



PLACEMENT OF INDIVIDUALS FOUND INCOMPETENT TO STAND TRIAL: A REVIEW OF COMPETENCY PROGRAMS AND RECOMMENDATIONS

Acknowledgments

Disability Rights California would like to recognize and thank CalMHSA for supporting the development of this important policy paper highlighting the placement needs of individuals found incompetent to stand trial.

We wish to thank the resident “PL” (pseudonym) who made himself available to provide his personal account of what happened to him while waiting in jail to be sent to the state hospital to be restored to competency. He mentioned how differences in cognitive levels in understanding the competency material might delay restoration and shared his belief that alternatives to state hospital placement for competency might be as effective.

An experienced Public Defender from the Bay Area offered important information about the lengthy jail wait times that cause harm to individuals waiting for transport to a state hospital to gain competency. He also mentioned how cognitive deficits in learning competency material could be a barrier to gain competency to return to court. He believes that the parties in the system that are impacted by the competency issue should work more effectively together and that there be sufficient funding directed towards the solution.

Conversations with Kevin Rice of Liberty Healthcare who is the Executive Director for the jail based competency program in San Bernardino County and Terry Fillman, the Health Services Administrator for jails in San Bernardino County were informative as to how that counties’ jail based competency program operates. Mr. Rice described the successful operational aspects of the competency program based on its small size. Mr. Fillman stated that there has been a reduction on overall length of stay at the jail since the operation of the competency program at the San Bernardino jail. He supports having the right people at the table including key decision makers to address the need for increased competency programming.

Table of Contents

Acknowledgments	i
EXECUTIVE SUMMARY.....	1
PURPOSE AND OUTLINE OF PAPER	2
BACKGROUND ON A CURRENT PROBLEM	3
<i>What is “Incompetent to Stand Trial?”</i>	3
<i>Current Law Regarding Placement of ISTs.....</i>	4
<i>The Conditional Release Program is a Placement Alternative to the State Hospital under a Statute that is Not Being Utilized</i>	5
CURRENT PROGRAMMING: REVIEW OF THE IST PROGRAM AT ATASCADERO STATE HOSPITAL AND NAPA STATE HOSPITAL.....	7
WHY CALIFORNIA’S PLACEMENT AND RESTORATION PROCESSES FOR INDIVIDUALS FOUND INCOMPETENT TO STAND TRIAL ARE A PROBLEM	10
<i>Legal Ramifications</i>	10
<i>Impacted Hospitals and High Costs for the State and Counties</i>	11
MOVING PAST THE PROBLEM: PROPOSED ALTERNATIVES	14
<i>Best Practices Model</i>	15
<i>Jail Competency: DSH’s Response as an Alternative Placement for ISTs</i>	15
<i>The Jail: A Non-Therapeutic Setting to Restore to Competency</i>	17
<i>Best Practice for Placement at a Jail.....</i>	19
<i>Involuntary Medication as a Means to Restore Competency: A Cautionary Approach</i>	20
<i>Specialized and Individualized Treatment Programs.....</i>	20
<i>Community-Based Restoration Models.....</i>	21
<i>Best Practice for Placement in the Community</i>	25
CONCLUSION	26
RECOMMENDATIONS	28
REFERENCE LIST.....	29

EXECUTIVE SUMMARY

Penal Code Section 1370 and the U.S. Constitution prohibit the trial of an individual who is incompetent but finding a proper placement for individuals to be restored to competency and charged with a felony is difficult. Many systems, including the court, state hospital, and custody, are involved and affected by the placement challenges. Currently, the most common placement is in state hospitals and in relying upon medication. The legal issues, high costs, and limited capacity make this issue prime for further study.

California state and federal law provide guidelines on treatment and placement for those found to be incompetent to stand trial. The rules include:

- Statutory time limits for commitment
- Placement in either a facility or in the community based on the severity of the crime and an assessment of public safety
- The option for community-based restoration through the Conditional Release Program

This paper highlights some of the problems with the current system. They include:

- Jeopardizing defendants' rights to a speedy trial by long wait times for a bed at state hospitals
- Jail based competency programs are limited
- Significant costs to the state and to local counties to implement a restoration program that does not work for many individuals, particularly those with cognitive deficits
- Defendants remain at a state hospital for a long period of time, occupy a bed space, and limit new transfers
- Poor client outcomes

California is currently looking into alternatives. The competency program at the West Valley Jail in San Bernardino County has yielded some promising data, but there are also reasons to be cautious. Other alternatives that California could consider include:

- Community restoration

- Individualized competency programs

Other states have developed competency programs in the community for individuals who meet certain criteria. Florida, for example, reaped a cost savings of 20% when comparing costs between an inpatient and a less traditional outpatient competency program. The data from Florida appears to indicate positive outcomes. Although there has been minimal movement to secure alternatives to inpatient competency programs in California, the current placement crisis indicates that further research and proposals by a workgroup dedicated to the issue would be useful.

PURPOSE AND OUTLINE OF PAPER

The purpose of this policy paper is to inform interested parties and policy makers regarding the placement of certain individuals found Incompetent to Stand Trial (IST) in California. Specifically, this paper considers the problem of those who are charged with a felony and are court ordered to receive treatment in the state hospital to restore competency. This paper does not attempt to address the current legal standard or process in determining legal incompetency.

One important aspect of this issue is the stigmatization of individuals with mental illness who are institutionalized unnecessarily under current law. California law states that individuals accused of certain crimes almost always have to spend time in the state hospital system, leaving many defendants with mental health problems little to no chance of a community placement. Additionally, because individuals found IST often languish in the county jails waiting for beds at the state hospital, the current process targets certain individuals with mental illness and restricts their ability to live in the least restrictive environment, such as a community setting with the necessary supports, when the law provides for this.

This paper provides an overview of the incompetency process, including relevant law and placement options. We also discuss the legal ramifications of the current backlog of individuals waiting in jail for placement in a competency program, the costs associated with placement at a state hospital, and the effect the policy has on individuals who have been found incompetent. We then consider a range of proposed alternatives and discuss their pros and cons. Finally, this paper makes recommendations for additional and close review.

BACKGROUND ON A CURRENT PROBLEM

Before delving into the problem and considering solutions, a little background is necessary on the current law and policies.

What is “Incompetent to Stand Trial?”

The U.S. Constitution prohibits the trial and conviction of a person while legally incompetent because he is incapable of adequately defending himself against criminal charges. *Pate v. Robinson* (1966) 383 U.S. 375, 378; *People v. Samuel* (1981) 29 Cal.3d 489, 494. Under California law, a defendant is mentally incompetent to stand trial if, as a result of a mental disorder or developmental disability, he cannot: (1) understand the nature of the criminal proceedings; or (2) assist counsel in the conduct of a defense in a rational manner. Penal Code §1367(a).

