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REVIEW ARTICLE

An overview of jail-based competency restoration

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Forensic populations in the United States are increasing, driven largely by a rise in individuals determined to be Incompetent to Stand Trial (IST). Across most states, including California, the number of mentally ill inmates awaiting competency restoration has increased dramatically in recent years. Traditionally, competency restoration has taken place in state hospitals, but incompetent inmates often experience a significant wait for state hospital beds because of the rising demand for beds in such facilities. The resulting waitlists, which range from days to months, have led to states being held in contempt of court for violating limits placed on how long incompetent defendants can be held in jail. Therefore, alternatives to state hospitalization for IST patients have been developed, including jail-based competency (JBCT) restoration programs. JBCT programs provide restoration services in county jails, rather than in psychiatric hospitals. The following article will review the nature of JBCT programs and will emphasize the structure and evolution of such programs within California.

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Introduction

Forensic populations in the United States are increasing, driven largely by a rise in individuals determined to be Incompetent to Stand Trial (IST).[1] According to the California Department of State Hospitals' 2017 Annual Report, the most common type of commitment (22% of all commitments) was defendants adjudicated IST.[2] While just 5 years ago, 343 mentally ill inmates were awaiting placement for competency restoration services, as of 2018, that number has increased to a staggering 819.[3] As defined by the *Dusky v. United States* (1960)[4] standard, a competent defendant must have the capacity to understand the legal proceedings, which includes an understanding of the various participants in the justice process. Defendants must also be able to function within the legal system by consulting with their attorneys. Competency restoration is the process used when an individual charged with a crime is found by a court to be IST. Incompetency to stand trial is generally the result of an active mental illness and/or intellectual disability. A criminal defendant must be restored to competency before the legal process can proceed. State mental hospitals have historically served as the primary source of competency restoration treatment for defendants.

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An estimated 60 000 competency evaluations are performed across the United States each year with at least one-fifth of these defendants being adjudicated incompetent.[5] This volume of incompetent defendants occupies a substantial portion of state hospital beds, contributing to an increase in forensic admissions to state hospitals, which increased from 7.6% in 1983 to 36% in 2012.[6] In a 2017 report from the National Association of State Mental Health Program Directors, a 76% increase in forensic patients in state hospitals occurred between 1999 and 2014.[1(p 8)]

In California, state hospitals maintain about 6200 beds, and more than 90% of these beds are occupied by individuals from the criminal justice system. Just a few decades ago, under 50% of patients in state hospitals had come from the criminal justice system. Despite California's recent addition of 700 beds dedicated to competency restoration, still more than 20% of beds occupied by forensic patients are filled with defendants found IST.[2(p 3)]

Defendants in need of competency restoration services are often held in jail, awaiting admission to a state hospital. The resulting waitlists, which range from days to months, have led to states being held in contempt of court for violating limits placed on how long incompetent defendants can be held in jail. For example, the United States District Court of Washington case of *Trueblood, et al v. Washington State Department of Health and Human*

Services et al[7] (2015) found that it is a violation of due process for defendants adjudicated incompetent to be held in jail for longer than 7 days awaiting competency restoration services. In California, a recent Superior Court order in the case of *Stiavetti, et al v. Ahlin, et al*[8] (2016) imposed a 28-day limit to the time a defendant can await competency restoration services, and this trend in litigation can be seen throughout the United States as jails are filling with patients awaiting state hospital admissions (Warburton et al,[9] in press). As such, alternatives to state hospitalization for IST patients have been developed, including community-based restoration programs, and jail-based competency (JBCT) restoration programs. JBCT programs provide restoration services in county jails, rather than in psychiatric hospitals. If JBCT treatment is successful, a defendant may bypass a stay at the state hospital, resulting in an expedited resolution of the legal proceedings.

JBCT Programs in the United States

The first JBCT program was piloted in Prince George County, VA in 1997.[10] This program is held at Riverside Regional Jail in a converted unit where 48 cells were adapted into 38 patient rooms and 10 offices for mental health providers. The program is run by Liberty Healthcare (in independent contractor), and, in 5 years, they have reportedly evaluated and treated "over 1400 inmate-patients and completed 572 formal forensic evaluation reports for the courts."[11]

Over the last 2 decades, additional states have developed JBCT programs. JBCT programs are now established in Colorado, California, Georgia, Texas, Arizona, Florida, Tennessee, and Louisiana (Ref. 10, p 1). The characteristics of JBCT programs vary significantly in terms of size, selection criteria, physical layout, and availability of mental health services.

