Commentary: Jail-Based Competency Restoration

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Many factors influence restoration of competence to stand trial: age, IQ, severity of mental illness, criminal history, treatment history, and others. This commentary poses the question of whether competency to stand trial is also influenced by the setting in which restoration treatment occurs. Jail-based competency-restoration programs, which are in their infancy and have yet to produce large-scale data demonstrating their efficacy, are examined. Several factors related to jail-based restoration are considered: choosing the right candidates for the program, impact of treatment in a punitive setting, ability to maintain separation between treaters and forensic evaluators, procedures for involuntary medication, aggregation of incompetent defendants in regional jails, effect on malingering, and cost savings.

J Am Acad Psychiatry Law 39:311–15, 2011

The findings of Colwell and Gianesini[1] in "Demographic, Criminogenic, and Psychiatric Factors that Predict Competency Restoration" confirm what both common sense and previous studies have suggested—that no one factor predicts an individual's restorability. Competency restoration is instead influenced by many variables, some static (age, IQ, criminal history, previous treatment episodes) and some dynamic (group attendance, medications, observation status). Colwell and Gianesini broke new ground by examining several dynamic factors related to treatment in the hospital setting, and in this commentary, I pose the question of whether the hospital setting itself is an important variable in competency restoration. In other words, can restoration be accomplished successfully in jail?

It is a safe assumption that, given the choice, most defendants would prefer to be restored to competency in a hospital rather than in jail. The hospital usually offers greater freedom of movement for the defendant/patient, an explicitly stated mission of providing treatment rather than punishment, and more access to programs such as group and individual psychotherapy. However, high costs and long wait times for entry into the hospital currently plague many state systems. Although exact costs are difficult to calculate, one Texas study found that inpatient restoration costs an average of $401 per day ($35,689 per defendant), and wait times in local jails ranged from 72 to 180 days.[2] In Wisconsin, restoration in the hospital can cost between $667 and $833 per day ($80,000 and $100,000 per defendant).[3] In Connecticut, data reported in 2000 estimated the cost of a bed at the state forensic hospital to be $834 per day,[4] and it is undoubtedly higher today.

These high costs have led states to examine alternative competency restoration programs, including outpatient and jail-based restoration. In 2009, 35 states had statutes that allowed for outpatient restoration, and 16 states had active programs.[3] A few of these states—Florida, Pennsylvania, Virginia, Tennessee, Arizona, Texas, and Louisiana, and possibly others—have attempted jail-based restoration programs. Though their implementation remains spotty, initial estimates of cost savings from the programs are promising. In Arizona, jail-based restoration is estimated at one-fifth the cost of hospital-based restoration, saving 3.8 million dollars in one county in one year.[5,6] In Texas, savings of approximately 60 percent per defendant were reported from an outpatient restoration pilot program.[2] Even if the cost of incarceration ($42 per day)[7] were added to the $140 per day estimate for outpatient restoration,[2] the potential savings would still be almost 50 percent ($18,564 versus $35,689 per defendant).

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Disclosures of financial or other potential conflicts of interest: None.

Thus, from a fiscal standpoint, the idea of jail-based competency restoration certainly deserves further consideration.

Of course, fiscal concerns are not the only important considerations when examining jail-based competency restoration programs. As physicians, our primary concern must always be the well-being of the patient, regardless of how much money can be saved. Little has been written about the details of jail-based restoration, but a recent article in the *AAPL Newsletter*[6] provides a snapshot of one program at the Pima County Jail in Tucson, AZ:

> Once an individual has been determined incompetent to stand trial, [the psychiatrist] or another member of the team evaluates the individual within 48 hours. Individuals who are found incompetent to stand trial are not housed together in any particular area of the jail. They may be in the general population, administrative segregation, or one of the mental health areas. . .Staff will treat and attempt to restore inmates to competency wherever they are located. Sometimes small groups of inmates can be brought together for education about courtroom proceedings if they are not a security risk [Ref. 6, p 25].

Another program in Louisiana is described as follows:

> The wait time for hospitalization is currently over 100 days. . .While in jail, all [incompetent] defendants receive services from the District Forensic Coordinator (DFC) in that region. Traditionally, approximately 30 percent of [incompetent defendants] have been restored while in jail. The remaining 70 percent have been hospitalized. Of those hospitalized, 60 percent have typically been restored in the hospital within 110 to 120 days of admission. Because of demanding schedules, DFCs usually have time to work with defendants who are in jail on average once or twice per month for competency restoration. The goal is for defendants to receive competency restoration two to three times a week, which would increase the number of individuals who could be restored while in jail, thus removing them from the hospital waiting list [Ref. 8, p 5].

