# Competency Restoration Effectiveness: A Comparison of Hospital, Jail, and Community Programs

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## Abstract

More individuals in the United States court system are being found incompetent to stand trial then at any time before. Restoring these defendants to competency has traditionally been the work of the hospital system. However, with the influx of defendants in recent years hospitals have been struggling to keep up. The creation of jail and community outpatient programs have started to emerge to help cope. No comprehensive research has been done comparing the effectiveness of these competency restoration programs. A review of available literature and data on these programs has been compiled to start the comparison. The results show that there is little difference in the rate of effectiveness between hospital, jail and community based restoration programs. With the main difference being that jail and community based programs have a lower length of stay compared to hospital programs.

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## Introduction

The right to stand trial is a fundamental guarantee of the American constitution. In 2010, in America's federal court alone there were almost 161,000 criminal cases filed. (U.S. Department of Justice, 2010). Typically these cases will be solved by charges being dropped, plea bargains, or going to trial. However, some of these cases may never go to trial in light of the defendant being incompetent to stand trial. It is thought that anywhere between 50,000 to 60,000 competency evaluations are held every year. (Justice Policy Institute, 2011). Out of these evaluations about one in five will be found incompetent to stand trial and they will be placed in a program that will attempt to restore their competency so that the trial may proceed. (Justice Policy Institute, 2011) In cases where the defendant is never restored to competency the charges will be dropped and the defendant may be free to go or may be taken to civil court in order to forcibly commit the individual to a psychiatric hospital. Psychiatric hospitals were the first places to have programs that restored defendants to competency. In the beginning there were plenty of beds that were available for these defendants. However, as the criminal justice and court system grew so did the number of incompetent individuals. Many defendants were left languishing in jails waiting to be transferred to hospital programs. This issue led to the creation of jail and community outpatient competency restoration programs. However, since these programs are new alternatives there has been no collective research done into the effectiveness of hospital, jail and community restoration programs as a whole. To understand what

makes these programs necessary and the restrictions placed on them one must first understand what competency is and what treatments are allowed. This information is covered in the case laws surrounding competency and competency restoration.

**Competency Case Laws**

The mention of competency to stand trial is first mentioned in the mid-17th century. During this time competency was determined by those who stood mute in court instead of entering a plea. (Mossman et al., 2007)The court would then determine if the individual was "obstinately mute or whether he be dumb *ex visitatione Dei* [by visitation of God]"(Mossman et al., 2007) The original interpretation of this code was for individuals who were literally mute or deaf. However, over the course of time it started to include those who were mentally ill. In 19th century America, the courts followed the English case law of competency to stand trial which was based on the 1836 case of *King v. Pritchard* in which the jury was asked to consider "whether the defendant was mute of malice or not; secondly, whether he can please to the indictment or not; thirdly, whether he is of sufficient intellect to comprehend the course of proceedings on the trial." (Mossman et al., 2007)

English case law remained largely unchanged in the American court system until 1960 where the United States Supreme Court set the minimum standard of what is considered to be competent to stand trial. Dusky v. United States (1960) was the case of Milton Dusky who was accused of illegally transporting a girl across state lines and raping her. A pretrial psychiatric evaluation found a diagnosis of schizophrenia "reaction, chronic undifferentiated type". (Dusky v. United States, 1960) A separate psychiatric report and testimony at trial stated that "Dusky could not properly assist counsel

because of suspicious thoughts, including the belief that he was being framed." (Mossman et al., 2007) However, the court found that Dusky was competent to stand trial and that he was found guilty of rape; the Eighth circuit court of appeals upheld his conviction. However, the United States Supreme Courts stated that the test of his competency to stand trial was based on "whether he [had] sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he [had] a rational as well as factual understanding of the proceedings against him" and is not based on his orientation in the courtroom and his ability to recall events. (Dusky v. United States, 1960) Dusky's case was sent back to trial to see if at this time he had the competency to stand trial. The Dusky case was the groundwork for modern competency criteria in the United States criminal court system.

