

Community Competency Restoration Programs in Minnesota

Questions to consider:

Who should be eligible to receive CR in the community?

When the forensic examiner completes a report to the court of incompetent to stand trial they would also provide an opinion of inpatient or community placement. The evaluator would have preset criteria to reference for considering the appropriateness of community competency restoration. The evaluator would consider the following combination of factors:

1. Non-violent offense or non-sexual offense.
2. Psychiatrically stable or medication compliant.
3. Not currently using substances or illicit drugs.
4. Willing to participate
5. Has reliable transportation
6. Agrees to sign releases of information for current/recent treatment providers.
7. Agrees to remain free of violence.

Threats or assaults will result in discharge from the community program and referral to inpatient treatment.

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CR in the community shouldn't be based on level of offence but rather risk to public safety. CR in the community should most often be in an unlocked setting. I would also expect that people eligible for CR should have a reasonable chance of being restored. Certain conditions could be ruled out- those where restoration is impossible or highly unlikely.

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CRP in the community should be based on public safety *and* the level of the offense. I also think that there should be reason to believe the person could be restored to competency which I would hope was based on the examination. We have written letters to the court when we have concerns that a person most likely will not be restored to competency.

Who could be the providers of CR in the community?

- DHS
- Contract with individuals

Combination – depends on size of county

- Individual
- Liaison with courts
- Administrators –
- Case management
- Support staff

Jail based

- Contractors
- County or state

Train existing ARHMS workers, others

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CR is usually achieved through psychiatric stabilization, often through medication management and related supports. This requires certain professionals to deliver this care. The educational component can be delivered by anyone- peer supports, community health worker, SW, case manager, care coordinator, etc.

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Depending on the needs of the individual they will most likely need to have behavioral health services in place in the community. The education component of CRP could be delivered by a community mental health practitioner, social worker, Adult Foster Care staff and/or staff of the courts.

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The individual would need to be monitored by a case manager. Their medical treatment could be any licensed psychiatrist or mental health professional that is covered by the individual's private health insurance or medical assistance.

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What does it mean to do Competency Restoration? Is it education? Often when mentally ill people return to their baseline they are restored without further steps. I think we are talking about people who may never have the capacity (DD or some other condition that limits their cognitive functioning) to be restored. I just mention this again because counties are fine with being responsible when it is a mental health issue however in most of the situations where people are discharged from the hospital into a placement and have not been restored, it is not a mental health issue rather more of a cognition issue.

Where should CR take place in the community?

4 sites to begin (2 metro locations, 1 northern location, 1 southern location)

Or 2 metro sites to begin

Initially 4 sites. I suggest the program is located in the metro area on/near a major bus lines. It would minimally need a large conference room and several offices. The conference room would be for group restoration treatment sessions and any team meetings as appropriate. The offices would provide each of the staff the space to interview defendants, administer psychological testing, write competency evaluation, and/or complete associated paperwork.

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As close to the individual as possible – meet the person where they are at.

Provided in jail if person doesn't meet commitment criteria and doesn't meet criteria for community placement.

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Various settings depending on need. Could be outpatient clinic, partial hospitalization program, inpatient program, could be in home, short term residential setting, etc.

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I believe there a number of different settings. Could be in the community, treatment program inpatient or outpatient, IRTS setting, AFC setting, GRH setting, etc.

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There should be a variety of options based on the individual's needs. Home, Group Home, Hospital

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CR could take place in a variety of settings depending on the individual. Some could receive the supports in their own home (if available). Others may need need CR in foster care, crisis respite, or IRTS programs. Counties with a high need of CR could maybe work create an RFP to providers for settings specific to supporting individuals receiving CR or to specifically provide CR.

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It could still be community based and in their own home or the individual my require a more supportive setting such as a Foster Care Home, IRTS, Crisis Respite where CR could come in to complete their programming with the provider.

Cost of CR in the community?

One program administrator/forensic evaluator, one social worker, one 0.5 FTE psychiatrist, one 0.5 court liaison/manager.

