Jail-Based Competency-Restoration:

FINDINGS FROM LIBERTY HEALTHCARE'S 2-YEAR RESTORATION OF COMPETENCY (ROC) PILOT PROGRAM

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ROC Program Model

PROGRAM FEATURES
AND
PROGRAM PHILOSOPHY

Location: West Valley Detention Center

- San Bernardino County, California
- Segment of the Sheltered Housing Unit
- Consists of 16 cells/32 beds & an activity area

ROC Program Features

- Daily groups across 4 domains
- Twice daily 1:1 sessions
- Weekly Psychiatrist follow-up sessions
- Comprehensive use of psych testing
- Weekly case reviews with Tx team
- Voluntary meds
- Devoted deputy
- Multi-disciplinary Tx team

Liberty ROC Treatment Team: *in action*

ROC Program Philosophy: Fast Track Model

- The "Express Lane" idea
- *Slower traffic please keep to the right*
- Med/Surgical Hospital Model: ER, ICU, Inpatient care, etc.

*** Liberty Healthcare does not condone or promote speeding. (enjoy nonetheless)***

A How-To Guide

AN INTENSIVE APPROACH TO COMPETENCY RESTORATION TREATMENT

One Single Objective

- ROC has one primary goal ➔ Restoring CST
- This keeps evaluation/treatment focused and efficient, consisting of:
  - Identification of competence-related deficits & barriers to trial competence
  - Multimodal treatment focused solely on increasing competence-related abilities
  - Less focus on general clinical interventions (e.g., substance abuse/relapse prevention)
  - Goal of establishing a functional understanding of the court material, not just rote memorization

Treatment Planning

- Individual deficits that interfere with attaining CST are identified for each defendant.
- Appropriate treatment interventions are identified for each problem area.
- These problem areas may include:

1. Disorganized thinking
2. Delusional ideation/paranoia
3. Hallucinations
4. Impaired concentration
5. Memory problems
6. Comprehension deficits
7. Impaired reasoning/Decision-making skills
8. Abnormal rate of thinking
9. Difficulty cooperating with others
10. Disruptive behavior
11. Lack of motivation/Social isolation
12. Medication noncompliance

Competence Abilities Rating Scale (CARS)

- Completed by the LCSW and/or psychologist based on team discussions
- Provides tracking of individualized problem areas
- Each problem area rated on Likert-type scale
- Initial CARS = 1 week from admission
  - Aids in identifying functioning in areas relevant to CST
- Subsequent CARS = every 30 days
  - Serves as a quantifiable & measurable way of following progress & treatment response

Treatment Group Level

Level I: Lower Functioning	Level II: Higher Functioning
• Developmentally disabled • Below average intellectual functioning • Cognitively impaired (e.g., attention/memory deficits) • Disorganized thinking / Floridly psychotic	• Average/above average intellectual functioning • No significant cognitive impairment • No significant thought disorganization • Delusional/paranoid • Irrational thinking

Daily Treatment Program

- 2 – Individual Contacts
  - Range from brief check-ins to longer treatment sessions, depending on the defendant's needs
  - Provides an opportunity to discuss case-specific information
- 4 – Group Contacts
  - Trial Competency
  - Mental Illness/Stress Management
  - Mental Stimulation/Rational Thinking
  - Recreational /Social Activity
- Multimodal Treatment
  - Written material, lecture, games/activities, role-playing, and interactive discussions

Competence-*related* Treatment

- Mental Illness/Stress Management
  - Gain understanding of mental health issues, making choices about treatment, & preventing decompensation
  - Increasing coping skills & learning stress reducing behaviors, relaxation techniques, & stress prevention
- Mental Stimulation/Rational Thinking
  - Discussion of choices, consequences/outcomes, & goals in relation to various life situations
  - Increase attention/concentration ability
  - Foster reality-based thinking

- Recreational /Social Activity
  - Improve social/interpersonal skills & teach healthy boundaries
  - Foster appropriate sharing of opinion & effective negotiation
  - Increase motivation

Competence-*specific* Treatment

Level I	Level II
• 2 hours/week – Court Education Group • 1 hour/week – Court Activity Group • Individual contacts related to case-specific material (e.g., charges, penalties)	• 1 hour/week – Court Education Group • 1 hour/week – Court Activity Group • 1 hour/week – Working with Your Attorney / Rational Ability Group • Individual contacts related to case-specific material (e.g., charges, penalties, evidence, weighing options)

Court Education/Factual Component

- Educational group focused on increasing knowledge of the court proceedings.
- Combination of didactic presentation, discussion, written exercises, quizzes, and activities.
- Provided with 40-page workbook/study guide.
  - Written at 4th grade reading level
  - Reviews legal rights, court personnel, court process, plea options, plea bargaining, possible outcomes, courtroom behavior, basics of attorney-client relationship, testifying, and weighing evidence.
- Utilized with both Level I and Level II groups.
  - Level I: Lessons focused on basic information and skills in each topic area.
  - Level II: Lessons move at a faster pace, & allow for more in-depth coverage.

