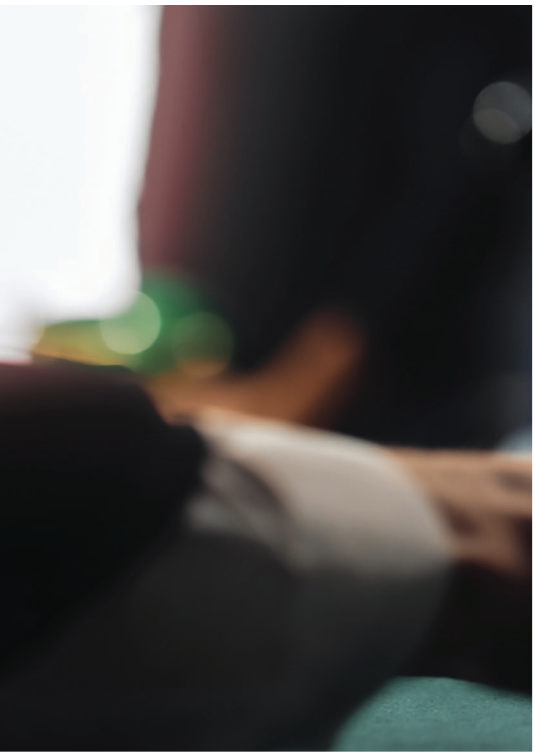
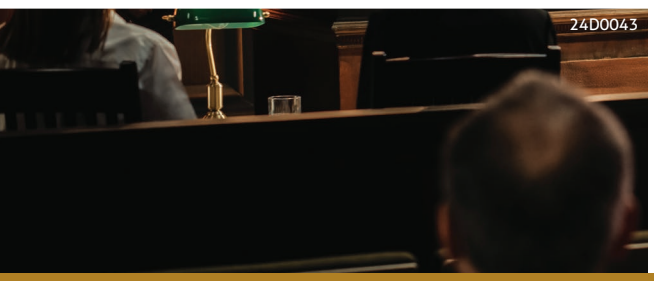


Texas Competency Restoration Guide

September 2023



TEXAS BEHAVIORAL HEALTH AND JUSTICE TECHNICAL ASSISTANCE CENTER

TEXAS Health and Human Services

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Introduction

The competency to stand trial process is designed to protect the rights of people who do not understand the charges pending against them and are unable to assist in their own defense. In Texas, the prosecution, defense, or trial court can suggest that the person accused of a crime may be incompetent to stand trial (IST). The court can dismiss the charges against the person or pause court proceedings and order a competency evaluation if, after conducting an informal inquiry, the court determines that evidence exists to support a finding of incompetency. If the court does not dismiss the charges and the person is found IST, the court can order the person to receive competency restoration (CR) services in an inpatient facility, outpatient or community-based program, or jail-based setting.

The purpose of this guide is to provide general guidance and education to judges, lawyers, mental health and intellectual and developmental disability providers, law enforcement, family, and other members of the community on the CR process. The provided guidance is meant to be suggestive rather than prescriptive and used in the context of the services and support available in a community. Although the CR system in Texas serves justice-involved people with mental illness or intellectual or development disabilities, this guide focuses exclusively on the services and support provided to people with mental illness.

Foundations of Competence to Stand Trial

The competency to stand trial process is designed to protect the rights of people with mental illness or an intellectual or developmental disability. A person may be found incompetent to stand trial (IST) if they do not have (1) sufficient ability to consult with their lawyer with a reasonable degree of rational understanding or (2) a rational and factual understanding of the proceedings against them (Code of Criminal Procedure (CCP) Art. 46B.003).

In Texas, the competency to stand trial process begins when the prosecution, defense, or trial court raises the issue of competency. The court may dismiss the charges against the person or pause court proceedings and order a competency evaluation if, after conducting an informal inquiry, the court determines that evidence exists to support a finding of incompetency. Local courts are liable for the costs associated with the provision of a competency evaluation.

If the court orders a competency evaluation and the person is found IST, the court can order the person to competency restoration (CR) services. These services are designed to stabilize symptoms of mental illness and provide legal education so that the criminal trial can resume. The appropriate use of the competency to stand trial process and consideration of alternatives to inpatient CR services can reduce the strain placed on state, county, and municipal resources when demand for CR services exceeds capacity.

Interventions used to restore competency may include psychotropic medications, legal education, and specialized or individualized treatments. Psychotropic medications are the most common form of treatment for people found IST and research strongly supports their use in CR. Legal education provided during CR may vary by program, but generally includes multiple elements of legal education to ensure the participant understands the criminal justice system. The education component of CR may also include skills training on how to manage stress or other adverse experiences that can occur before, during, or after court. Specialized treatments may include deficit-focused remediation, individual or group therapy, and life skills training. Depending on the person receiving services, deficit-focused remediation may focus on deficits in rational understanding as it pertains to the charges against them and their ability to consult with their attorney.

It is important to note that CR is not designed to be an avenue to ongoing treatment for people with MI or IDD. A person may be connected to ongoing treatment over the course of their engagement in CR, but connection to ongoing treatment is not a requirement for successful program completion. CR is intended only to ensure that criminal proceedings may resume.

CR services can be provided in multiple settings, including state hospitals, jails, and in community-based outpatient programs. Although the interventions used by a CR program may vary between providers and settings to a small degree, all can provide psychiatric medication and legal education as primary foundations. The primary differences between CR settings may be program structure and the level of supervision.

Inpatient CR takes place in a secure hospital setting and includes medication stabilization, treatment planning, and legal education. Inpatient care is the most expensive form of CR.[1] The expense associated with inpatient CR increases when considering the costs of incarceration incurred by counties for the period between arrest and receipt of CR and the period between hospital discharge and the resumption of criminal proceedings. A national study found that the average length of stay for inpatient CR in a state hospital setting was 73 days with a rate of restoration of 80 to 90 percent.

For a person committed to a non-maximum security (Non-MSU) inpatient CR unit in Texas in 2023, the average total cost of incarceration prior to hospital admission and inpatient CR is approximately $361,000.[2] For a person committed to a maximum-security unit (MSU), the average total cost of incarceration prior to hospital admission and inpatient CR is $248,000. The cost of incarceration and hospitalization can increase or decrease depending upon the period between arrest and the issuance of a commitment order, the period between the issuance of the commitment order and hospital admission, and the hospital length of stay required to restore the person to competence.

Jail-based competency restoration (JBCR) is provided in jail to people found IST. In Texas, the Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA) must contract with the county jail to provide CR services (CCP Art. 46B.091(c)). The JBCR program must:

- Operate in a designated space in the jail to conduct JBCR services;
- ensure coordination of general health care; supply clinically appropriate psychoactive medications to administer court-order medications to program participants; and
- provide weekly competency restoration hours commensurate to the hours provided as part of a competency restoration program at an inpatient mental health facility (CCP Art. 46B.091(d)).

