State of South Carolina
Department of Mental Health

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Mark Binkley
Interim State Director

August 30, 2019

The Honorable John Taliaferro (Jay) West, Subcommittee Chair
South Carolina House of Representatives
Legislative Oversight Committee
Healthcare and Regulatory Subcommittee
Post Office Box 11867
Columbia, South Carolina 29211

Re: August 19, 2019 Letter

Dear Chairman West:

Thank you for your letter of August 19, 2019 transmitting a number of requests for information following the August 12, 2019 Subcommittee hearing.

Attached is Part 1 of the Department's response to those requests. Please let me know if you or other members have any questions about the information provided.

Sincerely,

Mark W. Binkley, JD
Interim State Director of Mental Health

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Answers to Questions from August 19, 2019 Letter of Subcommittee
South Carolina House of Representatives
Legislative Oversight Committee
Healthcare and Regulatory Subcommittee
Part 1

Amendments to the Sexually Violent Predator Act (2019 S.797)

- **What is the timeline to receive input from the criminal defense bar (i.e., attorneys representing the group of inmates affected by S.C. Code Ann. § 44-48-10 et seq.)?**
  Senator Hutto indicated a willingness to discuss S.797 with members of the defense bar during meetings with him in the spring of this year. The Attorney General's Office and SCDMH provided him with the list of attorneys who are contracted to provide representation for the SVP process at that time. SCDMH will follow-up with Senator Hutto's office with the goal of receiving input from the defense bar prior to the beginning of the Legislative Session in 2020.

Amendments to Title 44, Chapter 23 Regarding Commitments of Defendants for Treatment Services to Restore Capacity to Stand Trial and Regarding Defendants Found to Lack Capacity to Stand Trial and Further Found to be Unlikely to be Able to be Restored

- **Provide proposed strikethrough and underline language.**
  Response pending.

- **Provide citations to the studies referenced in the August 12, 2019, meeting regarding the improvements to the system that could be gained by creating flexibility in the settings (e.g., hospital, detention center, and/or community) where a defendant can be restored and how much time is allowable for restoration.**
  See Attachments 1-9.

- **Quantify the increase in the agency's evaluative capacity with the addition of each new evaluator.**
  With each new full time evaluator position, DMH can complete approximately 100 additional CST/CR evaluations. See also Attachment 20.

Amendments to Tort Claims Act

- **Provide proposed strikethrough and underline language.**
  SECTION 15-78-30. Definitions.

  (d) "Governmental entity" means the State, ~~and~~ its political subdivisions, and contractors operating a governmental health care facility on behalf of the State or its political subdivisions.

  (j) "Governmental health care facility" means one which is operated or contracted for operation by the State or a political subdivision through a governing board appointed or elected pursuant to statute or ordinance and which is tax-exempt under

state and federal laws as a governmental entity and from which no part of its net income from its operation accrues to the benefit of any individual or nongovernmental entity, other than a contractor operating the facility on behalf of the State or a political subdivision. Health care facility includes any facility as defined in Title 44, S. C. Code Ann. for the provision of mental or physical care to individuals, whether or not it is required to be licensed under those provisions.

SECTION 15-78-60. Exceptions to waiver of immunity.

The governmental entity is not liable for a loss resulting from:

(25) responsibility or duty including but not limited to supervision, protection, control, confinement, or custody of any student, patient, resident, prisoner, inmate, or client of any governmental entity, except when the responsibility or duty is exercised in a grossly negligent manner;

Note: Persons receiving nursing care services in a licensed nursing home are referred to as "residents." Additionally, SCDMH refers to individuals who have been committed to the Sexually Violent Predator Treatment Program as "residents," and Section 1 of Senate bill 797, proposing multiple amendments to the State's Sexually Violent Predator Act, would codify the term:

SECTION 1. Section 44-48-30 of the 1976 Code is amended by adding an appropriately numbered new item to read:

"( ) 'Resident' means a person who has been committed as a sexually violent predator for the purposes of long-term control, care, and treatment."

Inpatient Services

- **Provide a detailed organizational chart.**
  See Attachment 20.

- **For inpatient medical services, provide the following:**
  - **Position descriptions for nurse practitioners, primary care physicians and psychiatrists, including scopes of practice, skill set requirements, and the reporting chain.**
    See Attachment 20.

  - **How do South Carolina's position descriptions, scopes of practice, skill set requirements, and reporting chain compare to public psychiatric hospitals in other states?**
    Response pending.

- **What positions perform the practitioner evaluations described by Representative Ridgeway, beginning at time stamp 1:45 of the August 12, 2019, meeting? What position in the inpatient services organizational chart includes the responsibilities typically performed by a hospital peer-review coordinator?**
  See Attachment 20.

- **For the last three years, what are the annual morbidity and mortality rates for each inpatient facility?**
  See Attachment 20.

Human Resources

- **How does the agency measure the effectiveness of its different recruitment methods?**
  At this time, DMH has no mechanism to capture effectiveness of its recruitment tools.

- **What changes have been made, based on what the agency has learned about the relative effectiveness of its different recruitment methods?**
  Not applicable. See response above.

Relationships with Other Entities

- **Are you able to forecast future needs?**
  SCDMH is embedded in 12 EDS around the state. The evaluation of effectiveness is in the clinician's EPMS and in the contract monitoring with the specific ED. Hospitals will not pay for the service if it is not meeting the hospital's needs. Our goal is to divert patients away from an ED, so we do not need to have SCDMH clinicians in the EDs. Some hospital systems have their own psychiatric evaluation service serving their own EDs.

  The table below outlines those EDs in which SCDMH has embedded staff (MHP). It also outlines those EDs in which SCDMH has deployed the SCDMH Emergency Department Telepsychiatry Program (EDTP) and illustrates those EDs that benefit from both SCDMH services.

Hospitals	MHP	EDTP
Abbeville Area Medical Center		X
AnMed Health Medical Center - Anderson		X
Beaufort Memorial Hospital		X
Cherokee Medical Center		X
Coastal Carolina Hospital		X
- Tidewatch Emergency Department		X
Conway Medical Center	X	X
Edgefield County Hospital	X	X
Hampton Regional Medical Center		X
Hilton Head Hospital		X

Lexington Medical Center	X	
McLeod - Dillon		X
McLeod - Clarendon		X
McLeod - Florence	X	X
McLeod - Loris[1]	X	
McLeod - Seacoast[1]	X	
MUSC Chester		X
MUSC Florence		X
MUSC Lancaster		X
MUSC Marion		X
Oconee Memorial	X	
Prisma - Columbia	X	
Prisma - Greenville	X	
Prisma - Laurens	X	X
Prisma - Tuomey		X
Regional Medical Center – Orangeburg	X	
Spartanburg Regional Healthcare System	X	X
Tidelands Health - Georgetown Memorial Hospital[2]	X	X
Tidelands Health - Waccamaw Community Hospital[2]	X	X
Union Medical Center		X
Williamsburg Regional Hospital		X

[1]An MHP is shared between these hospitals.
[2]An MHP is shared between these hospitals.

- **When the re-draft of the MOA with DJJ is complete, provide it to the Subcommittee.**
  SCDMH will provide the Memorandum of Agreement upon completion.

- **What is the difference in PRTF Medicaid reimbursement rates for South Carolina and Georgia?**
  See Attachment 10.

- **Is DHHS aware of the disparity and its presumed impact on the availability of slots for South Carolina residents in custody of DJJ?**
  Yes.

Agency Strategic Planning

- **Please provide an analysis of patients treated by county (i.e., what categories of mental illness present from each county?).**
  See Attachment 11.

- **Which counties have definitive gaps in service (i.e., what percentage of patients from each county can be treated by the community mental health center serving**

that county without being referred to a different community mental health center?)?

There are no waiting lists at the Community Mental Health Centers, indicating that CMHCs are able to provide services to 100% of patients from respective catchment areas without referring patients to a different CMHC. Augmented by stakeholder feedback, including patients and clinicians, the CMHCs are able to identify areas of need and any shortfalls in access to and availability of services.

Inpatient Services Planning

- **Is there a notation of the review, such that it is easy for agency management and auditors to determine if the review has actually occurred?**
  See Attachment 20.

- **Quantify the shortage. Explain the method for the quantification.**
  Response pending.

Inpatient Services Human Resources

- **Does the agency know if higher scores on the training assessments correlate with a higher rate of service provision with fidelity to agency policies? If so, how does the agency know this?**
  See Attachment 20.

Screening Procedures

- **What types of needs precipitate adjustments?**
  Screening/clinical evaluation tool is updated annually with the publication of new accrediting body standards after approval by the State Director's Quality Management Advisory Committee. National psychiatric practice standards as well as community medical standards are also considered relative to the screening/clinical evaluation tool content/updates.

- **Is there a regular review schedule? If so, what is it?**
  See above answer.

- **Is the inadequacy of the workforce related to numbers of staff, training, experience, or some other issue?**
  Associated with the MHCs' capacity to sustain timely screening/clinical evaluation, the availability of qualified Mental Health Professionals is a vulnerability as the demand for services rises in concert with population growth.

Feedback

- **Provide the results of the most recent employee survey.**
  A sample from Spartanburg CMHC is attached. See Attachment 12A.

  A sample from the Division of Inpatient Services is attached. See Attachment 12B.

  A sample from the whole of SCDMH is attached. See Attachments 12C1 and 12C2.

- **How do agency staff synthesize and use the feedback? Provide some examples of changes made based on employee feedback.**
  Centers issue staff satisfaction surveys, sometimes on an annual basis. The results are shared with all center staff, and then the senior management of the center reviews the data to institute needed changes. Also, every center director has been directed to conduct exit interviews with each staff person separating from the center. The info gathered from those exit interviews is then shared with the senior management of the center. Changes, as needed, are implemented.

Community Mental Health Services

- **Break down by contribution from each county.**
  See Attachment 13.

Patient Care

- **On average, what percentage of an administrator's time is spent providing patient care? If this allocation of duties is present in their position descriptions and is accurate in practice, use those time allocations.**
  Physicians in administrative positions all continue to see patients. DMH sees this as beneficial to maintaining skills and as a part of efficient use of manpower. The percentage of time spent seeing patients ranges from 20 to 80 depending on the level of supervisory responsibility.

- **What drug classes are being prescribed and to what percentage of the DMH population?**
  - Schizophrenia - 20% of patients-antipsychotics
  - Bipolar disorder - 10% of patients-mood stabilizers, antipsychotics, antidepressants, hypnotics
  - Schizoaffective disorder - 5% of patients-mood stabilizers, antipsychotics, antidepressants, hypnotics
  - Major depression - 30% of patients-antidepressants, mood stabilizers, anxiolytics, hypnotics
  - Anxiety disorders - 15% of patients-antidepressants, anxiolytics, hypnotics
  - Attention deficit/hyperactivity - 15% of patients-stimulants, clonidine, bupropion, mood stabilizers
  - Other diagnoses - 5%
  - No medication in 5% of patients noted in above categories

Feedback

- **Is public input a regular agenda item on the DMH Commission agenda?**
  Response pending.

- **Provide examples of positive or negative feedback being used to influence agency decisions.**
  See Attachment 14.

