jail for that evaluation (called a "552 evaluation," referencing Chapter 552 of the Missouri Code); currently the average wait time for transfer from jail to state hospital is 15 months; and an additional 60 individuals have been opined incompetent to stand trial by DMH and are waiting for a court to order them committed to DMH custody.³ Individuals on the waitlist to be transferred for competency restoration services at state hospitals are pre-trial, meaning they have not been convicted of a

³ Suggestions in Supp. of Mot. for Class Cert., Ex. 4 (Jeanette Simmons, Mo. Dept of Mental Health Deputy Dir., Chapter 552: Competency Challenges, Mo. Dep't of Mental Health), *Darrington v. Missouri Department of Mental Health*, No. 2:25-cv-04268-MDH (W.D. Mo. Nov. 24, 2025) Doc.6-4. P; *see also*, Suggestions in Supp. of Mot. for Class Cert., Ex. 2 (May 5 Presentation by Mo. Dep. of Mental Health), *Darrington v. Missouri Department of Mental Health*, No. 2:25-cv-04268-MDH (W.D. Mo. Nov. 24, 2025) Doc. 6-2.

crime, but they are serving long terms in jail awaiting trial. DMH's waitlist has more than doubled in size since July 2023.⁴

Reasons for the severe backlog in admissions to the state hospitals for competency restoration services include limited bed capacity (currently all of the 440 state hospital beds in Missouri are occupied, as are the very small number - eight - outpatient beds in the community designated for competency restoration services), limited staffing, limited community placements after treatment, and increased pre-trial evaluations (48% increase in the last 5 years) ordered by the courts.⁵ Competency restoration treatment requires both the treatment of the underlying illness that causes incompetence and education about the legal proceedings and training in collaboration with an attorney, so that the individual can participate in their own defense. Thus, if an individual has decompensated—i.e., is acutely psychotic or so depressed that focus, rational thought, concentration on task, and judgement are seriously impaired—the underlying mental illness must be treated first to render the individual capable of taking part in the competency restoration classes and training.

Adequate competency restoration treatment can only occur in a setting conducive to mental health treatment as well as education about the criminal justice system in Missouri. This case is about getting individuals who are incompetent to stand trial evaluated and into effective competency restoration treatment in a timely fashion. Long waits in jail between the order for an evaluation for competency and the completion of the evaluation, and long waits in jail subsequent to the determination individuals are IST, have very harmful effects because of the stress of the jail environment and the sparse mental health treatment available in jail, on average.

IV. Mental Health Treatment in Jail

Jails, or local detention facilities, are typically designated for pre-trial detainees as well as sentenced inmates serving less than a year behind bars. In recent years, the length of stay in jails can be significantly longer than one year, and many pre-trial detainees spend many months or even years in jail prior to trial. Nationally, the prevalence of serious mental illness among jail

⁴ Steph Quinn, *'It Sure Looks Like a Crisis': Lawmakers Confront Mental Health Backlog in Missouri Jails*, Mo. Indep. (Feb. 11, 2026, 5:55 AM), <https://missouriindependent.com/2026/02/11/it-sure-looks-like-a-crisis-lawmakers-confront-mental-health-backlog-in-missouri-jails/>.

⁵ May 5 Presentation by Mo. Dep. of Mental Health, Doc. 6-2 at p. 6.

residents is estimated between 15% and 64%.⁶ The Appleseed Report on Mental Health Needs in Missouri Jails states: “According to state and federal estimates, more than one in four Missouri adults (26%) have some degree of mental illness. Of that group, 6% have a serious mental illness. At the St. Louis City Justice Center, more than one in four jail residents are prescribed psychiatric medications.”⁷

Typically, a person with mental illness is screened upon admission to the jail, and seen by a medical nurse if there are indications on the screening instrument that he or she has an acute need for treatment, or if the person is deemed at risk of suicide or self-harm, they are housed in an observation cell (a cell with little in the way of appliances and amenities, with a window or video through which the suicidal inmate can be constantly observed by staff or observed at regular intervals, for example every 10 or 15 minutes). If the person had been prescribed psychotropic medications prior to arrest, there must be some mechanism for those medications to be continued. A psychiatrist should be on hand to see prisoners and prescribe and monitor medications. In smaller jails, a psychiatrist comes in infrequently, if at all, to monitor medications, or, alternatively, a medical physician contracted to provide services at the jail may prescribe psychotropic medications in consultation with a psychiatrist. In some smaller jails, there is no psychiatrist visiting the facility, or a psychiatrist is available only by phone to consult with the general medical officer or nurse, or a psychiatrist may perform tele-psychiatry interviews with prisoners and prescribe medications. In other words, psychiatric coverage is variable and can be quite thin.

In many jails, the county or local government provides the mental health services in the jail and either the Sheriff’s Department or the local county mental health department is

⁶ National epidemiological studies until recently had placed the prevalence of serious mental illness in jails and prisons between approximately 15% and 30%. *But see* Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* (2006), <https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf>. U.S. Dep’t of Just., Bureau of Just. Stats., *Mental Health Problems of Prison and Jail Inmates* (2006), <https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf> concludes that 64% of jail inmates suffer from a significant mental health problem, as measured by a structured interview (not necessarily a clinician’s diagnosis). The wide range of estimated prevalence likely results from somewhat different subgroups being measured and different criteria for establishing the presence of mental illness. Thus, the 15%-30% estimate is offered by correctional clinicians who are reflecting the size of their caseload, while the 64% figure results from questionnaires filled out by prisoners.

⁷ Suggestions in Supp. of Mot. for Class Cert. Ex. 5, Evelyn Annor & Katie Quinn, *Mental Health Needs in Missouri Jails, Part I: Surveying County Sheriffs & Jail Administrators*, Missouri Appleseed, (Sept. 2025), <https://missouriappleseed.org/wp-content/uploads/2025/09/FINAL-Mental-Health-in-Jails-Report-9.23.25-1.pdf>, *Darrington v. Missouri Department of Mental Health*, No. 2:25-cv-04268-MDH (W.D. Mo. Nov. 24, 2025), Doc. 6-5 (“Appleseed Report”).

responsible for such services, but in quite a few jails, mental health and medical services are provided per contract with private companies. There is an ethical requirement that clinicians providing treatment in the jails not be the ones determining the mental state (sanity) or competence of defendants, the assumption being that their doing so would constitute a conflict of interest.⁸

The quality and intensity of mental health programming in jails varies from county to county. In large urban centers, there tends to be relatively more mental health treatment available, and a psychiatrist should be (but is not necessarily) at the jail several days per week, while in smaller counties, especially rural counties, very little mental health treatment is provided, on average, and the psychiatrist typically appears only a few hours per week, if at all, or psychiatric coverage is limited to tele-psychiatry visits (tele-psychiatry involves the use of video for meetings between prisoners and a psychiatrist who is not at the jail). In many jails, a large proportion of inmates in treatment for mental illness spend almost all of their time in a cell by themselves (electively they choose to remain in their cell, or they are consigned to some form of solitary confinement, even to Suicide Watch – and Suicide Observation can mean 23 ½ hours per day in a cell, albeit with brief conversations with the mental health provider), or in a crowded dormitory where they are mostly idle, and, though there may be some groups, have relatively little opportunity to participate in group encounters.

Though standards⁹ require multiple levels of mental health treatment to be available on site or in nearby facilities – including emergency mental health treatment and crisis intervention, outpatient mental health treatment, intermediate treatment units, and inpatient psychiatric treatment – most jails, in my experience, do not have inpatient units nor intermediate treatment units. There simply are not enough resources at each level of treatment intensity, on average, to serve the population adequately.

⁸ Am. Acad. of Psychiatry & the L., Ethics Guidelines for the Practice of Forensic Psychiatry 3 (2005), <https://www.aapl.org/docs/pdf/ETHICSGDLNS.pdf> (“The forensic evaluation and the credibility of the practitioner may also be undermined by conflicts inherent in the differing clinical and forensic roles. Treating psychiatrists should therefore generally avoid acting as an expert witness for their patients or performing evaluations of their patients for legal purposes.”), <http://www.aapl.org/ethics.htm>.

⁹ Nat’l Comm’n on Corr. Health Care, *Jail and Prison Standards* (last visited Feb. 27, 2026), <https://ncchc.org/jails-and-prisons/> (Standards of the National Commission on Correctional Health Care); Am. Corr. Ass’n, *Standards* (last visited Feb. 27, 2026), <https://www.aca.org/standards> (The American Correctional Association Standards); and Am. Psych. Ass’n, *Psychiatric Services in Correctional Facilities* (3d ed.) (The American Psychiatric Association Standards).