After Dusky several other important case laws were established that affected starting competency evaluations and hearings. Pate v. Robinson (1966) established that a hearing regarding a defendant's competency is necessary under due process. This case stated that defendant is entitled to a pre-trial competency hearing in a court case and that denying the hearing is a violation of the due process. Stemming from this case is a similar case of Drope v. Missouri (1975). In the Drope case, the defendant's past and current behavior created doubt about the competency of the defendant during trial. The U.S. Supreme Court ruling on the case stated, "[e]vidence of a defendant's irrational behavior, his demeanor at trial, and any prior medical opinion on competence to stand trial are all relevant in determining whether further inquiry is required, but . . . even one of these factors standing alone may, in some circumstances, be sufficient." (Drope v. Missouri, (1975). Additionally, Drope v. Missouri (1975) held that a

competency hearing must be held any time there is bona fide doubt raised about the defendant's competency, regardless of the doubt appearing pre-trial or during the trial. In the 1993 case of Godinez v. Moran, states are allowed to have competency criteria that is more elaborate then Dusky. In fact, many states often have a mental abnormality requirement in order to be declared incompetent. This typically requires that a defendant have a mental illness in order to be declared incompetent to stand trial in addition to the Dusky criteria.

An important court decision emerged in 1972 in regards to the amount of time that an incompetent defendant can be held to be restored to trial. Jackson v. Indiana (1972) founded that an incompetent defendant cannot be held indefinitely. The United States Supreme Court stated: a defendant may not "be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that competency in the foreseeable future" (Jackson v. Indiana, 1972) The Jackson case did not put a particular time limit on how long a defendant could be held to restore competency. As such this allowed states to make their own determination on what is considered a reasonable period of time. Due to the vagueness of this law, states vary widely in the time period that they allow a defendant to be held. In the end, if a defendant cannot be restored to competency the defendant must either be released or have civil commitment hearings started.

Medication is the most common treatment that is utilized when restoring individuals back to competency. In Washington v. Harper (1990) the United States Supreme Court ruled that prisoners have a limited right to refuse medication and that the needs of the institution out weight the needs of the individual. However, the ruling

did state that a formal hearing must be started and the prisoner needs to show serious mental illness, must be a danger to himself or others, and a physician must state that the medication is in the best interest of the individual. In the ruling of Jurasek v. Utah State Hospital (1990) set the precedence that patients who were not competent could be forcibly medicated in the hospital setting if they were a danger to themselves or others. Riggins v. Nevada (1992) the Supreme Court found that a defendant can be forced to use medication during his trial if the medication is appropriate and essential for the safety of the defendant and others, after less intrusive alternatives have been ruled out. Riggins v. Nevada (1992) also established that forced medication can be done to pre-trial detainees. This is particularly important because majority of competency to stand trial motions occur pre-trial, though the motion may come about at any point during the trial. However, the case that determined whether a defendant can be forced to take medication solely to restore competency is discussed in Sell v. United States (2003). The Supreme Court deemed that forced medication solely to restore competency to trial can be done in considering four points: 1. If the court is interested in prosecuting the defendant based on the seriousness of the charge. 2 the proposed medication would be substantially likely to restore the defendant to competency without side effects that would interfere with the ability to work with the attorney. 3 Whether there is a less intrusive option to restore competency to the defendant. 4. Whether the medication is medically appropriate. While these are not all the case laws that have been founded that affect competency to stand trial these are the major ones that have influenced the finding of incompetent to stand trial and impose rules and regulations on restoring individuals to competency.

## Competency Restoration

Competency restoration is the treatment of those deemed incompetent to stand trial. Programs aimed at competency restoration have traditionally been in forensic or state mental hospitals. In the early years of competency restoration hospital programs had very little specialization in restoring defendants to competency. These early programs relied mostly on multiple medications to stabilize the defendant's mental illness, without focusing on the factual information that a defendant needs to understand the courtroom. (Samuel & Michals, 2011) However, current restoration programs today have changed in light of advancing research. Current restoration programs still make use of medications and many find it a vital part of the program in stabilizing the defendants. In addition, to the medication regimen, programs also use a combination psychoeducational training and therapy. Medication, psychoeducational training, and therapy form the three core components of competency restoration programs. While there are some differences in the way the educational material is presented from program to program most follow a common theme. There is often didactic learning, mock trials and video materials that are used to educate the defendants on the individuals in the court and the court process. In a survey of 151 state hospitals 88% use didactic or psychoeducational training. (Pinals, 2005) The amount of training provided varies from program to program. Majority of programs have at least two to three sessions of training a week. The therapy portion of restoration comes in the form of either individual sessions or group therapy sessions. The frequency and types vary greatly from program to program with some having a therapy session just once a week to six times a week. Most programs will often have a mix of individual and group therapy