Employee Training

- **Are employees ever asked what was successful or unsuccessful about training, as far as preparation for work?**

  During new employee orientation the nursing staff spend one day on the lodge to which they will be assigned. The purpose is to give them a better understanding of what they will be experiencing when they finish orientation and report to work. After that one day ETR has them complete a survey and asks them the following questions:

  - Was the orientation they received from ETR useful?
  - Was the one day on the unit useful?
  - What did they like most about the training they received from ETR?
  - What did they like most about the one day they spent on the unit to which they will be assigned?
  -

  The findings are shared with the Chief Nursing Officer and the Director of Nursing for Bryan Psychiatric Hospital.

  See also Attachment 20.

- **When was the Clinical Competency Oversight Committee established and what are its guiding principles and procedures?**

  See Attachment 20.

Vulnerable Adult Fatalities Review Committee

- **How does that person provide feedback to the agency's administration on the committee's discussions of statistical studies, cross-agency training and technical assistance needs, and service gaps?**

  See Attachment 20.

- **Please provide the Vulnerable Adult Fatalities Review Committee attendance record of the agency's designee for the last three years, when the agency receives it.**

  The Minutes of the Vulnerable Adult Fatalities Review Committee are confidential, because the proceedings take place in Executive Session, and per statute those proceedings are confidential.

  However, a staff attorney for SLED and his administrative staff excerpted from otherwise confidential minutes the meetings at which the SCDMH representative – Dr. Gary Ewing – was in attendance, and also included any general (not individual specific) recommendations in each meeting that would pertain to SCDMH, if any. See Attachment 15.

Residencies

- **<u>What percentage of the agency's current psychiatric staff were residents in the Prisma Health (formerly Palmetto Health) residency program and interacted with DMH during that residency?</u>**

  There are 209 psychiatrists who currently work for DMH full or part-time. This includes DMH employees and contract physicians. Ninety-one did residency rotations at one of our facilities prior to coming to work for us.

Note: Documentation cited below is provided in response to requests for information issued during Subcommittee hearings, or as updates to previously submitted documentation.

- Also included as Attachment 16 is an updated Comprehensive Permanent Improvement Plan.
- Also included as Attachments 17, 18, and 21 are examples of Forensic Waiting List Elimination Plans.
- Also included as Attachment 19 is the SCDMH Grant Portfolio as of August 28, 2019.

[End]

Attachment 1

Citations related to timeframes for restoration:

- Zapf, P. (2013). *Standardizing protocols for treatment to restore competency to stand Trial: Interventions and clinically appropriate time periods* (Document No. 13-01-1901). Olympia: Washington State Institute for Public Policy.

- Zapf, P. A. & Roesch, R. (2012). Evaluation of competence to stand trial in adults. In Zapf, P. A. & Roesch, R. (Eds.), *Forensic assessments in criminal and civil law: A handbook for lawyers* (pp. 17-31). New York: Oxford University Press.

- Zapf, P. A. & Roesch, R. (2011). Future directions in the restoration of competency to stand trial, *Current Directions in Psychological Science, 20*, 43-47.

- Justice Policy Institute. (2011, October). *When treatment is punishment: The effects of Maryland's incompetency to stand trial policies and practices*. Retrieved from http://www.justicepolicy.org/uploads/justicepolicy/documents/jpi_when_treatment_is_punishment_national_factsheet.pdf

Citations related to non-hospital restoration:

- Danzer, G. S., Wheeler, E. M., Alexander, A. A., & Wasser, T. D. (2019). Competency restoration for adult defendants in different treatment environments. *Journal of the American Academy of Psychiatry and the Law*. Advance online publication. doi: 0.29158/JAAPL.003819-19.
- Heilbrun, K., Giallella, C., Wright, H. J., DeMatteo, D., Griffin, P. A., Locklair, B., & Desai, A. (2019). Treatment for restoration of competence to stand trial: Critical analysis and policy recommendations. *Psychology, Public Policy, and Law*. Advance online publication. http://dx.doi.org/10.1037/law0000210
- Wik, A. (2018). *Alternatives to inpatient competency restoration programs: Community-based competency restoration programs*. Retrieved from https://www.nri-inc.org/media/1500/jbcr_website-format_oct2018.pdf
- 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, 2*2, 293-305.

Information related to restoration timelines:

- The Justice Policy Institute (2011) article includes a table that lists each state's maximum restoration period. The lowest end of this range was 60 days, and most states provide for a longer period. While this is a few years old now, the data still seems to be fairly consistent with current states' laws.
- Zapf & Roesch (2011) noted that "the vast majority of defendants are restored to competency within a 6-month period (and even more within 1 year)."
- Zapf & Roesch (2012) discussed recent studies and restoration timeframes. They concluded that most defendants are returned to court as competent within 6 months the vast majority by one year.

- Zapf (2013) article, which was written for Washington state, includes tables summarizing data about typical restoration timelines. This ranged from 45 days to 3 years, with an average restoration timeline of 153 days. In summary, Zapf indicates: "Research exploring the rates of competency restoration consistently indicates that the vast majority of defendants (80 – 90%) are eventually restored to competency. Most defendants are restored to competency within 180 days and an even greater number are restored within one year." This article also includes the National Judicial College's best practices model for length of time for restoration – they recommend 120 days, with a possible extension if someone is not restored in that timeframe.
- The Danzer et al. (2019) and Heilburn et al. (2019) articles discussed below also include data about typical timeframes for in-patient restoration efforts (e.g., up to 75% within 6 months or more).

Information related to non-hospital restoration:

In general, all the articles about jail-based and outpatient restoration programs have noted there is wide variability regarding restoration rates and the timeframes in which defendants were restored. This is also an emerging area of research, and new data continues to be released.

- Danzer et al. (2019) summarized various studies about the effectiveness of jail-based and outpatient restoration programs. Their article included this table:

Table 1 Attributes of State Hospital, Jail and Outpatient Restoration Programs

Treatment Setting	State Hospitals*	Jails†	Outpatient‡
Costs	$300–$1,000 per day	$42–$222 per day	$100–$500 per day
Rates of restoration	80–90%	55–86%	54–70%
Mean LOSR (per research)	73 days	57.4 days, usually followed by transfer to state hospitals	149–207 days
Patients served	High % of defendants with psychotic disorders	Moderate % of defendants with psychotic disorders	Moderate to low % of defendants with psychotic disorders
Crime type/risk	Moderate to high level of dangerousness	Moderate to high level of dangerousness	Moderate to low level of dangerousness
Medication considerations	High % of adherence, largely due to greater resources to administer involuntary medications	Limited resources for involuntary medication administration	High % of adherence, largely based on screening
Malingering considerations	May teach defendants how to malinger more convincingly	Theoretically ideal for malingerers	Setting less likely to affect malingering either way

* Data on hospital-based restoration obtained from References 2, 3, 5, 8, 13, 16, 19, 23, 29.
† Data on jail-based restoration obtained from References 1, 16, 17, 36, 37, 38.
‡ Data on outpatient-based restoration obtained from References 2, 8, 16, 17, 29, 39, 40.
LOSR = length of stay necessary to achieve restoration.

- Heilbrun et al. (2019) looked at hospital, jail, and outpatient restoration data, and included a 2-page table listing various studies that have looked at average timelines and restoration success rates. For hospital settings, they noted estimates of 75% restorability within 6 months (citing Zapf & Roesch data). They also noted that 13 outpatient programs had a 70% restoration rate within 149 days. In addition, they provided data regarding specific jail-based programs across the county (e.g., a Virginia program had a 83% restored rate and an average timeline of 77 days, a CA program averaged 55-58% and 57 days, AZ programs averaged 84% in 82 days and 87% over 4 months, Colorado had 71% within 2-3 months, Georgia had 34% within 4 months, and LA had 33% in 90-day program).
- Wik (2018) reviewed data about outpatient competency restoration programs and essentially expanded on the Gowensmith et al. article (see below). Her data indicated the following restoration success rates and typical timeframes for restoration:

- Arkansas - 79%, 2-3 months
- California - 35%, 11 months
- Colorado - limited info available
- Connecticut - 75%, 6 months
- DC - 77% 1-4 months
- Georgia - 77%
- Hawaii - 95%, 3 months
- Louisiana - 55%, within 1 year
- Minnesota - still being piloted
- New York - no info available yet
- Ohio - 80%, 2 months
- Oregon - 67%, 3 months
- Tennessee - 6 months
- Texas - 77%, 4 months
- Virginia - 64%
- Wisconsin - 79% 4 months

- Gowensmith et al. (2016) studied 16 state' outpatient competency restoration programs (OCRPs). Some of their specific findings:
  - 36 states' laws allowed outpatient competency restoration, 7 states explicitly prohibited it, and 8 states had "silent" statutes (i.e., the location of restoration is not explicitly addressed).
  - Most OCRPs were relatively new programs (i.e., under 10 years of operation) with small numbers of participants (i.e., up to 50 defendants per year).
  - Most defendants served by these programs had been charged with misdemeanors or non-violent offenses.
  - Restoration rates averaged 70.0%, ranging from 35% to 95% (which they say is slightly lower than inpatient restoration rates)
  - States reported an average of 149 days for participants restored to competency
  - Forensic directors reported length of stay was slightly longer than inpatient restoration
  - Daily costs were between $101 to $500 per day
    - Private providers were paid between $40 to $75 per hour
  - Average total daily costs for OCRP restoration averaged ~$215 per defendant.
    - Versus...inpatient costs between $300 to $1,000 per bed day (average $603)
  - Using an average length of stay for OCRPs of 149 days, this translated into overall estimated savings of $57,800 on average

JUSTICE POLICY INSTITUTE

WHEN TREATMENT IS PUNISHMENT:

The effects of Maryland's incompetency to stand trial policies and practices

OCTOBER 2011

INTRODUCTION

When a person is brought into court to stand trial, it is legally imperative that they understand what is happening to them and to be able to assist in their defense. If they are unable to do so, they may be found to be incompetent to stand trial (IST) and ordered to inpatient or outpatient treatment to restore competency.[1] A person cannot legally be tried for an offense if he or she is found to be incompetent to stand trial.

The most recent U.S. estimates suggest that 50,000 to 60,000 people undergo competency evaluations every year,[2] and that in about a fifth of these cases the person was found incompetent to stand trial.[3] In other words, around 12,000 people are found incompetent to stand trial in the U.S. every year, and around 4,000 of these people are hospitalized for treatment to restore competency at some point during a single incident of court involvement.[4]

"In reality, statutes tying treatment to the maximum sentence attempt to assure that incompetent defendants are punished sufficiently for their alleged crimes."
~ Grant H. Morris and J. Reid Meloy

Over the years, states have enacted laws addressing the constitutional standards and due process rights of people found incompetent to stand trial. While some have adopted reasonable maximum treatment periods and have shifted to greater use of outpatient treatment to attempt to restore competency, others require costly inpatient treatment for too many people and allow those people to remain confined for long periods of time.[5]

As people's liberty is denied when they are involuntarily confined to a mental institution pretrial, and is severely curtailed when required to enroll in residential and outpatient programs, it is critical that they not be held in "competency limbo" beyond the time that research shows is reasonable to either restore competency or to determine that he or she is not substantially likely to be restored. Failure to do so raises questions not only of civil liberties, but also of fiscal efficacy, as state mental hospitals frequently cost significantly more than community-based treatment programs.

WHAT IS THE LAW?