These brief descriptions provide some insight into the practical workings of jail-based restoration. In the remainder of this article, I outline some of the factors that I believe warrant our attention when engaging in the endeavor.

Treatment in a Punitive Setting

It is no secret that prisons and jails have replaced large state psychiatric hospitals as the *de facto* treatment centers for large numbers of mentally ill persons in the United States over the past few decades.[8–12] As a result, much of the work of mental health policy makers in recent years has centered on diverting persons with mental illness away from the criminal justice system through the use of prearraignment diversion programs, mental health courts, substance abuse treatment, and postincarceration support services. The goal has been to end the mass incarceration of persons with mental illness who would be better served by treatment than punishment.

What, then, does it say when we propose jail-based restoration—that is, to detain persons, who are mentally ill and have not been convicted of any crime, in a correctional facility rather than in a hospital? Take the example of the Pima County Jail program, which reports an average length of stay of 82.5 days.[6] We must ask ourselves whether we really want our patients to spend almost three months in a correctional facility for the sake of restoration. Particularly in the case of minor charges, the effect is to prolong incarceration. Although we can argue that receiving psychiatric treatment for competency restoration is in the best interest of the patient, this argument sounds less compelling when the treatment occurs in a correctional facility rather than a hospital.

Separation of Evaluators and Treaters

Many jails have limited mental health staff and tight quarters for patient evaluation. In addition, most county jails are likely to have only a handful of incompetent defendants at any given time. This creates a situation—at least from an efficiency standpoint—in which the jail's existing mental health staff is best suited to serve as the competency restoration team. The staff could simply add a court education group to the medication and therapy services already provided to inmates. An independent evaluator would then inform the court when the defendant has been restored to competency.

While this arrangement may be most efficient, it makes it difficult to maintain a separation between the restoration team and the evaluator who reports to the court. In many cases, the evaluator may be another member of the jail mental health staff. Although this person may not have been directly involved in the defendant's treatment, he may still be influenced by the views of the treatment team, which is made up of his colleagues. One can easily imagine the informal conversations that could occur between treaters and the evaluator, which could, in turn, compromise his objectivity.

One solution to this problem is to hire an evaluator who does not work in the jail to monitor the

progress of restoration. While this could work in theory to solve the problem of bias, in practice, most county jails do not have enough incompetent defendants to merit the hiring of a person whose sole job is to evaluate the progress of restoration. Even if such a person could be hired, over time, he would be likely to become identified with the jail's restoration team from working repeatedly with them and therefore subject to the same potential influence and bias. However, this detriment must be weighed against the potential benefit to the defendant of having an independent clinician provide more intensive evaluation and case consultation than may otherwise be possible in a jail setting.

Choosing the Candidates

What makes an ideal candidate for jail-based restoration? At first glance, we might choose a defendant with less severe mental illness and a bond too high for him to pay. In essence, he would be appropriate for outpatient restoration were he to make bond. This seems like a simple enough analysis, but it does create a scenario in which indigent defendants are preferentially chosen for jail-based restoration, while wealthier defendants are afforded outpatient treatment. By engaging in this type of restoration treatment, mental health professionals could be contributing to the disproportionate incarceration of the poor—or at least not doing anything to stop it. Would our efforts be better concentrated on jail diversion programs or bond reductions for these defendants?

Differences in Setting

Despite recent improvements in mental health treatment, jails are still not the same as hospitals. As the description of the Pima County program illustrates, mental health care in jails is often decentralized, and contact with treatment providers is dependent on transport of inmates by correctional staff. This creates frequent interruptions and barriers to mental health care: lock-downs, lack of an officer for transport, "count" time, shift change, and meals. Furthermore, defendants are housed most commonly in general population units, which are often characterized by a culture of machismo, toughness, gang affiliation, and pecking order—hardly a therapeutic milieu.