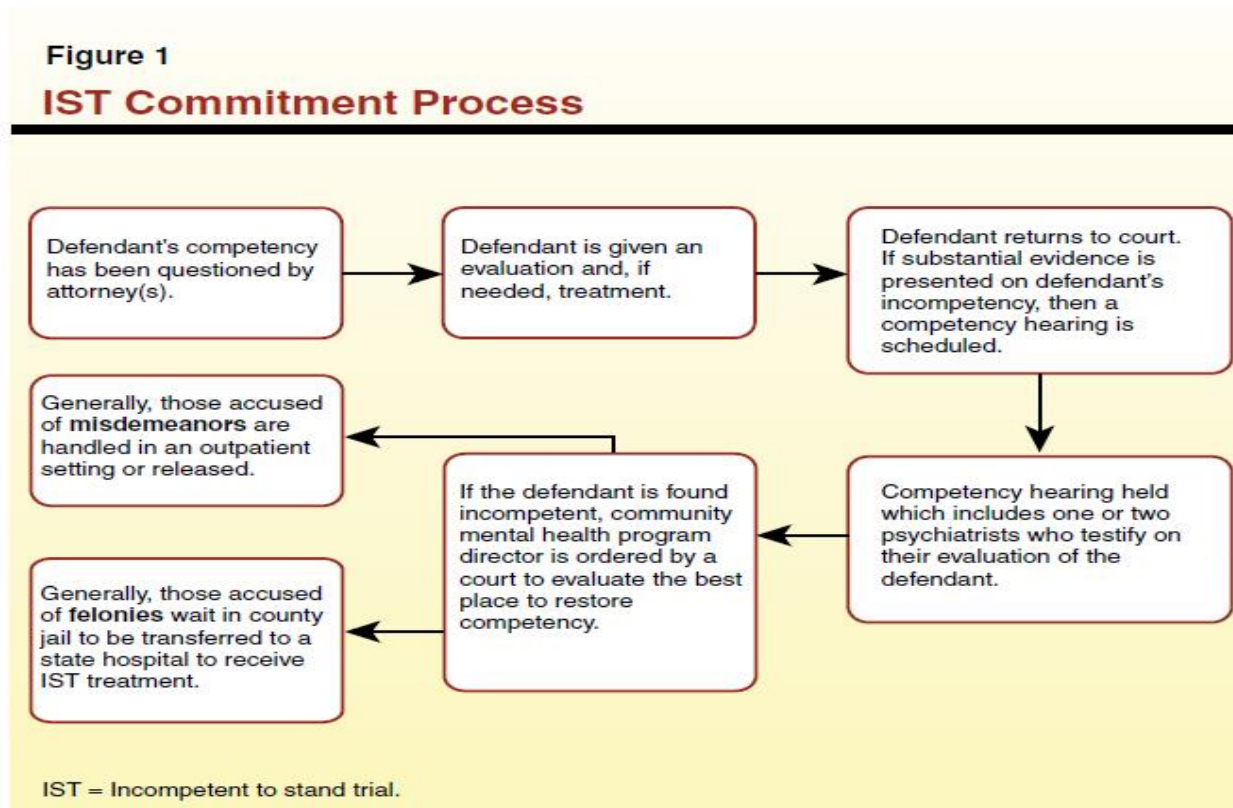
A trial court must initiate IST proceedings when there is “substantial evidence” raising a doubt as to the defendant’s competency to stand trial. *People v. Lawler* (2002) 27 Cal.4th 102,131. “Substantial evidence” has been defined as evidence that raises a reasonable doubt concerning the defendant's competency to stand trial. *People v. Davis* (1995)10 Cal.4th 463, 527. If there is substantive evidence, the court appoints psychiatrists and/or licensed psychologists to examine the defendant and make a recommendation to the court. Penal Code §1369. The defendant is presumed to be competent to stand trial unless incompetency is established by a preponderance of the evidence. Penal Code §1369(f).

There are limitations on length of commitment for an IST defendant. Generally, a defendant found incompetent to stand trial has a right not to be confined for longer than is reasonably necessary to restore him to competency or determine that his competency cannot be restored. *Jackson v. Indiana* (1972) 406 U.S. 715, 738. California law limits IST commitment to a maximum of three years for a felony or one year for a misdemeanor, or up to the maximum term of imprisonment for the defendant’s alleged crime, whichever is shorter. Penal Code §§1370(c)(1), 1370.01(c)(1).

If the defendant’s commitment reaches the statutory limit, the court may consider alternatives such as LPS or “Murphy” conservatorship proceedings. (“Murphy” conservatorship named after the legislator who sponsored the amendment that added the definition to the Act in 1974.) Welf. & Inst. Code §§5008(h)(1)(B); Penal Code §1370(c)(2).

When a person is subject to a “Murphy” conservatorship after an earlier finding of IST in which the individual has not regained competency “timely,” the individual’s county of origin becomes fiscally responsible for the individual. Previous to this point in time, the state is fiscally responsible for the individual. If a conservatorship is granted, the question of where the court should order the individual placed arises which is often at the continued and costly placement at the state hospital at the expense of the county.

Figure 1 outlines the IST commitment process.



Source: Legislative Analyst Office, “Alternate Approach: Treating the Incompetent to Stand Trial,” 2012.

Current Law Regarding Placement of ISTs

After a defendant is found incompetent to stand trial, the next step is a placement hearing to determine where the defendant is to be treated for restoration of competency. Whether the individual should be transferred to a state hospital or a community mental health facility depends on the severity of the charge. California law provides that individuals who are IST and charged with a listed felony must be placed in a secure setting, or the state hospital, for a period of 180 days unless the court finds another placement would provide more

appropriate treatment without endangering the safety of others. Penal Code § 1601(a)¹. These defendants cannot be placed in a state hospital, developmental center, or treatment facility unless it is secure and the court determines that the public safety will be protected. Penal Code §§1370 (a)(1)(D), 1370.1 (a)(1)(E). After 180 days at a state hospital or other treatment facility, a defendant charged with a violent felony on the list may be placed in the outpatient treatment program, otherwise known as the Conditional Release Program (CONREP), if the court finds that such placement would not pose a danger to the health or safety of others. Penal Code §§1370(a)(1)(F), 1370.1 (a)(1)(G), 1601(a).

There is greater flexibility with individuals charged with felonies not considered violent or with misdemeanors. Misdemeanor IST defendants and individuals charged with nonviolent felonies may be placed directly in CONREP for outpatient treatment for restoration. Penal Code §1601, Penal Code §§1601(a) & (b), 1603, 1370.01(a)(1)(A). These individuals cannot be committed to a state hospital unless there are no less restrictive placements available, and the county and Department of State Hospitals have a contract for placement. Penal Code §1370.01 (a)(2)(A). The community program director who is associated with a CONREP must submit a written placement recommendation to the court at least 15 court days before the placement hearing. Penal Code §§1370(a)(2); 1370.01 (a)(2); 1370.1 (a)(2).

The Conditional Release Program is a Placement Alternative to the State Hospital under a Statute that is Not Being Utilized

The Forensic Conditional Release Program (CONREP) is an outpatient treatment and supervision program for individuals who are under forensic commitments with the Department of State Hospitals and who the court has determined can be treated safely and effectively in the community. Penal Code §§1602, 1603. An individual placed on CONREP remains ultimately under the supervision of DSH Penal Code §§1605, 1615.

CONREP is a network of programs administered by counties and funded by the state. DMH contracts with county mental health programs, private agencies, or non-profit contractors to provide services in the CONREP. The state budget provides 100% of the funding for CONREP assessment, treatment and supervision services. DSH designates a community program director to be

¹ AB 2190 Chaptered 2014. Exempting from the 180 day prohibition on placement in certain circumstances.

responsible for administering CONREP for each county or region. Penal Code §1605(a).