In 1972, the U.S. Supreme Court ruled in *Jackson v. Indiana* that people can only be held for a "reasonable period of time" to determine whether there is a substantial probability that they may soon be restored to competency to stand trial.[6] The Court did not set a maximum time limit on attempts to restore competency, leaving it up to the states to make this determination. A number of states base this time limit on research that shows that most people will be restored within six months to a year, and continued treatment and detention to restore competency beyond this time period is unnecessary.[7] Twenty

states have a maximum treatment period of one year or less (see chart on pages 4 - 5).[8] Yet, other states, like Maryland, base this maximum treatment period on other conditions, including the maximum possible sentence for the alleged offense, a practice that goes against research and against the purpose of competency treatment.

RESEARCH SHOWS THAT PEOPLE ARE LIKELY TO BE RESTORED TO COMPETENCY WITHIN SIX MONTHS OF RECEIVING TREATMENT.

A number of factors can determine whether a person will be restored to competency with specific treatment and within a given time period. But research shows that for the majority people who are likely to be restored, it usually happens within the first six months starting treatment to restore competency. Studies are inconclusive on the exact factors that will increase a person's likelihood of restoration. However, a number of studies report characteristics that may make a person more or less likely to be restored. A study out of Ohio, for example, found that people who are chronically psychotic with a history of lengthy inpatient hospitalization and people whose incompetence stems from irreparable cognitive disorders like an intellectual disability have a low probability of competency restoration.[9]

American Bar Association standards recommend that a person be re-evaluated for competency whenever a staff person feels that competency has been restored, if the person is not likely to have their competency restored, or at a minimum of every 90 days.[10] But some states are not following these recommendations, resulting in people remaining in treatment for longer than necessary.

Studies also show that the majority of people who are restored to competency are restored within a certain timeframe. Research on competency restoration for people with mental illness shows that 70 percent or more become competent within six months of starting treatment;[11] nine out of 10 will be restored within a year. A very small percentage of people do take longer to be restored to competency, and if substantial progress is shown, and the state's interest in prosecution is great, it may be appropriate to continue treatment for a brief additional period.

- A study of people in Oklahoma found that the average length of stay for people who were restored to competency was 63.7 days; less than 6 percent of the subjects had a length of stay greater than six months.[12]
- A study that reviewed 18 years of data in Indiana found that 72.3 percent of people admitted for incompetency to stand trial were restored within six months and 83.9 percent restored within one year.[13]
- A Florida study found that 40 percent of people were restored to competency in three months or less and 78 percent within six months.[14]

People with intellectual disabilities and brain disorders such as dementia, may face particular challenges in restoring competency to stand trial.

The issue of competency to stand trial for people with an intellectual disability is vital,[15] yet most programs designed to restore competency do not explicitly consider the

needs of people with intellectual disabilities.[16] One study found that 60 percent of people with an intellectual disability who undergo competency hearings are found incompetent.[17] Restoring competency can be a challenge for people with an intellectual disability; a study of 75 people with an intellectual disability who were incompetent to stand trial found that two-thirds failed to be restored.[18] Multiple studies have shown that people with dementia have lower chances of being restored to competency once deemed incompetent.[19] And for people with Traumatic Brain Injury (TBI) and other acquired brain injuries (ABI) the traditional treatments provided in state hospitals may be ineffective and inappropriate, due to the unique characteristics of people with these injuries.

RECOMMENDATIONS

People who are mentally ill generally spend more time in the criminal justice system under some form of incarceration both pretrial and post-conviction than the general public due to their unique cases.[20] The lack of community-based treatment options, the training for police officers, and available crisis services, have been leading to more people with mental illness in the justice system, including prisons and jails as well as secure hospitals, many for minor offenses. While not everyone who has a mental illness who comes into contact with the justice system will be found incompetent to stand trial, for those who do, the consequences can be dire and long-lasting. Reducing the impact of the justice system on people with mental illness will lead to better life outcomes for individuals, fewer people in prisons and jails, reduced costs and improved public safety.

1. Ensure that effective community-based mental health resources are available and properly utilized.
2. Develop policies and practices for people with TBI or other ABI, including valid and reliable measures for screening, training for court personnel and treatment providers, and appropriate community-based programs.
3. Invest in quality, affordable and supportive housing for people who need it.
4. Eliminate quality of life policing sweeps that bring more people with mental illness and other mental disabilities, including TBI, into the justice system.
5. Expand Baltimore's existing special police team to one based on Memphis' Crisis Intervention Teams model used to respond to mental health or other behavioral crises that warrant police attention.[21]

Justice Policy Institute is a national nonprofit organization that changes the conversation around justice reform and advances policies that promote well-being and justice for all people and communities. For the full report, *When Treatment in Punishment*, please visit our website, www.justicepolicy.org, or call 202-558-7974 for more information.

State	Maximum Defined Competency Treatment Periods
Alabama	No max treatment
Alaska	180 days for crimes not involving force; 1 year crime of force against another
Arizona	21 months
Arkansas	1 year
California	Misdemeanor charges – lesser of 1 year or maximum sentence; felony – lesser of 3 years or maximum sentence.
Colorado	max sentence
Connecticut	Lesser of max sentence or 18 months.
Delaware	No max
D.C.	180 days total if charge did not involve crime of violence; If crime of violence max is required dismissal of charges at 5 years (except murder or 1st degree sex abuse and 1st degree sex abuse of child, in which case, no requirement to dismiss charges).
Florida	No max treatment limit. Criminal charges dismissed after 1 year for misdemeanors and 5 years for felonies.
Georgia	1 year.
Hawaii	No treatment maximum; no required dismissal of charges.
Idaho	270 days.
Illinois	At the end of 1 year, state either asks to dismiss charges or there is a "discharge hearing" in which there must be a finding of guilt "beyond a reasonable doubt," or person released or civilly committed. If found "guilty" can have treatment for an additional 15 months to 5 years, depending on criminal charge.
Indiana	6 months
Iowa	Lesser of 18 months or maximum sentence of charged offense
Kansas	6 months.
Kentucky	60 days.
Louisiana	maximum sentence
Maine	1 year.
Massachusetts	40 days (plus possible 6 month civil commitment).
Michigan	Lessor of 1/3 of max sentence or 15 months.
Minnesota	Cannot be ordered for treatment on misdemeanors (charges dismissed); felonies, excluding murder = 3 years.
Mississippi	No max either treatment or criminal charges.
Missouri	12 months.
Montana	No max treatment or criminal charges.
Nebraska	No max treatment or criminal charges.
Nevada	Lessor of max sentence or 10 years.
New Hampshire	12 months.

New Jersey	No max treatment or required dismissal of charges.
New Mexico	9 months, except if felony involving "infliction of great bodily harm on another person," use of firearm, aggravated arson, criminal sexual penetration or sexual contact of a minor, in which case (unless charges dropped) court may order hearing on "factual guilt" and if found "guilty and dangerous may order continued treatment for period not to exceed max sentence.
New York	90 days misdemeanor; felonies 2/3 of max sentence.
North Carolina	60 days.
North Dakota	No maximum treatment; charges dismissed at max sentence.
Ohio	1 year maximum through tiered system: 3rd or 4th degree misdemeanor = 30 days; 1st or 2nd degree misdemeanor = 60 days; Non-violent felonies = 6 months; Violent felonies = 1 year
Oklahoma	Lesser of max sentence or 2 years.
Oregon	Lesser of 3 years or max sentence.
Pennsylvania	No maximum; criminal charges dismissed after lesser of maximum or 10 years except 1st or 2nd degree murder can remain indefinitely.
Rhode Island	2/3 of maximum term of imprisonment for most serious charged offense.
South Carolina	90 days total.
South Dakota	1 year for other than Class A or B felony; in those cases, maximum sentence could have received.
Tennessee	no maximum treatment; no requirement for charges dismissed.
Texas	180 days maximum.
Utah	36 months if charged with aggravated murder; 18 months serious felony; 1 year all other charges (not to exceed maximum penalty).
Vermont	No commitment
Virginia	Misdemeanors max 45 days (except for "peeping into dwelling/enclosure or disorderly conduct in public places); for all other charges – lesser of max penalty or 5 years, except murder charge, no limit.
Washington	Non-felony & no history of violence or previous findings of IST or NGRI = no commitment Non-felony and history of one or more violence acts or previously been found IST or NGRI = 120 days
West Virginia	9 months
Wisconsin	Lesser of 12 months or max sentence
Wyoming	No maximum.

Source: Based on a 2005 review of the 50 state statutes and District of Columbia, conducted by the Maryland Disability Law Center.

[1] RD Miller, "Hospitalization of criminal defendants for evaluation of competence to stand trial or for restoration of competence: clinical and legal issues," *Behavioral Science in the Law* 21 (2003):369 –91; DA Pinals, "Where two roads meet: restoration of competence to stand trial from a clinical perspective," *New England Journal of Criminal Civil Confinement* 31 (2005): 81–108.

[2] JL Skeem, SL Golding, G Berge, et al, "Logic and reliability of evaluations of competence to stand trial," *Law of Human Behavior* 22 (1998): 519–47; RJ Bonnie and T Grisso, "Adjudicative competence and youthful offenders, in Youth on Trial: A Developmental Perspective on Juvenile Justice," Edited by T Grisso and RG Schwartz. Chicago: University of Chicago Press, 2000, pp 73–103

[3] GB Melton, J Petrila, NG Poythress, et al, *Competency to stand trial, in Psychological Evaluations for the Courts* (ed 2). New York: Guilford Press, 1997; JI Warren, WL Fitch, PE Dietz, et al, "Criminal offense, psychiatric diagnosis, and psycholegal opinion: an analysis of 894 pretrial referrals," *Bulletin of the American Academy of Psychiatry & Law* 19 (1991):63–9, Cited in Douglass Mossman, et al, "AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial," *The Journal of the American Academy of Psychiatry and the Law* 35, no. 4 (2007) www.forensic-experts.net/files/Forensic%20Psychiatry%20CTST%20evals.pdf

[4] TG Gutheil and PS Appelbaum, *Clinical Handbook of Psychiatry and the Law* (ed 3). Philadelphia: Lippincott Williams & Wilkins, 2000; D Mossman, "Is prosecution 'medically appropriate'?" *New England Journal of Criminal Civil Confinement* 31 (2005):15– 80, Cited in Douglass Mossman, et al, 2007

[5] See Grant H. Morris and J. Reid Meloy, "Out of Mind? Out of Sight: The Uncivil Commitment of Permanently Incompetent Criminal Defendants," *U.C. Davis Law Review* 1, no. 27 (1993).

[6] 406 U.S. 715 (1972).

[7] See Grant H. Morris and J. Reid Meloy, 1993

[8] Based on a 2005 review of the 50 state statutes and District of Columbia, conducted by the Maryland Disability Law Center.

[9] D. Mossman, "Predicting restorability of incompetent criminal defendants," *Journal of the American Academy of Psychiatry & Law* 35 (2007): 34–43

[10] American Bar Association, Mental Health, Competence to Stand Trial, Accessed July 2011. www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_mentalhealth_blk.html#7-4.11

[11] See, G. Bennett and G. Kish, "Incompetency to stand trial: Treatment unaffected by demographic variables," *Journal of Forensic Sciences* 35 (1990): 403-412; S. L. Golding, D. Eaves, and A. Kowaz, "The assessment, treatment and community outcome of insanity acquittees: Forensic history and response to treatment," *International Journal of Law and Psychiatry* 12 (1989): 149-179; D. R. Morris and G. F. Parker, "Jackson's Indiana: State hospital competence restoration in Indiana," *Journal of the American Academy of Psychiatry and Law* 36 (2008): 522-534; R. Nicholson and J. McNulty, "Outcome of hospitalization for defendants found incompetent to stand trial," *Behavioral Sciences and the Law* 10 (1998): 371-383.