All of the individuals I interviewed in this matter averred that problems with access to mental health care exist in Missouri jails, and new reports describe similar issues. Tony Messenger, in a January 6, 2026, article in the St. Louis Post-Dispatch, reports that Nate Hayward, after spending his first 90 days as the Commissioner of Corrections overseeing the St. Louis City Justice Center, said “I didn’t know it was going to be this bad.”¹⁰ Mr. Hayward expressed concern about the use of restraint chairs at the jail, which had recently resulted in the death of a jail detainee. Mr. Hayward immediately ended the use of restraint chairs in the jail, though they are still used in other counties. In an outline of problems at the jail, Mr. Hayward included a lack of cleanliness, the fact that very many detainees at the jail were spending 24 hours per day isolated in their cells and were not able to communicate with their families, and they were not even permitted showers. Mr. Hayward criticized deficient staff training on the use of force and expressed concern that the jail was very understaffed, “The City Justice Center is about 60 corrections workers short of where it needs to be.” (The City Justice Center is where C.T. is detained as of this report.)¹¹

Substandard mental health and medical treatment in Missouri’s jails is also reflected in the September 8, 2025, reaccreditation audit report for the Buzz Westfall Justice Center (St. Louis County Jail) by the Commission on Accreditation for Corrections Standards Compliance.¹² The Commission found that the facility was non-compliant in regard to multiple mandatory standards, including “the facility could not provide proof there is an evacuation plan,” “Public health inspection documentation was incomplete,” “This facility was found to have poor sanitation and some areas were not in good repair,” “Facility did not provide proof of a plan for continuing operations in the event of a work stoppage,” “Documentation provided by the facility showed gaps in observations (of detainees) in excess of one hour,” “Facility provided no documentation that inmates are not allowed to exert authority over other inmates,” “Facility provided no documentation that all inmate movement is controlled by staff,” “Facility did not provide documentation proving an inmate is placed in disciplinary detention only after a

¹⁰ Tony Messenger, *Restraint Chair No Longer Being Used at St. Louis Jail*, (Jan. 6, 2026) St. Louis Post-Dispatch, https://www.stltoday.com/news/local/column/tony-messenger/article_3a112308-2f57-4d06-b21b-5153f9e25f0e.html?utm_medium=social&utm_source=twitter&utm_campaign=user-share.

¹¹ See § V(C) for more of a discussion of the impact of pretrial detention at CJC on C.T.

¹² Loretta Wimbley, *Woman Dies in Custody of St. Louis City Jail, Marking 22 Deaths Since 2020*, St. Louis Public Radio, (Feb. 1, 2026) <https://www.stlpr.org/government-politics-issues/2025-12-10/st-louis-county-jail-showers-black-mold-lacks-accountability-report>.

hearing,” “Facility did not provide documentation of a Behavioral Health Transition Program (including safe housing to meet the therapeutic needs of the inmate) with the required elements,” “Documentation provided does not show proof that inmates have the opportunity to shave and shower at least three times per week,” and so forth. The impression one gets reading the Commission’s audit report is that the jail is not an environment conducive to mental health treatment.

In most jails, there is very little, if anything, in the way of psychotherapy or psychiatric rehabilitation. *Psychotherapy* is a clinical intervention, provided individually or in groups, where a therapist spends appointed time with a patient to talk about the patient’s emotional problems and condition. *Psychiatric rehabilitation* is a collection of programs, including vocational training, anger management, art and recreational therapy, case management, and so forth, aimed at improving and sustaining the quality of life of individuals with mental illness. *Case management* involves the assignment of a clinician to each patient to track their progress in treatment and keep abreast of their progress in jail. In most jails, especially in small counties, there is little or no psychiatric rehabilitation or case management. And typically, mental health clinicians are tasked with supervising a relatively large caseload, so they cannot spend any significant time talking with each of their patients. The smaller counties cannot afford the level of staffing the larger counties enjoy, mental health programming is very thin, if it exists at all, and inmates with mental illness are often relegated to isolation in their cells most of the time.¹³ The Applesed Report on Mental Health Needs in Missouri Jails identifies solitary confinement¹⁴ as a major hazard for individuals who are IST in overcrowded and under-staffed jails:

Individuals awaiting a competency restoration program (CRP) placement or even civil commitment suffer when their medical needs remain unmet, and as their mental health inevitably deteriorates, jail administrators face difficult choices. Incarcerated individuals with mental illness cannot always safely co-exist with others in general population; they may be victimized by other residents, or their mental state may lead them to cause injury to staff or residents. The only physically “safe” place that remains is solitary confinement, but isolating someone with mental illness almost always aggravates their condition. The severe backlog for

¹³ *Rural Behavioral Health Care: An Interdisciplinary Guide* (B. Hudnall Stamm, ed. 2003); Melanie Race *et. al*, *Mental Health Services in Rural Jails*, (2009), <http://muskie.usm.maine.edu/Publications/rural/pb/mental-health-services-rural-jails.pdf>.

¹⁴ I discuss solitary confinement more fully in Section V(C), below.

competency assessment and transfer inevitably leads to worsening mental health but also justice delayed. Some individuals sit on the list for months or years longer than their original sentence would have lasted.¹⁵

There are two main problems with the scenario whereby individuals with serious mental illness spend almost all their time at the jail alone and idle in a cell or are sent to solitary confinement. *First*, the individual with serious mental illness is not receiving adequate mental health treatment, and the longer someone with an acute exacerbation of serious mental illness goes without adequate treatment, the worse the eventual prognosis. *Second*, the conditions of confinement in the jail – especially solitary confinement -- are exceedingly harmful to the individual suffering from serious mental illness and make adequate mental health treatment difficult if not impossible, even if increased mental health staffing were achievable. Indeed, when individuals deemed IST wait long periods in jail for assessment and then for competency restoration treatment, because of harsh and punitive jail conditions and the delay in instituting adequate treatment, they become more disturbed and more difficult to restore to competency.

Jail administrators and Department of Mental Health officials in Missouri have been quite forthcoming about deficiencies in jail mental health programs and the need to keep pre-trial detainees adjudicated IST in solitary confinement. For example, according to a local County Sheriff who was interviewed by Appleseed staff but wishes to remain anonymous:

I have a big guy, about 6'4" and 300 pounds, who hears voices. When he's in gen[eral] pop[ulation], he starts fights when he thinks others are talking about him. Everyone else gangs up on him and ends up injured. I have to put him in solitary to keep him from hurting others or getting beat up, but when he's in solitary he cries from loneliness. It's heartbreaking. I don't know what to do. He's been assessed incompetent by DMH but has been waiting for a bed for over a year. I've called anyone I can think of to try and get him out of here, with no luck.¹⁶ (Appleseed Report, p. 2)

And according to public testimony by the Director of the Missouri Department of Mental Health, Valerie Huhn:

I just wanted to make everybody aware of some of the risks that we know we're taking on because we can't get these individuals from jail into our state operated hospitals. Obviously, their illness is

¹⁵ See Appleseed Report at 2.

¹⁶ *Id.*

worse, and as their treatment is delayed, that makes it harder for us to turn them around.¹⁷

There is a large amount of clinical research showing that, when an individual is experiencing an acute psychotic episode, a manic state or a depressive or suicidal crisis, the longer that individual is left untreated or inadequately treated, the worse the prognosis.¹⁸ In her November 23, 2025, declaration in this matter, Annie Legomsky, JD, MSW, Director of Client Advocacy at Missouri State Public Defender, describes observing clients decompensate while in jail on the waitlist, including “seeing clients become nonverbal, catatonic, regularly eating their feces, peeling and picking their skin off, pulling out their fingernails and toenails, increased suicidal ideation, and increased suffering from worsened delusions and psychological torment.”

The presence in the jails of a large proportion of inmates suffering from serious mental illness, and the fact that mental health services are, on average, relatively skimpy with understaffing and too little resources, means that there is a huge amount of untreated or inadequately treated mental illness in the jails, and the high suicide rate continues to be a big problem. Besides, a significant proportion of inmates suffer from inadequately treated psychosis, as is the case in Missouri’s jails as it is nationally, and this makes the jail population rowdier and more difficult for staff to manage, on average.

V. The Impact of Jail Conditions on Mental Health

Compounding the problem of relatively inadequate mental health treatment in the jails, there are conditions that exacerbate or worsen mental disorders and disabilities. I will focus on three: crowding (often referred to as overcrowding in the scientific literature); the use of force and restraint by custody staff; and the problem of isolation.

¹⁷ Clara Bates, *Hundreds of Missourians Continue to Languish in Jail Waiting for Mental Health Services*, Mo. Indep., (May 7, 2025), <https://missouriindependent.com/2025/05/07/hundreds-of-missourians-continue-to-languish-in-jail-waiting-for-mental-health-services/>.

¹⁸ See, e.g., Terry Kupers, *Schizophrenia, its Treatment and Prison Adjustment*, in *Managing Special Populations in Jails and Prisons*, (Stan Stojkovic, ed. 2005); Werner M. Mendel, *Treating Schizophrenia* (1989); Noordsy, D. L. & C. O’Keefe, *Effectiveness of Combining Atypical Antipsychotics and Psychosocial Rehabilitation in a Community Mental Health Center Setting*, 60 *Journal of Clinical Psychiatry* 47-53 (1999); *Serious Mental Illness and Homelessness*, Treatment Advocacy Center, (Nov., 2016), https://www.tac.org/reports_publications/serious-mental-illness-and-homelessness/; Jennifer Bronson & Marcus Berzofsky, *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-2012*, U. S. Bureau of Just. Stats., June, 2017, <https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf>.