[1] Danzer, G.S., Wheeler, E.M.A., Alexander, A.A., & Wasser, T.D. (2019). Competency Restoration for Adult Defendants in Different Treatment Settings. Journal of the American Academy of Psychiatry and the Law Online, 47(1), 68-81. DOI: https://doi.org/10.29158/JAAPL.003819-19

[2] Calculation is based on the average number of days a person is incarcerated prior to receipt of competency restoration services, the average length of stay for a person receiving inpatient CR services in a state hospital, and county jail and state hospital bed day costs.

When the length of time for admission to an inpatient facility is great, JBCR services can be provided more expediently. For a person placed in JBCR in Texas, the average total cost of incarceration and the provision of CR services prior to adjudication is approximately $55,000.[3]

Outpatient competency restoration (OCR) may be provided by the LMHA or LBHA to people found IST and released on bail after consideration of public safety and effectiveness of treatment. OCR is the least restrictive setting in which to provide CR services, and service recipients may also have access to additional behavioral health services and support offered by the CR provider, including housing, case management, and peer support.

For a person placed in OCR in Texas, the average total cost is approximately $17,000.[4] OCR programs can be structured in various ways and may include housing or housing assistance. OCR programs that include housing are generally more costly on a per participant basis than those without a housing component.

Table 1 provides summary information concerning each setting in which CR can be provided.

[3] Calculation is based on the number of days a person is incarcerated, including time in a JBCR program and a county jail bed day cost of $100.

[4] Calculation is based on HHSC contract costs. The estimated cost of OCR does not include the average cost of incarceration for people ordered to OCR for the period between the person's arrest and their admission to the OCR program.

Table 1: Summary Information on CR by Setting

Type of Competency Restoration	Inpatient Competency Restoration	Outpatient Competency Restoration	Jail-Based Competency Restoration
Physical Location	State Hospital or Contracted Facility	Community or residential	In jail in designated space separate from general population
Bond Status	Bond NOT required	Bond required	Bond NOT required
Eligibility	No eligibility criteria	Specific eligibility criteria set by OCR provider	Specific eligibility criteria set by JBCR provider
Treatment Length **(Initial commitment)**	- Misdemeanor- up to 60 days (CCP Art. 46B.073) - Felony- up to 120 days (CCP Art. 46B.073) - Possibility of requesting a 60-day extension (CCP Art. 46B.080)	- Class B Misdemeanor – up to 60 days (CCP Art. 46B.0711) - Class A Misdemeanor or Felony – up to 120 days (CCP Art. 46B.072) - Possibility of requesting a 60-day extension (CCP Art. 46B.080)	- Misdemeanor – up to 60 days (CCP Art. 46B.073) - Felony – 60 days + may continue to provide services for authorized period unless inpatient or OCR slot available (CCP Art. 46B.091) - Possibility of requesting a 60-day extension (CCP Art. 46B.080)

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Principles of Competency Restoration

The following principles are intended to provide general guidance to judges, lawyers, mental health clinicians, law enforcement, family, and other community members to support an effective and efficient CR system. These principles are meant to be suggestive rather than prescriptive and used in the context of the services and support available in a community.

The principles were developed through a collaborative process:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) GAINS Center hosted an expert panel of CR experts in August 2022;
- attendees from the Texas delegation formed the Steering Committee to support development of this guide;
- the TA Center hosted two focus groups with subject matter experts from across the state; and
- additional review was solicited through a peer-review process.

Principles of Competency Restoration

1. Access to robust, appropriate, and timely community-based services and support is essential to divert people with mental illness from the criminal justice system and to promote reentry after a period of incarceration. This is the foundation for reducing the number of people determined incompetent to stand trial (IST) who need CR.

The National Association of Counties describes a behavioral health continuum of care as programs and practices that help people before, during, and after an emergency. The central components are:

> **Before an emergency** by connecting them to treatment and services in the community that target unmet behavioral and physical health needs before they escalate to a crisis;
>
> **During an emergency** through a coordinated crisis response system that provides community members with someone to call, someone to respond and somewhere to go; and
>
> **After an emergency** via continuing system collaboration and linkages to social services, peer support, and recovery care.

SAMHSA developed the Certified Community Behavioral Health Clinic (CCBHC) model to ensure access to coordinated comprehensive behavioral health care for people with mental health and substance use conditions. CCBHCs are required to provide a comprehensive array of behavioral health services and care coordination to help people navigate behavioral health care, physical health care, social services,

and the other systems. In Texas, all LMHAs and LBHAs are certified as CCBHCs. For more information, see, Texas Certified Community Behavioral Health Clinics.

In the context of this guide, the term "diversion" or "divert" describes any action or intervention that reduces justice involvement for people with behavioral health conditions. Communities have many options for diverting people with behavioral health conditions from the criminal justice system. Examples include specially trained law enforcement officers, behavioral health and law enforcement co-responder programs, diversion or drop-off centers, and specialty court programs. The Sequential Intercept Model (SIM) offers communities and partners a framework for identifying potential diversion opportunities at each stage of the criminal justice process.

Preventing justice involvement may be the most effective and efficient way to create an effective CR system. SAMHSA's Principles of Community-Based Behavioral Health Services for Justice-Involved Individuals can help behavioral health providers and their partners identify the core components of services to reduce and prevent justice-involvement for people with mental illnesses.

In addition to developing robust, appropriate, and timely community-based services, communities may need to undertake a public outreach and education initiative to raise awareness of the services and support available to the community, including targeted outreach to criminal justice partners such as law enforcement, the District Attorney's Office, the Public Defender's Office, the private defense bar, Managed Assigned Counsel Programs, and District and County Judges and court staff.

2. People for whom the compelling interest to prosecute is low are not considered for CR. People for whom the compelling interest to prosecute is high receive CR services in the least restrictive setting as appropriate.

How a community understands compelling interest may depend on its priorities, preferences, needs, and resources. In instances when a person with mental illness is charged with a crime due to the nature of their mental illness, variables to consider when determining compelling interest may include:

- Nature of the charged offense and aggravating factors;
- circumstances under which the offense was committed;
- concerns and safety of the alleged victims and community;
- Availability of inpatient CR; and
- wait time to receive CR in the context of the maximum sentencing term provided by law for the alleged offense.

There may also be differences in the understanding of compelling interest between partners within a community. To establish a uniform understanding and application of compelling interest, a community

may need to improve communication, coordination, and collaboration between partners that serve people at risk of justice-involvement, especially those who may interact with the CR system. Effective communication, collaboration, and coordination within a community may support greater understanding of compelling interest within such community as it pertains to the utilization of CR and CR placement decisions.

Common charges for which the compelling interest to prosecute may be low include non-violent misdemeanor offenses such as criminal trespass, criminal mischief, disorderly conduct, and those that relate to a person's substance use disorder. Community partners may benefit from training and education on the impact that mental illness can have on the commission of these or similar offenses.

Partners may also consider the purpose of CR as described in the introduction to this guide relative to the identified objective and preferred outcome of the court proceedings. For example, if the objective of the proceedings is to connect the person to ongoing community-based care, CR is not the most efficient and effective means to accomplish this objective. When the purpose of CR does not match the objective or preferred outcome of the court proceedings, partners may consider alternative dispositions.