JBCT Programs in California

California Penal Code (PC) §1369.1[12] permits the restoration of IST defendants to competency in county jails for a period not to exceed 6 months. California's[13] JBCT restoration first began in San Bernardino County in 2011 and has expanded to multiple programs across the state with a total of 324 beds.

Total admission for 2018 was 1289 defendants that were 72% male and 18% female. Average lengths of stays ranged from 57 to 82 days with average days to restore competency ranging from 41 to 66 days. Of the 1191 defendants discharged from the programs, 748 were evaluated as restored to competency and 10 were evaluated as unlikely to be restored. The remaining 433 defendants were not successfully restored by the JBCT program and were transferred to the state hospital for additional restoration services. The rate of competency restoration of discharged patients from individual California JBCT programs ranges from 52% to 86%.

Selection Criteria

An important consideration when assessing the efficacy of a JBCT program is the spectrum of patients the program is able to treat. Given that these programs are new, guidance in the scientific literature on the selection criteria for JBCT programs is lacking. Using characteristics identified in the literature as predictors of those defendants less likely to be restored may serve as a starting point in developing a set of selection criteria for JBCT programs. In 1992, Carbonell et al examined 152 hospitalized incompetent defendants and determined that both clinical and demographic variables were poor predictors of restorability.[14] That same year, however, Golding suggested that premorbid functioning, negative symptoms, insidious onset, prior psychiatric history, and a history of response to treatment were the best predictors of restoration of competence.[15] More recently in 2007, Mossman reviewed the records of over 350 defendants hospitalized for competency restoration and found that a lower probability of restoration was associated with older age, misdemeanor charges, and longer stays.[16] In general, older individuals with longstanding, treatment-refractory, severe mental illness or mental retardation as opposed to those with personality and nonpsychotic disorders are less likely to be restored.[17,18]

JBCT programs in California have evolved in terms of the patients that they accept. When the first programs were conceived in 2007 and 2008, the goal was to accept defendants that were expected to rapidly respond to treatment in hopes of quickly and effectively treating this subset of IST defendants. This led to JBCT programs selecting younger defendants that were treatment-naive and resulted in underutilization of available beds. Thus, programs began to accept defendants expected to require an intermediate term of restoration services. These defendants had earlier-onset mental illness and more significant levels of criminal involvement in the form of repeated visits to jail. An estimated 40% of such defendants ultimately went to state hospitals, but over half were successfully treated within the jail setting.

A 2011 study by Carbonell et al[19] of 71 male defendants ordered to undergo restoration, found that those who went more days before medications were initiated were more likely to be found nonrestorable. Recently, JBCT programs began to accept more complicated defendants with multiple incarcerations, longstanding mental illness, co-occurring substance use disorders, psychotic violence, and a history of poor treatment compliance. These defendants often have failed multiple medications or have refractory symptoms. California program administrators expected these defendants to require a longer duration of restoration

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services, likely necessitating transfer to state hospitals. However, the rationale was that beginning treatment sooner may decrease the length of stay once transferred. Further investigation is needed to determine if treatment in a JBCT program decreases the length of hospitalization for this population.

Certain populations are still difficult to accommodate in California's JBCT programs. For example, defendants with gang affiliations that may limit appropriate housing or their ability to program with peers could be excluded from JBCT. Language barriers may also limit the ability of a JBCT program to accommodate certain defendants. Additionally, individuals with major medical issues that cannot be adequately treated in a jail-based setting, such as those requiring frequent dialysis, can often lack needed accommodations by the JBCT programs. JBCT programs are also frequently unable to provide the necessary level of care to defendants with neurocognitive disorders. However, a brief period of evaluation and treatment in the JBCT setting may allow evaluators to identify these defendants as unlikely to be restored, avoiding an unnecessary attempt to restore competency at the state hospital.