A. Crowding

In recent decades, jail populations have swollen geometrically, leading to overcrowding.¹⁹ There has been a seven-fold multiplication of the jail and prison population nationally since 1970, and meanwhile, the proportion of jail inmates with serious mental illness has been rising. A report by the Treatment Advocacy Center and National Sheriffs' Association concludes that there are as many as ten times as many individuals suffering from serious mental illness behind bars than there are in mental hospitals.²⁰ With jail crowding, cells designed for one or two inmates contain two or four, and dormitories are filled with far greater numbers of prisoners than their design capacity. A review of a robust research literature concludes that with crowding, there is a significant rise in the rates of violence, psychiatric breakdown, suicide, and medical illnesses (such as hypertension and asthma) that are highly sensitive to stress.²¹ Quite a few jails have been the focus of reports and lawsuits claiming that the jails are too crowded and the mental health care is inadequate.²² Crowding in Missouri jails is exacerbated by the DMH waitlist, and the fact that jails often house people on the waitlist in single person cells.

Crowded jails are dangerous and the site of many psychiatric breakdowns and suicides. A 1995 study on suicide in jail reflects that the suicide rate (completed suicides, not attempts) is very much higher than that in the community.²³ The problem has been alleviated somewhat by the measures put into effect in the intervening years, but the jail suicide rate remains several times higher than that in the larger community.

The research finding that crowding correlates with increased violence, psychiatric breakdown, and suicide makes sense. With crowding, people get on each other's nerves, and tempers flare. When a dayroom is converted to a crowded dormitory and thus the room cannot be used for activities, prisoners sit around much of the day often getting into arguments with each

¹⁹ H. Richard Lamb, et al., *Treatment Prospects for People with Severe Mental Illness in an Urban County Jail*, 58 *Psychiatric Services*, no. 6, June 2007.

²⁰ E. Fuller Torrey et al., *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey* (2014), https://www.tac.org/reports_publications/the-treatment-of-persons-with-mental-illness-in-prisons-and-jails-a-state-survey/.

²¹ Terence P. Thornberry & Jack E. Call, *Constitutional challenges to prison overcrowding: The scientific evidence of harmful effects*, 35 *Hastings Law Journal*, 313 (1984).

²² I should note that jail populations vary, and some jails are not as crowded, their current population might even be below design capacity. This is partly due to seasonal fluctuations in population, and partly because different counties handle the influx of prisoners differently, some counties opting to grant lower security prisoners probation while others crowd the jails.

²³ Lindsay M. Hayes, *Prison Suicide: An Overview and Guide to Prevention*, 75 *The Prison Journal*, 431 (1995).

other. Consider the line to use the phone. The longer the line, the more likely someone in the line will get angry at the person on the phone and belligerently demand he end his call. Fights erupt. Then, in crowded dormitories or in locked, windowless cells with solid metal doors and two prisoners inside, officers are not really able to detect many of the altercations and sexual assaults that occur, and vulnerable prisoners – disproportionately prisoners with serious mental illness, especially those who are IST – are not provided a safe place to await trial or serve their time.

With crowding and increased violence, some of the prisoners with mental illness become the victims while others, their emotions out of control on account of their mental illness, become the perpetrators of impulsive acts of violence against others or against themselves. Mental illness makes one very vulnerable in jail. First, there is great stigma accompanying mental illness in jail, and other prisoners laugh at those with visible signs of mental illness, rob from them, take advantage of them and attack them. If a prisoner is intent on perpetrating a physical or sexual attack on another prisoner, he or she wants to be careful to choose someone without friends. If he or she attacks a prisoner with friends, especially one with ties to a gang, there is the risk of retaliation from the friends or gang members. So, he or she chooses a loner to attack. Prisoners with serious mental illness are, on average, loners with few if any friends. Therefore, they are easy targets and are attacked more often and sexually assaulted more often than other prisoners.²⁴ Jails are simply not a safe place, especially for individuals suffering from mental illness.

B. Use of Force and Restraint

Besides disproportionately being victims of violence and sexual assault, individuals with mental illness are not known to be great followers of rules. In jail, the rules are many and very strict, use of force and restraint (tasers, restraint chairs, etc.), and punishment with solitary confinement is widespread. It is no surprise that prisoners with serious mental illness are disproportionately represented in the punitive detention areas of the jail.

In fact, prisoners with serious mental illness are disproportionately the object of officers' use of force, and of excessive and abusive force. In a 2015 report, Human Rights Watch uncovers the massive abuse. The Introduction to that report includes:

Corrections officials at times needlessly and punitively deluge them with chemical sprays; shock them with electric stun devices; strap

²⁴ For a general discussion of this dynamic, see Terry Kupers, *Rape and the Prison Code in Prison Masculinities* 111-17 (D. Sabo, T. Kupers & W. London eds. 2001).

them to chairs and beds for days on end; break their jaws, noses, ribs; or leave them with lacerations, second degree burns, deep bruises, and damaged internal organs. The violence can traumatize already vulnerable men and women, aggravating their symptoms and making future mental health treatment more difficult. In some cases, including several documented in this report, the use of force has caused or contributed to prisoners' deaths.... **Experts consulted for this report say that the misuse of force against prisoners with mental health problems is widespread and may be increasing.** Among the reasons they cite are deficient mental health treatment in corrections facilities, inadequate policies to protect prisoners from unnecessary force, insufficient staff training and supervision, a lack of accountability for the misuse of force, and poor leadership.²⁵

The means of restraining prisoners in jail are often quite anti-therapeutic. Restraint chairs are an example of the jail's use of force and restraint that too often causes harm.²⁶ Restraint chairs are devices wherein an inappropriately behaving prisoner can be strapped. There are guidelines and policies in most jails that limit the amount of time an individual can be strapped in the chair and require frequent checks to ensure the individual is safe. But these policies are too often ignored. As Maurice Chammah reported:

Shortly after Christmas in 2016, Albert Okal began acting strangely in the Wayne County Jail. He was 'jumping around, seeing things,' his lawyer says. The 41-year-old was facing a charge of driving while intoxicated in southeastern Missouri. Okal does not recall why he became so agitated, but his lawyer said Okal does remember how the jail staff responded: They cuffed his wrists and ankles to a "restraint chair, 'where they force-fed him, covered his head with a blanket, addressed him with the n-word and refused to let him use the bathroom, leaving him to urinate and defecate on himself. He remembers being restrained for five days, his lawyer said.²⁷

Jail officers also utilize tasers, shackle or strap prisoners on a bed or gurney, and too often use excessive force to subdue recalcitrant prisoners. All of these uses of force and restraint are disproportionately applied to jail prisoners with serious mental illness, including those who

²⁵ *Callous and Cruel: Use of Force Against Inmates with Mental Disabilities in U.S. Jails and Prisons*, Human Rights Watch (May 12, 2015), <https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and> (emphasis added).

²⁶ Restraint chairs are utilized in some Missouri jails, and not others. See Maurice Chammah, *They Went to Jail. Then They Say They Were Strapped to a Chair for Days*, The Marshall Project (Feb. 7, 2020), <https://www.themarshallproject.org/2020/02/07/they-went-to-jail-then-they-say-they-were-strapped-to-a-chair-for-days>.

²⁷ *Ibid.*

are IST. And these uses of force are very rarely practiced in state psychiatric hospitals, where restraint only occurs in very rare situations and then with the least force and restraint necessary, and under the direct supervision of a psychiatrist.

C. Solitary Confinement

Prisoners with serious mental illness are often consigned to punitive segregation or solitary confinement as punishment for rule-breaking or assaultiveness, even if their unacceptable behaviors are expressions of their mental illness. But in addition to the individuals with serious mental illness who are consigned to solitary confinement or punitive segregation for disciplinary reasons, many more spend most of their time in jail in *de facto* solitary confinement. Since solitary confinement is generally defined as spending 22 or more hours in one's cell (even 18 or 20 hours alone in a cell causes emotional harm),²⁸ being cell-fed, and having very little in the way of meaningful programs and activities, there are quite a few forms of jail housing that constitute solitary confinement, even if the jail administration does not identify them officially as solitary confinement. In general, and in stark contrast to state hospitals, where daily activities include many forms of psychotherapy, supervised group projects, and recreation, there are relatively few programs and activities available to individuals detained in jail. For example, Mr. K.M., a plaintiff in this matter, was kept in the booking room so that he would be alone because jail staff did not believe it was safe for him to be in the jail's general population. The booking cell, as I understand it, was the only available cell for him to be alone in at the Buchanan County Jail.²⁹

For multiple reasons, as every Sheriff and Jail Commander knows, individuals with serious mental illness are reclusive and usually prefer remaining alone in a cell to participating in group activities. The result is self-imposed isolation. In a hospital setting, mental health staff make robust efforts to encourage the individual with serious mental illness to leave his room or cell and take part in social activities. But jail settings are very different. Rather than encouraging

²⁸ See Craig Haney, Restricting the Use of Solitary Confinement, *Annu. Rev. Criminol.* 2018. 1:285–310; at p. 286, Haney writes: “The definition of what constitutes solitary confinement turns less on the exact amount of in-cell time to which a prisoner is subjected and more on the deprivation of normal, direct, and meaningful social contact and access to positive environmental stimulation. Thus, an isolated prisoner who was afforded considerable out-of-cell time during which he or she was denied normal and meaningful forms of direct social contact and positive stimulation or programming would still be in solitary confinement. “

²⁹ See case of K.M. in Complaint.

the disturbed individual to take part in planned or informal social activities in the dayroom or recreation yard, custody staff are very willing to leave the individual in his cell – that makes it less likely he will get into trouble in a common area of the jail. In fact, many of the Sheriffs and Jail Commanders I have spoken to nationwide report that, with some exceptions usually related to crowding, they house jail prisoners suffering from serious mental illness in a cell by themselves (a single cell). This is to avoid the kind of trouble that regularly obtains in double-cell or dormitory settings, and to protect the disabled prisoner. But then, prisoners with serious mental illness tend to remain in their cell by themselves even when they are free to take part in programs or have free time in the dayroom or on the yard.