People for whom the compelling interest to prosecute is low and therefore not considered for CR may still require mental health services. Partners who interact with the CR system may benefit from education on the services and support available and accessible in their community, to ensure that people who are not considered for CR are considered for alternative mental health services and dispositions.

3. CR is used only to stabilize symptoms of mental illness and provide legal education to allow for the resumption of the adjudicative process.

The purpose of CR is to stabilize symptoms of mental illness and provide legal education so that a person may continue in the legal process. Psychotropic medications are the mainstay treatment to stabilize symptoms of mental illness for people who are IST. The limited scope of services provided to restore competency may mean that an alternative disposition that allows for substance use treatment, assertive community treatment (ACT), forensic assertive community treatment (FACT), or post-arrest diversion may better meet the needs of the person, court, and community.

CR services may include counseling, case management, and life skills training to help the person successfully transition back to the community upon case dismissal or discharge. People found IST who do not receive supplemental mental health services may experience challenges with community reintegration and stability.

4. The CR system provides clear accountability for systematic efficiency, equity, quality evaluators and evaluations, and is committed to confidentiality.

Article 46B.022 of the Texas Code of Criminal Procedure outlines the qualification criteria to be appointed as an expert to conduct a competency evaluation (See: Appendix D). However, adherence to the evaluator qualification criteria does not guarantee that the evaluator observes best- or promising practices when conducting an evaluation.

The Journal of the American Academy of Psychiatry and the Law provides principles and practices for competency evaluators to conduct quality evaluations, including that the evaluator should:

- Learn about the state's allegations and the actions that led to the prosecution, defense, or court to question the person's competence, and review court orders, discovery materials, court filings, indictments, transcripts, depositions, and other relevant collateral records or documents;
- obtain pertinent background information, including the personal and family history, housing status, and academic or occupational history; and
- consider the potential impact of cultural and social differences between the evaluator and the person being evaluated as they relate to the evaluator's assessment of the variables to be included in the written report.

The utilization of a peer review tool can improve the adoption of best and promising practices by competency evaluators in conducting competency evaluations. Peer guidance on ways in which evaluators can improve their performance and recognition of elements of the evaluation process that exceed established standards can contribute to greater efficiency and efficacy in the CR system. Elements or items of interest in peer evaluations may include an assessment of the evaluator's disclosure of the purpose of the evaluation and the process description provided prior to evaluation; necessity, sufficiency, and relevance of background information collected; completeness of the clinical review and mental status examination; full consideration of the patient's motivation; and adequacy of information provided in the evaluation.

The peer review process also provides forensic evaluators with the opportunity to engage in collegial peer-to-peer feedback. Peer-to-peer learning provides space for an open dialogue on ways to better incorporate psychological testing and the ways in which evaluators describe cognitive impairments, intellectual disabilities, and instances of feigning or exaggeration of symptoms. Evaluators may also identify opportunities for additional training opportunities to support ongoing improvement in report writing.

Similar to the qualification criteria for competency evaluators, the Code of Criminal Procedure stipulates the information that must be included in a competency evaluation but does not include best or promising practices to enhance the quality, accuracy, and utility of these evaluations.

The Council of State Governments' (CSG) publication Just and Well: Rethinking How States Approach Competency to Stand Trial provides guidance on providing quality and equitable competency evaluations, including that jurisdictions should consider conducting evaluations, to the degree possible, in the community to ensure that people are able to stay close to home and in the least restrictive setting possible. Videoconferencing applications can be used to expedite the evaluation process in rural and remote communities in which a competency evaluator may not be readily available.

Partners in the CR process must also emphasize the importance of confidentiality when handling or sharing Protected Health Information (PHI) and observe the protections provided by state and federal law. Information on state and federal privacy and information sharing provisions can be found below.

- Section 533.009 of the Health & Safety Code: Exchange of Patient Records
- Section 611.004 of the Health & Safety Code: Authorized Disclosure of Confidential Information Other Than in Judicial or Administrative Proceedings
- Section 614.017 of the Health & Safety Code: Exchange of Information
- Title 42, Part 2 of the Code of Federal Regulations: Confidentiality of Substance Use Disorder Patient Records

Please see **Appendix D: Qualifications of Competency Evaluators and Competency Evaluation Requirements** *for references to Texas statute on competency evaluator qualifications and requirements for competency evaluations.*

5. The CR system emphasizes early identification and intervention, matching the services provided to the person's needs, and ensures continuity of services and support for people moving between treatment settings.

Preventing justice involvement may be the most effective way to create an efficient CR system. Diversion before arrest, when appropriate, and connection to treatment can reduce the demand for CR.

Once a person has been arrested, opportunities for early identification include mental health screening at jail booking and CCP Article 16.22 interviews. Timely assignment of defense counsel can support early identification of people who may have a mental illness, including those who may be IST. In Texas, jails must run the Texas Law Enforcement Telecommunications System (TLETS) Continuity of Care Query (CCQ) at every booking to identify people who have received mental health services at an LMHA, LBHA, Local Intellectual and Developmental Disability Authority (LIDDA), or state hospital in the previous three years.

CR providers may consider utilizing a competency screen when they believe a patient has restored to trial competency to assist in determining if a full reevaluation may be necessary. Competency screens save time and resources and improve the efficient and effective utilization of the CR system.

Competency screens may be used as possible credible evidence of immediate restoration in a motion to re-evaluate trial competency for people awaiting CR.

There is no one-size-fits-all solution or treatment for people with mental illness. The most effective treatment for one person can be different for another person, even in instances when they share a diagnosis, treatment histories, and socioeconomic or demographic characteristics. Ensuring that the services provided meet the unique needs of each person with a mental illness, including those who may be IST, can help to improve treatment outcomes and reduce the strain placed on local and state mental health treatment providers.

Continuity of services and support for people moving between treatment settings relates to people who have been restored to competency who return to jail to await adjudication as well as people who have been adjudicated, had their case dismissed or discharged, and have returned or will return to their community. Continuity of services and support also captures people who "step up" or "step down" to a higher or lower level of care, based on service engagement or treatment outcomes.

Clear and consistent communication between local mental health providers and criminal justice partners is essential to early identification, service matching, and service continuity.

6. The CR system is defined by strong collaboration among mental health providers, law enforcement, jail administration, prosecutors, defense attorneys, the judiciary, and all three branches of state and local government.

The primary partners involved in the CR system include judges, prosecutors, defense attorneys, jail administrators and medical staff, and mental health clinicians. Each partner plays an important and complimentary role in each step of the CR system. The Eliminate the Wait Toolkit for rightsizing CR services in Texas provides partner-specific checklists with ways in which to improve coordination and collaborate across the CR system.

To successfully collaborate, partners should create a coordinated process for communication and action.

7. Partners involved in the CR process observe and promote appropriate and statutorily required timelines for tasks that fall within their respective domains.

The Texas Code of Criminal Procedure (CCP) provides timeframes within which the steps in the CR process must be complete. This guide includes steps that are part of the early identification process as well.

- The Sheriff or municipal jailer must notify the magistrate within 12 hours of the receipt of credible information that may establish reasonable cause to believe that a person in their custody has a mental illness (Art. 16.22(a)(1)).

