# Jail-Based Competency Restoration

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One of the most traditional, longstanding, and essential methods of providing the proper level of psychiatric treatment for severely disturbed jail inmates with serious mental illness has been hospital transfer. Transfer does not necessarily imply diversion from trial, but diversion from jail, at least while the detainee is in need of higher level care. Unfortunately, hospital transfer has become increasingly unavailable. Two responses to the unavailability of hospital care for pretrial detainees have been used as justification for maintaining this deficiency: the development of jail-based competency restoration programs and the acceptance of enforced medication of pretrial detainees in jail. The authors analyze each of these practices as inadequate responses to the state's failure to provide timely pretrial hospitalization to detainees who have a serious mental illness and are in need of this level of service.

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Jails are complicated institutions. Their populations include pretrial, often acutely ill, and very stressed detainees and posttrial offenders convicted of crimes and serving relatively short sentences. Most large jails now have the capacity to provide treatment for some of their inmates who require acute or semiacute psychiatric services, need voluntary medicine management, and have psychiatric problems that are routine in nature. These situations are usually managed while the inmate is in the general population or in a specialized mental health unit within the jail. However, there are situations that go beyond the expertise of most jails and for which involuntary psychiatric hospital level care is needed and should be sought.

Before we focus on the essential role and diminishing availability of hospital care for jailed inmates, we must make it clear that we are not advocating a return to the predominance of extended custodial care in state hospitals of the 1950s. Tremendous advances have been made and continue to be made in the provision of improved mental health services in jails.[1–4] In recent years, a body of literature has emerged describing the expanded and varied applications of jail diversion, pretrial diversion, and specialty courts that have developed in the attempt to ensure that mentally disordered offenders who are subject to jail and incarceration receive appropriate mental health services for their needs.[5,6] It is beyond the space allotted for this article and would distract from its theme to place state hospitals within the intricate context of the spectrum of mental health care needed for jail inmates who have mental illness on entering the facility or may develop it in the future. Herein, we focus on a topic that is extremely important: the current role of the state hospital in regard to mental health services for pretrial jail detainees.

In the past, civil commitment and competency-to-stand-trial statutes provided the main mechanisms for the transfer of detainees with serious mental illness from jails to state psychiatric hospitals. Civil commitment or, to a lesser extent, other specialized statutes, can be applied to any person who meets accepted criteria of having a mental illness and demonstrates either a danger to self or others or a grave disability. Over the years, such statutes have been used for either temporarily or permanently removing a detainee with serious mental illness (SMI) from the jail for treatment of mental illness. However, in recent decades, the use of commitment for the transfer of individuals with SMI from jails to psychiatric hospitals has decreased and jails often have had to go it alone. Several reasons generally explain the decreased use of commitment as a jail diversion strategy. First, state hospitals do not have enough beds to service the various needs of their communities[7–11] and commit-

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ments from jails to state facilities are often viewed as low priority. In addition, what beds they do have are now often used for designated forensic services focused on the criminal courts and not on civil commitment.[9] In addition to the shortage of beds, the interpretation of civil commitment criteria of dangerousness and grave disability have narrowed increasingly,[10] resulting in fewer civil commitments.[11]

Traditionally, most individuals with SMI found incompetent to stand trial (IST) were committed to state psychiatric hospitals for competency restoration. In recent years, there have been a small number of published reports of competency restoration taking place in jails. This has come about primarily because of the lack of beds in state facilities, resulting in long jail waits for beds for individuals found IST, and because of the costs associated with competency restoration in hospitals compared with jails.[12] The fact that such units now exist in jails raises questions about the limits of care that these jail units can reasonably be expected to provide. These include lack of appropriate facilities and staffing, and the lack of expert supervision of psychotropic medication, including the lack of proper mechanisms for handling treatment refusal. In this article, we focus on these concerns that should be answered as jail-based restoration gains in popularity.

## The Forensic Role of State Psychiatric Hospitals

State hospitals today provide the bulk of mental health services for forensic populations. A survey published by the National Association of State Mental Health Program Directors (NASMHPD) in 2014 states that, "86 percent of forensic status inpatients were in state psychiatric hospitals" (Ref. 13, p 55) as of 2014. Because of this fact, we concentrate in this report on state hospitals with the understanding that, in the future, other inpatient facilities, whether county or privately run, can reduce the amount of care now delivered in state facilities. The key fact is that forensic systems need hospital-level care as one service in the continuum of care.

