OVERVIEW OF COMPETENCY RESTORATION MODELS

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OVERVIEW

Over the past several decades, the field of forensic mental health has emphasized the use of diversion strategies for people with psychiatric and substance abuse issues. Offering therapeutic interventions as opposed to traditional correctional models is believed to reduce unnecessary incarceration and confinement. While diversion continues to be necessary to address forensic mental health issues, diversion efforts are not always effective at preventing a person from engaging in criminal behavior that necessitates their involvement with the legal system. In these cases, mentally ill defendants are subject to legal proceedings which may be significantly delayed when the issue of competency is raised. This paper provides background information on competency and the elements of Competency Restoration (CR) programs, an overview of factors associated with one's ability to become competent and describes barriers that result in unnecessary and costly confinement while waiting for services. This paper also addresses the range of CR services that can be provided in settings other than secure inpatient and residential programs. The Alabama Department of Mental Health is currently considering alternative models for delivering CR services.

COMPETENCY DEFINED

Under the Constitution of the United States, a person charged with a crime has the right to understand the charges against him or her and must have the ability to assist with establishing a defense to meaningfully respond to accusations made against him or her. The landmark case *Dusky v. United States* (1960)[1] legally defined competency as "*whether a defendant has sufficient present ability to consult with his/her lawyer with a reasonable degree of rational as well as factual understanding of the proceedings against him/her*." While Dusky confirmed a defendant's constitutional rights around competency, the case did not establish a uniform set of standards that must be met for a person to be ordered to restoration services (Heilbrun et al., 2019)[2].

In Alabama, a defendant is considered "*mentally incompetent*[3]" to stand trial or be sentenced when

- the defendant lacks the ability to assist in his or her defense by consulting with an attorney,
- the defendant does not have a basic understanding of the facts surrounding the accusation, or
- the defendant is unable to understand or participate in the legal proceedings.

In Alabama, the issue of competency can be raised at any time during the legal proceedings. When the issue of competency is raised, all proceedings must stop, (i.e., criminal proceedings are continued) so

[1] https://www.oyez.org/cases/1959/504%20MISC
[2] Heilbrun, K., Giallella, C., Wright, H., J., DeMatteo, D., Griffin, P.A., Locklair, B., & Desai, A. (2019). Treatment for Restoration of Competence to Stand Trial: Critical Analysis and Policy Recommendations. Psychology, Public Policy, and Law, https://doi.apa.org/doiLanding?doi=10.1037%2Flaw0000210
[3] Defined in Alabama Rules of Criminal Procedure (Ala.R.Crim.P.), Rule 11.1

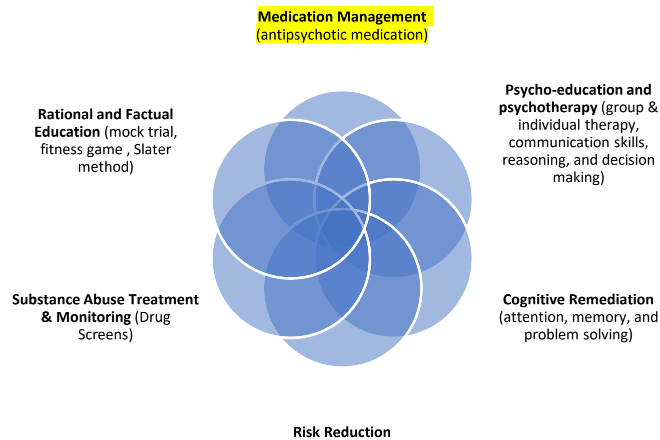
that the defendant may receive an examination of their current competency[4]. If the defendant is found incompetent to proceed[5], then the defendant may be ordered to receive competency restoration services that would enable the defendant to participate in their legal proceedings in the future.

DURATION OF COMPETENCY RESTORATION (CR)

While the State of Alabama does not statutorily define how long a person may be ordered to remain in a CR program, Ala.R.Crim.P. Rule 11.6 is intended to comply with the US Supreme Court's decision in Jackson v. Indiana (1972)[6]. Jackson's case established that the defendant must receive competency restoration services in the *foreseeable future*. While the term *foreseeable future* was not clearly defined, the Jackson case implies that there should be limitations on the number of days a defendant may be confined for restoration. Some argue that based on the Jackson case, CR programs should be tailored to meet the needs of the defendant so that targeted interventions could be delivered, or at least available to the defendant, as swiftly as possible to prevent undue delay that would interfere with someone's right to a speedy trial. The Jackson case also establishes that defendants should not be confined for CR services for a period of time longer than if the defendant had faced the charges.