- If ordered to conduct an Article 16.22 interview, the service provider that contracts with the jail, LMHA or LBHA, LIDDA, or other qualified MI or IDD expert must submit a written report of the interview to the magistrate within 96 hours of the issuance of the order or, if the person is no longer in custody, within 30 days of the issuance of the order except as permitted by the magistrate for good cause shown (Art. 16.22(b)(1) and 16.22(b)(2))
- If competency proceedings are initiated, the disinterested expert or experts who complete a competency examination must submit their report on the person's competency or incompetency within 30 days of the order for the exam except as otherwise permitted by the court for good cause shown (Art. 46B.026).
- If a person is committed to outpatient competency restoration (OCR), the program must report to the court the person's progress toward achieving competency within 14 days of the onset of CR services and at least once every 30 days until the defendant is released from the OCR program (Art. 46B.077).
- If a person is committed to inpatient CR or jail-based CR, the facility or program must report to the court the person's progress toward achieving competency at least once during the commitment period (Art. 46B.077).
- The CR provider must notify the court not later than 15 days before the expiration of the initial restoration period that the restoration period is about to expire (Art. 46B.079(a)).
- If the person has not been transported to court within 15 days of the date on which the court received notification that the CR period is about to expire or the person has attained or is unlikely to attain competency in the foreseeable future, the CR program administrator must cause the person to be promptly transported to the court and placed in the custody of the sheriff of the county in which the court is located (Art. 46B.082).
- The court shall notify the prosecution and defense of the person's return to the court within 1 business day of their return (Art. 46B.084(a)(1)).[5]
- Within 3 business days of the date that notice is received, or, on a showing of good cause, a later date specified by the court, the attorney for the person shall meet and confer with them to evaluate whether there is any suggestion that the defendant has not yet regained competency.[6]

[5] Notwithstanding Subdivision (1), in a county with a population of less than 1.2 million or in a county with a population of four million or more, as soon as practicable following the date of the defendant's return to the court, the court shall provide the notice required by that subdivision to the attorney representing the state and the attorney for the defendant, and the attorney for the defendant shall meet and confer with the defendant as soon as practicable after the date of receipt of that notice (Art. 46B.084(a)(2)).

[6] *Ibid.*

- The court must make a determination on the person's competency to stand trial within 20 days of the date the court received notice from the program administrator or within 5 days of the person's transport to the court, whichever occurs first (Art. 46B.084(a-1)(1)).[7] In most circumstances, the court must give preference over other matters before the court to the trial of a person found IST who has been restored to competency (Art. 32A.01)
- The court must resume criminal proceedings within 14 days of the court's determination that the person's competency has been restored (Art. 46B.084(d)(1)).[8]

Adhering to post-restoration timelines are critical to ensuring a person does not decompensate prior to the resumption of criminal proceedings.

Please see **Appendix E: Competency Restoration Flowcharts** *for CR process flowcharts that include information on statutorily allotted timelines for the completion of certain steps in the CR process.*

8. Partners implement data-driven decision-making processes, to include a data collection, analysis, and dissemination strategy.

There may be as many data systems with unique data elements and definitions as there are partners engaged in the CR system. However, enhanced coordination between partners may present the greatest opportunities to improve local and state CR systems.

Data points to consider when utilizing data to drive decision-making in the CR process include:

- Exact and probable TLETS matches to identify the percentage of people who have received services from an LMHA, LBHA and state hospital in the last three years that are being booked into jail.
- Percentage of people referred to CR with misdemeanor charges and types of offenses to assess if diversion opportunities are being utilized by law enforcement.

[7] Notwithstanding Subdivision (1), in a county with a population of less than 1.2 million or in a county with a population of four million or more, the court shall make the determination described by that subdivision not later than the 20th day after the date on which the court received notification under Article 46B.079, regardless of whether a party objects to the report as described by that subdivision and the issue is set for a hearing under Subsection (b) (Art. 46B.084(a-1)(2)).

[8] Notwithstanding Subdivision (1), in a county with a population of less than 1.2 million or in a county with a population of four million or more, on the court's own motion criminal proceedings in the case against the defendant shall be resumed as soon as practicable after the date of the court's determination under this article that the defendant's competency has been restored (Art. 46B.084(d)(2)).

- Number or percentage of people for whom the issue of competency is raised and were previously found incompetent to stand trial and not restorable.
- Average and median number of days a person is involved with the criminal justice system (incarcerated or on bond) from the time a person is arrested to a court order for CR to assess court efficiencies.
- SAMHSA's *Data Collection Across the Sequential Intercept Model (SIM): Essential Measures* provides guidance on how to collect, use, and share data, as well as data points to consider for collection relative to each intercept on the SIM, from community-based services and crisis response to community corrections and reintegration.

9. Partners are knowledgeable about the CR process, including the sequence of events, terminology, and processes.

Professionals and practitioners engaged in the CR system require expertise in their scope of responsibility. However, all partners can benefit from a full understanding of the CR system and the roles and responsibilities of each professional. A shared understanding of the CR system by all partners can support ongoing improvement and innovation in supporting people who may be IST and in the delivery of CR services.

Please See **Appendix E: Competency Restoration Flow Charts** *for a comprehensive flow chart of the CR system published in the Texas Mental Health and Intellectual and Developmental Disabilities Law Bench Book as published by the Texas Judicial Commission on Mental Health.*

10. CR placement decisions are guided by research, data, statute, administrative rule, and the best available tools to support decision-making that consider legal severity, clinical acuity, and risk of recidivism.

Inpatient settings are often the default when considering where a person will receive CR services. However, when outpatient and or jail-based CR services are available, the least restrictive setting should be utilized when appropriate. Using a structured decision-making tool that balances research, statute, and public safety, such as the one in this guide, can help judges, attorneys, and providers determine the most appropriate setting.

Please see **Appendix A: Principles of Competency Restoration** *for a printable graphic of the Principles of CR with select definitions and practical pointers.*