During every interview I conducted with Missouri officials and impacted individuals in this matter, I was told that in Missouri jails detainees with mental illness spend just about all of their time alone and mostly idle in a cell; this because of widespread understaffing, sparse mental health and rehabilitative programs, rule violations that land detainees with mental health problems in segregation, and the tendency of individuals with serious mental illness to isolate themselves, for example by electing to remain alone in their cell even when presented with the option of exiting their cell to take part in congregate activities.³⁰

And then there is *Protective Custody*. According to the Standards of the American Correctional Association (ACA),³¹ protective custody is not to involve solitary confinement, and the individual needing protection is to enjoy all the amenities and programs that his or her classification level permits, but simply in a separate area of the jail or prison where there is safety. According to the ACA standards:

Written policy, procedure, and practice provide that inmates in... protective custody have access to programs and services that include, but are not limited to, the following: educational services, commissary services, library services, social services, counseling services, religious guidance, and recreational programs. *Comment:* Although services and programs cannot be identical to those provided to the general population, there should be no major differences for reasons other than danger to life, health, or safety....³²

³⁰ Zoom Interview with Doug Burris, former administrator of St. Louis City and St. Louis County Jails (Dec. 22, 2025); Phone Interview with J.W., anonymous impacted person (Jan. 10, 2026); Phone Interview with S.A., anonymous impacted person (Jan. 11, 2026).

³¹ Am. Corr. Ass'n, *Performance-Based Standards and Expected Practices for Adult Correctional Institutions* (5th ed. 2020).

³² *Ibid.*

However, in practice, contrary to the ACA Standards, and in large part because of crowding and a lack of separate spaces to house individuals in Protective Custody, detainees who seek or require Protective Custody are relegated to solitary confinement. Sheriffs and Jail Commanders I have spoken to aver the reality of solitary confinement for individuals in Protective Custody and tell me they know that placing those individuals in a cell by themselves most of the day risks significant psychiatric damage from isolation and lack of meaningful activities. But they say they believe they have to risk that damage to maintain order and safety in the jail. In other words, individuals with serious mental illness spend a disproportionate amount of time alone in a cell, and whether it is official segregation or *de facto* solitary confinement, the isolation and idleness exacerbate their mental illness.

Haney, Weill, Bakshay and Lockett (2015) point out that isolation is used more in jails than in prisons, that prisoners with serious mental illness in jail are very likely to spend time in punitive segregation or another form of *de facto* solitary confinement (e.g. elective refusal to leave the cell, protective custody, Suicide Watch, or lockdowns) and that the isolation causes great harm. They review the recent history of widespread solitary confinement at Rikers Island, the jail for New York City, and the litigation aimed at diminishing solitary there, concluding: “This is precisely why the long-ignored and largely overlooked practice of jail isolation needs to be more carefully studied, independently monitored, effectively regulated, and legally controlled in local jails across the country.”³³

Besides the jail housing situations that obviously constitute solitary confinement, there is a tendency for jails that are crowded and relatively thinly staffed to keep prisoners in their cells or dormitories for most of each day simply to make management of the facility easier. Thus, even in general population housing situations, the prisoners remain in their cells or dorms all but a few hours each day, or in some cases they are permitted one or two hours out of their cells in the morning and again in the afternoon. This is why, when one tours a jail during the daytime, one sees hallways, dayrooms and yards with no prisoners occupying them, and sees prisoners sleeping or laying on their beds in the middle of the day. In other words, the jail milieu trends toward solitary confinement, isolation and idleness even in general population settings.

³³ Craig Haney et al., *Examining Jail Isolation: What We Don't Know Can Be Profoundly Harmful*, 96 *The Prison Journal*, 1 (2015).

Solitary confinement causes psychological damage. There has been a substantial amount of research into the harmful effects of isolated confinement, especially if the prisoner thus confined suffers from a serious mental illness or is vulnerable to mental illness.³⁴ It is predictable that prisoners' mental state deteriorates in isolation. Human beings require at least some social interaction and productive activities to establish and sustain a sense of identity and to maintain a grasp on reality. In the absence of social interactions, unrealistic ruminations and beliefs cannot be tested in conversation with others, so they build up inside and are transformed into unfocused and irrational thoughts. Disorganized behaviors emerge. Internal impulses linked with anger, fear and other strong emotions grow to overwhelming proportions. Sensory deprivation is not total in jail isolation settings; there is the intermittent slamming of steel doors and there is yelling (one has to yell in order to be heard by anyone from within one's cell), but this kind of noise does not constitute meaningful human communication. Prisoners in this kind of segregation do what they can to cope. Many pace relentlessly, as if this nonproductive action will relieve the emotional tension. Those who can read books and write letters do so.

The tendency to suffer psychiatric breakdown and become suicidal is made even worse by sleep deprivation, which is a frequent occurrence among prisoners in isolated confinement. There are noises at night as other prisoners, for example those suffering from serious mental illness, cry out. Then, besides the slamming of doors, officers yell out orders on the unit. Then, the lights are usually on all night. Loss of sleep intensifies psychiatric symptoms by interfering with the normal diurnal rhythm (the steady alternation of day and night that provides human beings with orientation as to time), and the resulting sleep loss creates fatigue and magnifies cognitive problems, memory deficits, confusion, anxiety, and sluggishness. It is under these extreme conditions that psychiatric symptoms begin to emerge in previously healthy prisoners. Of course, in less healthy ones (and individuals who would be designated for competency

³⁴ Terry Kupers, *Isolated Confinement: Effective Method for Behavior Change or Punishment for Punishment's Sake?*, The Routledge Handbook of International Crime and Justice Studies 213-232 (Bruce Arrigo & Heather Bersot Eds. 2006); Peter Scharff Smith, The effects of solitary confinement on prison inmates: A brief history and review of the literature, 34 *Crime and Just.* 441 (2006); Terry Kupers, *Solitary: The Inside Story of Supermax Isolation and How We Can Abolish It* (2017). In their amicus brief in *Wilkinson v. Austin*, 545 U.S. 209 (2005), leading mental health experts summarize the clinical and research literature about the effects of prolonged isolated confinement and conclude: "No study of the effects of solitary or supermax-like confinement that lasted longer than 60 days failed to find evidence of negative psychological effects." *Id.* at 4.

evaluation or restoration are in this group) there is psychosis, mania or compulsive acts of self-abuse or suicide.

A stunning statistic, born out in research around the country, is that 60% of all successful jail and prison suicides (not attempts, though the percentage would likely be comparable if we measured the much higher prevalence of attempts) occur among the approximately 5% of prisoners who are in isolated confinement (segregation).³⁵ One need merely contrast the chances of an IST prisoner committing suicide if he or she remains in such a harsh environment awaiting transfer to a state hospital for a very brief period versus, remaining there for months or years. The longer the time spent in jail, to a large extent in solitary confinement, the greater the risk of psychiatric breakdown and suicide.

That being said, someone need not be jailed for *years* in order to be negatively impacted by isolation. I have observed some relatively stable-appearing prisoners break down and become psychotic or seriously suicidal after being in solitary confinement for only a few days. The United Nations Special Rapporteur on Torture, Juan Méndez, issued a proclamation that indefinite and prolonged solitary confinement in excess of 15 days is a human rights violation, constitutes torture, and should be subject to an absolute prohibition.³⁶

VI. Mental Health Treatment in State Hospitals

State hospitals are the main site of competency restoration treatment in Missouri, although in recent years jail-based and community-based competency restoration services have come into the picture. The Missouri Department of Mental Health provides competency restoration treatment at three state hospitals, the Center for Behavioral Medicine (Clay County) (65 forensic beds); Nixon Forensic Center at Fulton State Hospital (Callaway County) (300 forensic beds); and the St. Louis Forensic Treatment Center-North (formerly Metropolitan Psychiatric Center) (75 forensic beds).³⁷

³⁵ Daniel P. Mears & Jamie Watson, *Towards a fair and balanced assessment of supermax prisons*, 23 Just. Q. 232 (2006); Bruce B. Way et al., *Factors Related to Suicide in New York State Prisons*, 28 Int'l J. of L. and Psychiatry 207 (2005); Raymond F. Patterson & Kerry Hughes, *Review of completed suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004*, 59 Psychiatric Services 676 (2008).

³⁶ See Press Release, U.N. Mr. Juan Mendez, Special Rapporteur on Torture, Addressed the UN General Assembly on 22 October 2013 and Outlined His Thematic Report on the "Revision of the Standard Minimum Rules for the Treatment of Prisoners (Oct. 22, 2013), <https://www.ohchr.org/en/statements-and-speeches/2014/03/mr-juan-mendez-special-rapporteur-torture-addressed-un-general>.

³⁷ See *supra* n3, Doc. 6-2.