The California Judges Benchguide 63 on Competence to Stand Trial, revised in 2010, and published by the Administrative Office of the Courts, Education Division/Center for Judicial Education and Research, is a good resource for understanding the competency procedure of individuals charged with felonies or misdemeanors.

Under Section 63.35, “Commitment to Treatment Facility or Outpatient Status Placement and Evaluation by the Community Program Director,” the material provides:

“If a defendant is found mentally incompetent, the court must order that the defendant be admitted to a state hospital, a private or public treatment facility, or placed on outpatient status...before making its commitment order, the court must order the community program director (or designee) to evaluate the defendant and submit to the court within 15 judicial days of the order a written recommendation as to whether the defendant should be placed on outpatient status or committed to a state hospital or other treatment facility...”

This section of the Benchguide reiterates the restrictions on initial release to outpatient status for individuals charged with or convicted of any of the long list of felonies under Penal Code section 1601(a). This indicates the central role of the community program director to make placement recommendations so long as placements exist and can be identified.

Note on Violence, Mental Illness and the Violence Risk Assessment as it relates to Placement

It is important to remember that individuals charged with a felony, even if considered a violent felony, and found to be Incompetent to Stand Trial have only been charged and not convicted. Often, the issue of the competency of a defendant is raised early in the criminal proceedings. Placement decisions for restoration of competency programming often occur early in the proceedings as well.

Placement decisions rely on a determination of whether the defendant can safely be treated in an outpatient setting. Clinical researchers have found that it is not possible to accurately predict dangerousness of individuals who have a mental disorder (Scott, C. L., & Resnick, P. J. 2006; Harris, A., & Lurigio, A. J. 2007).

Researchers Scott & Resnick (2006) found that there is no psychological test or interview that can predict future violence with high accuracy.

Researchers have noted the prediction of violence remains an inexact science likened to forecasting the weather. "Like a good weather forecaster, the clinician does not state with certainty that an event will occur. Instead, she estimates the likelihood that a future event will occur. Like weather forecasting, predictions of future violence will not always be correct. However, gathering a detailed past history and using appropriate risk assessment instruments help make risk assessment as accurate as possible" (Scott & Resnick, p. 608). Also, researchers noted that doubt was cast about a clinician's ability to predict violence effectively following the Court's finding in a 1966 U.S. Supreme Court case. *Baxstrom v. Herald* (Harris & Lurigio, p. 547). After *Baxstrom*, alternatives to predicting violence by use of structured assessment tools and actuarial methods to determine risk factors have gained clinical interest (Harris & Lurigio, pgs. 547-549).

CURRENT PROGRAMMING: REVIEW OF THE IST PROGRAM AT ATASCADERO STATE HOSPITAL AND NAPA STATE HOSPITAL

A high percentage of individuals found IST and charged with a felony are eventually transferred to a state hospital to regain competency. There the individual will be in a program that requires a relatively high level of cognitive abilities to understand and move through the program material. The programming does not appear to allow for modification for individuals who do not meet the needed cognitive level.

To illustrate the complexity and depth of material on competency, Napa and Atascadero State Hospital materials were reviewed.

The Trial Competency Project at Atascadero State Hospital, revised November 18, 2009, covers 40 pages and contains a Table of Contents that outlines the 1370 restoration program and process, explains how to use the orientation booklet and work with staff, describes the contents of the 1370 workbook, and contains a final review and glossary of terms sections.

The booklet describes the four steps to the 1370 program as 1) an oral examination as part of the "Competency Assessment Instrument known as (CAI) or the "CAT Test" where questions are asked about knowledge of the charges, the courtroom process, and the capacity to cooperate rationally with one's lawyer, 2) the mock trial, which creates courtroom scene that gives an individual the chance to practice what to do and say in a real courtroom setting, 3)

dispositional or team staffing, wherein the unit treatment team asks questions about the individual's case and the court process to determine whether the resident is ready to move to the last step, and 4) forensic staffing, which is a one to one interview with a specially trained forensic psychiatrist who makes a final decision whether the individual is ready to return to court or not and serves as the last interview for the patient.

For the description and overview of the 1370 process, the booklet describes the 1370 restoration program consisting of the following:

1. Education groups about court procedure
2. Individual meetings with your sponsor and social worker to discuss your legal situation
3. Recreation and leisure groups with your Rehabilitation Therapist to improve communication and social skills
4. Educational groups about mental illness and psychotropic medications
5. Medication to help control the symptoms of your mental illness (if needed)

Additionally, the booklet identifies that 1370 treatment will address:

1. The defendant's knowledge of
 - a. The alleged charge(s)
 - b. The various plea options available
 - c. The roles and functions of courtroom personnel
2. The defendant's ability to assist in his own defense, which includes:
 - a. Behaving appropriately in the courtroom
 - b. Interacting effectively with counsel

The material emphasizes cognitive understanding of the individual's own case, learning relevant legal terms and the criminal process, and being able to communicate with staff. There is also an emphasis on having appropriate courtroom behavior.

What is absent from the material is assessing for cognitive deficits, or identifying barriers to learning the competency material which a few outpatient programs assess for as described later in this paper. The material does not mention a modified approach to learning, leaving clients to utilize the workbook "as is" and

to speak with clinical staff about the knowledge they have gained from the material².

Napa State Hospital has a similar approach to its competency programming. A review of the Napa State Hospital Program 5 Trial Competency Workbook, revised 2/23/2000, also illustrates the heavy dependence on cognitive understanding of material. The 2000 version explains how a person can become trial competent which involves taking medications as prescribed, attending treatment groups, especially Sponsor groups, and passing the three steps of the 1370 program. There are three tests of the 1370 program listed in the workbook: the revised "CAT Test," the Mock Competency Hearing, and Dispositional Staffing.

There are two Sponsor Groups, Level I and II which are facilitated by clinical staff who assist individuals with the competency material. In Level I, questions are asked which are followed by the printed answer. The questions cover the person's knowledge of the charges, the possible sentences, the difference between a felony and a misdemeanor, the definitions of court terms, what is time served and the different types of pleas. There are questions about the role of the judge, state's attorney, one's own attorney, witnesses and also about the job of the defendant which includes listening carefully, communicating and being truthful with one's attorney.

Under the Level II Sponsor Group questions, there are accompanying responses to the questions that include what a person has to do to commit the crime that the person was charged with but also lists as a caveat, "not incriminating self." Other questions are: "Why should you cooperate with your attorney?", "What is probation?", and "What are the rules of probation?", "Is the Public Defender and a Defense Attorney the same thing?", "What is a plea bargain?" There are additional questions such as "Why did the court decide you were incompetent?", "Are you ready to return to court?", "Name your current medications and what affect each has" and "What are the potential side effects of these medications?"

The CAT Test is an oral exam where questions are asked that test the person's knowledge of the criminal charges against the person, the courtroom process, and the person's capacity to cooperate rationally with counsel and helps to

² An experienced public defender believes that cognitive deficits are not accounted for in the competency program and added that medications might even contribute to problems with cognition. He has been puzzled by how individuals found Incompetent to Stand Trial are not better served by the community program. (Anonymous, personal communication, March 12, 2014).

determine whether the person is able to realistically apprise the likely outcome of the case.

The Mock Competency Hearing is a “pretend courtroom scene which gives the person a chance to practice what to do and say in court.” The Dispositional Staffing is the final step where a person appears before the Interdisciplinary Treatment Team and is asked questions to determine whether the person is competent to stand trial.