Court Activity Group

- Utilizes more engaging & interactive methods of increasing understanding & awareness of court proceedings.
- Multimodal treatment including:
  - Games (e.g., Personnel Bingo, Courtroom Matching Game)
  - Videos (e.g., Law & Order: Trial by Jury)
  - Movies (e.g., 12 Angry Men, My Cousin Vinny)
  - Current crime/court news
  - Role-play/Mock Trial

Assisting Counsel/Rational Component

- The component missing from most competency restoration treatment programs is the ***rational*** thinking abilities necessary to effectively assist an attorney in the conduct of a defense
- Designed for Level II, which already possesses an adequate factual understanding.
- Group utilizes hypothetical legal cases and recent crime/court news to stimulate discussion of:
  - Identifying & weighing available evidence
  - Appraising likely outcomes based on the evidence
  - Determining most appropriate plea
  - Evaluating the pros & cons of various legal options (e.g., testifying, plea bargaining, NGI)
  - Identifying relevant information to develop a defense strategy

"Pay No Attention to the Man Behind the Curtain"

THE SECRET LIES IN COMPREHENSIVE & ONGOING ASSESSMENT

Admission Triage Assessment

- Completed within 24 hours of admission.
- Assessment done by psychologist or LCSW
- Key areas to address:
  - Admission criteria / Appropriateness for ROC
  - Current mental status
  - Suicide/homicide risk assessment
  - Orientation to ROC

Intake & Evaluation Period

- New admissions undergo 1 week of assessment / observation before beginning the normal treatment schedule.
- Allows time for the defendant to get oriented to the ROC Program rules/expectations, to evaluate the defendant's level of functioning, and to determine the most appropriate treatment plan.
- Intake assessments are completed by all disciplines: psychiatry, psychology, social work, nursing, & recreation therapy.

Attorney Questionnaire

- During the intake period, a questionnaire is faxed and emailed to the defendant's attorney.
- Provides information related to the attorney's experience with the defendant and case-specific deficits that impacted trial competency.
- Questions involve:
  - Factors that led to doubting the defendant's competence
  - Likely outcomes the defendant faces
  - Likely demands on the defendant in the case (e.g., plea bargaining, testifying)
  - Factors that interfered with the attorney-client relationship and/or the preparation of a defense

Psychological Intake Assessment

- The psychologist completes the most comprehensive intake assessment
  - Includes thorough clinical interview, mental status exam, and psychological testing/screening instruments.
- Provides information regarding:
  - Psychological/cognitive functioning
  - Likelihood of malingering
  - Current level of trial competence
- Vital to developing an appropriate treatment plan focused on individual deficits, and determining the need for further testing.

Initial Psychological Testing

- Clinical interview/Mental status exam
  - Evaluates psychiatric and legal history, case-specific competency issues, & cognitive functioning.
- Miller Forensic Assessment of Symptoms Test (M-FAST)
  - Brief 25-item screening interview to determine the probability that an individual is feigning psychiatric symptoms.
- Test of Memory Malingering (TOMM)
  - Measure for evaluating feigned nonverbal memory deficits.
- Revised Competency to Stand Trial Assessment Instrument (R-CAI)
  - A semi-structured interview format to aid in assessing 13 competency-related functions.

Follow-up Psychological Testing

Psychological Functioning	Cognitive Functioning

• Personality Assessment Inventory (PAI)
  ▪ Multi-scale inventory used to assess patterns of psychopathology and personality functioning
• Mini International Neuropsychiatric Interview (MINI-Plus)
  ▪ Structured diagnostic interview used to assess the presence of Axis I disorders
	• Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)
	  ▪ Neuropsychological screening battery
	• Wechsler Adult Intelligence Scale – 4th Ed (WAIS-IV)
	  ▪ Measure of IQ
	• Wide Range Achievement Test 4 (WRAT4)
	  ▪ Measures basic academic skills