Colorado's Restoring Individuals Safely and Effectively (RISE) program at Arapahoe County Detention Center is an example of a JBCT program that uses specific criteria for identifying appropriate defendants. RISE only accepts defendants that are not an imminent danger to themselves or others; are likely to be restored in 60 days or less; and are medication and treatment compliant. Additionally, candidates must be motivated, medically stable, and able to engage in self-care. Over an approximately 30-month period ending in May of 2016, RISE discharged 221 defendants, restoring 158 (71%) to competence and transferring 43 (19%) to a state hospital facility. RISE's selection criteria are like those used in earlier iterations of California JBCT programs.[20]

Examining the effects of selection criteria on JBCT outcomes requires further study. Evidence-based selection criteria for JBCT program participants may help identify the most efficient use of the various settings where competency restoration services are administered (ie, inpatient, outpatient, and in county jails). In the absence of selection criteria, JBCT programs may need to adjust their designs to accommodate the most acutely ill patients, who have historically required restoration services in a state hospital.

Medication and Medication Compliance

The issue of involuntarily medicating IST defendants is complex, especially outside of an inpatient psychiatric hospital setting. Most relevant to the issue of involuntarily medicating incompetent defendants is *Sell v. United States* (2003).[21] In this case, the Supreme Court of the United States found that medications may be involuntarily administered solely to restore competency when an important state interest is at stake and medication can further that interest by restoring the defendant to competency. Additionally, there can be no less restrictive treatment alternative available. If the Sell criteria are met, a Judge may order that a defendant be involuntarily medicated for the purpose of competency restoration. However, even with a Sell order in place, the medication must still be administered. The Sell criteria need only to be applied when an inmate is not dangerous or gravely disabled. For those inmates that are dangerous or gravely disabled, the Supreme Court of the United States case of *Washington v. Harper* (1990)[22] allows for the involuntary medication of these inmates after administrative review.

In California, "If the defendant is examined by a psychiatrist and the psychiatrist forms an opinion as to whether or not treatment with antipsychotic medication is medically appropriate, the psychiatrist shall inform the court of his or her opinions as to the likely or potential side effects of the medication, the expected efficacy of the medication, possible alternative treatments, and whether it is medically appropriate to administer antipsychotic medication in the county jail," pursuant to PC 1369(a).[23] When identifying those defendants appropriate for involuntary treatment, PC 1370(a)(2)(B)(ii)(II)[24] does not specify that an important state interest be at stake (as is specified in the Sell criteria), but does require the defendant be charged with a "[s]erious crime against property or person…"

While statutes provide mechanisms for the involuntary administration of medication to JBCT clients, whether involuntary medication is actually administered is facility dependent. In general, medication administration is managed by correctional mental health providers who, as a matter of facility policy, do not involuntarily medicate inmates that are outside of an inpatient psychiatric hospital setting. However, select programs do have dedicated program nurses that administer the medication for JBCT participants.

Fortunately, medication refusals are uncommon in JBCT programs. In California, program administrators estimate that medication compliance is greater than 85%. Voluntary medication administration is emphasized in JBCT programs and various modalities are employed to improve compliance. Defendants are extensively educated on the importance of medication in resolving their symptoms. Additionally, reward systems that incentivize medication compliance may also be permitted. Such incentives can range from access to preferred foods or recreational items to access to additional services or visitation privileges.

While California JBCT programs have not excluded patients that are noncompliant with medications, other states make voluntariness a requirement for admission. For example, Colorado's RISE program lists medication compliance as a selection criterion for participants. In her 2016 National Alliance on Mental Illness (NAMI)

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presentation, Dr. Galin noted 99% medication compliance for RISE participants (Ref. 20, p 16).

In 2013, Dr. Patricia Zapf,[25] a national expert in the field of competency restoration wrote, "The available research and commentary suggests that successful restoration is related to how well the defendant responds to psychotropic medications administered to alleviate symptoms of mental disorders." Attempts to restore most defendants to competency without medications are a futile approach. Thus, if involuntary medications are not consistently administered to JBCT participants, these untreated individuals are at risk of deteriorating and are unlikely to be restored in this setting. At the time of the submission of this manuscript, program-specific data on involuntary medication administration were not available.