CR is generally effective. In one study, 81% of defendants who had engaged in restoration procedures were subsequently found by the court to be competent to proceed (Pirelli & Zapf, 2020)[7]. Pirelli and Zapf (2020) cite another study that found that most (8 out of 10) defendants are deemed by the court as restored within 6 months. ADMH's current average length of stay at a secure inpatient hospital is currently around 20 months, with efforts underway to decrease this length of stay to the extent possible.

COMPONENTS OF COMPETENCY RESTORATION (CR)



CR is multifaceted and therefore CR services should be coordinated using a **person-centered treatment plan**. Interventions on the plan could include education on the components that define competency; **factual and rational knowledge** (e.g., roles of people in the courtroom, understanding the adversarial nature of legal proceedings, working with an attorney to develop a legal strategy). In addition to the educational component, CR may include **psycho-education** (e.g., education on coping skills, distress tolerance, behavioral control, mindfulness, anger management, and

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[4] Ala. R. Crim. P. Rule 11.2
[5] Ala. R. Crim. P. Rule 11.6
[6] https://www.lexisnexis.com/community/casebrief/p/casebrief-jackson-v-indiana
[7] Pirelli, G. & Zapf, P.A. (2020). Are we restoring competency, competently? *Journal of Forensic Psychology Research and Practice*. 20(2), 134-162. https://concept.paloaltou.edu/resources/translating-research-into-practice-blog/are-we-restoring-competency-competently/

communication skills), **psychotherapy** (e.g., cognitive behavioral treatment to mitigate risk, address criminogenic factors), **medication management**[8], and/or **substance abuse treatment**. Finally, A key element to restoration is using an assessment instrument to screen the defendant so that the clinician can develop a **person-centered plan.** Using a plan allows for the provision of targeted interventions to address relevant deficits in a timely manner.

NUMBER OF PEOPLE WHO RECEIVE CR

Research suggests that approximately 2 to 8 percent of felony cases involve the completion of a competency evaluation (Danzer et al., 2019)[9]. Of those evaluated, defendants are found incompetent around 30% of the time (§6.06 (a))[10]. In Alabama specifically, within a six-month period of time, 103 defendants were ordered into the custody of ADMH for CR services. Of those on the inpatient waitlist, approximately 87% of defendants are ordered for CR and treatment. It is estimated that around 20-25% of defendants on the waitlist could be restored to competency if jail or community-based restoration services were available. The largest forensic facility operated by the ADMH serves predominately defendants who have been deemed incompetent to stand trial (on average, 65% of current patients are admitted for CR while 35% are admitted following an NGI adjudication).

FACTORS ASSOCIATED WITH INCOMPETENCE

Defendants who experience the conditions below are more likely to be found both incompetent and unlikely to be restored to competency within a reasonable period of time (Danxer et al., 2019)[11]. When presented with such case, the court should determine whether the Defendant poses a real and present threat to themselves or others. If the person does not pose a threat, then the court may dismiss the charges. If the defendant poses a threat, then the court may release the person under conditions for outpatient treatment or the person may be committed to receive inpatient care[12]. Defendants who experience the conditions below are not likely to be appropriate for referral for community-based or jail-based restoration services and alternate options for responding to the defendant's needs should be considered.

- Serious Psychotic Disorders
    - People with severe psychotic disorders are 8 times more likely to remain incompetent.
    - The prognosis is guarded for patients who have schizophrenia, particularly for people who have co-occurring cognitive impairment and negative symptoms (e.g., hallucinations, delusional thinking, confusion and disorientation, memory impairment, communication deficits, withdrawal, and flat affect).

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[8] The use of antipsychotic medications has been shown to have a significant effect on restoration; with a restoration rate of around 70-84% of people being restored using medication intervention (Cochrane et al., 2013; Cochrane, Herbel, Reardon, and Lloyd, 2013; Kassen, 2016; Herbel and Stelmach, 2007).

[9] Danzer, G.S., Wheeler, E., Alexander, A.A., Wasser, T.D. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. *Journal of the American Academy of Psychiatry and the Law, 4*(1), http://jaapl.org/content/early/2019/02/08/JAAPL.003819-19

[10] Melton, G.B., Petrila, J., Poythress, N.G., Slobogin, C., Otto, R.K., Mossman, D., & Condie, L.O. (2018). *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers* (4th ed). The Guilford Press.