during the week that the defendant is required to attend. A large improvement in many hospitals today is that the staff is trained in competency restoration and understands the program and its purpose. 67% of hospital staff in a competency restoration is trained in competency restoration. (Pinals, 2005)This is an improvement considering that in the early years of restoration programs there was no training available at all.

Programs have also changed settings in recent years. Though the majority of restoration programs are still held in hospitals a shift to jail-based and community based restoration programs have emerged. Unlike the traditional hospital programs, where defendants must wait for long period of times to be placed in the programs, these new settings offer a quicker start at treatment and prevent further decompensation while waiting in the jail. There is no record of when the first out-patient community restoration program was created. There is however data on one of the earliest Jail based restoration programs. The first program was located in the state of Virginia in 1997. (Jennings & Bell, 2007). The program was part of a renovation to the jail that included a completely separate psychiatric unit. The unit was not used for solely for competency restoration, but it did provide one of the first jail restoration programs in the United States. In the years that the competency restoration program was operated the program boosted an effectiveness rate of 83% with the average length of stay at 77 days. (Jennings & Bell, 2007) The unit was operated for five years until the restoration of competency program was closed down for undisclosed reasons.

Jail-based restoration programs are based in county or local jails and defendants receive treatment within a special mental health unit based in the jail. As of 2009, there were 9 jail based restoration programs in various states including California, Florida,

and Texas. Proponents of jail restoration programs state the cost of jail restoration is far more cost effective then hospitals. Arizona reported that the cost of the jail restoration program per patient was one fifth the cost of hospital restoration. (Kapoor, 2011) Jail restoration offers quicker access to treatment with many programs evaluating the needs of the individual within 48 hours and treatment implemented within days of arrival to the mental health unit.(Kapoor, 2011) Jail restoration programs differ in standards as much as hospital restoration. Typically defendants are seen anywhere from two to three times a week to four or five times a week for individual and group therapy sessions along with psychoeducational training. Medication in jail restoration programs are also used and as in most restoration programs is a vital part of restoring competency. In some cases with jail restoration programs the unit is able to do proceedings for forced medication. In other units the jail is required to have the patient transferred to a hospital for forced medication.

Community restoration programs are also another avenue being taken in competency restoration. Community restoration programs are considered to be the form of least restrictive environment to undergo competency restoration. Community restoration programs allow continuity of care for the patients and close support of family and friends. Community restoration programs like jail based models boost a lower cost than the hospitals with a Texas program saying that they were saving approximately 60% per defendant. (Kapoor, 2011) Thirty six states have statues allowing for community based restoration programs, though only 16 active programs are found nationwide. (Kapoor, 2011) Community restoration may vary; though typically there is eight hours per week of require psychoeducational training as well as various individual

and group therapy sessions depending on the defendants plan. Community restoration programs differ from jail and hospital restoration in that a court order is often required in most states for the defendant to be released into the community. Additional criteria must also be met in order for a defendant to participant in a community restoration program. The most common criteria for these programs is that the defendant must not be a danger to themselves or others in the community and they must live with a family member or in a specialized half-way house. Majority of the programs also require medication compliance with failure to comply resulting in the defendant being returned to the county jail.

With the recent emergence of jail and community based restoration programs little research has been done to effectively compare the effectiveness of these types of programs in regards to programs located in the hospital setting. There is little research into competency restoration programs not located in hospital settings. Many papers focus more on the programs aspects then the location of the program. Few papers at all have looked into community and jail based restoration programs. There is no research that could be found that compared hospital, jail and community restoration programs in effectiveness. In response to this the paper seeks to determine the effectiveness of restoration in community, jail, and hospital based programs in comparison to each other.

