Disability Rights California
California's protection & advocacy system

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DRC Recommendations
Incompetent to Stand Trial

Disability Rights California is the agency mandated under federal law to protect and advocate for the rights of Californians with disabilities. In addition to this federally required service, we provide the clients' rights advocates at the 21 regional centers and patients' rights advocates at each of the five state psychiatric hospitals.

We appreciate the Health and Human Services Agency analysis of challenges faced with the increasing number of individuals found Incompetent to Stand Trial (IST). We have the following comments and recommendations.

Recommendations for Increasing Competency Based Programs Not Addressed in the Administration's Proposal

1. **Increase Community-Based Competency Programs**

We are concerned that the Administration's recommendations generally speak only to increasing capacity in institutional settings. Consistent with competency restoration programs in other states, it is important to increase community capacity to provide competency program. We note that the Department of Developmental Services (DDS) has the authority to develop small (6-15 bed) community based secure perimeter homes with 50 of the 150 beds for targeted for regional center consumers "who are placed and participating in forensic competency training pursuant to Section 1370.1 of the Penal Code." We are not aware of similar development efforts for individuals with mental health disabilities, and as a result, too often the only community option is an Institute for Mental Disease (IMD) or Psychiatric

Health Facilities (PHF). In addition to the secure perimeter homes, it is also important to develop other community options and services similar to those used in other states including the development of step-down options, and use of other small community-based homes including supported living. Attached is a summary of best practice recommendations.

Other states also have robust outpatient competency programs. We believe that California should explore the feasibility of additional outpatient competency programs, perhaps using the services provided by the ConRep Program as a way of addressing any public safety concern.

2. **Increase Community Based Options for Individuals Whose Competency Can Not Be Restored**

The proposal does not appear to address non-institutional services for individuals when it is determined that an individual's competency cannot be restored. We note, that DDS has the authority to develop another 100 secure perimeter beds for individuals not part of a forensic competency program and the capacity to develop Enhanced Behavioral Homes for individuals who have challenging behaviors. We are not aware of efforts to develop similar living options for individuals who have mental health challenges. As a result, there few placement options for mental health consumers whose competency cannot be restored. Often they are returned to jail and then to a state hospital under a Murphy or Lanterman Petris Short (LPS) Conservatorship.

3. **Increase Overall State Hospital Capacity by Expanding the Use of the ConRep Program for Individuals No Longer Needing State Hospital Services**

California Conditional Release Program provides one of the means by which state hospital residents can return to the community. However, that program is capped to 600 individuals and the number of individuals served by that program has not significantly changed overtime even with the increase in the number of state hospital residents and the number of individuals referred to state institutions for competency-based training. Increasing capacity in that program would allow more individuals to be discharged thus freeing up bed capacity for individuals who require competency services in state hospitals. The current ConRep program does not serve regional center consumers and we encourage consideration of a similar program as a means of expanding

outpatient competency programs for individuals with intellectual and other developmental disabilities.

4. **Implement the Remaining Judicial Council Recommendations to Increase Judicial Discretion for Competency Restoration Programs**

We support changing current law to allow individuals to receive competency services in the community rather than custodial or inpatient settings when the alternative placement would provide more appropriate treatment. As recommended by the Judicial Council, we support amending Penal Code Section 1601 to expand the court's discretion to include an outpatient placement program without the necessity of institutional confinement when the court determines the placement provides more appropriate mental health treatment and does not pose a danger to the health and safety of others. See Judicial Council of California December 13, 2013 Report.

5. **Require Better Coordination between Agencies to Avoid Placement of Regional Center Consumers in State Hospital Competency Programs**

We are concerned with the apparent increase in the number of regional center consumers are placed in state hospitals where it is more difficult to provide appropriate treatment including competency based programs. Generally, the competence programs at state hospitals are not sufficiently tailored to the needs of individuals with intellectual disabilities. In our experience, the individuals with developmental disabilities placed at state hospitals records do not reflect that they are a regional center consumer, suggesting a lack of coordination between regional center, courts, and state hospitals.