[11] See footnote 9

[12] Ala.R.Crim.P. Rule 11.6(c)

- Cognitive impairment including intellectual deficits (IQ<64)
- Traumatic Brain Injury
- Developmental Disability
- Affective Disorders
- History of multiple psychiatric hospitalizations
    - History of multiple psychiatric hospitalizations is associated with a longer length of stay in CR programs.
    - Multiple hospitalizations could be due to the chronicity and complexity of the mental illness or could be due to the defendant not adhering to the medication regimen.
- Unresponsive to medication
    - Refractory or chronic condition
    - Defendants whose condition does not improve despite medication trials are at risk of longer lengths of stay in CR programs.
- Non-compliance with medication either during or after the completion of CR programs[13]
- Older age
- Defendants whose performance falls three to four standard deviations below average on the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS).

Research suggests that some social and demographic factors may also be associated with incompetence including unemployment, homelessness, minority race, limited education, substance abuse, and history of receiving social security income.

PROBLEM

Across the nation, the growing number of people in need of forensic services combined with finite resources (i.e., the limited number of inpatient beds) has resulted in incompetent defendants remaining in jail, on a waitlist, for a considerable length of time before they can begin CR. Time on the waitlist can range from six to nine months. This means that people who have not yet been tried for an alleged crime have their case held in abeyance, and often remain confined, until they become competent to proceed which is contingent upon bed availability. In some cases, the time spent waiting to be admitted into a CR program could exceed the duration of necessary CR treatment. Once a bed becomes available, defendants are placed in a CR program based on the availability of a bed rather than based on the defendant's clinical needs at the given point of time.

To address the problems described above, an adequately funded system and infrastructure needs to be available, accessible, and offer some degree of person-centered intervention. The infrastructure begins with diversion, which is beyond the scope of this paper. After diversion, the spectrum of services should range from community-based restoration through residential/inpatient restoration with the provision of services guided by a care coordinator, or what some states refer to as a Forensic Navigator (Minnesota

[13] The Supreme Court held in Sell v United States (2003) that the federal government could administer medications against a defendant's will for the purposes of restoration when certain circumstances were present: medication was likely to restore the person to competency so that an adjudication could be attained, any side effects would not cause a significant negative impact(s) on the patient, medication was appropriate and would improve the defendant's ability to consult with counsel or to plan their defense. See https://www.oyez.org/cases/2002/02-5664 Note: many programs and settings have specific policies, procedures, regulations, or laws that govern the use of medication over objection.

Department of Human Services, 2021[14]), to ensure that the defendant's service package meets their needs in the least restrictive setting. Ideally, defendants are assigned to a CR program based on their need not based solely on resource availability (Johnson and Candilis, 2015)[15].

SOLUTION- PROVIDE PERSON-CENTERED CR SERVICES ACROSS SETTINGS

One solution to address the waiting lists for CR is to expand the settings where CR can be offered.

Hospital, Inpatient, or Residential CR

This is the highest level of care for the most acute patients. Inpatient CR allows for treatment coordination, greater access to professionals experienced in forensic services and CR, medication management/ use of medication over objection, observation and evaluation services, and offers the possibility of greater immersion in restoration activities. Hospitals provide an array of psychiatric, mental health, and medical services as well as address social determinants through discharge planning.

The amount of time needed to restore someone to competency in this setting can vary. In one hospital, the length of stay ranged from one day to 560 days (Central State Hospital) (Danzer et al., 2019)[16]. At

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[14] https://mn.gov/sentencing-guidelines/assets/9-CCRTF-FinalReport_tcm30-470615.pdf
[15] Johnson, N.R. & Candilis, P.J. (2015). Outpatient Competence Restoration: A Model and Outcomes. World Journal of Psychiatry, 5(2), 228-233. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4473494/pdf/WJP-5-228.pdf
[16] See footnote 9

other hospitals (Eastern State and Western State Hospital), defendants were restored within 90 days on average (Zapf, 2013)[17]. Within 6 months after hospital admission, most patients (89%) are able to be correctly identified as either able to proceed (i.e., restored) or unlikely to be restored within a reasonable period of time (Daner et al., 2019).

Inpatient settings should be reserved for those who have, or who are suspected of having, serious or complex mental illness. People appropriate for inpatient level of care could be those experiencing uncontrolled mental health symptoms associated with:

- Schizophrenia,
- Psychotic disorders,
- Mood disorders with psychotic features, or
- Serious substance use/abuse issues that require ongoing monitoring by a medical team.