**Materials and Methods**

The effectiveness of the programs being evaluated will be determined by the average length of stay needed for a patient to be restored to competency along with the percentage of patients restored to competency during the time frame. Due to prior

research it is known that about 80% to 90% of defendants are restored to competency within 6 months (Samuel & Michals, 2011)

The materials used to find out the number of defendants and the length of stay in various programs was found in material available to the public. All material comes from 3rd party sources and none of it was collected by the author. None of the organizations that are listed in the paper were able to provide any data directly to the author. As such the material used is available to the general public and published in various years.

The hospital sample includes data found on five programs located in various states with two of these programs located in Washington. The five programs are: Washington's States Western State Hospital between the years of 2010 to 2012, Washington's Eastern State Hospital between the years of 1987 to 2011, Maryland State Hospital Spring Grove in 2011, Indiana State Hospital between the years of 1988 to 2004 and Texas State run hospitals in the year of 2012.

The outpatient community based sample are three different programs located across the country. These three programs are: Miami-Dade Forensic Alternative Center based in Florida in 2009, Texas's Outpatient community restoration programs in the year 2011, and Washington D.C's Community restoration program between the years of 2011 to 2014,

There are only two jail based programs with information currently available. Though more have been developed in recent years there is no information that has been disclosed to the public. The first program is San Bernardino Jail in California

between the years of 2011 to 2013. The second is programs is located in Yavarpai County in Arizona at the Camp Verde Jail with the data collected in 2009.

## Results

### *Hospitals*

Eastern State Hospital of Washington had admitted to its competency restoration program 373 individuals between the years of 1987 and 2011. (Zapf, 2013) During this time period 241 defendants were restored to competency while 132 were deemed unrestorable. The average length of stay for the restorable defendants was found to be 89.2 days. The success rate for the eastern state hospital was 64% restoration.

Western State Hospital of Washington had 272 defendants admitted to its program between 2010 and 2012. Of the 272 only 35 were unable to be restored. (Zapf, 2013) The remaining 237 individuals were restored to competency. The average length of stay in Western State Hospital was 80.56 days. Western state hospital had a restoration success rate of 87%.

Spring Grove Hospital in Maryland had 48 defendants in their competency restoration program in the first 6 months of 2011. Of the 48, 12 were restored to competency. (Justice Policy Institute, 2011) The average length of stay for defendants was 411.5 days. There was no data provided on how many were deemed unable to be restored to competency.

Indiana State Hospital had 1,475 admissions to its competency restoration program between the years of 1988 to 2005. (Morris & Parker, 2008) Of the number of defendants admitted 1237 of them were restored to competency. The remaining 238

were deemed unrestorable. The study did not give an average length of stay for the program, only noting that 83.7% were restored to competency within a year. Indiana State hospital has an overall restoration rate of 83%.

Texas Forensic Hospitals which consists of 10 state funded hospitals throughout Texas. In 2012, these hospitals admitted 940 defendants to their various competency restoration programs. (Hogg Foundation for Mental Health, 2013) Of these 940 defendants, 705 were restored to competency. The remaining 235 were either found unrestorable or had charges dropped while in the program. The average length of stay in the program is 120 days. Texas forensic hospitals have a restoration rate of 75%.

Table 1

Hospital Restoration Programs

| Hospital Name | Number of Defendants | Number Restored | Number Unrestorable | Success Rate | Length of Stay |
|---|---|---|---|---|---|
| Eastern State Hospital | 373 | 241 | 132 | 64% | 89.2 |
| Western State Hospital | 272 | 237 | 35 | 87% | 80.56 |
| Spring Grove Hospital | 48 | 12 | Na | Na | 411.5 |
| Indianan State Hospital | 1475 | 1237 | 238 | 83% | Na |
| Texas Forensic Hospitals | 940 | 705 | 235* | 75% | 120 |

*number is total of unrestorable defendants and those whose charges were dropped before program completion.

*Community*

The Miami-Dade Forensic Alternative Center had admitted 24 defendants to the program between August of 2009 and September of 2010. The average length of stay in the program was 99 days. No information was provided on the amount who were not restored to competency.(The Florida Senate, 2011) It should be noted that 14 people were originally denied admittance to the program. Of the 14 that were denied admittance to the program, six did not meet the legal criteria, three did not meet the criteria for commitment, two did not meet the clinical/diagnostic criteria, two required medical treatment beyond what the program was able to provide, and one refused to participant in the screening.