Comments to the Administration's Options

1. **Patient Management Unit for IST Competency Defendants in Jail Based Competency Programs**

We do not support providing the Department of State Hospitals (DHS) with unilateral authority to make placement decisions, for two reasons: 1) We think the court should have the discretion to make the appropriate treatment decision and that the defendant's counsel should have the ability to advocate for the appropriate placement; and, 2) We have concerns about Jail-Based Competency Treatment due to our monitoring visits at county jails

concerning improper and inadequate mental health treatments, including treatment in specially designated mental health units.

In addition, at least one court has determined that individuals who are regional center clients cannot receive competence services in jails. Additionally, given our concerns about regional center consumers being placed at DSH facilities, we are concerned that this could increase the number of regional center consumers receiving services in jail-based programs. If regional center consumers are placed at state hospitals, we request that the clients' rights advocate for the regional center be notified of that placement.

2. **We Support a Reduction in the IST Maximum Term Provided There is Appropriate Discharge Planning and Increased Options for Community-Based Services for Individuals Who Are Not Restored to Competency**

Unfortunately, for individuals with mental health disabilities, whose competency is not restored, they too often are returned to jail, where they do not receive appropriate mental health treatment and ultimately are returned to state hospitals under a Murphy Conservatorship.

Of note, is the progress DDS has made in reducing the waiting list for admission to the secure treatment program at Porterville Developmental Center. We believe, in part, is due to rapid determinations about whether the individual's competence can be restored. If the individual's competency is not restored, this generally results in a WIC 6500 commitment and the identification of appropriate community based services.

3. **Improve Alienist IST Evaluation Report Accuracy**

We support, in concept, additional training standards for professionals to perform competency evaluations. It would be helpful to better understand the training standards. We suggest that regional center staff be involved in any evaluation of a regional center consumer.

4. **Joint Use Facility**

We look forward to receiving additional information about this proposal. If this is a correctional treatment facility, it is not clear how the costs would be less. To the extent that this allows for the development of small community-based programs similar to some of the DDS initiatives, we support that effort.

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MEMORANDUM

TO: Anne Hadreas, Rebecca Cervenak

FROM: Jeanette Hawn

RE: Positive Features of Community-Based Competency Restoration Programs Outside CA

DATE: July 21, 2016

In preparation for a meeting of the IST Workgroup on July 22, 2016, a brief review of a few community-based competency restoration programs (also referred to as outpatient competency restoration programs) in other states has been conducted to identify features that a California community-based competency restoration program may include. According to a 2015 article in the World Journal of Psychiatry, 35 states have specific statutes allowing for outpatient community restoration but only 16 states have functioning programs. Nicole R. Johnson, et al., *Outpatient Competence Restoration: A Model and Outcomes*, 5 WORLD J. PSYCHIATRY 2 (July 22, 2015), at 229, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4473494/pdf/WJP-5-228.pdf. Wisconsin's program restored 75% of the 121 individuals served in the period studied (2012-2013), making it one of the most successful programs in the nation. *Id.* More states are adopting and expanding such programs because they provide treatment in less restrictive environments and are less costly than inpatient programs. *Id.* at 230.

Specific information about how these programs are run is not readily available on the internet but there appear to be more detailed reviews of these programs in private forensic psychiatry and psychology journals that may aid with future research on this subject. A brief summary of some positive features of these community-based competency restoration programs can be found below followed by notes regarding the characteristics of the programs reviewed.