Follow-up Malingering Testing

Psychological Feigning	Cognitive Feigning

• Structured Interview of Reported Symptoms – 2nd Edition (SIRS-2)
  ▫ Comprehensive structured interview developed to assess feigning of psychiatric symptoms and related response styles
	• Validity Indicator Profile (VIP)
	  ▫ Measure of effort on cognitive tasks designed to identify valid and invalid responding approaches
	• Inventory of Legal Knowledge (ILK)
	  ▫ Designed to detect feigned deficits in legal knowledge

Ongoing Progress Evaluations

- Every 30 days the defendant undergoes a competency evaluation with the psychologist to determine progress toward trial competence.
- One or more of the following measures are used:
  - Revised Competency to Stand Trial Assessment Instrument (R-CAI)
    - Semi-structured interview format that directs the examiner to assess 13 competency-related functions
  - Evaluation of Competency to Stand Trial-Revised (ECST-R)
    - Standardized instrument designed to assess psycholegal domains directly related to the *Dusky* standard for competence to stand trial
  - MacArthur Competence Assessment Tool – Criminal Adjudication (MacCAT-CA)
    - Designed to assess three psycholegal conceptual domains relevant to the competency to stand trial, including understanding, reasoning, and appreciation

Why So Much Focus on Assessment?

- Objective Methods
  - Every defendant is evaluated using same methodology, providing uniformity & standardization
  - Controls for bias in either direction
  - Avoids missed and mis-diagnoses
- Clarifying Clinical Picture
  - Records often reveal multiple opinions & diagnoses, at times quite contradictory (e.g., psychotic vs. malingering)
  - Start with a blank slate
  - Use testing & observations to come to our own conclusions

Case Examples – Already CST

Note: Some defendants stabilize on medications in jail while going through competency evaluations/hearings.

- **IST evaluation on 12/20:** "speech was rushed and disjointed;" "mood and affect reflected mania;" "thought processes were loose and tangential;" and "thought content was delusional."
- **IST evaluation on 1/8:** "motor movement was almost constant... he greeted me and then immediately lay on the floor and began doing leg exercises;" "Speech was pressured;" "Affect was labile and ranged from euphoric and laughter to crying;" "Thought processes were marked by tangentiality;" "behavior is unpredictable, inappropriate, and at times disorganized."
- **Psychotropic medication started:** 1/23
- **Committed to IST Treatment:** 1/31
- **Admitted to ROC Program:** 2/1
- **Clinical Presentation at Admission:** Milder version of some of the symptoms noted by alienist evaluators (i.e., rapid speech, grandiosity, and elevated mood), but not severe enough to interfere with functioning or CST. Able to communicate in coherent / logical manner. Cooperative behavior. Rational thinking.
- **Discharged after 3 weeks of further stabilization and observation**

Case Examples – Malingering

- Several defendants enter ROC believing they were going to the state hospital... and are often quite displeased to still be in jail!
  - *"If I don't say anything, then you'll have to send me where I was supposed to go...;" "You just want to send me back to court and think you're helping me but that's not what I want. I want to go to Patton. Ya'll need to do what I want."*
  - Since the desired outcome is not achieved, their motivations / behaviors / goals seem to shift back & forth while they try to adapt to their situation.
    - Admission – Reported extensive/debilitating/bizarre psychotic symptoms. Psychological screening instruments suggested feigning. Claimed extreme impairment. Asked how to get to Patton.
    - 1-month later – Denied all psychotic symptoms. Psychological testing indicated defensive response style/minimization/denial of common issues (Note: he also explained in great detail how he believes psychologists assess for malingering). Expressed desire to be found CST & return to court.
    - After informed that he would not be returning to court just yet... he returned to his initial bizarre presentation & again asked to go to Patton.

Case Examples – Malingering

- Some are motivated by a desire to "do time" in a better environment and delay their criminal proceedings.
- And some have even admitted it!
  - *"I got myself here... I thought I could just stay here in jail for a year in the program and not have to go to state prison but it backfired... I've been here since September... now I have to be here until November?"* He admitted to "faking" some of his symptoms in the past in an effort to "fit in," such as smearing feces, not showering, & flashing staff.
  - "I was acting a little bit then. I wanted to go to Patton, but not anymore."

Case Examples – Malingering

Note: Some defendants are not feigning in an attempt to appear IST.