[12] RA Nicholson and JL McNulty, 1998

[13] D. R. Morris and G.F. Parker, 2008

[14] Data provided by Forensic Services Division, Florida Department of Children and Families cited in Gary B. Melton and others, *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers*, 3rd Edition (New York: The Guilford Press, 2007)

[15] R. Bonnie, "The competence of criminal defendants: A theoretical reformulation," *Behavioral Sciences and the Law* 10 (1990): 291-316.

[16] Barry W. Wall and others, "Restoration of Competency to Stand Trial: A Training Program for Persons with Mental Retardation," *Journal of the American Academy of Psychiatric Law* 31, No. 3 (2003): 189-201, p. 189.

[17] C. Everington and C. Dunn, "A second validation study of the competence assessment for standing trial for defendants with mental retardation (CAST-MR)," *Criminal Justice and Behavior* 22 (1995): 44-59

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[19] Douglas R. Morris and George F. Parker, "Effects of advanced age and dementia on restoration of competence to stand trial," *International Journal of Law and Psychiatry* 32 (2009): 156-160, p. 158; Richard L. Frierson and others, "Competence-to-Stand-Trial Evaluations of Geriatric Defendants," *The Journal of the American Academy of Psychiatry and the Law* 30 (2002): 252-256, p. 254

[20] Criminal Justice/Mental Health Consensus Project (Washington, D.C.: Council of State Governments, 2002). www.consensusproject.org.

[21] For more information on the Memphis Crisis Intervention Teams model, see Justice Policy Institute, *Due South: Looking to the South for Criminal Justice Innovations* (Washington, D.C.: 2011)

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Current Directions in Psychological Science 2011 20: 43
DOI: 10.1177/0963721410396798

aps ASSOCIATION FOR PSYCHOLOGICAL SCIENCE

Current Directions in Psychological Science
20(1) 43-47

DOI: 10.1177/0963721410396798
http://cdps.sagepub.com
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Future Directions in the Restoration of Competency to Stand Trial

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Abstract
While a vast amount of research has focused on the evaluation of competency to stand trial, there is a relative dearth of research on competency restoration. Only recently have systematic research efforts begun to focus on the issue of restoration. Two primary areas of inquiry regarding restoration have emerged: the prediction of restorability (and the examination of variables related to successful and unsuccessful restoration attempts) and the investigation of various treatment programs for competency restoration. This article will briefly summarize the recent research with respect to these two areas and will highlight deficiencies in our current knowledge with the hope of providing an impetus for future research on competency restoration and related issues.

Keywords
competency to stand trial, competency, restoration, treatment

Incompetency to stand trial is a legal concept of jurisprudence that allows defendants who are unable to participate in their own defense to postpone their trial until competency is regained. The U.S. Supreme Court established the current legal standard for determining competency to stand trial in *Dusky v. United States* (1960), and every jurisdiction has adopted or adapted this standard into their competency statutes. The issue of how to deal with incompetent defendants, however, was not addressed in *Dusky*.

Until the landmark case of *Jackson v. Indiana* (1972), most states allowed the automatic and indefinite confinement of incompetent defendants. This resulted in many defendants being held for lengthy periods of time, often beyond the sentence that might have been imposed had they been convicted. In *Jackson*, the Supreme Court held that a defendant committed solely on the basis of incompetency "cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future" (p. 738). The Court did not specify restrictions to the length of time a defendant could reasonably be held, nor did it indicate how progress toward the goal of regaining competency could be assessed. Nevertheless, this decision resulted in changes to state laws regarding confinement of incompetent defendants. Many states now place limits on the maximum length of time an incompetent defendant can be held and, if a defendant is determined to be unlikely to ever regain competency, the commitment must be terminated. It is worth noting, however, that some states appear to continue to circumvent Jackson by allowing long-term and even indefinite confinement of incompetent defendants (Miller, 2003).

Since 1980, a relatively limited amount of research has begun to accumulate with respect to the issue of competency restoration. Although outpatient treatment is possible, most treatment continues to take place in residential forensic facilities (Miller, 2003). The vast majority—around 75%—of incompetent defendants are returned to court as competent within about 6 months (Bennett & Kish, 1990; Golding, Eaves, & Kowaz, 1989; Morris & Parker, 2008; Nicholson & McNulty, 1992). In general, research has examined two types of questions: (a) whether there are certain variables that can predict who will and will not regain competency and (b) whether certain types of treatment programs are more successful than others. We will review the literature on these two questions in the next two sections.

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Prediction of Restorability

As a result of the *Jackson* decision, mental health professionals are often required to predict a defendant's probability of regaining competency. That is, examiners must determine if competency can be restored in a reasonable amount of time. Extrapolating from the work of Meehl (1954), it could be argued that, due to the low base rate of failure to restore competency, evaluators could not predict with any degree of accuracy those defendants who would not regain competency, as those evaluators were likely to automatically assume that competency could be restored. Indeed, in 1980, Roesch and Golding speculated that mental health professionals were limited in their ability to predict which defendants would not be restorable to competence. Research conducted since then has confirmed that the ability of clinicians to predict competency restoration is poor (Carbonell, Heilbrun, & Friedman, 1992; Hubbard, Zapf, & Ronan, 2003; Nicholson, Barnard, Robbins, & Hankins, 1994; Nicholson & McNulty, 1992). An early study conducted by Cuneo and Brelje (1984) illustrates the problems in predicting restoration. These researchers found a 78% accuracy rate for professionals who were asked to predict whether competency would be restored within 1 year. Although at first glance, this rate may seem impressive, it becomes less so when the high base rate for restoration is taken into consideration (i.e., the fact that most defendants are restored within a 6-month period). The false-positive rate (i.e., the proportion of defendants who are predicted to regain competency but do not) is a more appropriate statistic to evaluate the ability to accurately predict responsiveness to treatment. In the Cuneo and Brelje study, the false-positive rate was 23%. Thus, it appears that clinicians have a difficult time identifying the smaller percentage of incompetent defendants who will not respond to treatment.

Hubbard and Zapf (2003) used logistic regression to investigate the variables related to predictions of restorability in a sample of 89 incompetent defendants and found that current violent charge and previous criminal history were the two most significant predictors of restorability decisions. In attempting to explain this finding, the authors interviewed key players in the forensic system who postulated that this might be the result of political pressure to hold accountable and to take to trial those individuals charged with violent crimes and those with criminal histories. When criminal, diagnostic, and sociodemographic variables were considered individually, defendants predicted to not be restorable were more likely to be older and to have impairment in the ability to understand information about the legal process, whereas those predicted to be restorable were more likely to have less serious diagnoses (i.e., nonpsychotic mental disorders) and more serious, violent criminal histories (Hubbard et al., 2003).

In a statistically well-controlled study on prediction of competence restoration, Mossman (2007) examined the records of 351 inpatient pretrial defendants who underwent competence restoration at a state psychiatric facility in Ohio, to determine whether there were certain variables available to forensic examiners that could predict restoration outcome. The variables of interest included demographic characteristics, diagnoses, symptom patterns, criminal charges, number of prior psychiatric hospitalizations, and cumulative prior length of stay. Mossman found that there were two typical instances in which a defendant might be considered to have a low probability of restoration: first, if the basis for the defendant's incompetence was a long-standing psychotic disorder that had resulted in lengthy periods of hospitalization, and second, if the basis for the defendant's incompetence was an irremediable cognitive disorder, such as mental retardation, that resulted in a limited grasp of the information that an examiner attempted to convey during an evaluation. Each of these scenarios appears to result in a well-below-average chance of successful restoration.

In a similar study, Morris and Parker (2008) examined data from 1,475 admissions for competency restoration in Indiana between 1988 and 2005 to determine the factors associated with successful restoration to competence. These authors reported that 72.3% of the admissions over this time period were restored to competence within 6 months and 83.9% within 1 year. In addition, those with mood disorders were most likely to be restored to competence and were significantly more likely to be restored than were those diagnosed with psychotic disorders. Defendants with mental retardation (either alone or in conjunction with a mental illness) were significantly less likely to be restored than were defendants with any other psychiatric disorder, and those diagnosed with both mental retardation and a mental illness were significantly less likely to be restored than were defendants with mental retardation alone. Regression analyses indicated that females and those with affective disorders were most likely to be successfully restored, whereas older age, mental retardation, and a psychotic diagnosis were significantly related to a decreased chance of restoration.

The available research has provided two important insights for clinicians who are required to make predictions regarding restorability and for lawmakers charged with developing or refining competency statutes. First, the vast majority of defendants are restored to competency within a 6-month period (and even more within 1 year). Second, certain characteristics have been consistently suggestive of a reduced chance of successful restoration: older age, a diagnosis of mental retardation, and a diagnosis of psychotic disorder (especially if it has resulted in lengthy periods of hospitalization). This is important information for evaluators to consider when opining about the chances of a defendant's successful restoration.

The weaknesses in the available research, however, are its primary focus on diagnosis as a psychiatric indicator of successful or unsuccessful restoration and its reduction of competence to a single construct. Information regarding the specific *symptoms* associated with unsuccessful and successful restoration attempts and the specific *competency-related abilities* that are impaired and/or remediable would be more useful in this regard. To date, research on competency (and other psycho-legal issues) has focused almost solely on diagnosis as a psychiatric indicator; however, diagnosis per se is far less informative than is information regarding the extent to which specific psychiatric symptoms

are associated with competency-related deficits and successful and/or unsuccessful restoration attempts.

Only relatively recently have some investigators begun to focus more on the specific competency-related abilities than on competency as a singular construct (see Jacobs, Ryba, & Zapf, 2008; Viljoen, Zapf, & Roesch, 2003). Moving forward, research that examines both symptom-level impairments and competency-specific deficits will provide a more detailed illustration of the ways in which specific symptoms (regardless of diagnosis) impact various competency-related abilities. This information could provide key insights regarding the types of symptoms and competency-related deficits that have the most significant implications for competency status and successful remediation. Competency restoration programs could then be developed and tailored to individual defendants and their specific symptoms and deficits.

Treatment Programs for Competency Restoration[1]

Incompetence is predicated on two components: a mental disorder or cognitive impairment and a deficit in one or more competency-related abilities that occurs as a result of the mental disorder or cognitive impairment. Thus, treatment programs for the restoration of competency have typically targeted both mental disorder/cognitive impairment and competency-related abilities. It is often the case that improvement in the underlying mental disorder or cognitive impairment results in improvement in competency-related deficits. The most common form of treatment for the restoration of competency involves the administration of psychotropic medication.

The majority of incompetent defendants consent to the use of medication. The issue of an incompetent defendant refusing to consent has been tested in a number of court cases (e.g., *Washington v. Harper*, 1990; *Riggins v. Nevada*, 1992). The U.S. Supreme Court held, in *Sell v. United States* (2003), that antipsychotic drugs could be administered against the defendant's wishes for the purpose of restoring competency, but only in rare, limited circumstances. Writing for the majority, Justice Breyer noted that a court "must find that medication is substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a defense" (p. 167).