Other material in the workbook includes “A list of words or phrases you will need to know” which make up common court words such as knowing the roles of individuals in the courtroom, sentencing and “enhancements,” and the different types of pleas.

WHY CALIFORNIA’S PLACEMENT AND RESTORATION PROCESSES FOR INDIVIDUALS FOUND INCOMPETENT TO STAND TRIAL ARE A PROBLEM

California’s approach to restoration of competency results in a long process, and costs the state millions of dollars. The problem also impacts defendants’ constitutional rights and results in overcrowded jails and poor mental health care. These problems are discussed below.

Legal Ramifications

Individuals who are found IST may have their rights to a speedy trial violated. Many of these individuals charged with a felony have been ordered to the state hospital system to be restored to competency. Because of the number of individuals ordered to the state hospitals when the hospitals have reached their bed capacity, the result often leads to the individual waiting in jail until a bed is available.

Individuals who are found IST also are subject to their criminal case being suspended. Both the state and federal Constitutions guarantee a criminal defendant the right to a speedy trial (U.S. Const. 6th Amend.; Cal. Const., Art. I, Sect. 15, Cl.1). A defendant should typically be brought to trial within 60 days for a felony (Penal Code 1382(a)(2)). However, all criminal proceedings are suspended pending a resolution of competency to stand trial (Penal Code 1368(c)). Often this means that a criminal charge has been filed against the individual but no conviction or plea bargain has been secured. While a criminal case is suspended, any possible defense to the criminal charge(s) are not presented.

In the 2010 case of *Freddy Mille v. Los Angeles County* (182 Cal.App. 4th 635), the Second District Court of Appeal ruled that a person determined to be IST must be transferred to a state hospital within a “reasonable amount of time,” which the court interpreted to mean 35 days in order for the state hospitals to examine and report to the court on the likelihood of competency restoration within 90 days of the defendant’s commitment. Under the Penal Code, the first status report to the court is to be completed within 90 days of the commitment order.

In practice, this 90-day timeline is routinely missed. Litigation on placement delays has resulted. In several counties, attorneys have asked the court for orders to show cause and some have filed class action lawsuits. The Public Defender in San Francisco has been securing orders to show cause when the hospital is unable to comply with the timeline resulting in the state being held in contempt of court. In Riverside County, the Public Defender filed a class action suit resulting in Patton State Hospital finding a bed immediately and the case was dropped. In 2006, a court in Sacramento County ruled that DMH had seven days to place IST inmates in Napa State Hospital which resulted in Sacramento County’s IST inmates being placed at the top of Napa’s waiting list.³

Additionally, while IST defendants are waiting for a bed to become available at a state hospital, they often find themselves in a county jail receiving inadequate mental health treatment for long periods of time. This failure to provide adequate treatment may be challenged as a violation of the individual’s right to treatment under the due process clause of the U.S. Constitution. *Oregon Advocacy Center v. Mink* (9th Cir. 2003) 322 F.3d 1101.

Impacted Hospitals and High Costs for the State and Counties

At the time of the Legislative Analyst Office (LAO) report, “Alternate Approach: Treating the Incompetent to Stand Trial” was prepared in January 3, 2012, more than 1,000 persons, or about 20 percent of the state hospital population, were IST felony commitments.

As the LAO reports, the Department of State Hospitals (DSH), formerly Department of Mental Health, gathered data reflecting that during 2009-2010,

³ An experienced public defender for over twenty years of experience in a medium to large county in California said that the wait time to be transferred to the state hospital for defendants found to be incompetent is excessive and violates the 90 day time line in *Mille*. He wondered if litigation based on the *Mille* case might lead to the release of a defendant who was otherwise ordered to treatment but none has been provided. (Anonymous, personal communication, March 12, 2014).

defendants waited an average of 68 days, almost double the 35 days recommended by the court in *Mille*, for transfer from a county jail to a state hospital for evaluation. As DSH reports, in the case of Patton State Hospital, it is taking an average of 87 days for IST's to be transferred from their county jail while some transfers are taking as long as 162 days.

DSH found that a total of 1,261 persons were placed on an IST waitlist at some point during fiscal year 2009-10. At the time the LAO report was prepared, there were 264 persons on the IST waitlist. While waiting for transfer to the state hospital, counties pay for the cost of care of persons found IST. Statewide, jails report spending \$92 per day on average for all their inmates with costs for IST patients as expected to be higher because of their medical needs. Counties spend an estimated combined annual total of \$3.5 million to hold IST commitments in their jails beyond the 35 day period while they wait for a state hospital bed to become available.

State hospitals have very strict "one-in/one out" policies which results in extensive backlogs and long waiting lists. As a result, jails are expected to house inmates with mental disorders found incompetent to stand trial for six (6) to nine (9) months and sometimes a longer before a hospital will accept them. While in jail awaiting hospital admission, "these mentally ill people are not getting the treatment they need; they are often difficult and disruptive in the jail environment and cause significant hardships for jail staff, other inmates and mental health service providers who work in the jail." (Jail, pg. 10)

Placement in a state hospital to receive competency programming is also expensive. An average daily population in state hospitals of 1,000 IST's at a cost of approximately \$450 per day per patient results in the state spending approximately and over \$160 million annually, not including facility-related costs. The LAO found that once at the state hospital, it takes an average of six or seven months to restore a defendant to competency. The state law provides that the maximum time of commitment as an IST is three years or the maximum prison term the court could have sentenced the defendant to, whichever is shorter.

The ability of the state hospital system to accept new commitments is constrained by the physical capacity of these facilities and the state's ability to hire sufficient staff. The LAO concludes that if the state were required by the courts to comply immediately with *Mille* to eliminate the backlog of IST's solely by expanding staff capacity and filling the remaining available beds in the state hospital, it would face ongoing annual costs of about \$20 million.

An Individual Who is Incompetent to Stand Trial and His Experiences

In a phone interview with “PL” (initials assigned, personal communication February 7, 2014), his experience illustrates the many problems with the incompetent to stand trial placement system. PL was found IST, charged with a felony and ordered to be placed at Napa State Hospital to regain competency. Until a state hospital bed was available, PL languished in the jail, was injured and harmed there. When he was finally transferred to Napa, the competency programming fell below a level of efficacy in his view. As he shared, alternative settings might have been more appropriate and effective to restore him to competency.

PL had been placed in an urban jail charged with assault with a deadly weapon, a felony, found IST, and waited in jail for close to six months before placement at Napa State Hospital. PL said he was abused and beat up by guards resulting in rib injuries. He had no history of dramatic weight loss, but while at the jail he lost 26 lbs. from not being fed or being fed poor quality food. He maintains his innocence but is unable to return to court to defend against the charge.

He said that the competency program at Napa State Hospital is comprised of a group of about 30 individuals who meet once a week on Monday morning for about 30 to 45 minutes to discuss a booklet of material on competency. A psychologist leads the group alternating between a lecture and discussion format. PL said that there are different levels of understanding by the attendees. He is not sure if the learning needs of the members are met. He believes that for some members that individual attention is important to help get through the program material.

As an alternative placement and program, he mentioned that a board and care setting would match his needs. He said that in such a setting what is needed is competency material, clinical staff, a class-like situation to learn in, and that basic needs like food are met adequately. He said that a jail might be a setting for competency programs, but noted that there are rules that prohibit inmates from talking to each other which would limit the ability to discuss the competency material. He believes that being able to talk with others about the material would be helpful. He added that given that the jail he was placed in already had limited clinical staff to meet the mental health needs of all the inmates there. Because of this, he does not expect any added clinical staff to focus primarily on competency programming.