State hospitals have reached this pre-eminent position in regard to forensic services for two main reasons: reduction over the years in the total number of beds and a dramatic increase in the number of forensic patients. In the late 1950s, the state mental hospitals were antiquated institutions where warehousing of patients was commonplace. This was illustrated by Goffman[14] whose work highlighted the negative institutional and custodial aspects of large state hospitals. In his 1958 presidential address to the American Psychiatric Association, Harry C. Solomon expressed[8] the prevalent pessimistic view of the country's large state hospitals.[15]

He previewed the optimism that preceded the birth of the community mental health center movement, developed in the 1961 report of the Joint Commission on Mental Illness and Health entitled *Action for Mental Health*,[16] and later by the presidential administrations of John F. Kennedy and Lyndon B. Johnson.[17]

Now, some 60 years later, state psychiatric hospital capacity has been greatly reduced[18] by forces related to deinstitutionalization,[19] by legal changes in civil commitment statutes in the late 1960s and early 1970s,[20] and by diminishing state financial support for these hospitals. The reduction of state psychiatric beds, together with the failure of community programs to meet expectations led in part to a large increase in the numbers of individuals with SMI in our communities, many of whom were homeless.[21,22] It also led to overrepresentation of persons with mental illness in the nation's jails and prisons.[23,24] These dynamics developed over decades and continue today (The Joint Report[25]). With more individuals with SMI in jails there has been a concomitant substantial increase in the number of jail detainees who are referred for evaluation of competency to stand trial and subsequently for competency restoration.

## Competency to Stand Trial and Competency Restoration

### *Traditional Approach to Competency Restoration*

Competency-to-stand-trial statutes require the suspension of criminal proceedings when an accused has demonstrated an inability to form a factual and rational understanding of the criminal proceedings against him or to participate meaningfully in his defense. Traditionally, when an individual has been found IST, that person is either committed to a state psychiatric hospital or, as occurs more recently, placed in a community treatment program for competency restoration. The Oregon statutes provide an example of a traditional statute that authorizes the transfer of the detainee to a state psychiatric hospital:

> (2) If the court determines that the defendant lacks fitness to proceed, the criminal proceeding against the defendant shall be suspended and:
>
> (a) If the court finds that the defendant is dangerous to self or others as a result of mental disease or defect, or that, based on the findings . . . (1) that the services and supervision necessary to restore the defendant's fitness to proceed are not available in the community, the court shall commit the defendant to the custody of the superintendent of a state mental hospital. . . .[26]

After the Supreme Court decision in *Jackson v. Indiana*,[27] the period of competency restoration in Oregon is limited to a maximum of three years, after which the case has to end, either with the release of the person, or by the judge's instituting civil commitment proceedings.

There has been recent focus on the length of time that an incompetent defendant can wait in a jail for transfer to an inpatient competency restoration program. This question was examined first in the federal district court in the state of Oregon and most recently in the federal court in the state of Washington, with review by the Ninth Circuit Court of Appeals. In both states the various federal courts found that prolonged stays in jail waiting for a bed violates the constitutional rights of inmates. The Oregon case, *Oregon Advocacy Center v. Mink*,[28] was eventually settled by a consent decree between the parties that declared that seven days was the maximum length of time that an individual found IST could be held in jail before a transfer from of the jail to a hospital is required. One of the authors (J.D.B.) has observed that over the years this agreement has worked well in Oregon except that in recent years it has been very difficult for the state to uphold the agreement because of an increase in the number of patients found IST and a static or slightly reduced number of state hospital beds.