Although medication is the most frequent treatment, some jurisdictions have established educational treatment programs designed to increase a defendant's understanding of the legal process or individualized treatment programs that confront the problems that hinder a defendant's ability to participate in his or her defense (competence-related deficits). In addition, some jurisdictions have implemented treatment programs specifically targeted toward those defendants found incompetent to proceed on the basis of mental retardation.

The success of treatment programs for the restoration of competence is variable and dependent upon the type of treatment program and the type of defendant targeted. Anderson and Hewitt (2002) examined treatment programs designed to restore competency in defendants with mental retardation and found that only 18% of their sample was restored. These researchers concluded that "for the most part, competency training for defendants with [mental retardation] might not be that effective" (p. 349). Other researchers and commentators have found similar results and have noted the difficulty in treating a chronic condition such as mental retardation (Appelbaum, 1994; Pinals, 2005; Wall, Krupp, & Guilmette, 2003).

Treatment programs that target defendants with various other types of mental disorders have met with more success, in that larger proportions of the defendants are restored to competency. Siegel and Elwork (1990) evaluated the use of an educational program as part of the competency restoration process by comparing randomly assigned control and experimental groups. The experimental condition included the use of a videotape that described the roles of courtroom personnel and court procedure, as well as group problem-solving sessions in which problems arising from a defendant's actual legal case were presented and discussed. Results showed greater improvement on Competency Assessment Instrument scores for the experimental group and a greater number of staff recommendations of competency to stand trial (45 days after treatment, 43% of the treated group, but only 15% of the controls were considered competent by staff).

Bertman and colleagues (2003) examined the effectiveness of three types of treatment programs for the restoration of competence: standard hospital treatment, legal rights education, and deficit-focused (competency-related, not psychiatric, deficits) remediation. While the individualized treatment programs (both legal rights education and deficit-focused remediation) led to higher scores on posttreatment competency measures than did standard hospital treatment, the authors were unable to tease apart whether this was a result of the individualized attention or simply a result of the greater number of treatment sessions that those in the individualized treatment groups received. Thus, it is not clear that individualized treatment programs that target specific underlying deficits for each defendant are any more effective than educational programs that teach defendants about their legal rights.

What the available research appears to indicate is that successful restoration is related to how well the defendant responds to psychotropic medications administered to alleviate the symptoms of the mental disorder. The addition of an educational component (either general or individualized) appears to offer some benefit for increasing a defendant's legal knowledge; however, to date, there has not been any published research that specifically examines how either the improved symptoms of mental disorder or improved legal knowledge might impact a defendant's specific competency-related abilities or deficits. Once again, it becomes clear that more information regarding the interplay between psychiatric symptoms and competency-related abilities or deficits could provide better direction for the development and personalization of competency restoration programs.

Call for Research

Recently, Schwalbe and Medalia (2007) have argued for the use of cognitive remediation as an adjunct to competency restoration programs on the basis that there is evidence to suggest that it leads to improved cognitive functioning (e.g., improved attention, reasoning, memory, executive function), which not only improves the success of competency training but also improves the individual competency-related abilities required of a defendant (i.e., the specific prongs of the *Dusky* standard). Although they provide no data, Schwalbe and Medalia make a sound, rational argument for the inclusion of a specific treatment component that targets the exact abilities to be restored. This is precisely the type of rationale upon which treatment programs for competency restoration should be developed and tested.

Future research on competency restoration is necessary to further develop and refine effective competency restoration programs for various types of defendants. Focusing on specific cognitive deficits and symptoms of mental disorder and the interplay between these and various competency-related abilities and deficits will provide critical information to increase our understanding of both the construct of competence (and all that it entails) and how we can develop and refine effective interventions for the successful restoration of competency.

Notes

1. Our discussion of treatment focuses on adults found incompetent. As Viljoen and Grisso comment (2007), adolescent competence concerns are due infrequently to mental illness but more often to deficits stemming from developmental immaturity and/or mental retardation. As a consequence, neither psychotropic medication nor psychoeducational programs are likely to be effective.

Declaration of Conflicting Interests

The authors declared that they had no conflicts of interest with respect to their authorship or the publication of this article.

Recommended Reading

Mossman, D. (2007). (See References). Examines the characteristics of incompetent defendants and concludes that two types of defendants appear to be unrestorable.

Schwalbe, E., & Medalia, A. (2007). (See References). Promotes using cognitive remediation to improve specific competence-related abilities in unrestorable or hard-to-restore defendants.

Viljoen, J., & Grisso, T. (2007). (See References). Examines the issue of juvenile incompetence and discusses potential remediation strategies.

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2

Evaluation of Competence to Stand Trial in Adults

PATRICIA A. ZAPF AND RONALD ROESCH

This chapter provides a review of the legal context for competency evaluations and the relevant forensic mental health concepts, a discussion of the empirical foundations and limitations of competency evaluation, and information about the evaluation process, report writing, and testimony for legal professionals involved in cases where the competency issue is raised (see Zapf & Roesch, 2009, for a more detailed review).

LEGAL CONTEXT

The legal context for competency to stand trial in the United States can be traced back to English common law dating from at least the 14th century. The competency doctrine evolved at a time when defendants were not provided with the right to assistance of counsel and, in many cases, were expected to present their defense alone and unaided.

Various legal commentators have delineated several principles underlying the rationale for the competency doctrine. The Group for the Advancement of Psychiatry (1974) summarized four underlying principles: (1) to safeguard the accuracy of any criminal adjudication; (2) to guarantee a fair trial; (3) to preserve the dignity and integrity of the legal process; and (4) to be certain that the defendant, if found guilty, knows why he is being punished (p. 889). Bonnie (1992) explained that allowing only those who are competent to proceed protects the dignity, reliability, and autonomy of the proceedings. The underlying rationale, then, concerns both the protection of the defendant as well as the protection of the state's interest in fair and reliable proceedings.

Although the term *competency to stand trial* has been used for centuries, there has begun a recent shift in terminology to reflect the fact that the vast majority of cases are plead out before getting to trial and that the issue of "trial" competency can be raised at any stage of the proceedings—from arrest to verdict to sentencing. Bonnie (1992), Poythress and colleagues (1999, 2002), and others have suggested the use of terms such as *adjudicative competence* or *competence to proceed* to better reflect the reality of this doctrine. Throughout this chapter the terms *competency to stand trial*, *adjudicative competence*, and *competency to proceed* are used interchangeably.

Legal Standards for Competency

Legal standards for adjudicative competence clearly define competency as an issue of a defendant's present mental status and functional abilities as they relate to participation in the trial process. This distinguishes competency from *criminal responsibility*, which refers to a defendant's mental state at the time of the offense. In an extremely brief decision, the U.S. Supreme Court established the modern-day standard for competency to stand trial in *Dusky v. United States* (1960). Citing a recommendation of the Solicitor General, the Court held that "the test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him" (p. 402).

Fifteen years after *Dusky*, the United States Supreme Court in *Drope v. Missouri* (1975) appeared to elaborate slightly on the competency standard by including the notion that the defendant must be able to "assist in preparing his defense" (p.171). Legal scholars, such as Bonnie (1993), as well as the *American Bar Association Criminal Justice Mental Health Standards* (1989), indicated that *Drope* added another prong to *Dusky* by requiring that defendant be able to "otherwise assist with his defense" (ABA, 1989, p. 170). Similarly, the addition of this "otherwise assist" prong to the *Dusky*

standard has been affirmed in cases such as *United States v. Duhon* (2000).

The federal standard for competency and each of the states' competency standards mirror *Dusky*, either verbatim or with minor revision, but at least five states (Alaska, Florida, Illinois, New Jersey, Utah) have also expanded or articulated the *Dusky* standard to include specific functional abilities. Since the definition of competency varies by state, it is necessary for an evaluator to consult the relevant competency statutes and definitions before proceeding with the evaluation of a defendant's competency. Legal professionals who retain competency evaluators may wish to confirm that the evaluator is familiar with the relevant jurisdictional standards and procedures.

Case Law Subsequent to *Dusky*

Case law subsequent to *Dusky* serves to offer some elaboration and interpretation of that competency standard. In *Wieter v. Settle* (1961), the United States District Court for the Western District of Missouri determined that it was improper to further detain a defendant who had been charged with a misdemeanor offense and held for 18 months for *competency restoration* since prosecution was no longer probable. In delivering the court's opinion, Chief Judge Ridge delineated a series of eight functional abilities related to *Dusky* that a defendant must possess to be competent (see p. 320).

The U.S. Court of Appeals considered the relevance of amnesia to adequate participation in legal proceedings in *Wilson v. United States* (1968). The court, in *Wilson,* delineated six factors that need to be considered (see pp. 463–464). The *Wilson* factors clearly specify a functional approach to evaluating competency, in which the specific deficits of a defendant would be related to the legal context.

All defendants are provided the Constitutional right to assistance of counsel; however, defendants may choose to waive this right and represent themselves (to appear *pro se*). This raises the question of whether competence to waive counsel should be evaluated separately from competency to stand trial. The U.S. Supreme Court considered the issue of whether a higher standard should apply for waiving counsel or pleading guilty in *Godinez v. Moran* (1993). The U.S. Supreme Court rejected the argument that although the defendant was found competent to stand trial, he was not competent to waive his right to counsel and represent himself, and held that "while the decision to plead guilty is undeniably a profound one, it is no more complicated than the sum total of decisions that a defendant may be called upon to make during the course of a trial…Nor do we think that a defendant who waives his right to the assistance of counsel must be more competent than a defendant who does not, since there is no reason to believe that the decision to waive counsel requires an appreciably higher level of mental functioning than the decision to waive other constitutional rights" (p. 2686). Thus, the Court in *Godinez* indicated that the *Dusky* standard is the Constitutional minimum to be applied, regardless of the specific legal context, and that a defendant's decision-making abilities appear to be encompassed within this standard.

The Supreme Court revisited the issue of competency to represent oneself (proceed *pro se*) in *Indiana v. Edwards* (2008), where it considered the issue of whether a State, in the case of a criminal defendant who meets the *Dusky* standard for competence to stand trial, can limit a defendant's right to self-representation by requiring that the defendant be represented by counsel at trial. The Court answered in the affirmative, thereby establishing that competence to proceed *pro se* requires a higher level of competence than competence to stand trial, but was silent on the issue of how this should be determined. The Court was clear to make the differentiation between their decision in *Edwards* and that in *Godinez* by stating that the issue in *Godinez* was whether the defendant was competent to waive counsel, not represent himself.

Competency Procedures

Legal procedures are well established to ensure that defendants are competent to proceed. In *Pate v. Robinson* (1966), the Supreme Court held that the competency issue must be raised by any officer of the court (defense, prosecution, or judge) if there is a *bona fide* doubt as to a defendant's competence. The threshold for establishing a *bona fide* doubt is low, and most courts will order an evaluation of competence once the issue has been raised. Commenting on its decision in *Pate*, the Supreme Court in *Drope v. Missouri* (1975) noted that "evidence 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 that even one of these factors standing alone may, in some

circumstances, be sufficient" (p. 180). The *Drope* Court added that even when a defendant is competent at the outset of trial, the trial court should be aware of any changes in a defendant's condition that might raise question about his competency to stand trial. Thus, the issue of competency can be raised at any time prior to or during a trial.