Program Staffing

Each California JBCT program has staff that are distinct from that of the jail's psychiatry service. Programs have at least one psychiatrist available to treat JBCT defendants. While participants have daily contact with mental health professionals, psychiatric encounters for medication adjustments generally occur weekly. The amount of time the psychiatrist is available to JBCT defendants varies based on the program size. Emergencies that occur after hours are managed by the jail psychiatrist on call. Jail medical staff manage medical issues.

In addition to psychiatrists, all programs employ psychologists, social workers, and a program director. Ratios of staff to defendants are established upon program inception based on anticipated participants. Recreational therapists and behavioral health technicians may also be employed by larger programs. Social workers run most of the daily programming. Social workers also develop individualized treatment plans but do not conduct individual therapy. Psychologists perform initial and follow-up assessments and are responsible for submitting progress reports to the court.

Texas uses a similar staffing model, which includes at least one psychiatrist and a multidisciplinary team. Texas' policies for county JBCT programs are outlined in a section of their Administrative Code adopted in August, 2018. Texas emphasizes providing services like those available in an inpatient mental health facility, specifically prescribing similar staffing requirements and hours of restoration services.[26] Additionally, Texas requires the programs to be supported by a "specially trained jailer."[27] Overall, Texas' average ratio of staff to defendants is not to fall below 3.7 to 1.[28]

Colorado's RISE program also makes use of a multidisciplinary team but has added a peer support model approach. Experienced peers help minimize limitations in terms of staff time and materials. Peer support specialists may also enhance the therapeutic milieu by developing trust with defendants participating in the program. Peers are thought to have a unique appreciation of the circumstances in which other defendants find themselves and can, in theory, provide guidance in overcoming barriers to competence by acting as role models and advocating for other patients. Additionally, Colorado's RISE program makes use of a re-entry specialist who facilitates the return of an individual to the general jail population with the goal of reducing both rates of regression and the need for a second course of competency restoration (Ref. 20, pp 19-22).

Physical Layout

There are significant differences in the ways that individual JBCT programs house participants. Ideally, defendants undergoing competency restoration are housed separate from the general population. In her 2011 commentary on JBCT restoration, Dr. Kapoor[29] identifies several difficulties inherent to correctional facilities that include: "lock-downs, lack of an officer for transport, 'count' time, shift change, and meals." Dr. Kapoor also notes the potential for incompetent inmates to be victimized by their competent peers. Many of these problems are addressed by separating JBCT program participants from other inmates.

California's JBCT programs are generally housed in a single pod with similar accommodations to those living spaces for the general population. Open cells with yard access are important. Efforts are made to allow defendants to move more freely and attend groups in a more comfortable setting than that of the standard common areas in jail. Large communal areas outside of the cells that are aesthetically discernible from standard jail housing units are ideal. Additionally, an effective JBCT environment is free of loud noises and distractions that are typical of other housing units.

Programs are encouraged to create an environment that feels like a treatment center to enhance the milieu. For example, in some counties, features of the JBCT environment include couches and carpeting. Recruiting custody officers that are amenable to a more relaxed environment and that can have positive interactions with program participants is also desirable. Having access to single cells is critical in order to accommodate more acute or mentally ill participants. If single occupancy cells are not available, unstable defendants may still require their own space, resulting in inefficiencies as one defendant will solely occupy a cell with two beds.

Smaller counties in California have few pretrial defendants requiring restoration. JBCT programs in these counties are currently being developed, but their design is necessarily different. With one to five total participants at any given time, having a dedicated pod is impractical. Therefore, the milieu environment and peer interaction available to JBCT participants in larger county facilities

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is limited. Competency restoration specialists schedule visits with these defendants on a regular basis, and psychiatrists are hired for a limited time each week to address medication needs. Given that these smaller county models are in their infancy, the outcomes of these programs and how they will evolve remain uncertain.