In the state of Washington, the recent case of *Cassie Cordell Trueblood et al. v. Washington State Department of Social and Health Services et al.*,[29] presented the same problems as in Oregon, with a similar result at the district court level: a seven-day limit of continued jail stay before transfer to a hospital was required. Again, the court addressed the matter of criminal defendants found IST who had their hospital transfer delayed because of lack of beds and found this situation to be in violation of constitutional rights to a speedy trial and due process of law. The Ninth Circuit Court of Appeals agreed with the trial judge that a seven-day limit to continued jail stay was appropriate but remanded the case back to the trial court to consider giving the state more time before making the seven-day limit permanent.[30]

## Competency Restoration in Jails

Contrast the Oregon statute with the competency restoration statute now in force in the state of Arizona:

> A. The court may order a defendant to undergo out of custody competency restoration treatment. If the court determines that confinement is necessary for treatment, the court shall commit the defendant for competency restoration treatment to the competency restoration treatment program designated by the county board of supervisors.
>
> C. A county board of supervisors that has designated a county restoration treatment program may enter into contracts with providers, including the Arizona state hospital, for inpatient, in custody competency restoration treatment. A county competency restoration treatment program may do the following:
>
> 1. Provide competency restoration treatment to a defendant in the county jail, including inpatient treatment [Arizona Revised Statutes[31]].

In Oregon, the IST individual is committed to either hospital or community restoration. In Arizona, the statutes allow for hospital or community restoration but also allow for restoration in jails. Today, most competency evaluation and restoration in Arizona is conducted in county jails, as observed by one of the authors (J.D.B.).

There is emerging discussion of jail-based restoration in the professional literature. Reena Kapoor[12] discussed various concerns associated with the use of the jail setting for restoration and identified seven states that use or have used jail-based restoration. The main reasons for the use of jail restoration were long waits in jails for limited available hospital beds and the costs associated with psychiatric hospitalization. Dr. Kapoor also identified disadvantages to jail-based restoration programs: the austerity of penal institutions, elevated noise levels, the facility's pri-

macy of security over emotional support and limited availability of therapeutic modalities.

Jerry Jennings and James Bell[32] described a pilot competency restoration program in Virginia as a jail-based treatment program with provisions for forensic evaluations, intensive psychiatric stabilization, and restoration of competency. The program was described with attention to many of the program elements necessary for a successful mental health program in any setting. A five-year outcome study demonstrated that the program achieved an overall competence restoration rate of 83 percent, and the average treatment length was only 77 days.

Potential advantages of jail-based competence restoration programs, suggested by the authors, include decreased length of time to restore competence, reduced waiting times for hospital beds, lower costs, elimination of incentives to malinger, seamless transition from competence restoration to adjudication, and support for jail staff to improve their management of this subset of the jail population.[32]

Aniket Tatugade and colleagues[33] described a cooperative jail and university department of psychiatry project in Fulton County, Georgia, in which jail detainees were offered restoration either in a special jail restoration unit or, for some detainees, while the inmate was in the jail's general population. Results showed that about one-third of inmates were restored and that approximately the same number eventually required inpatient hospital-level treatment. Those who were not restored in the unit were primarily inmates who refused treatment and those with an intellectual disability.

## Involuntary Medication in Jails

If there is a trend toward using jail settings for competency restoration, two critical questions must be answered: how jails should allocate their limited resources when creating a hospital-like competency restoration program and how jails would manage the use of involuntary medication within their setting.

The joint report of the Treatment Advocacy Center and the National Sheriff's Association[25] did not delineate what treatment services are needed in jails. Instead, the report focused solely on the adaptation of procedures for the involuntary administration of antipsychotic medication in correctional facilities. This position seemingly was due to the limited availability of hospitalization for treatment of inmates with an SMI,[23] and to an overreaching interpretation of the United States Supreme Court's decision in *Washington v. Harper*.[34] Interpretations of *Harper* have been used for the involuntary medication of inmates without hospital transfer.[35] Typically, no mention is made of the fact that the policy for the involuntary medication of Walter Harper was not for a regular correctional facility, but specifically for a specialized psychiatric treatment unit within the Washington state prison complex in Monroe, Washington. In *Harper*, the Court required that the involuntary administration of psychotropic medication be medically appropriate, but without considering what setting, staffing, and programming would render the administration of medication as appropriate, leaving the possible interpretation that only the medication itself must be appropriate.