Mental health professionals are called upon to evaluate defendants with respect to their competency and once the evaluation has been completed and a report submitted to the court, a hearing is scheduled to adjudicate the issue of competence (these hearings usually take place in front of a judge but a few jurisdictions allow for a jury to hear the issue of competency in certain circumstances). *Cooper v. Oklahoma* (1996) established that incompetency must be proved by a preponderance of evidence, and not the higher standard of clear and convincing evidence. The evaluator's report is highly influential in the court's decisions. Often, the opinion of a clinician is not disputed, and the court may simply accept the recommendations made in the report. Indeed, research has shown that the courts agree with report recommendations upwards of 90% of the time (Hart & Hare, 1992; Zapf, Hubbard, Cooper, Wheeles, & Ronan, 2004). Thus, this appears to be the norm in those jurisdictions in which the court orders only one evaluator to assess competency. Hearings on the issue of competency appear to occur more often, although still relatively infrequently, in those jurisdictions where two experts are asked to evaluate competency.

Defendants determined to be competent may then proceed with trial or with another disposition of their criminal case. The trial of defendants found incompetent is postponed until competency has been restored or, in a small percentage of cases, until a determination is made that the defendant is unlikely to regain competency.

Competency Restoration

Until the landmark case of *Jackson v. Indiana* (1972), most states allowed the automatic and indefinite confinement of incompetent defendants. This resulted in many defendants being held for lengthy periods of time, often beyond the sentence that might have been imposed had they been convicted. This practice was challenged in *Jackson*. The U.S. Supreme Court in *Jackson* held that defendants committed solely on the basis of incompetency "cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future" (p. 738). The Court did not specify limits to the length of time a defendant could reasonably be held, nor did it indicate how progress toward the goal of regaining competency could be assessed. Nevertheless, this decision resulted in changes to state laws regarding confinement of incompetent defendants.

Many states now place limits on the maximum length of time a defendant can be held and, if a defendant is determined to be unlikely to ever regain competency, the commitment based on incompetency must be terminated. However, in many states the actual impact of *Jackson* may be minimal (Morris, Haroun, & Naimark, 2004). State laws regarding treatment of incompetent defendants vary considerably, and Morris and colleagues found that many states ignore or circumvent *Jackson* by imposing lengthy commitment periods before a determination of unrestorability can be made, or tie the length of confinement to the sentence that could have been imposed had the individual been convicted of the original charge(s). Even after a period of confinement and a determination that competency is unlikely to be restored in the foreseeable future it is possible that such defendants could be civilly committed, but *United States v. Duhon* (2000) makes clear that defendants who are not dangerous must be released. Charges against defendants who are not restorable are typically dismissed, although sometimes with the provision that they can be reinstated if competency is regained.

Medication

Medication is the most common and arguably most effective means of treatment for incompetent defendants; however, defendants do have the right to refuse medication. There have been two major cases decided by the U.S. Supreme Court dealing with the issue of the involuntary medication of defendants who had been found incompetent to stand trial. In *Riggins v. Nevada* (1992), David Riggins had been prescribed Mellaril® and found competent to stand trial. He submitted a motion requesting that he be allowed to discontinue the use of this medication during trial, in order to show jurors his true mental state at the time of the offense since he was raising an insanity defense. His motion was denied and he was convicted of murder and sentenced to death. The U.S. Supreme Court

reversed his conviction, holding that his rights were violated. Specifically, the Court found that the trial court failed to establish the need for and medical appropriateness of the medication. In addition, the Court also addressed the issue of whether the involuntary use of antipsychotic medications may affect the trial's outcome (see p. 127).

The U.S. Supreme Court further specified the criteria to determine whether forced medication is permissible in the case of *Sell v. United States* (2003). In *Sell* the Supreme Court held that antipsychotic drugs could be administered against the defendant's will for the purpose of restoring competency, but only in limited circumstances. Writing for the majority, Justice Breyer noted that involuntary medication of incompetent defendants should be rare, and identified several factors that a court must consider in determining whether a defendant can be forced to take medication, including whether important governmental interests are at stake; whether forced medication will significantly further those interests (i.e., the medication is substantially likely to render the defendant competent to stand trial and substantially unlikely to interfere significantly with the defendant's ability to assist counsel); whether involuntary medication is necessary to further those interests (i.e., alternative, less intrusive treatments are unlikely to achieve substantially the same results); and whether administering drugs is medically appropriate (see p. 167).

FORENSIC MENTAL HEALTH CONCEPTS

Evaluation of a defendant's psychological functioning is an essential component of the assessment of competency. Though not clearly specified in the *Dusky* decision, most state laws require that a finding of incompetence be based on the presence of a mental disorder. Once the presence of mental disease or defect has been established, the following must ensue: (1) evaluation of relevant functional abilities and deficits; (2) determination of a causal connection between any noted deficits and mental disorder; and (3) specification of how these deficits may have an impact upon functioning at trial.

Mental Illness as a Prerequisite for Incompetence

Determination of serious mental disorder, cognitive deficit, or mental retardation is merely the first step in finding a defendant incompetent to stand trial. As Zapf, Skeem, and Golding (2005) noted, "the presence of cognitive disability or mental disorder is merely a threshold issue that must be established to 'get one's foot in the competency door'" (p. 433). Although evaluators a few decades ago appeared to base competency decisions largely on a finding of *psychosis* or mental retardation (see Roesch & Golding, 1980, for a review), it is now recognized that the presence of a diagnosis, even severe mental disorder, is not by itself sufficient to find a defendant incompetent. Psychosis is significantly correlated with a finding of incompetence; that is, a majority of incompetent defendants are diagnosed with some form of psychosis (mental retardation and organic brain disorders account for most of the remaining diagnoses). However, only about half of evaluated defendants with psychosis are found incompetent (Nicholson & Kugler, 1991), a clear indication that incompetence is not equated with psychosis. Rather, it is necessary for the evaluator to delineate a clear link (causal connection) between a defendant's mental impairments and his ability to participate in legal proceedings. This is referred to as a *functional assessment of competency*.

Before turning to a discussion of functional assessment, it is important to note that a defendant may have clearly demonstrable pathology, but the symptoms or observable features may be irrelevant to the issue of competency. Such features would include depersonalization, derealization, suicidal ideation, and poor insight. Even a person who meets civil commitment criteria may be considered competent to stand trial, although there does appear to be a strong relationship between incompetence and commitability. For the most part, evaluators will need to determine that the level of mental disorder is severe enough to affect a defendant's ability to proceed with trial. A diagnosis is useful in this regard, but more attention should be paid to symptoms rather than broad diagnostic categories. Many incompetent defendants have a diagnosis of schizophrenia, for example, but it is the specific symptoms that will be relevant to the competency evaluation.

It is most helpful to evaluators if legal counsel is able to provide information regarding the types of symptoms (behaviors, observations) that appear to impair or limit his or her discussions or interactions with the defendant. Any observations regarding the defendant and his or her demeanor, thoughts, actions, or behaviors should be passed along to the evaluator. Although relevant symptoms can vary

widely, there are a few that tend to be more prevalent in incompetent defendants. These include formal thought disorder (as indicated by disorganized speech, loose associations, tangentiality, incoherence, or word salad); concentration deficits; rate of thinking (abrupt and rapid changes in speech or profound slowing of thought or speech); delusions (strongly held irrational beliefs that are not based in reality); hallucinations (sensory perceptions in the absence of a stimulus); memory deficits; and mental retardation or intellectual or developmental disability.

Psycholegal/Competence-Related Abilities

A review of competency case law (including *Dusky*, *Drope*, *Wieter*, *Godinez*, *Edwards*, and other relevant cases), legal commentary (such as Bonnie's reconceptualization of the construct of competence, 1992, 1993), and the available body of literature on competency evaluation and research indicates a number of psycholegal abilities relevant to the issue of competence. These include understanding, appreciation, reasoning, consulting with counsel, assisting in one's defense, and decision-making abilities. Each of these areas will be an important and relevant area of focus for an evaluation of competency.

Understanding

Within the context of competence to stand trial, factual understanding generally encompasses the ability to comprehend general information about the arrest process and courtroom proceedings. The defendant's factual understanding of the legal process includes a basic knowledge of legal strategies and options, although not necessarily as applied to the defendant's own particular case (case-specific understanding usually is encompassed by appreciation [rational understanding]; see next section). Thus, the competence-related ability to understand involves the defendant's ability to factually understand general, legally relevant information.

Appreciation

Appreciation generally refers to a defendant's rational understanding and encompasses specific knowledge regarding and accurate perception of information relevant to the role of the defendant in his or her own case. Within the context of competence to stand trial, appreciation encompasses the ability to comprehend and accurately perceive specific information regarding how the arrest and courtroom processes have affected or will affect the defendant. The defendant's appraisal of the situation must be reality-based, and any decisions that he or she makes about the case must be made on the basis of reality-based information. Thus, the competence-related ability to appreciate involves the application of information that the defendant factually understands to the specific case in a rational (i.e., reality-based) manner.

Reasoning

Reasoning generally refers to a defendant's ability to consider and weigh relevant pieces of information in a rational manner in arriving at a decision or a conclusion. To demonstrate appropriate reasoning ability the defendant must be able to communicate in a coherent manner and make decisions in a rational, reality-based manner undistorted by pathology. It is important to distinguish between the outcome of a decision and the process by which the decision is made. What is important is not the outcome of the decision but that the defendant be able to use appropriate reasoning processes—weighing, comparing, and evaluating information—in a rational manner. In the case of a defendant who is proceeding with the assistance of an attorney, reasoning encompasses the ability of the defendant to consult with counsel and to make rational decisions regarding various aspects of participation in his or her defense.

Consulting and Assisting

Although the *Dusky* standard indicates that the defendant must be able to "consult with his lawyer," the U.S. Supreme Court in *Drope v. Missouri* (1974) used the terminology "assist in preparing his defense" and the Federal standard (U.S. Code Annotated, Title 18, Part III, chapter 13, section 4241) indicates that the defendant must be able to "assist properly in his defense." Thus, the defendant's ability to consult with and assist counsel must be considered as part of the competency assessment. The defendant must be able to engage with counsel in a rational manner; thus, effectively assisting counsel requires that the defendant be able to communicate coherently and reason.

Decision Making

Closely tied to the abilities to appreciate, reason, and assist counsel is the ability to make decisions. The U.S. Supreme Court decision in *Cooper v. Oklahoma* (1996) appeared to equate a defendant's

inability to communicate with counsel with incapacity to make fundamental decisions. In addition, the Supreme Court in *Godinez* incorporated decision-making abilities about the case into the standard for competence. Thus, a defendant's decision-making abilities with respect to specific, contextually relevant aspects of the case need be considered in the trial competency evaluation. It is important to note that research examining the content of competency evaluation reports has shown that certain abilities important and relevant to competence to stand trial, such as decision-making abilities, have rarely been addressed by evaluators in their reports (LaFortune & Nicholson, 1995; Skeem, Golding, Cohn, & Berge, 1998). Thus, legal counsel should ensure that competency evaluators are including this information in their evaluation reports.