Length of Stay

A primary goal of JBCT programs is to more efficiently restore defendants to competency. Rapid competency restoration allows programs to accommodate more defendants and ensures defendants a speedy trial. California program administrators report that historically programs are asked to consider state hospital transfer if a defendant continues to require restoration services after 100 days. As a defendant approaches 100 days, programs evaluate the case closely to determine an appropriate disposition. An emphasis is placed on receiving input from the treatment team to determine the value of additional days of JBCT versus transfer to a state hospital. Recent medication changes and progress may suggest that a transfer is unnecessary. Therefore, it is possible for a defendant to remain in the program for several weeks beyond the 100-day mark. Thus, program administrators do not place hard limits on the duration of JBCT services, empowering individual programs and treatment teams to make decisions on a case-by-case basis.

The average length of stay for California JBCT participants in 2018 was about 69 days. However, the average time to restore patients was only about 52 days. Statewide JBCT administrators identify programs that strictly focus on achieving competency and closely monitor each defendant's progress with routine re-evaluation as characteristics resulting in shorter lengths of stay. Determining what accounts for the period between when defendants are restored to competency and when they are discharged from the JBCT program is an area that requires further investigation.

The average length of stay for California JBCT programs seems consistent with other programs that publish these data. For example, in 2016, Colorado's RISE program reported an average length of stay for restored defendants as 55 days with 76% of defendants restored in less than 60-days and 90% restored in less than 90 days (Ref. 20, p 16). While average lengths of stay for Texas were not available, their Administrative Code, Rule §416.89, mandates that if a defendant charged with a felony is not restored to competency after 60-days, "the psychiatrist or psychologist must coordinate with provider staff members to link the individual for continued services and supports post discharge from the jail-based competency restoration (JBCR) program to a mental health facility or residential care facility."[30] In a 2010 Request for Information, Louisiana reported that the state maintains a 90-day JBCT program.

Head-to-head studies of competency restoration programs in jails and psychiatric/state hospitals are insufficient to find one environment definitively more efficient than the other. However, in general, JBCT program administrators report an ability to restore defendants to competence as quickly as hospital programs. JBCT programs may allow the restoration process to start sooner and decrease the amount of time IST defendants idle in jail awaiting transfer.

Potential Cost Savings

In their comparison of competency restoration in different treatment environments, Danzer et al[31] noted that the cost for competency restoration in state hospitals ranged from $300 to $1000 per day while the cost of competency restoration services in jail ranged from $42 to $222 per day. Although similar efficacy is reported in both treatment environments, because of strict selection criteria in some JBCT programs further comparisons of efficacy are necessary to control for the severity of symptoms, as the most mentally ill IST defendants, and those least likely to be restored, are treated in hospitals. This logical trend may artificially increase the relative efficacy of JBCT programs when compared to hospitals.

Lessons Learned in California

Interviews with program administrators identified the most important take-away lesson is the importance of county government. Trust must be developed. Consistency and follow-through on the part of the JBCT programs are essential. Additionally, many stakeholders may initially oppose JBCT programs. However, opposition may be mitigated by incorporating reputable treatment providers with positive track records in the county that the program will serve.

Conclusion

JBCT is one strategy that states are employing to address the challenges posed by increasing numbers of IST defendants in need of competency restoration services. Potential advantages of JBCT include more rapid access to treatment, decreased costs, and less incentive to malinger (Ref. 31, pp 7, 8). Potential disadvantages include treating IST defendants in a custodial environment, variability in the ability of JBCT program staff to provide involuntary medication despite an involuntary medication order being in place, and, particularly in smaller programs or those with limited staffing, a lack of separation between evaluators and treaters (Ref. 30, p. 311).

Initial outcomes regarding cost savings, efficiency, and efficacy of JBCT programs seem promising, especially in light of the lengthy waitlists for state hospitals due to increasing referrals. However, various questions

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arise as states consider JBCT programs. Is a JBCT program appropriate for all IST defendants or only those with less-severe mental illness that have a higher probability of rapid restoration? Are jails equipped to treat IST defendants involuntarily, and, if not, should treatment refusal exclude a defendant from participating in a JBCT program? Additional quantitative research is necessary to solidify the role of JBCT services in addressing the increasing burden of IST defendants.

Disclaimer

The findings and conclusions in this article are those of the authors and do not represent the views or opinions of the California Department of State Hospitals or the California Health and Human Services Agency.

Disclosures

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