The environment and programs at state hospitals are quite different than what exists in the jails. There are some differences between state hospitals, but generally the use of space, the staffing levels and the programs available in state hospitals are much more similar than they are different. Typically, state hospital wards contain large dayrooms that are full of patients during the day (in contrast to many jails, where few if any prisoners are sitting in the dayroom), they are sitting on comfortable seats watching television, talking to each other and meeting with nurses, social workers and other mental health staff informally in the dayrooms and in adjoining offices. Meals are mostly eaten together in a dining area, in contrast to a large proportion of jail prisoners eating their meals alone in their cell. The patients can enter and leave their rooms on their own volition, for the most part the doors are not locked (there are exceptions for patients who are severely ill or disruptive, but the staff enhance treatment for these individuals with the treatment goal of preparing them to participate peacefully in ward activities and have their doors unlocked). Groups and individual treatment and rehabilitation meetings are frequent, taking place multiple times each day. On the forensic unit for patients receiving competency restoration services, there are relevant classes each day. This is in contrast to once or twice per week classes in most jail-based competency restoration programs. At state hospitals, psychiatrists are on duty and meet with patients regularly. Mental health staffing and nursing are relatively rich in comparison with jail mental health programs. Every patient has a treatment team wherein the psychiatrist is in charge, and there are psychologists, social workers, and rehabilitation therapists. Nursing staff are involved in the treatment teams. Of course, state hospitals are not problem-free, and often have difficulties filling all staff positions, but here I am merely contrasting the state hospitals with the situation in the jails.

Patients are encouraged to attend activities. If a patient elects to remain in his or her room instead of attending the milieu meeting, a psychotherapy group or a competency restoration class, staff go to the room and gently encourage the patient to come out of the bedroom and attend the activity. The reason for this is that seeking isolation is a troublesome symptom of many psychiatric illnesses – depression is a prime example, schizophrenia as well – and it is an important part of the treatment for the treatment staff to encourage and facilitate the patient's participation in formal and informal congregate activities. This is in stark contrast to the average jail situation, where officers selectively assign prisoners with serious mental illness to a single cell, and if the prisoner elects to remain in that cell even when permitted out-of-cell, nothing is

done to encourage that individual to participate in congregate activities. State hospitals structure progressive phases into the inpatient treatment, incremental levels of freedoms and amenities that patients earn successively as they accomplish their treatment goals and act appropriately. For example, a disturbed or suicidal patient might be required to stay on a locked ward at first, until his or her behavior and inclinations can be assessed. Then, he or she is advanced to a higher level where he or she can be on an unlocked ward. Eventually he or she, if there is sufficient improvement in symptoms and behaviors, is permitted to leave the ward in the company of staff. And eventually, some of the most advanced patients are granted permission to roam the yards of the hospital unaccompanied.

Visiting involves contact, and there usually are no windows and phones to limit the contact (there may be a few non-contact visiting rooms in some hospitals for the rare moments of behavioral dyscontrol). And security is mostly provided by nurses and technicians who are available in sufficient numbers to manage the population of patients quite safely and effectively. Of course, there are relatively more professionally qualified staff compared to the jails, including psychiatrists, nurses, social workers, vocational therapists, occupational therapists, psychologists, psychiatric technicians and trainees from the various disciplines. The patients receive quite a lot of therapeutic attention, including individual and group psychotherapy, case management, social work and so forth. And in addition to psychotherapy, they are involved in groups, rehabilitation programs and competency restoration (if they are IST) classes in the mornings and afternoons most days.

Of the three Missouri state hospitals that provide competency restoration services, Fulton State Hospital is where patients with the highest-level security needs are admitted. At Fulton State Hospital, according to Ms. Mary Fox, former Director at Missouri State Public Defender, there is very little use of solitary confinement. Rather, when there are tensions or altercations between patients, those patients are separated, confined to separate areas of the hospital where they will have no contact with the individuals who pose a security risk for them. But in their separate areas, they are permitted the option of participating in the group milieu and congregate activities. In other words, steps are taken to minimize or entirely avoid solitary confinement.

Nowhere is the stark contrast between jail and hospital more dramatic than in regard to restraint and use of force. In the jails, as reported above, the use of force and restraint is a matter of custodial management; prisoners are restrained in handcuffs, or in more difficult situations

with shackles, spend most of their days locked into their cells or, in the one or a few hours they are permitted out of their cells, the common areas where they are permitted are locked and officers have control of the locks. When they are suicidal, they are placed in very restrictive confinement such as “suicide observation” or “safety cells.” There might be restraint chairs. In contrast, at the state hospitals, except in the rare exception when a patient is entirely out of control and violent, it is nurses and technicians and other members of the treatment team who surround an unruly patient and perform a “take down,” and when the patient must be restrained or placed in a seclusion room essentially for a “time out,” the procedure is carried out in compliance with standards in psychiatry that require a doctor (or other high level clinician) to first examine the patient being restrained or secluded and order the restraint or seclusion, and then after very few hours the doctor must return and re-examine the patient and re-order the seclusion or restraint if it is still required, and the seclusion or restraint must be utilized only when less restrictive measures have been tried and failed, and must be the minimum to achieve safety, and be terminated in the shortest possible time. In summary, the environment and programs in the state hospitals are a stark contrast to those in the jails.

VII. Dangers of Retaining Individuals Assessed IST in Jail While they Await Transfer to a State Hospital, and Competency Restoration Treatment.

Jail conditions place pre-trial detainees found IST at a significant risk of harm while they await treatment. At the time the Plaintiffs filed their Motion for Class Certification in this case, there were approximately 489 people on a waitlist for competency restoration services.³⁸ A recent report indicates that as of the first week of February 2026, there were 446 people were in jail on a waitlist for DMH competency restoration services.³⁹ In January 2026, there were an average of 518 people on the waitlist.⁴⁰ Compare these numbers to August, 2013, when there were 10 individuals waiting in jail for a bed at a state hospital; or September, 2021, when there were 106 individuals waiting in jail for a bed.⁴¹ This is a bleak picture.

³⁸ Clara Bates, *Missourians Waiting in Jail for Court-Ordered Mental Health Care Reaches All-Time High*, Mo. Indep. (Jan. 27, 2025), <https://missouriindependent.com/2025/01/27/missourians-waiting-in-jail-for-court-ordered-mental-health-care-reaches-all-time-high/>; Jesse Bogan, *‘Lost’ in Missouri Jail Cells*, The Marshall Project (Oct. 30, 2025), <https://www.themarshallproject.org/2025/10/30/missouri-mental-health-trial-treatment>.

³⁹ Steph Quinn, *‘It Sure Looks Like a Crisis’: Lawmakers Confront Mental Health Backlog in Missouri Jails*, Mo. INDEP. (Feb. 11, 2026, 5:55 AM), <https://missouriindependent.com/2026/02/11/it-sure-looks-like-a-crisis-lawmakers-confront-mental-health-backlog-in-missouri-jails/>.

⁴⁰ *Id.*

⁴¹ Suggestions in Supp. of Mot. for Class Cert., Ex. 1, *Darrington v. Missouri Department of Mental Health*, Case No. 2:25-cv-04268, (Mo. W.D. Nov 24, 2025), Doc. 6-1.

The worst-case scenario is a suicide or death by self-harm – or another form of violence known to be prevalent in jails – while a psychiatrically disturbed individual deemed IST is in jail pre-trial awaiting transfer to a State Hospital. Several individuals assessed IST have died in custody in Missouri Jails while waitlisted for many months for transfer to the State Hospital. In the Complaint in this matter, and again in the Suggestions in Support of Motion for Class Certification, the case of Timothy Beckmann is discussed:

Following his arrest, Mr. Beckmann's condition started deteriorating to the point where he was engaging in self-harm, pulling out his toenails, scratching himself, and losing touch with reality. At one point, Mr. Beckmann stopped eating or taking his blood pressure medication. Mr. Beckmann died in the Jackson County Detention Center in May 2025 after waiting months for DMH to provide restoration treatment. At the time of his death, Mr. Beckmann was number 109 on the waiting list for admission to a DMH facility. He was 64 years old at the time of his death....⁴²

While death by suicide or other preventable causes is the most dramatic harm of long waits in jail for transfer and competency restoration treatment, many prisoners who are harmed in other ways. I mentioned above the prevailing wisdom in psychiatry and other mental health fields that the longer an individual is left to suffer symptoms and disabilities of serious mental illness without receiving adequate mental health treatment, especially if he or she is subject to the continuing stressors and risk of violence that exist in jail, the mental illness becomes more severe and more long-lasting and difficult to treat, the eventual disability is worsened, and the prognosis made more dire.

VIII. The Impact of the Delay in Treatment on Named Plaintiffs and Others

The Complaint in this matter details several cases (K.M., M.R., M.T., O.J., C.T., and D.W, Complaint pp. 31-38) where plaintiffs have had to wait a long period of time in jail to undergo assessment for competency, and then have been declared IST and have had to wait a much longer period of time to be transferred from the jail to a state hospital for competency restoration treatment. For example, there is C.T.'s story:

C.T. is a white 31-year-old man currently detained at the St. Louis City Justice Center on a waitlist for DMH services. He is represented by his mother, Carrie Miner, as next friend. C.T. was arrested on

⁴² Suggestions in Supp. of Mot. for Class Cert., *Darrington v. Missouri Department of Mental Health*, Case No. 2:25-cv-04268, (Mo. W.D. Nov. 24, 2025), Doc. 6 at 19.