The unique characteristics of jails are almost all therapy-inhibiting; it is difficult to identify features of the correctional environment that could enhance competency restoration treatment. For example, would routine contact with competent, nonmentally ill inmates and their legal problems serve as an adjunct to formal courtroom education groups? It seems unlikely. What seems more likely is that incompetent defendants would be targeted and victimized by other inmates. They would also have less direct access to mental health staff who could help them negotiate such problems, as staff may be unaware of the problem or unable to intervene in the traditionally custody-run domain of safety and security. Thus, on balance, the environment of a correctional facility is less desirable as a setting for competency restoration when compared with a hospital.

Regional Jail Model

Rather than keeping incompetent defendants in local county jails, states could create a system in which such defendants are transferred to regional facilities that would serve as hubs for competency restoration treatment. The main advantage of this type of system would be to aggregate competent staff, including correctional officers, in one place to be involved with restoration treatment. With adequate staffing and training, some of the logistical barriers to treatment outlined above could be avoided. Moreover, the jail could more closely mimic the hospital setting.

Some important disadvantages include cost and removing defendants from their home communities. A regional jail devoted to competency restoration would require essentially the same mental health staff that exists in hospital restoration programs, which would result in duplication of resources. It is not clear that states would save money in this case. Furthermore, removing defendants from their local environments could create additional stress on them by diminishing contact with supportive family members, which could ultimately impede competency restoration. This may be less relevant in small states, where distances between jails are relatively short, but it could be a significant factor in large states.

Involuntary Medication

The question of what happens when an incompetent defendant in a jail-based restoration program

refuses psychotropic medication is a complicated one. Two Supreme Court decisions are relevant: *Washington v. Harper*[13] and *Sell v. United States*.[14] *Harper* authorizes the involuntary medication of inmates who are dangerous to themselves or others by use of an internal administrative process. *Sell* outlines the conditions under which medication can be administered involuntarily for the purpose of competence restoration: an important government interest is at stake; medication significantly furthers the state's interest (i.e., is substantially likely to render the defendant competent without undue side effects); alternative, less restrictive treatments are unlikely to achieve the same results; and the medication is in the patient's best interest in light of his medical condition. The court in *Sell* stressed that these criteria should be used rarely, as involuntary medication would more commonly be administered on *Harper* grounds—to control dangerousness—or in cases in which a defendant could not give informed consent.

In *Sell*, the court did not specifically say that the guidelines applied only to incompetent defendants in a hospital setting, although the defendant in that case was confined in a federal forensic psychiatric hospital rather than a correctional facility. It is unclear whether the same standard for involuntary medication would apply in a jail-based restoration program. To my knowledge, this issue has not yet been brought to the attention of the courts. Perhaps existing jail-based restoration programs have avoided the question so far by screening out those patients who would require involuntary medication and instead referring them to hospital-based programs. However, it remains an unanswered question that is likely to arise in the future, as one could easily imagine an incompetent, nondangerous defendant who forces the courts to consider the applicability of the *Sell* criteria in a jail setting.

Impact on Malingering

If a person were restored in jail rather than a hospital, would he be more motivated to demonstrate his competence? Mental health lore in both correctional facilities and forensic hospitals is replete with tales of defendants who feigned incompetence so that they could hide out in the hospital. Jail-based restoration would eliminate the possibility of transfer to a hospital, thereby making restoration to competence the only path toward release from confinement, perhaps leading to a decrease in malingered incompetence over time. At best, this benefit would be small, as most incompetent defendants suffer from serious psychotic and cognitive disorders,[1] but it is nonetheless worth considering.

Conclusion

Many questions about jail-based competency restoration remain, the broadest of which is, should we be doing this at all? The answer is unclear. In an ideal world, psychiatric hospitals would have beds and adequate funding for cutting-edge treatment, and jail-based competency restoration would not even be a consideration. However, in the real world of budget cuts and hospital closures, it is easy to see why some states regard this as a legitimate option. Money is saved, and defendants do not spend months waiting for a hospital bed.

Ultimately, the choice of whether or not to pursue jail-based restoration may rest with the decision maker's belief about the essential aspects of competency restoration. Is the magic of restoration in medication (available in both settings), court education (available in both places), freedom (only in hospital), abstinence from illicit substances (available in both places), or something more mystical like a therapeutic milieu (only in a hospital)? Further study is needed. For now, jail-based restoration offers a compromise between the idealists and the realists. Long-term efficacy and viability of the programs have yet to be determined.

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