Functional and Contextual Nature of Competency and its Evaluation

A functional assessment dictates that competency to stand trial cannot simply be assessed in the abstract, independent of contextual factors. Thus, an evaluation of contextual factors should always take place. This is the essence of a functional approach to assessing competence, which posits that the abilities required by the defendant in his or her specific case should be taken into account when assessing competence. The open-textured, context-dependent nature of the construct of competency to stand trial was summarized by Golding and Roesch (1988):

> Mere presence of severe disturbance (a psychopathological criterion) is only a threshold issue—it must be further demonstrated that such severe disturbance in *this* defendant, facing *these* charges, *in light of existing* evidence, anticipating the substantial effort of a *particular* attorney with a *relationship of known characteristics*, results in the defendant being unable to rationally assist the attorney or to comprehend the nature of the proceedings and their likely outcome. (p. 79)

The importance of a person–context interaction has also been highlighted by Grisso (2003), who defined a functional assessment in the following manner:

> A decision about legal competence is in part a statement about *congruency or incongruency between (a) the extent of a person's functional ability and (b) the degree of performance demand that is made* by *the specific instance of the context in that case.* Thus an interaction between individual ability and situational demand, not an absolute level of ability, is of special significance for competence decisions. (pp. 32–33)

Obviously, a functional assessment requires evaluators to learn about what may be required of a particular defendant. Some of this information may be provided by the defendant but other information will need to come from court documents and from the defendant's legal counsel. Some cases are more complex than others and may, as a result, require different types of psycholegal abilities. As Rogers and Mitchell (1991) note, the requisite level of understanding for a complex crime is higher than for a less complex one. Thus, it may be that the same defendant is competent for one type of legal proceeding but not for others. In cases in which a trial is likely, a defendant's demeanor in court and the ability to testify will certainly be of relevance. A defendant who is likely to withdraw into a catatonic-like state if required to testify, or one who may appear to jurors as not caring or not paying attention to the trial due to medication side effects, may not be capable of proceeding. But these same defendants may be able to proceed if the attorney intends to plea bargain.

Unfortunately, research has indicated that evaluators often fail to relate specific abilities and deficits to the particular case (Heilbrun & Collins, 1995) and that they often fail to provide a discussion of the link between symptomatology and legal abilities in their evaluation reports (Skeem et al., 1998). Legal counsel should expect an evaluator to ask for detailed information regarding those abilities that will be required of the particular defendant in the particular case so as to guide their competency-related inquiries. In addition, legal counsel should expect that evaluators might ask to observe their interactions with the defendant so as to truly perform a functional evaluation of the defendant's ability to relate to counsel, communicate with counsel, and participate in his or her own defense. If these requests do not occur, legal counsel should feel comfortable in raising these issues with the evaluator so as to ensure that a contextual and functional evaluation, in line with current best practices, is conducted.

EMPIRICAL FOUNDATIONS AND LIMITS

Prior to 1980, research on competency to stand trial was limited; however, the past few decades have witnessed a surge in research on this issue and there currently exists a robust literature in this area. In addition to research on various aspects of competency, structured and semi-structured instruments for assessing competency to stand trial have been developed. A review of this literature is well beyond the scope of this chapter, but this section will highlight those areas in which a literature base exists and attempt to provide a representative sample of the findings. More detailed information about all aspects of this section can be found in Zapf and Roesch (2009).

Research on Adjudicative Competence

The available research on adjudicative competence has mainly focused on procedural and assessment issues, the characteristics of referred and incompetent populations, the reliability and validity of competency evaluation, and the development and validation of instruments for the evaluation of competency. In addition, a limited but growing literature is developing on the restoration of competence. We will attempt to highlight representative findings in each of these areas.

Procedural Issues

Poythress and colleagues (2002) reported a series of studies of defense attorneys in several jurisdictions who responded to questions about their perceptions of the competence of their clients. These researchers found that the lawyers had concerns about the competency of their clients in 8% to 15% of the cases; however, competency evaluations were requested in less than half of these cases (in some of those cases where competency evaluations were not requested, the attorney tried to resolve the concerns through informal means, such as including a family member in the decision-making process). Poythress and colleagues noted that the attorneys indicated that their concerns were based on the functional abilities of the clients, such as communicating facts and decision-making capacity.

Reasons other than a concern about a defendant's competency may at least partially account for the consistent finding that only a small percentage of defendants referred for competency evaluations are found incompetent. Roesch and Golding (1980) reported on 10 studies conducted prior to 1980 and found an average incompetency rate of 30%. They also noted a considerable range of rates, with some jurisdictions finding almost no referred defendants to be incompetent while others reported rates as high as 77%. A recent meta-analysis of 68 studies found the rate of incompetence to be 27.5% (Pirelli, Gottdiener, & Zapf, 2011).

Characteristics of Referred and Incompetent Defendants

A vast amount of the competency research has examined the characteristics of both referred individuals as well as those found incompetent. Defendants *referred* for competency evaluations are often marginalized individuals with extensive criminal and mental health histories. Research has indicated that the majority of these defendants tend to be male, single, unemployed, with prior criminal histories, prior contact with mental health services, and past psychiatric hospitalizations. Viljoen and Zapf (2002) compared 80 defendants referred for competency evaluation with 80 defendants not referred and found that referred defendants were significantly more likely to meet diagnostic criteria for a current psychotic disorder, to be charged with a violent offense, and to demonstrate impaired legal abilities. In addition, referred defendants were less likely to have had previous criminal charges. Notably, approximately 25% of non-referred defendants demonstrated impairment on competence-related abilities. In addition, approximately 20% of referred defendants either did not meet criteria for a mental disorder or demonstrated no impairment of competence-related abilities.

With respect to the characteristics of defendants found incompetent, a recent meta-analysis found that unemployed defendants were twice as likely to be found incompetent as those who are employed and those diagnosed with a psychotic disorder were approximately eight times more likely to be found incompetent as those without such a diagnosis (Pirelli et al., 2011).

Reliability and Validity of the Evaluation Process

Since evaluators are assessing a defendant's present ability to perform a series of relatively clearly defined tasks, it seems reasonable to expect that competency evaluations would be highly reliable. In fact, this is precisely what the numerous studies on reliability have shown, with agreement about

the ultimate opinion regarding competency being reported in the 90% range (Golding et al., 1984; Rosenfeld & Ritchie, 1998; Skeem et al., 1998). However, a reliable system of evaluation is not necessarily a valid one. For example, at one time it was the case that evaluators equated psychosis with incompetency (Roesch & Golding, 1980). Thus, if clinicians agreed that a defendant was psychotic they would also agree that the defendant was incompetent. As noted in this chapter, while psychosis is highly correlated with incompetency, it is also the case that a large percentage of competent defendants experience psychotic symptoms. The view that psychosis and incompetency are not inextricably entwined has changed as evaluators have become better trained and more research is available to guide decisions.

The problem of evaluating validity is that there is no gold standard for competence against which to compare evaluator decisions/opinions. Relying on court decisions is not particularly helpful since agreement rates between evaluator recommendations and court determinations have been shown to be well over 90% (Cox & Zapf, 2004; Cruise & Rogers, 1998; Hart & Hare, 1992). How, then, can the issue of construct validity be assessed? Golding and colleagues (1984) suggested the use of a panel of experts, referred to as a "blue ribbon panel," to serve as an independent criterion. In their study, they asked two experts to make judgments about competency based on a review of records, reports from hospital evaluators, and evaluations using the Interdisciplinary Fitness Interview (IFI). Golding and colleagues found that "for the 17 cases seen by the blue-ribbon panelists, they agreed with the IFI panelists 88% of the time, with the hospital staff 82% of the time, and with the courts 88% of the time" and they concluded that "on the basis of these data it would be hard to argue for one criterion definition over another" (p. 331).

The aforementioned study illustrates the methodological problems inherent in studies of competency evaluations, particularly in terms of the lack of a "correct" outcome against which to compare different methods of decision making. We are left with the reality that there can be no hard criterion against which to test the validity of competency evaluations because we do not have a test of how incompetent defendants would perform in the actual criterion situations. Since incompetent defendants are not allowed to go to trial until competency is restored, there is no test of whether a defendant found incompetent truly would have been unable to proceed with a trial or other judicial proceedings. Short of the provisional trial, the ultimate test of validity will never be possible.

Restoration of Competence

Empirical research on competency restoration indicates that most defendants are restorable: Nicholson and McNulty (1992) reported a restoration rate of 95% after an average of two months; Nicholson, Barnard, Robbins, and Hankins (1994) reported a rate of 90% after an average of 280 days; Cuneo and Brelje (1984) reported a restoration rate of 74% within one year; and Carbonell, Heilbrun, and Friedman (1992) reported a rate of about 62% after three months. Thus, regardless of the upper time limits on competency restoration allowed by state statute, it is now the case that most incompetent defendants are returned to court as competent within six months (Bennett & Kish, 1990; Nicholson & McNulty, 1992; Pinals, 2005; Poythress et al., 2002) and the vast majority of incompetent defendants are restored to competency within a year.

Research has also examined the issue of nonrestorability. Mossman (2007) found that individuals with a longstanding psychotic disorder with lengthy periods of prior psychiatric hospitalizations, or irremediable cognitive deficits such as mental retardation, were well below average in terms of their chances of restoration.

The most common form of treatment for the restoration of competence involves the administration of psychotropic medication. Some jurisdictions have also established educational treatment programs designed to increase a defendant's understanding of the legal process or individualized treatment programs that confront the problems that hinder a defendant's ability to participate in his or her defense (Bertman et al., 2003; Davis, 1985; Siegel & Elwork, 1990). In addition, some jurisdictions have implemented treatment programs specifically targeted towards those defendants with mental retardation who are found incompetent to proceed.

The success of treatment programs for the restoration of competence is variable and dependent upon the nature of the treatment program and the type of defendant targeted. Anderson and Hewitt (2002) examined treatment programs designed to restore competency in defendants with mental retardation and found that only 18% of their

sample was restored. Treatment programs that target defendants with various other types of mental disorders have met with more success in that larger proportions of the defendants are restored to competency; however, it is not clear that individualized treatment programs that target specific underlying deficits for each defendant are any more effective than educational programs that teach defendants about their legal rights (Bertman et al., 2003). What appears to be accurate is that successful restoration is related to how well the defendant responds to psychotropic medications administered to alleviate those symptoms of the mental disorder that initially impaired those functional abilities associated with trial competency (Zapf & Roesch, 2011).

Competency Assessment Instruments

Prior to the 1960s no *forensic assessment instruments* (a term coined by Grisso in 1986) existed to assist experts in the evaluation of various legal issues. Trial competency was the first area for which forensic assessment instruments were developed. The evolution of forensic assessment instruments for the evaluation of competency has gone from early checklists (e.g., Robey, 1965) and sentence-completion tasks (e.g., Lipsitt, Lelos, & McGarry, 1971) to self-report questionnaires (e.g., Barnard et al., 1991) to interview-based instruments without, and then with, criterion-based scoring. Suffice it to say, this is a large area of research and the interested reader should consult the following resources for more information: Grisso (2003); Melton, Petrila, Poythress, and Slobogin (2007); Zapf and Roesch (2009); and Zapf and Viljoen (2003).

Three instruments show a great deal of promise in terms of their utility in the evaluation of competency to stand trial: the MacArthur Competence Assessment Tool—Criminal Adjudication (MacCAT-CA; Poythress, et al., 1999), the Evaluation of Competency to Stand Trial—Revised (ECST-R; Rogers, Tillbrook, & Sewell, 2004), and the Fitness Interview Test—Revised (FIT-R; Roesch, Zapf, & Eaves, 2006). Each of these instruments can be used to assist in the evaluation of a defendant's competency status and each has its strengths and weaknesses. All three of these instruments show evidence of sound psychometric properties.