- Obtain medications that are highly abused in corrections
  - Presented as CST
  - Reported ongoing bizarre symptoms but appeared stable
  - Psychological testing suggested feigning
  - Frequent specific requests about highly abused meds (e.g., Wellbutrin, Seroquel, Ativan)
  - Reported symptoms changed depending on the med requested (Trazadone=↑ depression; Thorazine=↑ psychotic symptoms)
- Lay the foundation for NGI defense
  - Presented as CST
  - Reported numerous psychological symptoms, but no evidence of psychological impairment
  - Psychological testing indicated extremely high likelihood of feigning symptoms of mental illness
  - Cooperative/appropriate during time in ROC but in court "spit on my attorney's paperwork… the demons told me to do it."
  - Expressed desire to plead NGI & be sent to PSH

Case Examples – *NOT* Malingering #1

Note: Some defendants are wrongly labeled malingerers by jail staff & then not treated!

- **2 weeks after arrest:** WVDC psychiatrist diagnosed him with ASPD & Malingering. Described as "manipulative, dissimulating what he thinks passes as psych symptoms, trying to bait the psych, attempts to look messy and disorganized."
- Not prescribed medications.
- **Throughout 2-month incarceration:** Consistent pattern of psychiatric instability (disorganized; toothpaste on his face; smelled of feces; gassing staff; bizarre behavior; uncooperative; yelling at night; pressured speech)
- **ROC Admission:** Exhibited disorganized thinking/behavior, bizarre/incoherent thought process, agitation/aggressiveness, hallucinations, and poor hygiene.
- **Diagnosis:** Schizophrenia, Disorg. Type
- Prescribed medications
- **Discharge (67 days):** Vast improvement in functioning (no disorganized behavior, adequate hygiene, coherent/logical thought process, cooperative/appropriate behavior

Case Examples – *NOT* Malingering #2

Note: Some defendants are wrongly labeled malingerers by jail staff & then not treated!

- **WVDC records:** "Appears client was exaggerating and possibly manufacturing symptoms for secondary gain;" "No evidence of mental illness, no medical necessity for psych M.D."
- WVDC mental health contacts stopped.
- No psychiatric diagnosis.
- Not prescribed any psychotropic medication throughout his 8-month incarceration (despite requests from the defendant and his attorney).
- **ROC Admission:** Disoriented, confused, distracted, nonresponsive, hygiene and grooming were poor, significant thought blocking, great difficulty processing information ("it's hard to think").
- **Diagnosis:** Psychotic Disorder NOS
- Prescribed medications
- **Discharge (43 days):** Vast improvement / psychiatrically stable (no confusion/cognitive impairment, no thought blocking, adequate hygiene, rational/logical thought process, cooperative/appropriate behavior, no delusions/hallucinations)

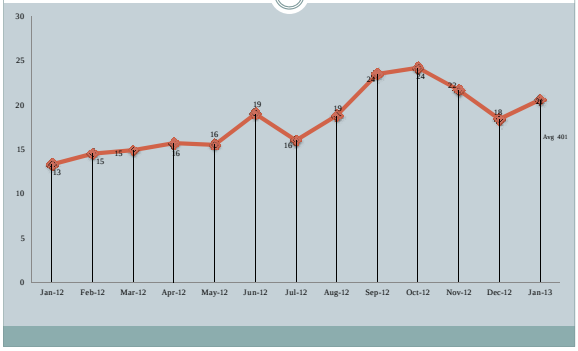
Outcomes

... SO HOW'S IT WORKING OUT?

Outcome Data
January 2011 to January 2013

- Total Admissions: 162
- Total Discharges: 139
- Restored to Competency: 58%
  - 55 days: Average length of treatment (LOT) for restored patients
  - 16-150: days LOT range for restored defendants
  - 92%: Restored in < 90 days
- Transferred to State Hospital: 42%
  - 60 days: Average time between admission and transfer request
  - 86 days: Average length of stay (LOS) for transfers

ROC Daily Average Census by month
20-bed program



Psychopharmacology

- Total Patient's prescribed meds: 94%
  - Fully med compliant: 85%
  - Intermittently compliant: 4%
  - Refusing meds: 11%
  - Incentivized: 27%

Jail-based Treatment: Viability

WHERE THE RUBBER MEETS THE ROAD

The Questions

- Can therapeutic results be achieved in a jail setting?
- Does a fast track model work with competency restoration tx?
- Who are the best candidates for ROC?

Who are best candidates for ROC?

- Already Competent (13%)
  - Average length of treatment: 33 days
- Rapid Responders (36%)
  - Average length of treatment: 66 days
- Malingering (8%)
  - Average LOT: 49 days

Who are the long-term patients?

- Refusing meds: 33%
- Med compliant, but fixed delusions related to charges and/or court proceedings
- Severe cognitive impairment

Questions?

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