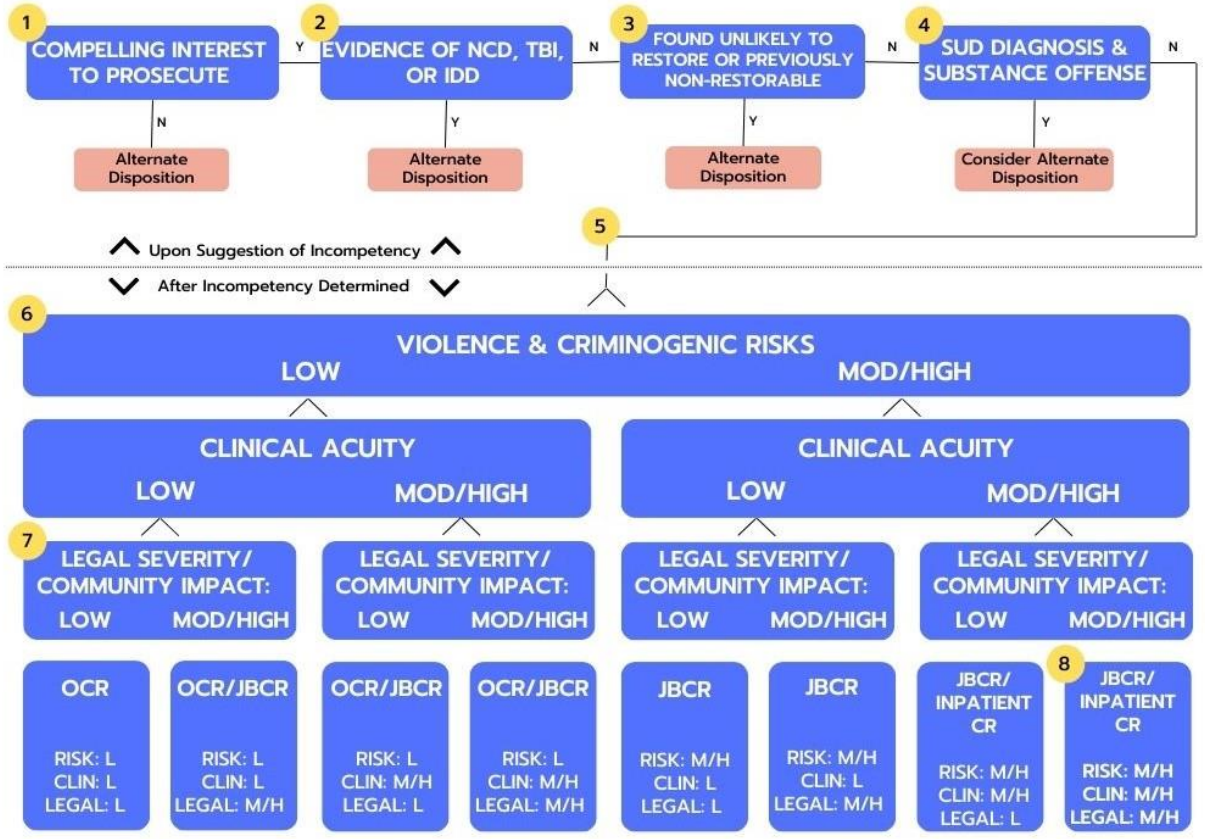
Competency Restoration Placement

The CR placement decision-tree was developed to help judges, lawyers, and mental health clinicians identify and prioritize the various factors that can be used to determine the best available CR placement for people who are IST. This decision tree is meant to be suggestive rather than prescriptive and used in the context of the services and support available in a community.

The decision-tree was developed through a collaborative process:

- The SAMHSA GAINS Center hosted expert panel of CR experts in August 2022;
- attendees from the Texas delegation formed the Steering Committee to support development of this guide;
- the TA Center hosted two focus groups with subject matter experts from across the state; and
- additional review was solicited through a peer review process.

Competency Restoration Placement Decision-Tree



Supplemental Guidance

The below guidance provides additional explanation or clarification for certain steps in determining the most appropriate CR placement, as indicated by the number inside the yellow circle provided in the graphic.

1. CCP Articles 46B.0711, 46B.072, and 46B.073 may require certain placements if the person is charged with a Class B misdemeanor.
2. Neurocognitive Disorders (NCDs) include a group of conditions previously classified as dementia, which manifest as declines in attention, executive function, learning, memory, language, and social cognition. NCDs are degenerative in nature and the likelihood of restorability declines over time. Traumatic Brain Injuries (TBIs) may impact brain functioning and cognition. Both NCDs and TBIs may be independent of or co-occurring with mental illness. Alternate placements can include nursing homes or assisted living facilities. Restoration may or may not be likely for people with NCD or TBI.
3. People who have received CR services in the past and been determined unlikely to restore may be less likely to restore to competency on subsequent commitments. Partners may consider the fiscal implications to local and state systems as well as the health and legal impacts to an individual when pursuing CR for people previously found unlikely to restore or assessed unlikely to restore in the foreseeable future during a competency evaluation. Alternate dispositions can include a dismissal of charges or dismissal of charges and transfer to civil commitment.
4. People with a primary diagnosis of a substance use disorder (SUD) who are charged with a substance-related offense may be better served in a setting that can provide robust substance use treatment. SUD treatment can be provided in inpatient and outpatient settings. Partners may consider the person's willingness and ability to participate in SUD services prior to a referral to SUD treatment. Courts may order SUD treatment under Health and Safety Code Chapter 462. Alternate dispositions may include services provided by the LMHA, Salvation Army, or other non-profit entities, as well as services accessible through private or public health insurance.
5. If a person who is IST is in the community on bond, OCR, where available, may be the most appropriate and least restrictive setting to receive CR services.
6. Clinicians should use validated and reliable assessment tools to measure violence and criminogenic risks. Violence risk assessments, such as the *Historical-Clinical-Risk Management-20 (HCR-20)*, must be completed by a clinician. Criminogenic risk assessments, such as the *Texas Risk Assessment System (TRAS)*, can be completed by anyone trained to use the TRAS. Validated and reliable assessment tools can be utilized pre-trial to help divert people with behavioral health conditions from further involvement in the criminal justice system. See the Bureau of Justice Assistance's Public Safety Risk Assessment Clearinghouse for more information on criminogenic risk assessment instruments.

7. Considerations of legal severity and community impact may include violence and risk of recidivism, the nature of the offense, the severity of the offense, and the potential impact to public safety if the person was to return to the community.
8. A person committed to inpatient CR may be able to transition to an alternative setting if they are clinically ready and can be safely transferred to OCR or JBCR.

Please see **Appendix B: Competency Restoration Placement Decision-Tree One-Pager** *for a printable graphic of the Principles of Competency Restoration with select definitions and practical pointers.*

Appendix A. Principles of Competency Restoration

1. Access to robust, appropriate, and timely community-based services and support is essential to divert people with mental illness from the criminal justice system and to promote reentry after a period of incarceration. This is the foundation for reducing the number of people found incompetent to stand trial (IST) who need CR.

2. People for whom the compelling interest to prosecute is low are not considered for CR. People for whom the compelling interest to prosecute is high receive CR services in the least restrictive setting as appropriate.

3. CR is used only to stabilize symptoms of mental illness and provide legal education to allow for the resumption of the adjudicative process.

4. The CR system provides accountability for systematic efficiency, equity, quality evaluators and evaluations, and is committed to confidentiality.

5. The CR system emphasizes early identification and intervention, matching the service provided to the person's needs, and ensures continuity of services and support for people moving between treatment settings.

6. The CR system is defined by strong collaboration among mental health providers, law enforcement, jail administration, prosecutors, defense attorneys, the judiciary, and all three branches of state and local government.