Texas's outpatient community restoration program has 11 sites across the state. In 2012, 187 defendants were admitted into the program. 123 of the defendants were restored to competency, the remaining 64 were deemed unrestorable. (Hogg Foundation for Mental Health, 2013) The average length of stay in the program is 112 days. The restoration rate for the program was 65.7%.

Washington's D.C's outpatient community restoration program admitted 69 defendants between the years of 2011-2014. (Johnson & Candilis, 2015) Of the 69 defendants, 55 were restored to competency. 14 defendants were deemed unrestorable. The program did have 101 defendants whose charges were dropped before completely the program. These 101 have not been counted as part of the average length of stay or as defendants admitted and completed the program. The average length of stay in the program was 57.5 days. The restoration success rate for the program was 79.7%.

Table 2

| Community Restoration Programs | | | | | |
|---|---|---|---|---|---|
| Program Name | Number of Defendants | Number Restored | Number Unrestorable | Success Rate | Length of Stay |
| Miami-Dade Forensic Alternative Center | 24 | na | na | na | 99 |
| Texas Community Restoration Program | 187 | 123 | 64 | 65.7% | 112 |
| Washington D.C Community | 69 | 55 | 14 | 79.7% | 57.5 |

*Jails*

San Bernardino County restoration program operated out of San Bernardino Jail admitted 162 defendants into the program between the years of 2011 to 2013. (Carabello,2013) 93 of the defendants admitted were restored to competency. 69 defendants were deemed unrestorable in the jail program and were admitted to the state hospital for longer treatment or for forced medication proceedings. The average length of stay in the program is 56 days. The restoration rate for the jail program is 57%.

Camp Verde in Arizona had 37 defendants admitted to the program between April 2010 and June 2011. (Orr, 2011) Of the 37 admitted, 19 have been restored to competency while 2 have been deemed unrestorable. 16 of the defendants are still in the program. The average length of stay is 63 days. The restoration success rate is 90% for the jail program.

Table 3

| Averages for All Programs by Location | | | | | |
|---|---|---|---|---|---|
| Program Location | Average Number of Defendants | Average Number of Restored | Average Number of Unrestorable | Average Success Rate | Average Length of Stay |
| Hospital | 621.6 | 486.4 | 160 | 77.25% | 175.32 |
| Community | 93.3 | 89 | 39 | 72.7% | 89.5 |
| Jail | 91.5 | 44 | 35.5 | 73.5% | 59.5 |

**Discussion:**

The results of the review show that in terms of actually restoring a defendant to competency there was no significant difference in the success rate between the locations. However, there was a large difference in the average length of stay between the locations. The jail programs as a whole that were reviewed in this paper had the lowest length of stay of any of the programs at 59.5 days. The jail restoration program at Camp Verde also boast the highest restoration rate at 90%. The hospital programs' average was 175.32 days and was the largest of the three groups. The hospitals also had a large range in the average length of stay from as low as 80.95 days to the highest at 411.5 days. The longest average length of stay was at Maryland State Hospital. The longer average length of stays in hospitals might be due to the fact that jail and community programs as able to move defendants from their programs to the hospital program. Hospitals also have the resources to devote to patients that require more intensive competency restoration treatment by being able to provide around the clock support. Additionally, because of the nature of jail and community restoration programs,

there is certain criteria that defendants must meet in order to participant in the programs. This criteria might eliminate patients that require longer to return to competency, like those with intellectual disability, and would result in a longer stay at the hospital while keeping the average length of stay for the alternative programs lower.

There are also various differences in average length of stay and success rates between the programs at the same location. For instance the community restoration program in Washington D.C. and San Bernardino jail programs cannot do forced medication. (Johnson & Candilis, 2015) In the cases of these two programs defendants have to be moved to a hospital where forced medication proceedings are undertaken. In the Texas Community restoration program, program providers can start forced medication proceedings if it is deemed necessary without having to go through a hospital. This can have a significant impact on the amount of individuals restored to competency as medication is often an important tool used in competency restoration programs.