He believes it would be therapeutic if his mom was closer to him and she visited while he is working on gaining competency at the hospital.

PL strongly emphasized his surprise that when he arrived at Napa State Hospital, he had to wait about a week to receive competency material, which to him seemed like an unreasonable amount of time to wait. During the wait, he was highly anxious, worried and scared after arriving at the hospital not knowing what to expect. He emphasized the importance of giving restoration material upon arrival to newly admitted individuals to Napa for competency restoration. He believes that adding at least another competency class in the afternoon in the week was important especially for individuals who are not alert enough in the morning due to medications. This would likely allow more individuals to participate in the competency program.

MOVING PAST THE PROBLEM: PROPOSED ALTERNATIVES

In 2013, a workgroup was formed at the request of Governor Brown to address the problem of placement of individuals found IST and charged with a felony. Among the numerous agencies who participated were staff from the Department of State Hospital, and other state agencies, Finance staff, court officers such as Superior Court judges, and directors of county mental health or behavioral health departments. Additionally, correctional officers, as well as representatives from the provider or corrections system, and representatives from a disability advocacy group participated⁴.

At the initial meeting, the competency issue was framed and summarized by staff from the Department of State Hospitals (DSH). They acknowledged that there was significant problem of placing ISTs at state hospitals when there are limited beds. They acknowledged that defendants were waiting at a local jail for long periods of time for bed space to be available. DSH also stated a key challenge was keeping and hiring a sufficient number of clinical staff at the hospitals.

Over the course of the meetings, stakeholder members identified possible solutions, some which were not fully agreed upon, and which included the following:

1. Develop new procedures to be back in court at a faster pace

⁴ The workgroup is continuing to meet in 2015. After the passage of the 2015 budget and the allocation of money to increase state hospital bed space for individuals who are IST, DSH is activating beds at many of the hospitals. DSH admits that they will be at or near capacity. DSH has considered other options including releasing a Request for Information (RFI) to providers at an Institute for Mental Disease (IMD) but only three responded. DSH has reached out to local detention facilities to determine if they would be interested in operating a restoration of competency program in the jail but few counties are interested. There is discussion about exploring the capacity and viability of community based restoration programs operated by the Conditional Release Program.

2. Create a tickler and court calendaring systems to keep track of the status of cases
3. Develop placements other than the state hospital for competency
4. Seek involuntary medication orders
5. Review current competency program at the state hospitals
6. Ensure a therapeutic program that is a least restrictive environment

This policy paper responds to some of these recommendations and later includes recommendations as possible solutions to the placement issue.

Best Practices Model

The National Judicial College, in existence for more than 50 years, is considered a national leader in judicial education and offers a best practice model for restoration of competency. (<http://www.judges.org/about/history.html>).

The College offers programs to judges nationwide, and works to improve productivity, challenge current perceptions of justice and inspire judges to achieve judicial excellence. The College offers a broad range of specialized, practical and advanced programs designed specifically for state, local, administrative law, military and Tribal justice systems, as well as for international countries seeking to enhance the rule of law.

Overall they support that the best practice is to *restore the defendant in the least restrictive treatment setting* or facility consistent with the public safety and treatment needs of the defendant.

Jail Competency: DSH's Response as an Alternative Placement for ISTs

The Health Services Administrator, Terry Fillman, cited security reasons for disallowing a visit to the restoration program at the West Valley San Bernardino County jail where DSH had contracted with Liberty Healthcare Corporation to create a pilot program for 20 beds dedicated for individuals who were to be restored to competency. That program is now in a post pilot status and in a fully operational mode with 20 beds. San Bernardino jail officials provide security, management, food and medication to the inmates. The state paid Liberty \$278/day per patient, while Liberty paid San Bernardino \$68 per day. Results of the pilot showed that treatment was started and completed more quickly,

treatment was effective, and the number of IST referrals in the county decreased (LAO).⁵

San Bernardino County estimated that it has been able to achieve net savings of more than \$5000 for each IST commitment Liberty treats, for a total savings of about \$200,000. The state saved about \$1.2 million when individuals were treated and released without being placed in a state hospital. Combined public sector savings was over \$70,000 for each IST patient directed to Liberty Healthcare (LAO).

Under Liberty Healthcare, individual deficits that interfere with competency to stand trial are identified for each individual, and appropriate treatment

⁵ Calls were made to the Executive Director of the restoration program, Kevin Rice of Liberty Healthcare (personal communication, March 5, 2014), and the Health Services Administrator for San Bernardino County, Terry Fillman (personal communication March 14, 2014), which includes the West Valley Jail, where the competency program is housed. And Mr. Rice described that the twenty beds are set aside in an “octagon” section of the jail in an attempt to create a “therapeutic milieu,” but custody staff are present at all times. Because the earlier pilot program was and is small, he said that they had a lot of flexibility in developing the program compared to a larger program.

Mr. Rice said there must be a court order for both the San Bernardino competency program and the state hospital so there would not be a delay in placement if circumstances change. Liberty Healthcare staff review the background of the individual and make an initial determination of whether they think they can restore an individual to competency in 90 days or less. If so, they accept the individual and if not, the person is transferred to the state hospital. When their capacity is full, they apply a priority system to determine who stays and who goes because there is limited space even there. Specific factors are considered such as whether the person is medication compliant, has a previous incompetency history, and has a chronic mental health condition before a decision is made as to who will remain in the program. When asked about the jail setting itself for a clinical program on competency, he implied that it is not so therapeutic because inmates are wearing their outfits and there is a deputy present at all times. He said that obtaining the buy-in, or support, of custody staff was challenging.

He said that the smaller program allowed for assessments to happen at a faster pace and that the jail setting itself makes it convenient for a person to be admitted to the competency program when the person is on the custody side. He mentioned public safety as an issue if a restoration program was in the community and acknowledged the possibility of stigma as a barrier. Having worked at Gateways, the Los Angeles Conditional Release program, he said that there is no current standard competency program for clinicians.

Terry Fillman, RN, and Health Services Administrator for San Bernardino County is responsible for the health, and mental health of inmates in accordance with requirements under the California Code of Regulations, Title 15. He mentioned that AB 109 impacted the length of stay for inmates requiring a change in programming due to the longer stays, and the chronicity of health needs. Before, health needs were responded to upon somewhat an urgent need. Now, he said that since the stays are longer than one year, and the length of stay tripling, the programming and services had to be modified to meet the needs better. In his opinion, the restoration program at West Valley is a success because he believes that inmates receive the care that they need and in a shorter period of time.

He mentioned that electronic monitoring might be a means to keep track of an individual in a community restoration program. He said that they currently have electronic monitoring in place whereby the individual pays for the ankle bracelet. He said that there would be less jail cost and a savings on jail bed stays.

interventions for each problem area are responded to. These problem areas include: disorganized thinking, delusional ideation or paranoia, hallucinations, impaired concentration, memory problems, comprehension deficits, disruptive behavior, abnormal rate of thinking to name most but not all of the areas. (See <http://www.fmhac.net/Assets/Documents/2013/Handouts/Rice.pdf>)

The Liberty program materials also described mental illness and stress management, mental stimulation and rational thinking, and recreational and social activity as “competence-related treatment.” Under the court activity group description, the program utilized engaging and interactive methods to increase understanding and awareness of court proceedings, as well as a multimodal treatment approach that included games, videos, movies, and current crime or court news, role play and a mock trial.