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Cost should be data informed

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The cost will depend on the setting and in part how it's paid. This analysis needs to carefully determine which part of the CR is Medicaid billable and which is not.

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For those that can be treated in the community we will need to utilize the funding mechanisms that are in place to determine payment for the various components. The specific educational piece or the follow up examination after CRP doesn't have a billable source so that would need to be established. For our community CRP program we utilized various providers based on their needs and they bill for those services accordingly. If a person is eligible we have opened them for Targeted Case Management (TCM) yet this does not cover the educational component of CRP or the subsequent evaluation needed prior to returning to court after the treat to competency is completed.

Barriers to providing CR in the community and how to resolve them?

- No shows
- No stable funding stream
- No entity responsible for CR in current law. Nobody is required to do it.
- Lack of affordable housing and housing stability
- Lack of accessible transportation
- Lack of access to basic needs resources (health care, food) – social determinants of health
- Medication adherence
- People not wanting the treatment facilities in their neighborhood. Stigma and fear of the mentally ill. Education and a public relations campaign.
- Timeline to be screened, placed on waiver and have waiver opened for those needing waiver services in addition to the CR process.
- Locating a provider that has the ability to support an individual. We currently have lots of individuals fighting for the same resources.
- Education. People will need to have the process communicated to them on what needs to be completed and timelines things need to be done to ensure services are in place for individuals.

The specific barriers that come to mind include the lack of funding to support the educational component as well as who will provide the service. There are also some barriers with the setting. If they don't have their own home in the community you have to identify a placement that will either offer the treat to competency or staff are within close proximity to deliver CRP. An example was we had a treat to competency individual at ARMTC not meeting level of care (DNMC) and the treatment team, our agency and the courts all had to be in agreement on the placement. The placement being recommended by the treatment team was two hours away from our county and the placements we were pursuing were near our home county so that we could continue the treat to competency work. Currently, we are very limited as no one other than a few counties are doing Community CRP.

How to pay for CR in the community?

Legislatively request funding. Jail based funding would be based on the time limited model – which would allow for an individual to start restoration services immediately while the individual is waiting for inpatient admission

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Consider funding sources for grants for community competency services, including evaluating use of DNMC funds or other funds. State general fund appropriation.

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This should be paid through the courts since CR is a court status. The educational component and subsequent evaluation after CRP should be paid for by the courts.

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Community restoration should take a large burden off the state and would open beds for individuals that require a more restrictive placement. However, I feel the state should still be financially responsible for the treatment and care. I also feel some of the medical cost could be covered by private insurance and medical assistance.

Additional Comments:

Community Competency Restoration Staff Responsibilities:

The program administrator/forensic evaluator would be responsible for various administrative tasks associated with creating and managing a new program and clinical tasks associated with the evaluation of competence and writing competency reports. So as to streamline and target restoration efforts, the program administrator/forensic evaluator would conduct an intake interview with each participant for the purposes of triage. The administrator/evaluator's clinical impressions would be communicated to the social worker and the psychiatrist. As a team, the group would identify a defendant's particular treatment needs as it relates to competence to proceed. The administrator/evaluator would administer psychological testing as appropriate. This individual would also conduct re-evaluations of defendants' competence to stand trial.

The social worker would facilitate group competency restoration sessions to address factual deficits. They would also conduct individual meetings with defendants for the purposes of discussing case specific information and assessing rational understanding. The social worker would be an integral member of the treatment team, and s/he would convey relevant clinical impressions to the evaluator and medical provider throughout programming. When appropriate, the social worker would assist the medical provider in identifying appropriate psychiatric treatment options in the community for program participants.

The medical provider would be responsible for an initial psychiatric evaluation of all program participants. The psychiatrist would then consult with participants' psychiatric treatment providers in the community regarding their impressions and the identification of an appropriate treatment plan. In those instances in which the program participant does not have a community psychiatric treatment provider at the time of admission, the program medical provider would provide temporary psychiatric coverage until such time that a community provider could be identified. As noted above, the medical provider would work with the social worker to identify such a provider.