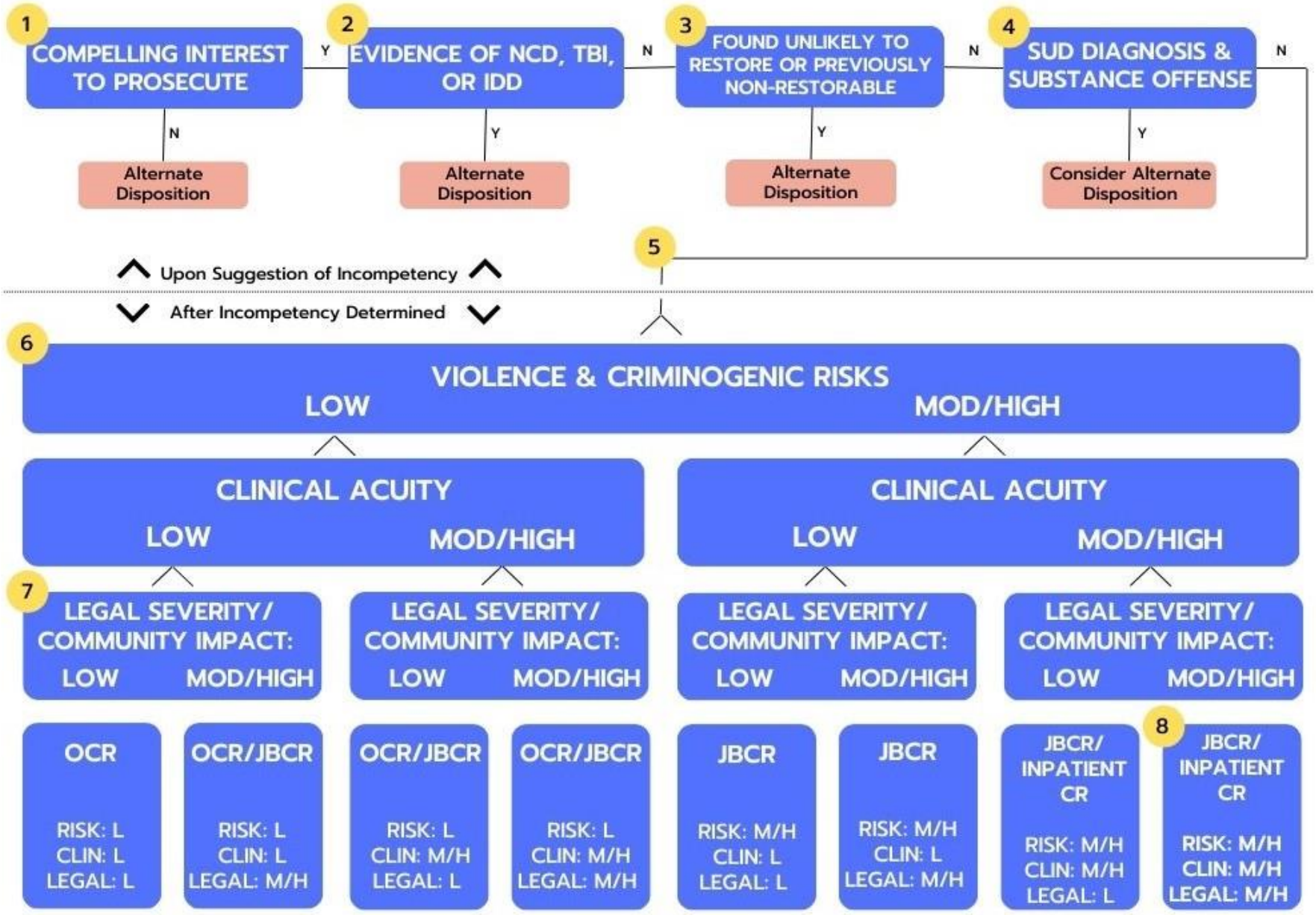
7. Partners involved in the CR process observe and promote appropriate and statutorily required timelines for tasks that fall within their respective domains.

8. Partners implement data-driven decision-making processes, to include a data collection, analysis, and dissemination strategy.

9. Partners are knowledgeable about the CR process, including the sequence of events, terminology, and processes.

10. CR placement decisions are guided by research, data, statute, administrative rule, and the best available tools to support decision-making that considers legal severity, clinical acuity, and risk of recidivism.

Appendix B. Competency Restoration Decision-Tree



1. The Code of Criminal Procedure (CCP) Articles 46B.0711, 46B.072, and 46B.073 may require certain placements if the person found IST is charged with a Class B misdemeanor.

2. Neurocognitive Disorders (NCDs) include a group of conditions previously classified as dementia, which manifests as declines in attention, executive function, learning, memory, language, and social cognition. NCDs are degenerative in nature and the likelihood of restorability declines over time. Traumatic Brain Injuries (TBIs) may impact brain functioning and cognition. Both NCDs and TBIs may be independent of or co-occurring with mental illness. Alternate placements can include nursing homes or assisted living facilities. Restoration may or may not be likely for people with NCD or TBI.

3. People who have received CR services in the past and been determined unrestorable may be less likely to restore to competency on subsequent commitments. Alternate dispositions can include a dismissal of charges, consideration of civil commitment, or alternative mental health services.

4. People with a primary diagnosis of a substance use disorder (SUD) who are charged with a substance-related offense may be better served in a setting that can provide robust substance use treatment interventions.

5. If a person has bonded out of jail, outpatient competency restoration (OCR) may be the most appropriate and least restrictive setting to receive CR.

6. Clinicians should use validated and reliable assessment tools to measure violence and criminogenic risks.

7. Considerations of legal severity and community impact may include violence and criminogenic risks, the nature of the offense, the severity of the offense, and the impact if the person was to return to the community.

8. A person committed to inpatient CR may be able to transition to a less restrictive setting if the person is clinically ready and can be safely transferred to outpatient or jail-based CR.

Appendix C. Competency Restoration Research and Resources

The following research on CR may support the efficient and effective utilization of the CR system for people with unique needs and experiences who may be IST.

American Bar Association. (2016, August 8). Criminal justice standards on mental health. https://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf

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Callahan, L., & Pinals, D. (2020). Challenges to Reforming the Competence to Stand Trial and Competence Restoration System. Psychiatric Services, 71(7). https://doi.org/10.1176/appi.ps.201900483

Colwell, L. H., & Gianesini, J. (2011). Demographic, criminogenic, and psychiatric factors that predict competency restoration. The Journal of the American Academy of Psychiatry and the Law, 39(3), 297–306.