Further, *Harper* is often cited as the authority for involuntary medication in correctional settings, even for pretrial jail detainees, even though Harper himself was a convicted and sentenced offender. Not said is that Mr. Harper was in the Special Offender Unit (SOU), and the policy that allowed for his involuntary medication which the Court found to be constitutional was specific to that specialized treatment unit. How closely the unit approximated a hospital unit is not described in the opinion itself. However, the *amicus* brief for the American Psychiatric Association[36] provided a brief description of the Washington Special Offender Unit to which the involuntary medication policy applied. The SOU "provides diagnosis and treatment for convicted felons who suffer from serious behavioral or mental disorder . . . and thereby endeavors to bring these prisoners up to a level of functioning that permits their transfer to other state facilities for the duration of their sentence" (Ref. 36, p 3). The specialized purpose of this unit is the housing and treatment of the most seriously psychiatrically ill prisoners in the state prison system. This unit does not compare with the typical services available in a jail and does not immediately transfer to an argument in support of involuntary medication in any jail or prison setting. As described in the *amicus* brief, it is within this context of the Monroe facility that the Court arrived at its opinion, a context that those who advocate for a procedure for involuntary medication in jails overlook in trying to apply *Harper* to pretrial detainees.

Aside from the question of medication alone, the *Harper* Court did not address the treatment needs of inmates with SMI, as hospital-level treatment consti-

tutes more than just involuntary medication. In the interpretations of *Harper,* clinicians and administrators are foreclosing perhaps a key component of the spectrum of essential mental health services available with timely hospital treatment.

Joseph Williams[37] noted that federal courts of appeal decisions after *Sell v. United States*[38] concluded that the *Harper* procedure for initiating involuntary medication can be applied to pretrial detainees.[39–44] Pretrial enforced medication does not mean enforced medication in jail.[45] In most of these cases, the pretrial detainees were treated in a hospital such as a federal medical center. Enforced medication in a jail was not explicitly recommended by a party to the lawsuit or the court in any of these cases.

In pointing out that *Harper* was treated involuntarily in a specialized treatment unit, we are not suggesting that this particular unit is a model for jails to follow in trying to develop a hospital-like jail unit. Recognizing the extreme variation in quality of state hospital care, especially historically, we also caution against using the worst examples of state and security hospitals against which to measure the suitability of jail mental health units for treatment of individuals with the most severe mental disturbances.

The most recent (third) edition of *Psychiatric Services in Correctional Facilitie*s provides many guidelines for improving and increasing psychiatric services in jails, such as having "housing areas for inmates with acute or emergent psychiatric problems" (Ref. 46, p 35). A facility should be available in which the inmate can receive treatment that includes "a full range of psychotropic medication with the capacity to administer them, including involuntarily in an emergency where state laws allow" (Ref. 46, p 35), an opinion added since the Second Edition. This raises the question of whether medication can be administered involuntarily where state law does not allow it. *Harper* is cited as having "recognized a constitutionally permissible model under which an inmate in a prison may be administered treatment over objection" (Ref. 46, p 3) (i.e., a legal model, as neither *Harper* nor the APA report provides a clinically acceptable model beyond that stated above. The APA report acknowledges that the *Harper* approach does not meet legal standards in all jurisdictions (Ref. 46, p 4)). Yet the report, in specifying that "[m]ental health treatment includes inpatient care in the correctional facility or in an external hospital" (Ref. 46, p 35), makes no distinction between in-jail attempts at hospital-like care and hospital treatment.

Michael Norko *et al.*[47] analyzed the question of whether to involuntarily medicate inmates within a correctional setting or initiate hospital transfer. (Ref. 47, pp 143–4). They recognized therapeutic advantages of hospital treatment but believed that medication can be administered more quickly in correctional settings without the procedural requirements for involuntary medication in hospitals. Dr. Norko and coauthors referenced clinical and legal concerns, such as the inherently coercive environment in correctional settings. They noted that the federal code favors seclusion and restraint over medication (Norko *et al.*,[47] citing 28 C.F.R. 546, 2011, 549.46(b)(1)(i))[48]), whereas, in a hospital setting, proper medication is emphasized and seclusion and restraint are to be minimized. A jail's reliance on restraining measures, we would add, can be further disincentive for hospital transfer where otherwise appropriate.