Hospitalization is also recommended when the following circumstances exist:

- The defendant requires intensive evaluation and observation to confirm the diagnostic impression, such as;
    - Serious mental illness,
    - Personality disorder,
    - Fictitious or dissociative disorder.
- The defendant is at serious risk of harm/danger to oneself or others if they were to be placed in another setting, or
- The defendant has a need for psychotropic medication management and monitoring beyond what can be offered in jails. This includes the need for medication trials to establish a medication regimen.

While inpatient hospital settings have the potential to immerse the defendant in ongoing and intensive evaluation and treatment services, such programs are very costly ($400 to $800 per day) and should therefore be reserved for defendants who truly need inpatient level of care (Danzer et al., 2019).

Jail-Based

Jail-based restoration is a viable option for defendants who are not eligible for bond or for those who need the security and ongoing monitoring and tracking offered by the jail. Some researchers suggest that jail-based CR should be attempted before a defendant is referred for inpatient CR.

A large research study conducted in Virginia involving 1,400 inmates found a restoration rate of 83% with a mean length of stay in the program of 77 days (cited in Heilbrun et al., 2019)[18]. A study involving inmates in California found that around 58% of inmates were restored within approximately 2 months. Research across states suggests that anywhere from 30-90% of people enrolled in jail-based CR are restored to proceed (cited in Danzer et al., 2019)[19]. A study conducted at a Philadelphia jail found 53% of

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[17] Zapf, P. (2013). Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods (Document No. 13-01-1901). Olympia: Washington State Institute for Public Policy.
[18] See footnote 2
[19] See footnote 9

defendants were restored to competency within 10 months without the need for inpatient hospitalization (cited in Heilbrun, 2019)

Jail-based CR services may be offered through a pod dedicated to only those defendants receiving CR services or, alternatively, defendants could reside within the general population and be pulled out for CR services, either delivered individually, in groups, or both. Regardless of the format, the curriculum must 1) be nimble to accommodate the defendant's learning needs and 2) address the person holistically to not only provide education but also address factors like symptom management, coping skills, social skills, etc.

Jail-based restoration should include medication management when appropriate. In addition, jail-based CR models should address each of the areas below when necessary;

- Factual understanding of the charges,
- Rational appreciation of the charges,
- The adversarial nature of the legal proceedings,
- Approaches to communicate with the attorney to plan a defense,
- Courtroom dress and behavior,
- Courtroom procedures, and
- Relevant testimony.

For defendants opined by the examiner as incompetent to stand trial, forensic examiners should make a recommendation to the court as to whether the defendant is appropriate for jail-based CR. Jail-based restoration may be more appropriate for defendants who do not experience psychosis, or active symptoms of psychosis, those without serious mental illness, or for those whose mental illness can be managed in the jail setting.

Community-Based

A person's mental health, their forensic/legal involvement, and community factors are often interrelated and must be addressed concurrently to reduce recidivism. Community-based restoration models are promising for defendants who can safely reside at home and in the community, who are psychiatrically stable, who generally comply with any treatment plans, and who do not have lengthy and more serious criminal histories. Community-based restoration is more cost effective as some costs can be covered by the defendant (e.g., insurance plan may cover visits to the psychiatrist).

For community-based restoration to be successful, defendants must have access to housing and the ability to access necessary services as they become competent. This includes access to any treatment necessary to address medical needs. Case management appears to be a critical component (Heilbrun, 2019), with some states like Minnesota using Forensic Navigators to support a defendant as they move through the competency restoration/forensic system.

Community-based restoration requires not only delivering the knowledge, factual, and rational components of a CR curriculum but also requires coordination with outpatient providers who can deliver other necessary mental health services (e.g., psychiatrists, case managers, substance-abuse treatment providers). Community-Based CR models could be simple, such as only offering the CR educational curriculum, or expanded to include one or more of the following; psychotherapy groups, individual therapy, family therapy, medication management, and drug monitoring screenings (Heilbrun, 2010).

In one study (Wolber et al. as cited in Danzer et al, 2019[20]), more than half (59%) of defendants offered community-based competency restoration were restored to competency. Around 14% of participants were re-arrested, 12% were ordered for inpatient level of care, and 15% had their charges dismissed or were found unable to be restored. Research suggests that most people can be restored to competency within 149 days; the average length of the service is three to six months.

Overall, community-based competency restoration is a highly flexible model that can be delivered in various settings, including the defendant's home. This CR model can also be offered through various formats (e.g., group, individual, or self-study) using different modalities (e.g., in-person or through telehealth).