Danzer, G., Wheeler, E., Alexander, A., & Wasser, T. (2019). Competency Restoration for Adult Defendants in Different Treatment Environments. The Journal of the American Academy of and the Psychiatry Law, 47(1), Online. https://doi.org/10.29158/JAAPL.003819-19

Gowensmith, W.N., Frost, L.E., Speelman, D.W., & Therson, D.E. (2016). Lookin' for beds in all the wrong places: Outpatient competency restoration as a promising approach to modern challenges. Psychology, Public Policy, and Law, Vol 22(3), Aug 2016, 293-305

Heilbrun, K., DeMatteo, D., Locklair, B., Giallella, C., Wright, H.J., Griffin, P.A., & Desai, A. (2019). Treatment for Restoration of Competence to Stand Trial: Critical Analysis and Policy Recommendations. Psychology, Public Policy, and Law, 25(4), 266-283. https://doi.org/10.1037/law0000210

Lewis, D. E., Ash, P., Roberts, V. C., Schwenke, T. J., Pagán-González, M., & Egan, G. J. (2023). Jail-Based Competency Restoration Services in the United States: The Need, the Controversy, the Impact of COVID-19, and Implications for Future Treatment Delivery. Criminal Justice and Behavior, 50(2), 216–234. https://doi.org/10.1177/00938548221120280

Mikolajewski, A. J., Manguno-Mire, G. M., Coffman, K. L., Deland, S. M., and Thompson, J. W. (2017) Patient Characteristics and Outcomes Related to Successful Outpatient Competency Restoration. Behavioral Sciences & the Law, 35: 225– 238. https://doi.org/10.1002/bsl.2287

Murrie, D. C., Gardner, B. O., & Torres, A. N. (2022). The impact of misdemeanor arrests on forensic mental health services: A state-wide review of Virginia competence to stand trial evaluations. Psychology, Public Policy, and Law, 28(1), 53. https://doi.org/10.1037/lhb0000417

National Center for State Courts. (2021, August 2). Leading Reform: Competence to Stand Trial System: A Resource for State Courts. https://www.ncsc.org/newsroom/behavioral-health-alerts/2021/august-2-2021

Pinals, D. A., & Callahan, L. (2020). Evaluation and restoration of competence to stand trial: Intercepting the forensic system using the sequential intercept model. Psychiatric Services, 71(7), 698-705. https://doi.org/10.1176/appi.ps.201900484

Pirelli, G., & Zapf, P.A. (2020). An Attempted Meta-Analysis of the Competency Restoration Research: Important Findings for Future Directions. Journal of Forensic Psychology Research and Practice, 20(2), 134-162. https://doi.org/10.1080/24732850.2020.1714398

Warburton, K., McDermott, B., Gale, A., & Stahl, S. (2020). A survey of national trends in psychiatric patients found incompetent to stand trial: Reasons for the reinstitutionalization of people with serious mental illness in the United States. CNS Spectrums, 25(2), 245-251. doi:10.1017/S1092852919001585

Appendix D. Qualifications of Competency Evaluators and Competency Evaluation Requirements

Qualifications of Competency Evaluators

Article 46B.022 of the Code of Criminal Procedure stipulates that, to qualify for appointment to conduct competency evaluations in Texas, a psychiatrist or psychologist with a doctoral degree in psychology must:

1. As appropriate, be licensed to practice in Texas;
2. have the following certification or training:
    a. The American Board of Psychiatry and Neurology with qualifications in forensic psychiatry;
    b. the American Board of Professional Psychology in forensic psychology; or
    c. completed at least 24 hours of specialized forensic training related to incompetency or insanity evaluations and at least 8 hours of continuing education related to forensic evaluations completed within the 12 months preceding the appointment; and
3. complete six hours of required continuing education in courses in forensic psychiatry or psychology within the 24 months preceding the appointment.

Quality Competency Evaluations

Regarding competency evaluations, Article 46B.024 of the Code of Criminal Procedure requires a competency evaluator to consider the capacity of the person to:

(1) Rationally understand the charges against them and the potential consequences of the pending criminal proceedings;

(2) disclose to counsel pertinent facts, events, and states of mind;

(3) engage in a reasoned choice of legal strategies and options;

(4) understand the adversarial nature of criminal proceedings;

(5) exhibit appropriate courtroom behavior; and

(6) testify.

The evaluator must also consider, as supported by current indications and the person's history:

(7) whether the person is a person with a mental illness or IDD;

(8) whether the identified condition has lasted or is expected to last continuously for at least one year;

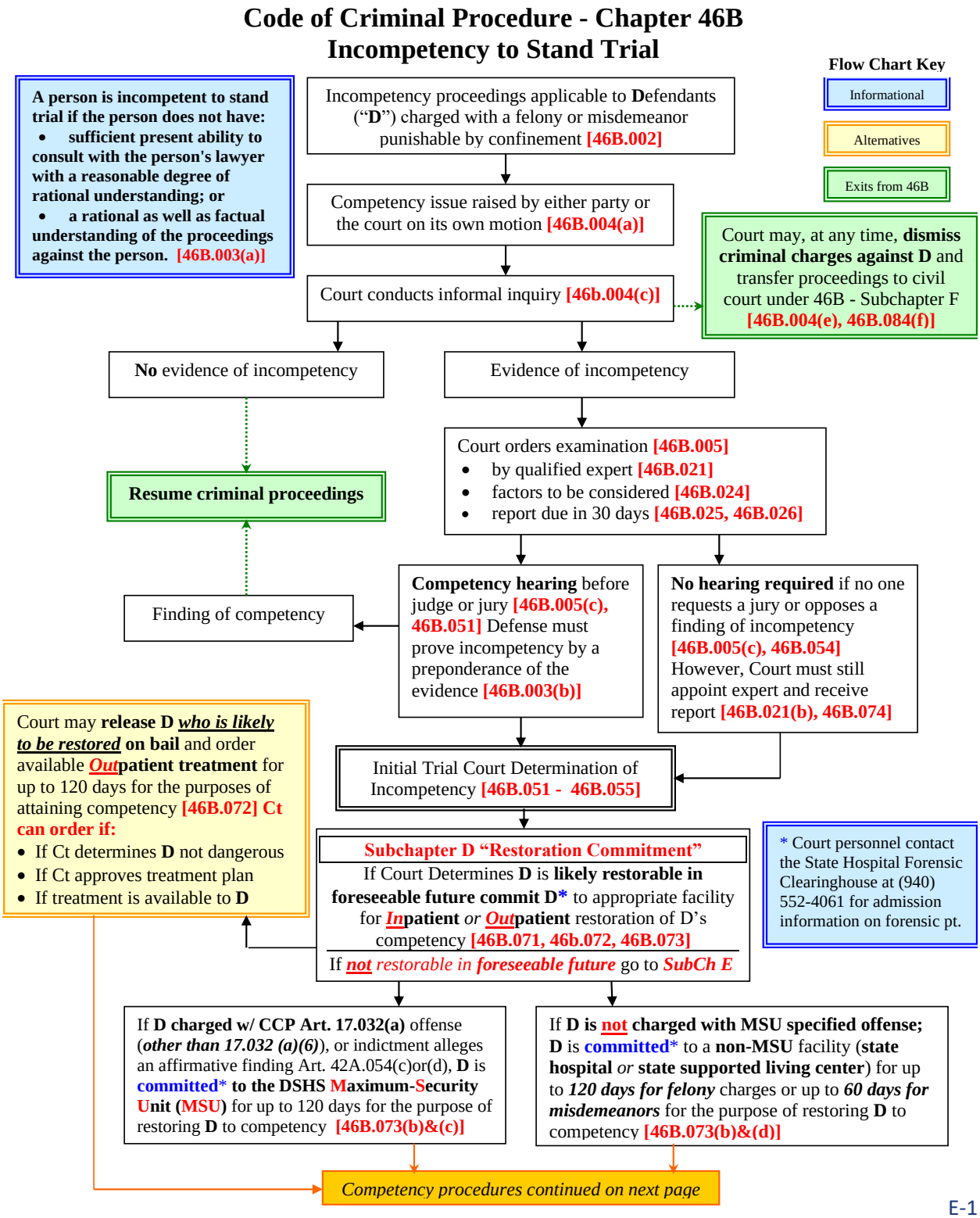
(9) the degree of impairment resulting from mental illness or IDD and the specific impact on the person's capability to engage with counsel in a reasonable and rational manner; and

(10) if the person is taking psychoactive medications, whether the medication is necessary to maintain the person's competence and the effect, if any, the medication may have on the person's appearance, demeanor, or ability to participate in the proceedings.