I. Summary of Positive Features of Community-Based Competency Restoration Programs

1. Starting point is placement in the community for restoration to competency, unless the court specifically finds inpatient hospital treatment is required
2. Step-down to less restrictive placement in community
3. Utilization of local specialized mental health service providers with oversight and funding provided by the appropriate state mental health agency
4. Dedicated entity to monitor compliance with contract requirements, laws, and regulations
5. Specialized and highly trained/experienced professionals on staff
    a. Director/Commissioner of overseeing agency, pursuant to statute, approves the training and qualifications of professionals involved in the evaluation and treatment of committed individuals
    b. "Boundary Spanner" – staff that bridges MH, criminal justice, and substance abuse systems and manages cross-system staff interactions
    c. Cross-trainer case managers – with adequate knowledge and experience in mental health and criminal justice systems
    d. "Peer-specialists" to provide peer support
6. Doctor (preferably psychiatrist) and/or committing judge meets with and/or reviews the individual's status every 3 months and 30 days before expiration of commitment period
7. Ability to arrange competency evaluation and notify court of restoration of competency, or determination that an individual is likely to remain incompetence for the foreseeable future, at any time after the initiation of restoration services
8. Review of treatment plan by committee comprised of representatives from the overseeing agency, mental health service provider, competency restoration program, state attorney's office

9. Coordination between competency restoration program and jail or court to ensure daytime release of individual and/or "warm hand-off"
    a. Provide care within 24 hours of release from jail or court. Provide access to a physician, preferably a psychiatrist, no later than 7 working days after release
    b. Provide prompt access to legal education using approved curricula based on individual needs
10. Thorough screening process to identify (1) Mental illness; (2) Social issues; (2) substance abuse issues; (3) risk of violence to self or others
11. Individualized treatment plan based on individual's deficiencies and provision of comprehensive services necessary to stabilize the individual and maximize their success including: access to medications, housing, transportation, structured activities, Social Security, Medicaid, counseling, work rehabilitation, support groups, substance abuse treatment
    a. Face-to-face services multiple times per week
    b. More frequent and shorter meetings if necessary due to individual's needs
12. Uniform manual for assessments and guidance in treatment
13. Regular assessments and reporting:
    a. Primary restoration contact completes weekly progress records and notes continuing problem areas and completes monthly progress records and project training goals for next three months (or less frequently for certain charges)
    b. Regular reports to committing court
14. Discharge planning to ensure continuity of care including a plan to: (1) maintain housing and utilities for at least three months post discharge; (2) facilitate ongoing services in the appropriate local service provider; (3) provide medication and follow-up psychiatrist appointment to ensure no lapse in medication compliance after discharge; (4) complete all appropriate benefits applications, including signing up for long-term subsidized housing
15. For those not restored or determined to be incapable of restoration, the competency restoration program works closely with the court to encourage timely resolution of legal issues and minimize jail time spent waiting for hearing

Notes Regarding the Programs Reviewed:

I. PROGRAMS REVIEWED:

- **a.** Florida – Florida's community-based competency restoration programs are truly community-based. The provision of services is decentralized and services are contracted for within each judicial circuit. These programs include: Florida Partners in Crisis (FLPIC) (Circuits 9 & 18) and Miami-Dade Forensic Alternative Center (MD-FAC) (Circuit 11)
- **b.** Wisconsin – Outpatient Competency Restoration Program (OCRP)
- **c.** Virginia – Similar to Florida, local Community Services Boards and Behavioral Health Authorities administer services in their communities
- **d.** Texas – NorthSTAR

II. OVERSIGHT

- **e.** FLPIC – Forensic Screening Committee (FSC) made up of representatives from the Northeast Florida State Hospital Care Coordination Department, DCF Substance Abuse and Mental Health Program Office, and Lakeside Behavioral Health Care; Each circuit has a Forensic Specialist
- **f.** OCRP - Department of Health Services contracts with Behavioral Health Consultants to manage the program but DHS ultimately oversees the program
  - **i.** Doctor and/or judge meets with the individual every three months and 30 days before expiration of commitment according to statute
- **g.** Virginia - VA Dept of Behavioral Health and Developmental Services (DBHDS) oversees (and provides a manual for guidance) Community Services Boards and Behavioral Health Authorities
  - **i. Commissioner of Behavioral Health and Developmental Services approves the training and qualifications of individuals authorized to conduct evaluations and provide restoration services pursuant to statute**
- **h.** Texas – contracts with private provider NorthSTAR pursuant to service contract