January 4, 2024.... At his detention hearing the following day, the court ordered a competency evaluation. However, a competency report was not filed until March 5, 2025.... On March 17, 2025, the Circuit Court entered an order finding C.T. IST, suspending proceedings, and committing C.T. to the custody of DMH. On September 2, 2025, DMH requested more time to provide treatment to C.T. due to waitlists at each of its facilities. Defendants have failed to take custody of C.T. and timely provide the restoration services required by Missouri law and the due process clause of the federal constitution. As of the filing of this complaint, C.T. has been waiting **252 days** for restoration treatment. While C.T. languishes in jail on DMH's waitlist, his mental and emotional condition deteriorate. He reports having been on suicide watch more than once and generally being on lockdown in his cell 24 hours per day. He has not had a single phone call during his nearly two years of incarceration, and so has not been able to communicate with his mother, Carrie Miner, or with his grandmother. C.T. often leaves sentences unfinished and periodically has nonsensical and loud verbal outbursts. He reports being threatened by other detainees at the jail and fears for his life.

I reviewed C.T.'s medical records from the St. Louis City Justice Center. At this writing Mr. C.T. remains incarcerated at the St. Louis City Justice Center, pre-trial (i.e., he has not been convicted of a crime). Mr. C.T.'s medical chart at the jail reflects that he had been diagnosed with Schizophrenia and Bipolar Disorder prior to the current admission to the jail in January 2024, and had previously been prescribed strong psychotropic medications. He had been admitted to the jail on an earlier occasion and had been released, but was admitted this time for violation of probation. His "Initial Mental Health Assessment" on February 1, 2024, contained only the diagnosis of Adjustment Disorder with Mixed Emotions and Conduct. In other words, he did not display sufficient signs and symptoms of psychosis or mood disorder for the mental health clinician to detect active clinical signs of Schizophrenia or Bipolar Disorder. By April 2, 2024, he reported "hearing voices" and was prescribed the anti-psychotic agent Risperdal. His diagnosis was changed to Schizophrenia on April 4, 2024.

Notes in his chart subsequent to April 4 reflect increasingly serious and more frequent mental health crises, with a need to increase the dosages of the multiple psychotropic medications he was prescribed. On January 7, 2025, and then again on April 2, 2025, C.T. had to be placed on Suicide Watch because of a suicidal crisis, and on August 8, 2025, he had to be placed on Crisis Watch, again for a suicidal crisis. A telehealth psychiatric evaluation by Jamie

Randall, PMHNP, on June 3, 2025, reflects that by that time he was “incoherent, angry, threatening and having auditory hallucinations.” His diagnoses included Schizophrenia and Bipolar Disorder as well as a “Neuro-cognitive Disorder,” “Traumatic Brain Injury” and “Encephalopathy.” His medications had to be upgraded to a stronger anti-psychotic agent and a stronger mood stabilizer.

Clearly, Mr. C.T. experienced severe deterioration of his serious mental illness over the course of his incarceration in jail. The mental health services provided to him in jail were minimal, consisting mainly of psychotropic medications and suicide watch whenever he was obviously suicidal, with a few psychotherapy sessions of unknown length. The medical record thus reflects that Mr. C.T.’s psychiatric status deteriorated quite a lot in jail while he was forced to wait, pre-trial, for a bed in a state hospital, and he is still waiting in jail. I can confidently say, to a reasonable degree of medical certainty, that had he been transferred to a state hospital timely, instead of waiting so long in the jail, his psychiatric condition would not have deteriorated, and his repeated suicide crises would have been met with more intensive crisis intervention, the result likely being much less inclination to harm himself.

I reviewed the medical records of Mr. M.R., a 31-year old man who had been treated for Schizophrenia for 5 years when admitted to Jackson County Jail in April, 2024. His medical chart at the jail reflects a diagnosis of Schizophrenia, he is noted to experience auditory hallucinations and disorganized thought process. At first he was prescribed Haldol, 5 mg. twice daily at the jail. The medication was changed to Geodon (a new generation anti-psychotic medication), 20 mg. per day on 7/1/2024. The Geodon was increased to 40 mg. per day on 8/11/2024. He was found IST and ordered to DMH custody for competency restoration on 9/5/2024. He was on the waitlist for transfer to state hospital until January or February 2026, when he was transferred to DMH to receive competency restoration services. Thus he spent over 15 months in the Jackson County Jail waiting for transfer to a state hospital for competency restoration services. The increased dosage of Geodon suggests his condition worsened while he was in the jail, but he was only seen by a psychiatrist every four months and had only a few sessions with a mental health clinician during that entire 15 months.

I reviewed medical records for Mr. O.J., a 36-year-old man who was admitted to Greene County Justice Center in mid-October, 2023. He reported he had been diagnosed Schizophrenia and Depression and was taking Trazadone (an antidepressant with sedative side effect). He had

attempted suicide and been admitted to a psychiatric hospital in Las Vegas during the month prior to his admission to the jail. He reported prior physical, sexual or emotional abuse. He averred auditory hallucinations. He was diagnosed Mental Disorder Not Otherwise Specified and prescribed Haldol 20 mg. per day, Ziprasidone 20 mg. per day – two strong anti-psychotic medications at therapeutic dosages, as well as Trazadone. At times at the jail he was reported to have descended into an acute psychotic decompensation. For example, on 10/30/2023 he was “placed on observation due to mental health hospitalization in the last 30 days and attempting suicide one week ago. Inmate presented with an extremely limited reality contact. He presented with paranoid, delusional thoughts. He appeared unable to process information or participate in the encounter appropriately. He repeatedly stated he was “the devil” and “the son of god.” He was prescribed anti-psychotic medications throughout his stay at the jail, with psychotherapy sessions lasting approximately 15 minutes a few times per month through 2025 noted in the chart. He was typically described as “lethargic with blunted affect,” speech noted to be “pressured” on multiple occasions, he was occasionally described as “paranoid” and “manic” and his reported “distressing” auditory and visual hallucinations continued throughout his stay in the jail. His medications were adjusted periodically, but he was prescribed strong anti-psychotic medications throughout his stay in the jail. In other words, Mr. O.J. was suffering chronic Schizophrenia and Depression, with occasional acute psychotic episodes, which were managed at the jail with psychotropic medications and some individual psychotherapy. He took part in no other treatment or rehabilitation programs and seems to have spent most of his time in his cell. Mr. O.J. was transferred to a state hospital for competency restoration services on January 21, 2026, after having spent **530** days on a waitlist for DMH services subsequent to being declared IST by the court and ordered transferred to a state hospital for competency restoration services.

Mr. J.W. told me during our video interview that he spent five months in a medium size county jail, where he was on Suicide Watch often because he told staff he felt suicidal. In Suicide Watch, where he would remain for 4 or 5 days at a time, he would be naked with a blanket the only cover provided, he would see the mental health staff person for a couple of minutes every day or two and would be asked whether he was still suicidal, and except very quick exchanges with custody officers he did not talk to anyone else, even while spending 23½ hours in a cell on Suicide Watch. when he was not on Suicide Watch, he spent all of his time alone in a cell. He reports it was very difficult to arrange to be seen by mental health staff

because mental health was very understaffed. He was placed in a “restraint chair” for four hours on more than one occasion, and that was very painful. After several months in the jail, pre-trial, waiting for an evaluation for competency, he was finally transferred to the state hospital for a competency evaluation, was soon after found to be competent and was released to a residential mental health program in the community. He believes his chart contains diagnoses of Schizophrenia and Bipolar Disorder.

Ms. S.A. told me during our video interview that she was admitted to the Franklin County Jail in the Spring of 2024 and was released from the jail on bond, still pre-trial, in the Fall of 2025 (approximately 14 months). She reports that she was in a drug-induced psychotic episode when first admitted to the jail, and was placed on Suicide Watch with no clothing. She was alone in a cell on Suicide Watch for many weeks, and that felt like solitary confinement to her. She believes her psychotic symptoms, including paranoid thoughts, continued the entire time she was on Suicide Watch, and she believes that was because of the isolation. Her symptoms waned after she was discharged from Suicide Watch and she was stable for the remainder of her time in the jail. She occasionally met with mental health staff at the jail, but does not feel she received adequate mental health treatment. Her attorney requested an evaluation for competency soon after she was admitted to the jail, but during the entire 14 months she was in jail she was not seen by DMH for an evaluation. Eventually her attorney retained a private psychologist who examined her and concluded she was competent to stand trial at that time. She was released on bond and still awaits trial.