The cost of jail and community restoration programs is significantly lower than the price of a defendant in a hospital program. In fact, in Arizona, due to the shift from the state to the county in restoring the defendant to competency Camp Verde was created. In 2009, the cost per day at Arizona State Hospital was 670 dollars per defendant. Arizona's Yavapai County's response was to create the jail restoration program that reduce the amount that they spent on the hospital program from 670 dollars per day for one defendants to 240 dollars. (Orr, 2011) This amounts to huge saving for the county and frees up hospital beds for those who need it most. In Texas's community program the average cost per defendant per day is 106 dollars. The average

cost of the state forensic hospital program is 421 dollars. The amount of taxpayer money being saved makes a case for jail and community restoration programs especially considering there is little difference in success of these new programs compared to hospital programs.

As stated before the majority of defendants will be restored to competency within 6 months no matter what program they are entered into. However, the advantage of community and jail restoration programs is the fact that they don't have long waiting times between the defendant being ordered to competency restoration and the actual start of the program. Unlike hospitals, that can have up to a year or more of a waiting period, these defendants are more quickly restored without decompensating in jail.

**Limitations**

One of the limitations of this research is that all of the data reported was collected by either the organization themselves or a 3rd party. Due to the fact that the data collection was done by outside sources the years that the data was collected are different for almost every source. The author did make attempts to have organizations in the study present the most recent data available but all attempts were denied or the author was directed to information that was already published.

The second limitation on the study is the fact that the sample size involved was very small. This is in part due to the fact that many of the jail and community competency restoration programs did not have any public data about the programs that they run. When the author attempted to contact them the organizations were not willing to offer any data or in the case of Arizona jail program referred the author to already

published data. Some of the organizations never contacted the author back. Due to the lack of data on these programs and hospital they were excluded from the study.

A third limitation of the study is that the study was conducted across multiple states in the United States. This effects the data on the length of average stay as some states have a longer period to restore an individual to competency then others. The Supreme Court never ruled on what the maximum time that a person could be held to be restored to competency. While most states have it so that the maximum length is one year or less some states have much longer timelines. For instance the state of Texas has a 180 day maximum restoration period. While the state of Maryland does not have a maximum length period for restoration. This is an important difference to note as the difference reflected in the results of the study. It also explains why Maryland's Spring Grove Hospital has such a large length of stay compared to other hospitals.

The fourth limitation of the study is that jail and community restoration programs are new compared to hospital programs that have been set up for decades. Many of the jail and community restoration programs are still being tested in their respective areas and compared to hospital programs are few and far between. Due to the fact that so many of these programs are new there has not been enough time for them to collect data.

The fifth limitation of the study is that jail and community restoration programs are able to exclude certain participants. In community programs typically an offender has to be non-violent in order to be able to participant in the program. Additionally, a judge must make the decision to release them back into the community only if they are not a danger to themselves or others. Jail programs also can remove a defendant from

their program. Typically those that refuse medication are sent to the hospital to go through forced medication proceedings. Since both of these programs are able to turn participants away this also effects the results of the data gathered. Hospital programs are not able to turn defendants away from their program.

**Future Research**

Due to the fact that the information gathered came from outside sources future researchers are advised to collect data first hand. This will allow future research to be able to access unbiased numbers all within the same time frame to portray a more accurate picture of the success of these programs. Additionally, a larger sample of hospital, community and jail programs would be advised if possible. However, due to the fact that there are not as many jail programs nor community program it might be impossible to increase the sample size in those areas.

Future researchers into this area would be advised to look at how jail and community restoration programs choose to exclude defendants from their programs. For instance, if a certain program chooses to exclude those with intellectual disability, this can greatly affect the results of the program as it is common knowledge that those with this disability are harder to restore to competency. Additionally, it would be of great benefit to know how these programs go about deeming a defendant unrestorable.

Future research could also look at a small sampling of each type of program in one state or in multiple states that have the same limitation on the maximum amount of time that a defendant can be restored to competency. For instance the state of Texas has a community restoration program, state forensic hospitals, and just recently in the

past year started a jail competency restoration program in the Dallas-Fort Worth area. As there is no data on the jail program at this time future research can look at all three types of these programs within the same state. Additionally, comparing states with similar laws reduces the limitation of the length of staying being effected by different standards in the time allowed to restore patients to competency, and thus provides a more accurate assessment of the programs.