III. REFERRAL PROCESS

i. FLPIC

i. Once found incompetent to proceed: (1) Referral to program is completed by defense counsel or community MHP; (2) The forensic/community restoration specialist at Lakeside Behavioral Health Care reviews the information and meets the individual for assessment; (3) The specialist's findings and the referral information are reviewed by the FSC to determine if the individual meets program criteria (reviews every two weeks or more often if necessary, referral source is invited to attend)

j. MD-FAC

i. Once found incompetent to proceed: (1) Mental Health Administrative Office of the Courts (MHAOC) makes referral to Forensic Team (Judge, MH staff from DCF, Bayview, and state attorney's office); (2) Forensic Team assesses the individual and determines whether admittance to the program is appropriate based on eligibility criteria; (3) MD-FAC staff screen the referred person and submit written disposition to MHAOC; (4) Presiding judge is informed of eligibility; (5) Court commits the individual to DCF; (6) Court orders Dept of Corrections to transport the individual to MD-FAC; (7) South Florida Behavioral Health Network (SFBHN) monitors and coordinates admission and provides ongoing monitoring to ensure compliance, provides program technical assistance to ensure compliance with contract requirements and applicable laws and regs, acts as liaison to program

k. OCRP

i. Recommendations for program can be suggested in the competency examiner's report or by the court by completing an Order of Commitment form noting referral to program

ii. (1) Behavioral Health Consultants' review the file (2) a licensed psychologists screens the referred individual (not clear what criteria used) and (3) an environmental assessment is conducted by case management personnel in the individual's residence to ensure general safety and stability of the residence, gather information on community providers and the support system, and review program

expectations and rules related to conduct outside the treatment sessions

iii. Clinical Director reviews and determines whether OCRP is appropriate

IV. ELIGIBILITY CRITERIA

l. FLPIC:

i. Adult

ii. Major Axis I diagnosis – usually schizophrenia, bipolar disorder, schizo-affective disorder

iii. Felony charge (most second or third degree felonies)

iv. Willing to participate in weekly training sessions

v. Excluded: (1) Complex medical conditions (i.e. closed head injuries, dementia); (2) Moderate to severe mental retardation; (3) Extensive violent criminal history

m. MD-FAC:

i. At least 18 years of age

ii. Charged with felony in 11th Judicial Circuit Court

iii. Free of major medical conditions or shall have controlled stable medical conditions as determined by the Southern Region's Medical Exclusionary Guidelines for Crisis Stabilization Units and Stand Alone Receiving Facilities for CSU 2009

iv. Individuals must be continent, ambulatory, or capable of self-transfer

v. Acutely mentally ill and in need of intensive staff supervision, support and assistance as documented in a psychiatric or psychological evaluation

vi. Excluded: previously convicted of, found incompetent to proceed on, found NGI, or currently charged with homicide, domestic battery by strangulation, kidnapping, sexual battery, lewd or lascivious battery/molestation, arson (including fire bombs or explosives), home invasion robbery, aggravated child abuse, aggravated elder abuse, aggravated abuse of a person with a disability, aggravated stalking

V. PROGRESS THROUGH THE PROGRAM

n. MD-FAC: (1) Initial placement in locked inpatient setting to receive crisis stabilization, short-term residential treatment, competency restoration services; (2) Step-down to less restrictive placement in

community (assisted with re-entry and ongoing services); (3) Once competency restored, program prepares treatment summary and recommendation for community placement; (4) Committing court holds hearing to review recommendations and appropriateness of recommendations; (5) If court approves community placement, MD-FAC staff provide assistance with re-entry and monitors individuals

o. Virginia – **(1) restoration to competency treatment is provided in the community unless the court finds inpatient hospital treatment is required** (Code of Virginia § 19.2-169.2)
    i. **At any point after initiation of restoration services, the restoration provider believes the individual (1) has been restored to competence or (2) is likely to remain incompetent for the foreseeable future, the restoration trainer should notify the treating organization's director so that a follow-up competency evaluation can be arranged**
p. Texas – **Ensure daytime release to NorthSTAR provider and avoid nighttime release of IST individuals**