The risk of harm in jail can come from mental illness-driven self-harm or suicide, from worsening of the serious mental illness, from force and restraint applied by custody staff, or simply from medical illnesses that are inadequately treated. Individuals with serious mental illness are also plagued by medical conditions and too often die from a combination of the two. I just received word that a 32-year old woman, Ms. D. M., died in the St. Louis City Jail on January 31, 2026. According to news reports, she had been in the jail since the Fall of 2024, she was suffering from serious mental illness and was on the waitlist for a DMH competency

evaluation, she had been losing weight, and she was thought to be suffering from severe medical conditions. An investigation into the cause of death is pending.⁴³

IX. Jail-Based Competency Restoration Treatment

According to the Suggestions in Support of Motion for Class Certification filed in this case:

Senate Bill 106 also imposed a requirement that evaluators assess whether the individual may receive restoration treatment “in a county jail or other detention facility.” This is sometimes referred to as “jail-based restoration,” and has been implemented to varying degrees at four jails in the state of Missouri. Jail-based competency restoration is sometimes proffered as a remedy to this constitutional crisis. But this solution is woefully inadequate and has been implemented poorly and incompletely in Missouri. Currently, only four jail facilities in Missouri have attempted to implement jail-based restoration programs. (*See* Declaration of Annie Legomsky). In St. Louis County’s jail-based restoration program, Restoration Class are kept in solitary conditions and receive no mental health treatment except medication.... When Restoration Class members held in a jail-based restoration program can meet with a mental healthcare provider, they receive little-to-no services beyond medication management.... DMH also has two mobile teams who allegedly provide treatment and support for class members in jails: one team supports the east side of the state; the other supports the west side.... Each team consists of an advanced practice nurse or nurse practitioner, a “diversion specialist” or social worker, and a community support nurse.... These mobile team services are focused almost exclusively on providing medication consultation and prescribing medication. The available data demonstrates that attempts at legislative reform have failed to adequately remedy the delays in competency evaluations and restoration services for pretrial detainees. Years later, there have been no improvements in wait times, and individuals continue to suffer while awaiting evaluation and treatment. The length of the waitlist and delays in evaluation and treatment have *increased* over time.⁴⁴

DMH identified jail-based treatment as one possible solution in its presentation, “DMH, Pretrial Evaluations & Competency Restoration,” by Timothy J. Wilson, Director of Forensic Services, and Jeannette Simmons, DBH, Deputy Director of DMH.

⁴³ Loretta Wimbley, *Woman Dies in Custody of St. Louis City Jail, Marking 22 Deaths Since 2020*, ST. LOUIS PUB. RADIO (Feb. 1, 2026, 7:44 p.m. CST), <https://www.stlpr.org/government-politics-issues/2026-02-01/woman-detainee-dies-custody-st-louis-jail-city-justice-center>.

⁴⁴ *Supra* n42, Doc. 6. at 15-17.

It seems clear that efforts thus far to effect jail-based competency restoration treatment using a DMH Forensic mobile team in Missouri has not reached very many IST jail detainees and has not been successful. Mental health treatment involves a lot more than meeting a few times per week with the DMH forensic mobile team at the jail and the prescription of psychotropic medications. The brief time an IST jail detainee sees mobile team members each week does not nearly compensate for the seven days a week the individual remains in jail subject to a harsh disciplinary system with punishments meted by custody staff, use of force and restraint by custody staff, victimization by other prisoners who stigmatize mental illness, and the large proportion of the IST detainee's time spent alone and mainly idle in a jail cell, if not in Administrative Segregation or Protective Custody – the two official forms of solitary confinement.

The main problem with jail-based competency restoration programs is that they occur in jails. The cold and unfriendly jail environment, the many rules that individuals with serious mental illness have great difficulty understanding and following, the harsh punishments meted by custody staff and including loss of visits or solitary confinement (punitive segregation), the violence level in the jail, the tendency for individuals with serious mental illness to be persecuted and victimized by other prisoners, and unfortunately in too many instances by custody staff, and staff shortages in the medical and mental health departments that make mental health and medical care substandard, on average. All of these factors make it very difficult or next to impossible to provide effective mental health treatment in jail. Psychotropic medications alone do not constitute adequate mental health treatment. Staff need to spend a significant amount of time talking to individuals with serious mental illness. There needs to be therapeutic and rehabilitative programs that are rarely available in jails, and even if jails in large cities are able to provide a modicum of therapeutic and rehabilitative services, smaller jails, especially in small towns and rural vicinities, are simply incapable of providing anything but medication management, if that. Visits from a forensic mobile team simply do not make up for the shortfalls in terms of the hardships of life in jail for a person with serious mental illness, nor the shortfalls in mental health treatment at the jail. This in contrast to the much more therapeutic milieu and richer clinical staff at a state psychiatric hospital.

The author of this expert report has visited jail-based competency restoration programs in several states and at multiple jails (mainly located in large urban areas) and found that however

rich the hours of competency restoration education are, when not in an actual class the IST jail detainees are subject to the same conditions and the same insufficiency of rehabilitative programming that all occupants of the jail suffer. Thus, when asked “how many hours per day are you out of your cell and involved in meaningful programs or classes?,” IST detainees universally respond “One (or a few) hour(s) per weekday and none on weekends.” Meanwhile, they spend most of their time alone and idle in a jail cell.

X. Community-Based Competency Restoration Treatment

I intend to file a full report in this matter after the parties have engaged in some discovery. That forthcoming report will discuss, among other things, the efficacy of community-based treatment programs. But such a discussion is outside the scope of this preliminary report.

XI. Preliminary Opinions

The following opinions are provided with a reasonable degree of medical certainty and are based on my training, knowledge, and experience, as well as the materials identified in Section II (Preparation).

1. Competency Restoration Treatment has two main parts, one is treatment of the underlying illness that causes incompetence and the other is education about the legal proceedings and training for participation in one’s own defense. Thus, if an individual has decompensated, i.e. is acutely psychotic or so depressed that focus, concentration on task and judgement are seriously impaired, the underlying mental illness must be treated to render the individual capable of taking part in the competency restoration classes and training.
2. Adequate competency restoration treatment can only occur in a setting conducive to mental health treatment.
3. Jail is not a setting conducive to mental health treatment, nor to competency restoration treatment. Jail crowding, the culture of punishment that permeates the facilities, the large amount of time detainees with serious mental illness spend idle and alone in a cell, and the relative inadequacy of programs and treatment have a very detrimental effect on the mental status of incompetent prisoners, and on the ability to participate effectively in competency restoration.
4. Solitary confinement for inmates with mental illness is simply the average and usual

situation in jail, either because they have trouble following the rules and are consigned to punitive segregation (as well as pepper spray, restraint chair, etc., in all too many cases), or, more often, because custody staff do not want them to be victimized or cause problems in congregate housing situations such as multiple occupancy cells or dormitories, they are consigned to isolation “for their own good.” And solitary confinement is very harmful for individuals suffering from serious mental illness.

5. Jails are relatively violent places. Prisoners with serious mental illness are disproportionately victims of violence, or lose control of their temper and get involved in altercations. Of course, there is some violence at state hospitals, but very much less than in the jails.

6. Studies and reports conclude that officers in jails use a significant amount of force, and disproportionately more excessive force against prisoners with serious mental illness, and there are more human rights abuses involving prisoners suffering from serious mental illness. In contrast, at state hospitals, clinical staff handle discipline problems with treatment goals in mind, and rarely call security officers.

7. At the hospital, in contrast to jail settings, there is much less crowding, more humane conditions, less violence, richer staffing, better mental health treatment and more classes and training events for competency restoration. There are windows that permit natural light and views of the environment, and there are contact visits in the hospitals, but neither are available in the jails, for the most part.

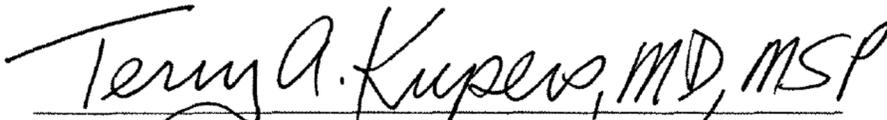
8. In Missouri jails, pre-trial detainees must wait up to six months before they are assessed by the Department of Mental Health for competency, and then if declared incompetent to stand trial they will be on a waitlist for an average of 15 months before they can be admitted to a state hospital for competency restoration treatment. That adds up to a lot of time spent in jail pre-trial.

9. The problems with jail-based competency restoration programs begin with the fact that they take place in a jail, an environment that is very harsh, with a high prevalence of violence, victimization and solitary confinement – an environment that both exacerbates the mental illness and makes mental health treatment very problematic, as discussed in Sections

V and VIII, above. Because of crowding, violence, isolation, the frequent use of force by staff and relatively inadequate mental health treatment and rehabilitation programs, individuals with serious mental illness are at risk of great harm while incarcerated in the jail. This makes the months-long wait to undergo mental health assessment for competency, and the average fifteen months wait after being declared IST very harmful to the pre-trial detainee with serious mental illness.

10. I conclude to a reasonable degree of medical certainty that the longer an individual suffering from serious mental illness is retained in jail, likely including a lot of time in isolation, and is not provided adequate mental health treatment, the worse his or her condition, disability and prognosis, and therefore the less likely there will be a restoration of competence (or, in a certain proportion of cases, the longer it will take for competence to be restored.)

Respectfully submitted,


Terry A. Kupers, M.D., M.S.P.

March 5, 2026

Exhibit 3

to

**PLAINTIFFS' SUGGESTIONS IN SUPPORT OF
MOTION FOR PRELIMINARY INJUNCTION**

SECOND DECLARATION OF DELICIA WALKER

I, Delicia Walker, pursuant to 28 U.S.C. § 1746 declare, as follows:

1. I am over the age of 18 and of sound mind. The statements set forth in this declaration are true and correct to the best of my knowledge and belief.
2. I am the sister of D.W., a plaintiff in this matter. I am named as his Next Friend by this court.
3. Before D.W. was in jail, he was receiving case management services from a behavioral health team at St. Patrick's Center.
4. His case worker would help him with getting food, using the bathroom, taking care of himself and his apartment.
5. Before he was in jail, I was able to talk with him every week by phone or visit him. He could also sometimes come stay with me.
6. Now that he is in jail, I don't get to see him or talk to him very much.
7. When I do see or talk to him in jail, he seems in worse physical health.
8. His teeth are in bad shape. His hair is matted. He has lost a lot of weight.
9. The last time I saw him, he was in a green smock instead of clothes. He told me he couldn't wear normal clothes because the jail workers were mad at him for urinating on the floor. Before D.W. went to jail, he had trouble using the bathroom in an appropriate way. This is something his case manager would help him with. Now that he is in jail, he still can't use the bathroom appropriately and I think his cell is dirty because of it.
10. He does not understand why he is in jail or what is going on with his case.
11. I don't think he takes any medication in jail.
12. He does not get the same kind of case manager now that he is in jail.