## Conclusion

The future of competency restoration programs are changing. While hospital programs are great for individuals who require intensive care in order to be restored, jail and community programs ease the burden off of hospitals by taking the defendants who do not need as restrictive of an environment. Consequently this allows hospitals to open up more beds for defendants who need more intensive treatment. Hospitals have long waiting list that leave some defendants languishing in jail for months and in some extreme cases, even years. Jail and community programs rectify these problems. Jail and community programs swiftly start the restoration programs and so far have a record of being able to restore individuals without long waiting periods. In the long run these programs keep defendants from decompensating while waiting for treatment from the hospital. Community programs allow defendants to continue contact with friends and family members, this support outside of the program not only helps in restoring a patient but also keeps them from sliding backwards and having to re-enter the program at a later time. Additionally, for defendants coming out of community programs there is more emphasis on continuity of care, in that they help connect the individual with medication services and other groups for treatment. The cost for the

state and counties that have access to jail and community programs find that the cost of treatment is significantly lower, allowing more money to be put towards other mental health services. The advantages of jail and community programs shouldn't be underestimated. They offer a fast alternative to restore the majority of defendants to competency without the price tag of a hospital.

# References

Burns, D. (Ed.). (2011). Mental Competency Best Practices Model. Retrieved May 21, 2015, from http://www.mentalcompetence.org/

Carabello, K. (2013). Jail-Based Restoration of Competency Factsheet. *Senate Committee of Judiciary*.

Drope v. Missouri, 420 U.S 162 (U.S. Supreme Court 1975).

Dusky v. United States, 362 U.S. 402 (U.S. Supreme Court 1960).

Godinez v. Moran, 509 U.S. 389 (U.S. Supreme Court 1993).

Hogg Foundation for Mental Health. (2013). Restoration of Competency to Stand Trial.

Jackson v. Indiana, 406 U.S. 715 (U.S. Supreme Court 1972).

Jennings, J., & Bell, J. (2007). The ROC Model: Psychiatric Evaluation, Stabilization and Restoration of Competency in a Jail Setting. Retrieved May 31, 2015.

Johnson, N., & Candilis, P. (2015). Out Patient Competency Restoration: A Model and Outcomes. *The World Journal of Psychiatry, 5*(2), 228-223.

Jurasek v. Utah State Hospital, 158 F3d 506 (United States Court of Appeals, Tenth Circuit 1998).

Justice Policy Institute. (2011, October 1). When Treatment is Punishment: The Effects of Maryland's incompetence to stand trial policies and practices. Retrieved May 1, 2015.

Kapoor, R. (2011). Commentary: Jail-Based Competency Restoration. *The Journal Of The American Academy Of Psychiatry And Law*, *39*(3), 311-315.

Morris, D., & Parker, G. (2008). Jackson's Indiana: State Hospital Competence Restoration in Indiana. *The Journal of the American Academy of Psychiatry and the Law, 36*, 552-534.

Mossman, D., Noffsinger, S., Ash, P., Frierson, R., Gerbasi, J., & Hackett, M. et al. (2007). AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial. *Journal Of The American Academy Of Psychiatry And The Law*, *35*(4).

Orr, S. (2011, June 6). Yavapai County Inmate restoration program saves money, time. *The Daily Courier*. Retrieved 2015.

Pate v. Robinson, 383 U.S. 375 (U.S. Supreme Court 1966).

Pinals, D. (2005). Where Two Roads Meet: Restoration of Competence to Stand Trial from a Clinical Perspective.

Riggins v. Nevada, 504 U.S. 127 (U.S. Supreme Court 1992).

Samuel, S., & Michals, T. (2011). Competency Restoration. In *Handbook of Forensic Assessment: Psychological and Psychiatric Perspective*. John Wiley and Sons.

Sell v. United States, 539 U.S. 166 (U.S. Supreme Court 2003).

The Florida Senate. (2011). The Forensic Mental Health System. *The Florida Senate: Interim Report*.

United States Department of Justice. (2010). United States Attorneys' Annual Statistical Report. Retrieved July 31, 2015.

Washinton v Harper, 494 U.S. 210 (U.S. Supreme Court 1990).

Zapf, P. (2013). Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods. *Washington State Institute for Public Policy*.