In contrast, restoration programming does not necessarily need to occur in a jail setting when considering how some of the components of Liberty Healthcare’s competency program material have also been applied in successful non-jailed based competency programs in other states such as Washington, Florida, Wisconsin and Hawaii. Washington, like a few others states, utilize a specialized and individualized treatment program and, like Liberty Healthcare, understood the importance of identifying problems and address them effectively to allow for an increased chance to gain competency.

The Jail: A Non-Therapeutic Setting to Restore to Competency

Jails possess a host of problems for inmates with mental health needs, which includes individuals who are IST. They are not the appropriate setting to provide mental health services because of the significant increase of inmates under AB109 or “realignment”, cuts in county budgets for staff, lack of qualified staff or clinicians who can adequately address the mental health needs of inmates, and custody staff resorting to use of force to address mental health symptoms.

Treatment facilities are required to care for and treat individuals committed as IST in a way that will “promote the defendant’s speedy restoration to mental competence.” Penal Code §1370(a)(1)(B)(i). Jails are known to not be sufficient treatment settings for individuals with severe mental illness, many who are ISTs. For example, Penal Code §4011.6 allows for the transfer of jail inmates with mental illness to treatment facilities that are better able to provide treatment. Only some county jails have designated units under the Lanterman Petris Short Act (LPS) that provide treatment and follow the due process rights for individuals who have mental illness and are in the jail setting.

Inmates with mental illness find it difficult to abide by the formal and informal rules that govern prison life. Staff neglects them, accuse them of malingering and treat them as disciplinary problems. Other prisoners exploit and victimize them. Prisoners who break the rules because of their illnesses are punished. Even self-mutilation and attempted suicide are dealt with as disciplinary matters. Special segregation or isolation units are disproportionately populated by mentally ill prisoners (San Diego Union-Tribune, Feb. 13, 2004). Additionally, jails often do not have sufficient policies to protect inmates with mental illness from self-harm. For example, the Department of Justice recently found that Los Angeles County violated the constitutional rights of inmates in the county jails because they did not take adequate steps to “protect prisoners from serious harm and risk of harm at the Jails due to inadequate suicide prevention practices.” A Way Forward, ACLU Policy Paper, July 2014.

A briefing paper by the California Department of Corrections underscores the burden and difficulty in providing mental health services generally which would include providing competency programs in the jail. “Jails and the Mentally Ill: Issues and Analysis” (Jails) developed by the California Corrections Standards Authority (CSA) and requested by the California Department of Corrections and Rehabilitation, Council on Mentally Ill Offenders, provides useful content on how jails have become “dumping grounds” for the mentally ill.

http://www.cdcr.ca.gov/comio/docs/mentally_ill_in_jails_paper%20.pdf

The briefing paper includes statistics from the national GAINS Center that estimates that approximately 800,000 people with serious mental illness are admitted annually to U.S. jails and that, among these admissions, the preponderance (72%) also meet criteria for co-occurring substance abuse disorders.

Other data collected reflects the significant needs of the inmate population as found in a 2009 American Psychiatric Association study that “14.5% of male and 31.0% of female inmates recently admitted to jail have a serious mental illness, [confirming] what jail administrators already know – a substantial proportion of inmates entering jails have a serious mental illness and women have rates two times those of men.”

California’s jails, according to CSA’s Jail Profile Survey (JPS) for the end of 2007, reported having 27,450 open mental health case files for the statewide jail population of 82,662 inmates. In that same time frame of 2007, jails reported that 9,263 inmates were receiving psychotropic medications.

Jails feel they're being used as "holding tanks" for mentally ill people who have been found by the court to be incompetent to stand trial. They see their facilities as a "dumping ground."

The authors of the Department of Corrections briefing paper make a recommendation that focuses on integration and improvement to the continuum of care between the jail and state hospitals. The parties to the conversation needed are the sheriff's departments (or local departments of corrections) and the state DMH and its state hospitals. Courts and probation departments should also be involved in these discussions as both play important roles in the continuum of care for mentally ill offenders. They suggest that the Administrative Office of the Courts (AOC), County Supervisors of California (CSAC), California State Sheriff's Association (CSSA), Chief Probation Officers of California (CPOC), and California Mental Health Directors Association (CMHDA) initiate strategic discussions about how to more effectively integrate these interdependent systems of care (Jail, p. 12).

While the San Bernardino program shows some preliminary success, space is limited because of the higher number of jail inmates since legislation under AB 109 passed in 2012, known as "realignment". Under realignment, individuals who would have been in a prison are instead serving their sentence in local detention facilities, or jails. (<http://www.bsa.ca.gov/pdfs/reports/2013-601.pdf>) This change has invariably led to higher local jail census numbers. Not every county jail is designed for, or can it so easily accommodate, the increased number of inmates let alone the unique needs of individuals who are mentally ill. It should be no surprise that jails are challenged to meet the mental health care needs of the inmates, including those requiring competency programming.

Best Practice for Placement at a Jail

The Judicial College provides its view of when restoration of competency in the jail setting might be appropriate. Its position on jail placement follows: "When circumstances requiring hospitalization are not present, and either the defendant needs to be detained or community restoration is not available, it is best practice to provide restoration in a jail setting." Its position is that the jail setting can be advantageous since the defendant does not have to wait for hospital restoration, nor transport. Also, they state additional advantages that family and counsel would be nearby to help the person to maintain competency, that there would be continuity of care, and that the cost is less than hospital placement.

However, the College describes competing considerations, many which are significant, such as the strong opposition even in the mental health system that

jails should not be treatment facilities. Also, given that jails are often locally operated, the cost of treatment is the responsibility of the local government. The College states, “each day spent providing treatment services to an incompetent defendant is one day fewer the locality can detain others”. Of note is their comment that “individuals with mental disorders are more likely to decompensate when introduced or re-introduced to a jail setting” and support the establishment of mental health pods in jails. The College believes that if individuals with mental health disorders are separately detained that this would be less disruptive to an inmate to attain and maintain competency.

Involuntary Medication as a Means to Restore Competency: A Cautionary Approach

Another proposal raised an increased use of psychotropic medication as treatment to restore competency. However, there must be caution exercised seeking to involuntarily medicate individuals to gain competency. The US Supreme Court reflected on the need for restraint or medication use in its decision in *Sell v. United States* (2003) 539 U.S. 166. The Court found that individuals who are IST have a liberty interest under the due process clause of the 14th Amendment to refuse antipsychotic medications for restoration to competency unless specific factors are satisfied.

The court, in *People v. O'Dell*, 126 Cal.App.4th 562 (2005), citing to *Sell*, and Penal Code §1370 (a)(1)(F)(2)(B)(ii)(III), also found that liberty interests are involved when seeking to involuntarily medicate an individual found IST. The court in *O'Dell* held that the court can issue an order authorizing the hospital to involuntarily administer antipsychotic medication to defendant if the following five factors are present: (1) the People have charged defendant with a serious crime against the person or property; (2) involuntary administration of antipsychotic medication is substantially likely to render defendant competent to stand trial; (3) the medication is unlikely to have side effects that interfere with defendant's ability to understand the nature of the criminal proceedings or assist counsel in conducting his defense in a reasonable manner; (4) less intrusive treatments are unlikely to have substantially the same results; and (5) antipsychotic medication is in defendant's best medical interest in light of his medical condition.