## Discussion

There are significant areas of concern that should be examined before widespread use of jail competency restoration services becomes a standard of care. First, should an inmate who has been determined by a court to be incompetent to stand trial remain in a jail at all, or should the individual be transferred without undue delay to a hospital or community placement for restoration services?[49] A review of relevant case law failed to show that this question has been examined by a court. The Oregon statute, reproduced above, implicitly answers this question by stating that once the court determines that a person is incompetent to stand trial, the "criminal proceedings shall be suspended" and the individual transferred to a psychiatric hospital or an outpatient setting for competency restoration. Does keeping an incompetent person in a jail where that person is subject to a correctional environment fulfill a definition of suspending the criminal proceedings? This should be an important first question and, as psychiatrists, we believe that this is a critical question to answer. The Oregon statute stands in stark contrast to the Arizona statute that explicitly allows for jail restoration at the discretion of Arizona county administrators. Subjecting the Arizona statute to appellate review might be an initial place to start answering the question of whether competency restoration should take place in

a jail. It would be interesting to see how this statute would fare in the same Ninth Circuit federal court that ruled in both Washington and Oregon that a detainee, once found incompetent to stand trial, could not be held, in most cases, in a jail longer than seven days before transfer to a hospital or treatment center for restoration services. To facilitate transfer to a state hospital or treatment center, the state of Washington has opened two new centers for competency restoration programs: one in Yakima and the other in Thurston County. Each program is housed in former correctional facilities but is run on contact from the state's Department of Social and Health Services.[50]

The Yakima Competency Restoration Center (YCRC) was subsequently found to be woefully inadequate both as an appropriate therapeutic environment for competence restoration and as a response to the court's directives.[49] Initially intended as a stopgap temporary measure to allow time for the state to create more hospital beds, the Yakima project became more expansive, less temporary, and in specific aspects, patently deficient. Plaintiff's specified particular deficiencies in the YCRC and submitted to the district court a motion for contempt regarding YCRC.[49] Subsequently, both parties arrived at a settlement[51] that included among other stipulations replacement of the YCRC with a building (Building 27 Residential Treatment Facility) and competence restoration program on the grounds of Western State Hospital.

Second, there is no consensus as to what a jail-based competency program should include within the scope of provided services and how much these services should replicate hospital-based competency restoration programs. Lamentably little scholarly attention has been given to the development of efficacious restoration modalities or model programs in general.[52–53] Although a few publications have summarized components of hospital-based restoration programs,[54–56] the effective legal and ethical incorporation of such components into nonmedical jail facilities remains uncharted territory. The Supreme Court has held, however, that prisoners have a right to treatment (*Estelle v. Gamble*[57]) and that pretrial detainees have a constitutional right to treatment as do convicted criminals (*Bell v. Wolfish*[58]), the latter protected by the Due Process Clause of the Fourteenth Amendment (*Revere v. Mass Gen Hosp*[59]).

Third is the matter of distribution of jail mental health resources. Most large jails should be resourced to provide counseling and medication for inmates in the general jail population whose mental disorder can be treated on an "outpatient" basis. Some inmates may require brief crisis intervention or stabilization and assessment in a jail mental health unit, which in only very rare occasions is similar to a hospital inpatient psychiatric unit. Unfortunately, the psychiatric care of inmates in the general jail population is also typically less than adequate. There are too few counselors and therapists to meet the need, too few psychologists to assist with assessments, and too few psychiatrists to manage medication clinics without shortening the sessions, rushing through, and spreading out return appointments. Moreover, a critical responsibility of mental health professionals working in jails is to ensure outpatient aftercare and continuity of treatment upon release from jail, but when time is insufficient providers must prioritize and ensure that inmates presently under their care receive their attention. Adding a competency restoration program to a jail environment may put the new program in conflict with the already existing demands on jail personnel with significant strain on the jail's functioning.

If a jail has the resources to develop and staff a competency restoration program, it should first ensure that it is meeting the mental health needs that are properly and traditionally within its purview. Before taking the burden of competency restoration from forensic hospitals, including the cost and responsibility of hospital-equivalent care and programming, much more attention is needed to ensure that jails provide the critical activities of attending to those already in its care, including aftercare referrals.