SUMMARY OF THE LITERATURE

A review of the research indicates that all models of CR (Inpatient, jail-based, and community-based) are promising approaches for restoring someone to competency or for identifying individuals who are likely unable to be restored to participate in their legal proceedings. On average, CR should be achieved within 6 months (Zapf, 2013)[21]; exceptions are for those with intellectual disabilities or cognitive impairment and those with severe mental illness, namely psychotic disorders.

There are six key points for ensuring that any of these models are effective.

1. Each defendant should be assessed, using an assessment tool, for the following:
    a. Deficits that must be addressed so that the defendant can become competent,
    b. Treatment providers that are necessary to support the defendant in addressing the deficit(s),
    c. The setting and approach to CR most appropriate for the defendant,
    d. Ongoing assessment to track progress, identify ongoing deficits and gaps, guide decision-making regarding changes to the CR plan, and to guide when a referral for the formal evaluation of competency should be made.
2. A multifaceted approach is necessary to ensure that treatment is integrated and holistic to best meet the needs of the defendant.
3. Psychotropic medication management is an important component of CR for many defendants.
4. Inpatient CR models should be reserved for defendants who cannot be safely or sufficiently served in either a community or jail setting.
5. A person-centered treatment/restoration plan should be developed to ensure that the defendant receives the necessary services most efficiently.
6. When the defendant has not progressed using a meaningful CR program for six months, then the defendant should be evaluated to determine if they have a condition that renders them unlikely to be restored in the future.

[20] See footnote 9
[21] Zapf, P. (2013). *Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods* (Document No. 13-01-1901). Olympia: Washington State Institute for Public Policy.

RESTORATION EXPANSION

ADMH is preparing to pilot additional restoration program models in settings other than inpatient and residential programs.

Community-based (outpatient) restoration:

Defendants found incompetent to stand trial, who are able to be safely served in the community, and who are low risk for non-compliance are released to the community to complete mandated competency evaluation and restoration services. This could entail the court establishing conditions for the Defendant to receive outpatient evaluation or treatment services.

During the fall of 2022, ADMH will offer certain community providers free training on Competency Restoration tools as well as post a self-study restoration curriculum on the Office of Forensic Mental Health Services website.

What is Jail-Based Competency Restoration (JBCR):

JBCR programs deliver CR to defendants found incompetent to proceed, who are deemed not appropriate or safe for the community-based CR program, and/or who are at high risk for non-compliance and benefit from the supervision and monitoring that a jail provides. States under lawsuits similar Hunter v Boswell (e.g., Washington, Colorado, California) started JBCR to reduce waitlists. Programs report strong restoration rates and medication compliance: 55% restored in 57 days, 83% restored in 77 days (Virginia), and 90% restored in 90 days (Colorado).

Recently, the Bureau of Justice Assistance announced that they will fund projects that establish collaborations between mental health agencies and criminal justice agencies. ADMH partnered with the University of Alabama FARE (Forensic Assessment, Research, and Evaluation) team to submit a proposal to receive these funds to further our goal of developing and implementing the JBCR program.

In addition, the department will carry out the steps below in effort to launch a JBCR program.

1. Educate judicial staff on CR models and identify pilot regions.
2. Educate judicial staff on procedures for accessing JBCR versus Inpatient restoration.
3. Develop a screening assessment tool to guide the formation of recommendations for whether a defendant should be offered jail based or inpatient CR.
    a. Educate Certified Forensic Examiners (CFEs) on the available restoration settings and the use of screening tools so that they can provide the court with a recommendation regarding the Defendant’s restoration needs and the most appropriate setting where the service can be delivered.
    b. ADMH will train CFEs on how to use the screening tool, a brief assessment instrument. CFEs will share findings from this assessment with the court which will help the court to determine whether a defendant should be ordered for jail-based or inpatient based restoration. It is anticipated that CFE training will take approximately one hour to deliver and the assessment screening tool will take no longer than 10 minutes to complete.
4. Train additional providers on ADMH’s CR program and curriculum.
5. Establish plans for both in-person and remote restoration services so that defendants throughout the state, even in rural areas, can access the mental health infrastructure.

6. Establish a method for data collection that will support program evaluation.
7. Establish a referral procedure.

CONCLUSION

In Alabama, restoration services are only available through the inpatient setting. This paper presented evidence on the efficacy of CR programs offered in jail and community-based settings. This paper also outlines ADMH's plan to begin the steps necessary to expand Competency Restoration, to include a jail-based CR model.

Inquiries regarding this paper or ADMH's plans to expand options for competency restoration can be submitted to Dr. Virginia Scott-Adams by calling (205) 554-4327 or by emailing Virginia.adams@mh.alabama.gov