Specialized and Individualized Treatment Programs

In the January 2013 publication by the Washington State Institute for Public Policy, “Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods,” the authors describe more specialized programming. This approach includes a problem-oriented

individualized treatment plan for the restoration of competence. Individuals are evaluated with respect to the following problems/issues and then placed into one of the groups with specific programming for each group.

For the group members who had perceptual or thought disturbances that interfered with understanding and communication, the competency program focused on reality testing skills and standard treatment approaches to address the psychosis. In another group, individuals who have a low IQ, brain injury or developmental disability would receive didactic, or learning of specific education techniques on the roles and function of the courtroom participants, the court procedures and possible legal consequences. Yet another group would have individuals who distort or misinterpret reality due to their situation would receive reinforcement and behavior management. Individuals who were awaiting discharge to the court and believed to be restored to competence would be given maintenance approaches to keep their current competency and further coping strategies.

Community-Based Restoration Models

An idea that has not been fully developed in California is the expansion of community-based restoration programs. The 2015 budget includes an increase of \$3.9 million GF to expand the Restoration of Competency Program (ROC) and allow ROC services to be provided in community facilities. The expansion will allow people who have been deemed incompetent to stand trial (IST) to receive mental health services in the county jail or community facilities, rather than being transferred to a state hospital. The goal is to reduce the IST waiting list for those who are waiting for space to open up in a state hospital.

At the National Association of Mental Health Program Directors Forensic Division Annual Meeting in 2009, a presentation on Community Based Competency Restoration Programs indicated that these programs can be successful. There are 35 states that have statutes that allow for outpatient competency restoration of which 16 have programs in operation. Based on the workshop materials of the programs in operation, common structural themes emerged such as:

- explicit statutory allowance for outpatient programs
- utilization of state community mental health system for outpatient services
- state mental health agency assumes sole responsibility for person in program
- violent charges and many felonies excluded
- specialized professionals on staff for restoration program

- young programs of less than 6 years

When comparing the programs, common clinical themes were identified as these:

- case management typically provided; housing; psychosocial rehab, forced meds were not
- individual treatment is typical
- outpatient length of stay often longer than inpatient length of stay because of less pressure and ability to continue restoration longer
- people returned to inpatient setting infrequently where clinical instability and increasing dangerousness are reasons for recommitment to inpatient setting

Benefits were found to be the following:

- outpatient program frees inpatient bed space
- outpatient less costly than inpatient program with about 20% savings
- less restrictive, more recovery-oriented

Some common challenges included the limited implementation within states due to funding for staff and resources, or by poor buy-in from the court and/or hospital.

In the workshop material, the states of Florida, Wisconsin, and Hawaii were highlighted as having community restoration programs. Some important highlights of each of these promising programs are worth mentioning as California seeks to address the IST placement problem.

In Florida, some main points about their program follow here:

- community based treatment, when appropriate, is advantageous to courts, defendants, communities, and the state
- treatment in the community allows defendants to receive services in less restrictive settings, reduces the need for more costly treatment in secure facilities, and allows individuals to remain closer to their community support systems
- community-based mental health service delivery is decentralized, regions and circuits procure local contracts to provide treatment

- regions have varied services, competency training in residential settings, community mental health centers, and jails
- treatment for restoration of competency provided by different disciplines
- services to restore competency are paid by state general revenue dollars
- over 600 individuals received competency restoration services in the community
- training packet developed to inform judges of the recommended minimal standards for competency education, and to provide community organizations with a reference
- standardized competency evaluations and reporting by the development of a standardized report format

Highlights of the Wisconsin programs for outpatient competency restoration included oversight by the Department of Health Services which determined where restoration services could be provided.

The Wisconsin Statute 971.14(5)(a) provided that "...the court shall suspend the proceedings and commit the defendant to the custody of the department of health services for the department to determine whether treatment shall occur in an appropriate institution designated by the department, or in a community-based treatment conducted in a jail or a locked unit of a facility..."

Wisconsin cited the reasons for placement options to be: 1) better for the client whereby certain individuals who do not need inpatient services which is very disruptive to their lives, 2) allows management of inpatient beds- saves inpatient beds for those who need to be inpatient, and 3) cost effectiveness – able to be done for a fraction of the cost of inpatient.

The components for development of the Wisconsin program included some of what Florida's program contained such as state funding for the program and standardized treatment but also included:

- courts presented with options and invited referrals
- contract with providers who have a long standing relationship with the department
- restoration services, psychiatric and medication as needed, and case management oversight
- all evaluations as required in the statute
- a treatment manual for providers with materials for patients

- same curriculum for inpatient and outpatient for standardized treatment in all settings

The selection criteria of individuals for the outpatient program in Wisconsin included 1) no per se exclusion of any crimes, but generally looking at defendants with less serious charges, 2) person must have stable living circumstances (program does not provide housing), 3) person must be sufficiently psychiatrically stable to make outpatient feasible, and 4) person must be cooperative and actively participate.

The procedural steps included contracting with evaluators who do the initial competency evaluations to do a screening for appropriateness. If a person appears to be a candidate, the contracted provider is notified to do a more in depth assessment. The role of the case manager is to assess for living situation, etc. If there is an appropriate candidate, then the court is informed and if the court agrees then the person is enrolled in outpatient treatment.

Once in the program, the provider meets with the patient individually, about four times a week, and case management and other services are provided as indicated with regular reports being sent to the court. If the person becomes unstable, fails to cooperate, or is determined to be a risk, then the person will be moved to an inpatient setting. Services continue until the person is restored, the maximum time is met, or it is clear that the person is not restorable to competency.

The material in the presentation given at the Forensic Division Annual meeting cited to data that in Wisconsin, 11 individuals had completed the program with eight successfully being restored, one not able to be restored to competency, and two individuals who were found to need inpatient services. The data described how typical candidates have some cognitive delays making psycho-education important. The average time to restore to competency was about 4 months. Although it is hard to estimate the costs, it roughly reflected a cost of \$3000 per client per month, or roughly \$12000 per client total. The authors said that these figures are to be compared with a range of \$80,000 to \$100,000 per client for inpatient services.

Lastly, Hawaii's community based competency restoration program follows the statute that allows for release to the community if dangerousness can be safely managed. This state-run program consists of a five bed cottage with services of case management, psychiatry, fitness restoration of individual and group services, a clubhouse, and mental illness and substance abuse services. Referrals are made exclusively from the state hospital although the court can

also make the referral directly. The eligibility criteria are that individuals be charged with non-violent misdemeanors and felonies, have willingness to take medication, and be restorable.

Hawaii credited the Florida CompKit restoration material as did Wisconsin and made local adaptations. Restoration classes and treatment were provided by licensed practitioners and pre-doctoral interns whereby individuals were being evaluated every 30 days for progress. There is an independent court-ordered exam when progress had been made or will not be made because problems can result when one is revoked from the program and returned to the state hospital.

Data from the Hawaii program during its two years of operation (from the date of the 2009 presentation) and of its 16 participants reflects that 95% have been found fit. The materials indicate an average length of stay as 101 days to restoration. The cost savings to date was \$750,000.