13. He said that he spends almost all his time by himself in his cell.

14. I think D.W. will need a lot of help for a long time because the symptoms of his schizophrenia are so bad.

15. I am worried about him waiting in jail for months and months to even get to a hospital.

I declare under penalty of perjury that this declaration is true and correct.

Date: 03/08/2026

By: Delicia Walker
Delicia Walker

Signature: *Delicia Walker*
Delicia Walker (Mar 8, 2026 14:10:45 CDT)

Email: 

2026.02.17 Declaration of Delicia Walker DRAFT (1)

Final Audit Report

2026-03-08

Created:	2026-03-07
By:	Maureen Hanlon (mhanlon@archcitydefenders.org)
Status:	Signed
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"2026.02.17 Declaration of Delicia Walker DRAFT (1)" History

-  Document created by Maureen Hanlon (mhanlon@archcitydefenders.org)
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Exhibit 4

to

**PLAINTIFFS' SUGGESTIONS IN SUPPORT OF
MOTION FOR PRELIMINARY INJUNCTION**

*** FILED UNDER SEAL ***

Exhibit 5

to

**PLAINTIFFS' SUGGESTIONS IN SUPPORT OF
MOTION FOR PRELIMINARY INJUNCTION**

*** FILED UNDER SEAL ***

Exhibit 6

to

**PLAINTIFFS' SUGGESTIONS IN SUPPORT OF
MOTION FOR PRELIMINARY INJUNCTION**

*** FILED UNDER SEAL ***

Exhibit 7

to

**PLAINTIFFS' SUGGESTIONS IN SUPPORT OF
MOTION FOR PRELIMINARY INJUNCTION**

SECOND DECLARATION OF DEBRA DARRINGTON

I, Debra Darrington, pursuant to 28 U.S.C. § 1746 declare, as follows:

1. I am over the age of 18 and of sound mind. The statements set forth in this declaration are true and correct to the best of my knowledge and belief.
2. I am the grandmother of M.R., a plaintiff in this matter. I am named as his Next Friend by this Court.
3. M.R. is my grandson. I have always been very close to him and raised him from approximately 2 years old until he was 19 years old. M.R. and I have a special relationship and are in constant communication, as I am the only person he will listen to.
4. M.R. began experiencing signs of schizophrenia in his twenties. I would notice him talking and giggling to himself, and I knew he needed to receive medical care.
5. After the onset of his schizophrenia, M.R. lived with his mother, father, and me. There were also times that he lived on the streets due to his drug use.
6. M.R.'s father took him to the University Health Truman Medical Center in Kansas City for his schizophrenia. While at Truman, M.R. was on regular medication, which helped to calm him down. He was an entirely different person, and like the old M.R. I knew.
7. M.R. also received treatment at Swope Park Health Services. There, he had access to a case worker, psychiatrist, and medication in the form of a shot for his schizophrenia. I would personally drive him to his appointments.
8. M.R. was also a patient at Northwest Missouri Psychiatric Rehabilitation Center in St. Joseph, Missouri.
9. When M.R. was medicated, he was able to work with his father, helping to transport the elderly by van to their doctor's appointments.

10. When M.R. stopped taking his medication, he would start abusing drugs.
11. M.R. went to jail on April 11, 2024.
12. Once M.R. was in jail, I could not visit him.
13. Instead, we would talk on the phone a couple of times a week. However, the phone line was terrible, and I had difficulty understanding him.
14. The longer he was in jail, the more unstable he became. He would tell me that when he got out, he was going to go home to his wife and kids. However, he is not married and has no kids.
15. He also became increasingly paranoid and would tell me that he thought that people were out to kill him in jail, and he feared for his safety. He would say there are five guys in here, they are going to get me, they are going to try and beat me up.
16. Other than calling me on the phone, he never left his cell. He preferred to stay in his room and read his bible.
17. After waiting for treatment for over a year, M.R. has recently started to receive treatment at a DMH Facility.
18. I have made sure that he has money in his commissary account.
19. We are able to talk on the phone a couple of times a week, and the phone line quality is much better, and I can hear his senses coming back to him. He sounds like the old M.R.
20. He is currently reading the Bible and can comprehend what he reads and talk to me about what he has read.
21. He is less agitated and paranoid.
22. He is looking forward to moving back in with his mother and desires to look for a job to help her with her bills and purchasing food.

21. I declare under penalty of perjury that this declaration is true and correct.

Date: 3/9/2026

By: /s/ Debra Darrington
Debra Darrington

Exhibit 8

to

**PLAINTIFFS' SUGGESTIONS IN SUPPORT OF
MOTION FOR PRELIMINARY INJUNCTION**

SECOND DECLARATION OF ERIC MASSEY

I, Eric Massey, pursuant to 28 U.S.C. § 1746 declare, as follows:

1. I am over the age of 18 and of sound mind. The statements set forth in this declaration are true and correct to the best of my knowledge and belief.
2. I am the brother of K.M., a plaintiff in this matter. I am named as his Next Friend by this court.
3. Before K.M. was in jail, he was living on his own and was always able to support himself financially.
4. Before he was in jail, I was able to talk with him every week by phone or visit him.
5. After K.M. was jailed, because of some of the circumstances related to his mental health and behavior, his sisters and I were unable to visit him for several months.
6. Recently, I have been able to visit him again in person. I am still not able to have phone calls with him.
7. Since entering jail, K.M. has lost a lot of weight.
8. K.M. is being kept in the booking area of the jail; He spends almost all his time by himself in his cell which I believe is detrimental to his mental health.
9. He is only allowed out of his cell for showers and visitors, otherwise he is alone.
10. In my recent visits with K.M., I have observed him to have delusional and disjointed thoughts; he jumps from topic to topic and makes untrue statements.
11. I believe that my brother's continued incarceration is negatively affecting his mental health; I believe that if he receives the appropriate care, he will get better.
12. I am worried about him waiting for months or years before receiving treatment, all the while waiting in jail, isolated and deteriorating.

I declare under penalty of perjury that this declaration is true and correct.

Date: March 9, 2026

By: /s/ Eric Massey
Eric Massey

Exhibit 9

to

**PLAINTIFFS' SUGGESTIONS IN SUPPORT OF
MOTION FOR PRELIMINARY INJUNCTION**

DECLARATION OF ANITA TABB

I, Anita Tabb, pursuant to 28 U.S.C. § 1746 declare, as follows:

1. I am over the age of 18 and of sound mind. The statements set forth in this declaration are true and correct to the best of my knowledge and belief.
2. I am the mother of M.T., a plaintiff in this matter. I am named as his Next Friend by this court.
3. Before M.T. was incarcerated, he received treatment at DePaul Hospital in St. Louis for over thirteen years.
4. I am aware that M.T. has a diagnosis of Schizophrenia.
5. His care team at DePaul was able to understand the best medical treatment for reducing M.T.'s symptoms.
6. M.T. comes from a large, loving family, and he lived with me prior to being incarcerated.
7. I helped M.T. take care of himself, including doing his laundry, maintaining his hygiene, getting to medical appointments, and getting to work.
8. M.T. had a job as a courtesy clerk at a grocery store, which he loved.
9. His employers at the grocery store knew they could reach out to me whenever they needed.
10. M.T. wanted to get a master's degree like his brothers, and we often talked about how he could continue his education in a supportive environment.
11. Now that he is in jail, I don't see him or talk to him as much.
12. It is heart-breaking to go visit him in jail because he is not being taken care of.
13. He has lost teeth while in jail and his hair has become matted.
14. It is evident that he has not been able to maintain his personal hygiene.
15. One time I visited M.T., he lifted up his shirt, and I could see his ribs—he has lost so much weight since being incarcerated.
16. For a long time, M.T. was in a cell where he was on lock-down, alone for twenty-three hours a day.
17. During his incarceration, M.T. is not getting the care he needs: he isn't getting therapy, he is not receiving proper psychiatric care, and he isn't taking the proper medication.

18. Sometimes M.T. says he is getting pills.
19. I have tried to advocate to M.T.'s caseworker about his medical treatment and to find out what sort of pills they are giving him, but they have not provided me with an answer.
20. He is not receiving a shot that was a key part of his treatment prior to incarceration.
21. When I visit my son, I sense he does not have a clue what is going on.
22. He does not know what day it is, he does not understand what is happening with his case, and he does not understand why he is still in jail.
23. I look at my son and I think, "He is completely gone."
24. Because he has been sitting in jail for a year and a half without the proper medicine, I am worried that irreparable damage has been done.

I declare under penalty of perjury that this declaration is true and correct.

Date: Mar 9, 2026

By: *Anita Tabb*
Anita Tabb (Mar 9, 2026 15:56:46 CDT)

Anita Tabb