The information that must be included in the competency report submitted to the court by the evaluator can be found in Article 46B.025 of the Code of Criminal Procedure.

Appendix E. Competency Restoration Flow Charts

The following flowcharts can be found in the *Texas Mental Health and Intellectual and Developmental Disabilities Law Bench Book* published by the Texas Judicial Commission on Mental Health.



Competency procedures continued from first page

Treatment Facility Responsibilities during **Subchapter D "Restoration Commitment"** apply to ***In*patient** and ***Out*patient MH treatment facilities** and **ID-State Supported Living Centers [46B.077(a)]**

- Develop individual treatment program for **D**
- Assess whether **D** will attain competency in the foreseeable future
- Report to the court and local MH/ID Authority on **D's** progress toward competency

Head of *Inpatient* or ***Jail-Based Competency Restoration*** (**JBCR**) programs sends **Notice to Court** when:

- **D** has attained competency **[46B.079(b)(2)]**
- **D**, while not competent, **is clinically ready for OCR** program **[46B.079(b)(1)]**
- **D** won't attain competency in foreseeable future **[46B.079(b)(3)]**
- Term of commitment is set to expire (≥ 15 days)* **[46B.079(a)]**

Head of *Outpatient* program sends **Notice to Court** when**:**

- **D** has attained competency **[46B.079(b-1)(1)]**
- **D** won't attain competency in foreseeable future **[46B.079(b-1)(2)]**

When giving **Notice to Court** the facility supplies the committing court a **Final Report** stating reasons for **D's** discharge/transfer and a list of types and dosages of medications **D** was on during treatment **[46B.079(c)]**

If the facility believes that a **non-restored D** meets **civil commitment criteria** the facility supplies court with either two Certificate of Medical Examination ("CME") for mental illness *or* affidavit supporting **D's** intellectual disability (should also include IDT recommendation on least restrictive appropriate setting) **[46B.083(a)/(b)]**

***Head of facility** may request one **60-day extension** of restoration order **[46B.079(d); and 46B.080]**

D is to be **returned to court** within **15 days*** of Notice under **46B.079** and court must make determination on **D's** current competency within **20 days** of receiving Final Report **[46B.084(a-1)]**

* If **D** not returned to ct. w/in 15 days, facility shall return **D** and charge the county for costs **[46B.082(b)]**

Even if a party **objects** to the findings of the **Final Report**, the issue of **D's** current competency **must still be heard within 20 days of receiving report [46B.084(a-1)]**

If the hearing is before the court, the hearing may be by electronic broadcast system **[46B.084(b-1); 46B.013]**

If **no objection** to the **Final Report** the court can determine competency based solely on the report **without a hearing [46B.084(a)]**

D found competent

D found ***in***competent

D found competent

Resume criminal proceedings

Are **criminal charges** against **D dismissed?**

Resume criminal proceedings

Charges not dismissed [46B.084(e)] after Subchapter D commitment **or** if **D *not*** *likely to be restored in foreseeable future* **[46B.071(b)]**

Charges dismissed [46B.084(f)]

Court determines if there is evidence of mental illness or intellectual disability **[46B.102(a); 46B.103(a)]**

Court determines if there is evidence of mental illness or intellectual disability **[46B.084(f); 46B.151]**

***46B - Subchapter E* "Civil Commitment; Charges Pending"**

- **Criminal court** conducts commitment hearing (*in*patient or *out*patient) for **D** with **mental illness** pursuant to Subtitle C, Title 7, Health and Safety Code **(Mental Health Code) [46B.102(b)]**
- Commitment proceedings for **D** with **intellectual disability** are conducted pursuant to Subtitle D, Title 7, Health and Safety Code **(Persons with Intellectual Disability Act) [46B.103(b)]**

Evidence of mental illness or intellectual disability

No evidence

D released **[46B.151(d)]**

Pursuant to **Subchapter F,** court **transfers D's** case to **civil court** for commitment proceedings **[46B.151(b)]**

***Subchapter E** commitment procedures continued on next page*

(Cont'd from previous page)

Does **D** meet **Subchapter E – Commitment Procedures?**

Yes

No

CCP, 46B is silent. According to **Health and Safety Code § § 574.033 (MH) and 593.051(ID)**, **D** should be released.

If **D (MH or ID) charged w/ CCP Art 17.032(a)** offense (other than "simple assault") or indictment alleges affirmative finding Art. 42A.054(c)or(d), **D** is committed to facility designated by Health and Human Service Commission (**HHSC**) **[46B.104]**

If **D is not charged with specified offense: D** is committed, for the continuing purpose of restoring **D** to competency to: **[46B.106]**

- **(MH)** a **non-MSU State Hospital**;
- (**MH**) available **outpatient** restoration; or
- **(ID) D** is committed to **State Supported Living Center** under provisions of PIDA

If **D** is sent to **Maximum Security Unit (MSU)** they must be presented to **Review Board**, w/in 60 days to determine if **D is Manifestly Dangerous.** If not D is transferred:

- **(MH)** a **non-MSU HHSC facility [46B.105(a)(1)]**
- **(ID) D** is committed to **State Supported Living Center** (SSLC) under provisions of PIDA **[46B.105(a)(2)]**

Facilities continue to pursue restoring **D** to competency

Redetermination of **D's** competency is available on the request of any party, the court, or the head of facility (state hospital, outpatient restoration program or state supported living center) **[46B.108-46B.110]**

Court may appoint Expert in accordance with Subchapter B **[46B.111]**

If both parties and court **agree** that **D** is **competent**, court shall find **D** restored to competency without a hearing **[46B.112]**

Court shall hold competency hearing if any party **disagrees** that **D** is **competent** (competency is presumed if head of facility submits opinion; presumption must be overcome at hearing by preponderance of the evidence) **[46B.113]**

Resume criminal proceedings

Finding of competency

Finding of incompetency

Court remands **D** back to appropriate facility **[46B.117]**

The head of facility must notify the committing court if they determine that **D** on **Subchapter E commitment** should be **released**. This would include a release due to:

- **expiration of D's commitment** under the Mental Health Code;
- facility determination that **D no longer meets commitment criteria** under Subtitle C or D, Title 7, Health and Safety Code (Mental Health Code/ Persons with Intellectual Disability Act) **[46B.107(a)-(c)]**; or
- **D** has "Timed Out" via Maximum Term of Commitment **[46B.0095]**

The court may hold a hearing on these matters by means of an **electronic broadcast system [46B.107(d)(2), 46B.013]**

If the court determines **release is not appropriate**, the court shall enter an **order** directing **D** not be released **[46B.107(e)]**