What Hawaii found to be challenging were the low number of referrals from the state hospital and the statutes governing community appropriateness, which were vague as to a process or structure for outpatient restoration, time limits for restoration, or revocation procedures. Also as described, there has been limited implementation and expansion given resources and staff.

Best Practice for Placement in the Community

In their discussion of a community restoration program, the National Judicial College includes an example of the significant cost savings compared to placement at a state hospital for restoration. In their description of best practice for the court to order community restoration, they include components of a disability profile, the importance of a stable living situation, and the lack of substance use.

“It is the best practice for the court to order community restoration for individuals with mental retardation, cognitive disorders or developmental disorders, or major mental illness, if all the following apply: (a) the community has a program to restore competency that is suitable for the treatment needs of the defendant; (b) the program provides intensive, individualized competency training tailored to the demands of the case and the defendant’s particular competency deficits; (c) the defendant has a stable living arrangement with individuals who can assist with compliance with appointments and with treatment; and (d) the defendant is

compliant with treatment, and not abusing alcohol or other chemical substances.”

In an example of cost savings, the College describes how in one county in Texas, the costs between competency restoration in a mental health hospital verses community restoration in a private psychiatric hospital was significant. In a six month study, the average length of stay in a state hospital for restoration was over 100 days at an average cost of \$37,000 per individual, whereas the community (in-patient) restoration stay was an average of 30 days at a cost of about \$21,000 per individual.

CONCLUSION

The appropriate placement of individuals found IST and charged with a felony is a multi-faceted problem. It impacts many systems, as well as the individual. Current placement practices affect the due process and legal rights of the individual. They also disregard the potential harm that can happen in jail while waiting for placement and the burden on local detention facilities, the judicial system, and the state hospitals. Clinical practices, the uncertainty of decisions about future dangerousness, and the cost of current placement practices require additional research into alternative placements.

A closer review of how a placement decision is made is needed as it may ignore the law on placement options. State hospitals will not be able to meet the ongoing demand for bed space when a defendant is ordered there when very few options have been developed. Predicting actual dangerousness is not an exact science. Identifying barriers to learning the competency program material and addressing them individually and efficaciously is also fundamentally important to allow an individual to progress through the program so they can leave the placement and return to court.

To not be forgotten is the crucial fact that an individual has been criminally charged and not convicted, and because of an incompetency finding is unable to return to court to defend him or herself.

Jails should not be treatment settings – a message echoed by their own representatives. While the San Bernardino program may have preliminary positive results, the capacity is limited. Reviewing the components of the program and applying those in a setting other than the jail should be considered.

The problems identified with placing individuals who are IST to gain competency will continue unless parties or agencies with the authority to implement change are courageous to do so.

RECOMMENDATIONS

We recommend that California assemble a dedicated workgroup comprised of individuals with subject matter, practical, and advocacy expertise to:

1. Project the future need for placements in a restoration to competency program for individuals charged with a felony
2. Examine the funding stream for alternative placements to not only include state revenue but also other systems such as Medi-Cal, the Affordable Care Act and others
3. Retain a researcher to gather current national data and examine how other states are operating community based restoration of competency programs
4. Contact officials in Washington, Florida, Wisconsin and Hawaii and tour their community based competency programs to gather information about operations and program components
5. Examine how placement recommendations are currently made including what assessment tool or approach is used and determine whether all placement options under the statute are being recommended
6. Review the current programming at the state hospitals for restoration of competency and whether it is individualized according to the needs of the individual that may include adaptation to learning styles or cognitive levels, or addresses how their mental health needs may impact learning or level of participation in the program
7. Review the capacity of community programs such as the Conditional Release Program to accept individuals found Incompetent to Stand Trial
8. Determine what actual barriers exist for the Conditional Release Program to accept individuals found Incompetent to Stand Trial
9. Determine the structure, service components and cost to develop alternative placements including community placement
10. Determine the cost of providing restoration programming and other services for individuals placed at the state hospital

REFERENCE LIST

- ACLU of Southern California and Bazelon Center for Mental Health Law (2014), *A Way Forward: Diverting People with Mental Illness from Inhumane and Expensive Jails into Community-Based Treatment that Works*. Retrieved from <https://www.aclusocal.org/wp-content/uploads/2014/07/JAILS-REPORT.pdf>
- California Department of Corrections and Rehabilitation, Council on Mentally Ill Offenders, Jails and the Mentally Ill: Issues and Analysis. Retrieved from http://www.cdcr.ca.gov/comio/docs/mentally_ill_in_jails_paper%20.pdf
- California Judges Benchguide 63 (revised 2010). Competence to Stand Trial. Administrative Office of the Courts, Education Division/Center for Judicial Education and Research.
- California State Auditor (2014), Updated Assessment of High-Risk Issues the State and Select State Agencies Face. Retrieved from <http://www.bsa.ca.gov/pdfs/reports/2013-601.pdf>
- Disability Rights California, *Forensic Mental Health Legal Issues* (2009). Retrieved from <http://www.disabilityrightsca.org/pubs/507701.pdf>
- Forensic Mental Health Association Conference (2013), Jail-Based Competency Restoration, Findings from Liberty Healthcare's 2-year Restoration of Competency (ROC) Pilot Program. Retrieved from <http://www.fmhac.net/Assets/Documents/2013/Handouts/Rice.pdf>
- Harris, A., & Lurigio, A. J. (2007). Mental illness and violence: A brief review of research and assessment strategies. *Aggression and Violent Behavior*, 12, 542-551. doi:10.1016/j.avb.2007.02.008
- Judicial Council of California, Administrative Office of the Courts, Report to the Judicial Council Business Meeting December 13, 2013. Retrieved from <http://www.courts.ca.gov/documents/jc-20131213-itemF.pdf>
- Legislative Analyst's Office (January 2013), *An Alternative Approach: Treating the Incompetent to Stand Trial*. Retrieved from <http://www.lao.ca.gov/reports/2012/hlth/ist/incompetent-stand-trial-010312.aspx>
- National Association of Mental Health Program Directors Forensic Division Annual Meeting in 2009, *Community Based Competency Restoration*

Programs. Retrieved from

<http://www.nasmhpd.org/Meetings/presentations/Forensic2009/Community%20ofitness%20NASMHPD%202009.pdf>

National Judicial College, *Mental Competency Best Practices Model VI Competency Restoration*. Retrieved from

<http://www.mentalcompetency.org/model/model-sec-VI.html#VIA.>)

Scott, C. L., & Resnick, P. J. (2006). Violence risk assessment in persons with mental illness. *Aggression and Violent Behavior*, 11, 598-611. doi: 10.1016/j.avb.2005.12.003

Washington State Institute for Public Policy (2007), *Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods*. Retrieved from

http://www.wsipp.wa.gov/ReportFile/1121/Wsipp_Standardizing-Protocols-for-Treatment-to-Restore-Competency-to-Stand-Trial-Interventions-and-Clinically-Appropriate-Time-Periods_Full-Report.pdf

We want to hear from you! After reading this report please take this short survey and give us your feedback.

English version: <http://fs12.formsite.com/disabilityrightsca/form54/index.html>

Disability Rights California is funded by a variety of sources, for a complete list of funders, go to <http://www.disabilityrightsca.org/Documents/ListofGrantsAndContracts.html>.

The California Mental Health Services Authority (CaMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families and communities. Prevention and Early Intervention programs implemented by CaMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