VI. INTEGRATED AND COMPREHENSIVE SERVICES

q. FLPIC – Funded by the Department of Children and Families (DCF), community mental health providers provide mental health treatment services
    i. Types: All necessary to stabilize symptoms and maximize success including medications, housing, Social Security, Medicaid, counseling, work rehab, support groups, substance abuse treatment
r. MD-FAC Specially Trained Staff
    i. "Boundary Spanner" – staff that bridges MH, criminal justice, and substance abuse systems and manages cross-system staff interactions
    ii. Cross-trainer case managers – with adequate knowledge and experience in mental health and criminal justice systems
    iii. Participants are linked with supportive housing
    iv. "Peer-specialists" to provide peer support
    v. Individual plan of active treatment containing clinical evidence of therapeutic goals to be met before the individual can be moved to a less-restrictive level of care
    vi. Integrated dual-diagnosis treatment

vii. Assistance securing employment
viii. Cognitive Behavioral Interventions – targeting risk factors for recidivism

s. OCRP – Treatment team consists of Supervisors, Clinical Program Director, Behavioral Specialist, and Case Manager
   i. Total of approximately four individual treatment session per week
   ii. Behavioral Specialists sessions 2/week for one hour sessions
   iii. Case Management 1/week in the home
   iv. Regular reports to the court

t. Virginia
   i. Uniform initial assessment form and uniform restoration training components to be presented to individual (i.e. purposes of restoration training, legal rights, review of charges/consequences/evidence, pleas, court system, defense attorney, etc)
   ii. Uniform materials to assess competency restoration
   iii. Treatment tailored to specific deficits of individual
      1. Restoration plan based on individual's factual understanding and rational understanding of legal issues and proceedings, ability to communicate, source of deficits (cognitive, symptoms of mental illness, impaired attention or concentration, affective issues, motivation issues)
         a. Restoration sessions; psychiatric evaluations; supportive counseling; medication monitoring; encourage involvement in structured activities; refer to case management for housing, transportation, benefits, etc.; individual/group psychotherapy;
      2. Restoration sessions at least once per week 45-60 minutes
         a. More frequent and shorter sessions as necessary (i.e. for individuals with cognitive impairments)
   iv. Restoration trainer to complete weekly progress records and note continuing problem areas

v. Restoration trainer to complete monthly progress records and project training goals for next three months (or less frequently for certain charges)
vi. Restoration trainer to provide organization's director with status update 30 days before expiration of commitment
vii. VA Dept of Behavioral Health and Developmental Services Forensic Office staff and forensic coordinators at state hospital are available for consultation with treating organization staff

u. Texas
i. Comprehensive screening in addition to eligibility and intake assessments – (1) Psychosocial assessment, (2) substance abuse screening, (3) risk assessment
ii. Provide referral and access to substance abuse treatment within 21 days of identifying a substance abuse issue
iii. Treatment plan shall address: (1) Physical health concerns/issues; (2) Medication and medication management; (3) Family and community support; (4) Co-occurring psychiatric and substance use disorder concerns or issues; (5) supported housing, including rental/utility subsidy; (6) transportation; and (7) assistance with benefits applications
iv. Provide care within 24 hours of release from jail or court. Provide access to a physician, preferably a psychiatrist, no later than 7 working days after release.
v. Provide prompt access to legal education using approved curricula based on individual needs
vi. Face-to-face services at least twice weekly
vii. Provide report to court no later than the 15th day before the date on which the commitment is to expire
viii. Promptly notify the court when the provider believes the individual has attained competency or is not likely to attain competency in the foreseeable future
ix. **Discharge planning to ensure continuity of care** – (1) discharge planning shall ensure there is a plan for maintaining housing and utilities for at least three months post discharge; (2) facilitate ongoing services in the appropriate local service provider; (3) provide medication and follow-up psychiatrist appointment to ensure no lapse in medication compliance after discharge; (4) complete all

appropriate benefits applications, including signing up for long-term subsidized housing; (5) For those not restored or determined to be incapable of restoration, work closely with the court to encourage timely resolution of legal issues and minimize jail time spent waiting for hearing