Fourth, there is the question of the appropriateness of using forced medication during competency restoration in jails through a *Harper* process. Advocates for forced medication in jail, which may, at least in practice, obviate hospital transfer, cite the Supreme Court's decision in *Bell v. Wolfish*,[58] which had nothing to do with enforced medication. In *Bell,* the Court distinguished between punishment, which is prohibited for pretrial detainees, and discipline, which is needed for safety in jails, just as in prison. Because enforced medication in *Harper* was justified by the need for order and safety in prison, a need that is equally valid in jails, it is argued that enforced medication should be permitted in jails. With this

logic, enforced medication would be allowed in jails while hospitalization, which would be even more supportive of order and safety in the jail, is not pursued.[60] We argue that *Harper*, designed for the management of dangerous behaviors, has limited use in competency restoration in jails, because jails have other means of providing security, such as lock-down and segregation, and jails use these mechanisms in some cases very freely. If *Harper* were the jail standard, there might be a tendency to used it too freely without any real examination of the detainee's objection to medications. An argument could be made that all detainees remaining in jail for restoration are "dangerous" because they could not make the bail necessary for outpatient restoration.

*Sell*[58] provides the more relevant criteria for forced treatment of persons found incompetent to stand trial and should be used if competency restoration over the detainee's objections is to include forced medication. *Sell* speaks directly to the question of competency to stand trial and, most important, to whether the case against the detainee is important enough for the government to override the detainee's objections. Once it is determined that the government has a sufficient and compelling interest in the case, the remainder of *Sell* focuses on a detailed examination about the use of medications and its effects on the detainee and the trial process.[61] Each institution, hospital or jail, must be able to participate competently in a true *Sell* hearing. This requirement would reflect on whether the institution has the staff and facilities and program to make sure that the medical component of *Sell* is applied in accordance with professional standards. We submit that most jails will not be able to provide the medical care necessary to make the *Sell* criteria meaningful. In other words, *Harper* may be too easy for a jail to implement whereas *Sell* may be hard to accomplish.

The recent decision by the Court of Appeals of Arizona, Division 2 in *Cotner v. State of Arizona*,[62] illustrates the challenge of applying *Sell* to force medication for competence restoration in a jail. The court found Elizabeth Cotner to be incompetent to refuse treatment and subject to involuntary treatment pursuant to A.R.S. §§ 13-4511 and 13-4512(E). Ms. Cotner objected, arguing that such a determination without establishing the *Sell* findings "violated her due process rights under the Arizona and United States Constitutions" (Ref. 62, p 5). The court entered *Sell* findings, denied her request for an evidentiary hearing and ordered Ms. Cotner to take the medications.[62] The Court of Appeals found that the "respondent erred as a matter of law and thus abused her discretion by entering findings that do not comply with *Sell*" (Ref. 62, p 27). Accordingly, the court granted relief for Ms. Cotner, vacated the involuntary medication order and directed a re-evaluation of her objection. The court essentially found that each of the *Sell* factors was insufficiently addressed. The court acknowledged that the administration of the medication must be medically appropriate, but did not address whether aspects of administration, such as the jail setting, beyond the pharmacology of the drugs was indeed medically appropriate.[63,64] From our present analysis, this is a critical, if often overlooked, consideration in such appellate decisions.

Finally, we return to the root causes behind the development of jail competency restoration programs. The first driver of such programs is that those operating in jails appear to be less expensive than those in hospitals. In many ways the focus on costs speak for itself. Public psychiatric hospitals are not profit-making ventures. The costs reflect what it costs to deliver proper mental health services in certified hospitals. The fact that it is cheaper to deliver restoration services in jails appears to be true, but this truth most surely reflects on the quality of these initial programs. Over time, those involved in such programs will and should demand that they develop clearly enunciated standards, and, as these develop, true costs will become apparent, making comparisons meaningful. At the present time, the claim of cost savings lack sufficient credibility to foster wholesale adoption of these services. In addition, such services in jails are an added burden on the functioning of those facilities and further undermine the purpose of jails and their ability to function properly. This is an area for additional attention.

The second root cause cited in the beginning literature on this topic is that, in most jurisdictions, there are not enough psychiatric beds to meet the needs of inmates with mental illness adjudicated as incompetent who then must remain in jail without proper treatment awaiting an available hospital bed. Their plight is a major problem, and a significant effort should be focused on ways to shorten the time defendants wait in jail before receiving appropriate restoration services. One approach to solving this problem is through the establishment of more hospital beds, not only in state hospitals but also incor-

porating community psychiatric facilities (hospitals and secure residential facilities) designed within psychiatric models that can concentrate on forensic patients.

A clear goal should be to re-establish proper roles and boundaries for and between these two systems, corrections and mental health, which now and for many decades have become blurred and distorted.

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