The MacCAT-CA uses standardized administration and criterion-based scoring, which increases its reliability and provides scores on three competence-related abilities—understanding, reasoning, and appreciation—that can be compared to a normative group of defendants. The methodology used, however, involves a vignette format that limits the ability to extrapolate to a defendant's own particular case.

The ECST-R uses a hybrid interview approach, containing both semi-structured and structured components, designed to assess competency to stand trial generally as well as specific competencies such as competency to plead and competency to proceed *pro se*. The ECST-R yields scores in four different areas—rational understanding, factual understanding, consulting with counsel, and overall rational ability—and also includes scales that screen for feigned incompetency.

Like the MacCAT-CA, the ECST-R is a norm-referenced instrument, which means that the scores obtained by a particular defendant can be compared to a normative group of defendants to provide an indication of how this particular defendant compares to other defendants on the various abilities measured. The structured approach of these two instruments limits the types of questions that can be asked of a particular defendant (of course, the evaluator should ask about all relevant contextual issues in addition to administering either the MacCAT-CA or the ECST-R).

The FIT-R provides an interview guide for assessing the relevant competency-related issues in three different areas—factual understanding, rational understanding (appreciation), and consulting/decision making. Its semi-structured format allows for broad discretion in the types of inquiries made so all contextual elements can be evaluated for each defendant.

THE EVALUATION

Selecting an Evaluator

Legal counsel able to select and retain forensic evaluators of their choice (as opposed to having them court-ordered) will want to consider the potential evaluator's knowledge, training, and education as well as his or her skill set and experience. The evaluation will typically consist of three elements—an interview, testing, and collateral information review—and so legal counsel may wish to inquire with potential experts regarding the methods they use for conducting competency evaluations, the instruments that they typically use (if any), their experience with competency evaluation in general, as well as their experience in the relevant jurisdiction.

Defense Counsel's Role in the Evaluator's Preparation

There are four ways in which defense counsel will play a role in the competency evaluator's preparation and evaluation. First, defense counsel should expect the competency evaluator to clarify the referral question. This is one of the first tasks that an evaluator should complete and so it will require a conversation with the referring party (which we assume to be the defense counsel since this is the most common referral source) about the basis for the referral. The evaluator will want to know what defense counsel has observed about his or her interactions and conversations with the defendant, whether the defendant has displayed any odd or unusual behaviors or beliefs, whether the defendant has been communicative with counsel, whether the defendant holds any animosity or mistrust for defense counsel, and the extent of the defendant's understanding of his or her charges as displayed to defense counsel. In addition, defense counsel should be prepared to provide information regarding why the referral for competency evaluation was requested.

Aside from information needed to clarify the referral question, evaluators will also look to defense counsel for specific information regarding the defendant's current charges and allegations. Providing information to the evaluator about the formal charges as well as a police report or some other report regarding the allegations for those charges will be an important initial step in assisting the evaluator in his or her preparation. Along with this, the evaluator will require information about the nature of the dispositions that the defendant might face in light of any previous criminal history, the likelihood of the defendant begin acquitted or convicted, and the likelihood of a plea deal being offered. This information will assist the evaluator in determining whether the defendant is able to provide a realistic view of his or her case and the possible outcomes. In addition, current best practices for competency evaluation require that the evaluator be able to assess the degree of congruence or incongruence between the defendant's capacities and the abilities required of him or her at trial (or for his or her relevant adjudicative proceedings). Thus, in order to do so, the evaluator must collect information regarding what will be required of the defendant for his or her proceedings. Defense counsel should expect the evaluator to ask a series of questions or obtain information using a standardized questionnaire regarding whether the defendant will be expected to make a decision regarding a plea bargain; whether evidence against the defendant is such that mounting a defense will depend largely on the defendant's ability to provide information (or whether there are additional information sources, aside from the defendant, that can be used); whether the case will involve a number of adverse witnesses; whether the defendant will be required to testify; whether the adjudication process will be lengthy; whether the adjudication hearing will be lengthy; and whether the adjudication hearing will be complex (i.e., difficult to follow, complicated evidence). Any information that the defense counsel can provide to the evaluator regarding the abilities that will be required of the defendant will assist in guiding the evaluation process.

The third way in which defense counsel will play a role in the evaluation process is by assisting the evaluator in obtaining relevant collateral records and information. Every competency evaluation requires that the evaluator review collateral information and/or interview collateral information sources to determine the weight to be given to the defendant's self-report. Competency evaluators are expected to go through legal counsel to obtain this information so as to meet the relevant requirements for discovery and attorney work product. Even in those situations where records are to be released directly to a mental health professional (as is sometimes the case with psychological test results), the initial request for information should be funneled through the defense attorney (the mental health professional can provide a release-of-information form to be signed by the defendant and used by the attorney to obtain the relevant documents).

Finally, the evaluator may request that he or she be allowed the opportunity to observe interactions between the defendant and defense counsel. This is to satisfy the functional component of competency evaluation whereby direct observation of the defendant and defense attorney engaging in discussion of the defendant's charges or defense strategy allows for a direct assessment of the defendant's abilities in this regard. Defense counsel can, of course, decide whether he or she will grant this request, but direct observation of these interactions will assist the evaluator in extrapolating to the trial context. Of note here is that information about the specific *content* of these discussions would be left out of the evaluation report; rather, observations regarding the *process* is the focus of these interactions.

The Goal of the Evaluation

The goal of the evaluation is for the evaluator to assess the degree of congruence or incongruence between the defendant's capacities and the abilities required of the defendant at trial (or his or her proceedings). To do this, the evaluator will assess the defendant's current mental status and his or her competence-related capacities (i.e., understanding, appreciation, reasoning, assisting/consulting, and decision making) within the specific context of the defendant's case (thus including any relevant abilities that will be required of the defendant for his or her proceedings); determine whether the cause of any noted deficits is a result of mental illness or cognitive impairment; and specify how the defendant's mental illness or cognitive symptoms may interact or interfere with his or her competence-related abilities by describing how this may present at trial. In addition, the evaluator should delineate the ways in which the court or defense counsel can assist the defendant in his or her functioning at trial (i.e., providing prescriptive remediation such as instruction regarding how best to work with the client to improve his or her functioning). Finally, many jurisdictions require the evaluator to include information regarding the likelihood and length of restoration and treatment recommendations for those defendants who appear to be incompetent.

The evaluator will use the data gathered through the evaluation process (interview, testing, and collateral information review) to arrive at a conclusion regarding the defendant's competency status; however, many evaluators believe that it is beyond their role to explicitly state their opinion regarding the defendant's competency status. That is, many evaluators are hesitant to speak to the ultimate legal issue, believing instead that this is for the court to determine. While the ultimate legal issue (competency status) is certainly a legal issue for the court to decide, counsel who desire the evaluator to provide an ultimate opinion should feel comfortable in making this request of the evaluator. Many evaluators will not provide such opinions unless explicitly asked or statutorily required to do so.

REPORT WRITING AND TESTIMONY

Court-ordered evaluators are required to complete a written report of their evaluation along with their opinions regarding the defendant's mental status and competence-related abilities. In most jurisdictions these written reports will be distributed to the prosecution and the defense as well as the court. In situations where the evaluator has been privately retained, however, there is no requirement for a written report and so the determination of whether a written report is to be provided is left with defense counsel. In these situations, the evaluator is expected to provide an oral report of his or her findings and opinions to defense counsel and await further instruction from counsel as to whether a written report is desired. Regardless of whether the evaluator was court-ordered or privately retained, the expectation is that the evaluator is an objective, neutral party who will include all relevant information in the written report. If the privately retained evaluator uncovers information that could be damaging or detrimental to the defense, he or she should provide this information to counsel in an oral report. If a written report is requested, it would be unethical for the evaluator to leave out relevant information not favorable to the defense.

Report Contents

Although there are numerous different ways to organize a forensic evaluation report, any competency evaluation report should contain the following types of information: relevant case and referral information; a description of the notification of rights provided to the defendant; a summary of the alleged offense (this should be from official documents and not the defendant's self-report); the data sources that were used or reviewed for the purposes of the evaluation (including any collateral interviews and the dates on which they occurred); background information on the defendant (typically a social history); a clinical assessment of the defendant (typically this will include a mental status exam as well as any relevant information or observations about the defendant's mental health and functioning); a forensic assessment of the defendant (with all relevant information regarding the defendant's competence-related abilities and/or deficits); and a summary and recommendations section (including any prescriptive remediation or information regarding treatment recommendations).

Forensic Evaluation

The forensic evaluation component of the written report is perhaps the most relevant and important to legal counsel and the court. This section of the

report should include a description of the defendant's competence-related abilities and deficits; the cause for any noted deficits; the impact of symptoms on the defendant's performance or participation in the case; possible prescriptive remediation; conclusions or opinions regarding each of the jurisdictional criteria; and the prognosis for restorability.

The best forensic evaluation reports are those that explicitly delineate the linkage between the defendant's mental illness or cognitive impairment and any noted competence-related deficits *as well as* describe how these deficits might affect the defendant's functioning at trial. For example, it would not be enough to simply state that the defendant has delusional disorder and therefore is unable to rationally understand (appreciate) his or her role as a defendant. Instead, the evaluator should clearly delineate the necessary linkages for the court and describe how these might affect the defendant's functioning at trial. For example, the defendant displays a fixed delusional belief system whereby he believes that his father "owns" all of the judges in the State and therefore no judge in the State would ever convict him. This delusion compromises the defendant's ability to make rational decisions regarding his defense.

In addition to a clear delineation of the linkage between any mental illness or cognitive deficit and any noted deficits in competence-related abilities and a description of how these could affect the defendant's functioning at trial or in various relevant proceedings, the report should also include some form of prescriptive remediation for any noted deficits. For example, the evaluator might indicate that the defendant demonstrates lower cognitive functioning, which might affect his ability to fully understand and engage in his defense strategy, and then indicate that the defendant's understanding might be improved by using concrete, as opposed to abstract, examples and by using shorter sentences with smaller words.

Most jurisdictions require that the evaluator include additional information in the report for those defendants opined incompetent. This additional information typically includes the cause of the incompetence, the probability and estimated length of restoration, and treatment recommendations for restoration. Evaluators are expected to understand and abide by the various jurisdictional requirements for competency evaluation reports; however, legal professionals should be aware that some research has indicated that not all evaluation reports include these statutorily required elements (Zapf et al., 2004). Legal consumers should not hesitate to bring any missing elements to the attention of the evaluator.

Inappropriate Report Contents

Two types of content are not appropriate for inclusion in a competency evaluation report. The first is the defendant's version of the circumstances surrounding the offense. A functional evaluation of competency requires that the evaluator inquire about the charges and allegations; however, evaluators are expected to exercise caution when writing the evaluation report so as not to include potentially incriminating information provided by the defendant. General statements regarding whether the defendant's account of events differs substantially from official accounts and whether this reflects an incapacity or deficit on the part of the defendant should be used instead of a summary of the defendant' s account or the defendant's verbatim answers. Similarly, the *content* of observed interactions and/or discussions between defense counsel and the defendant is not appropriate for inclusion in the written report; rather, a description of the *process* of these interactions is what should be highlighted.

The second type of inappropriate report content involves the inclusion of information or opinions related to other legal issues. Evaluators should be careful to address only those referral questions that have been asked and to refrain from offering unsolicited information about other, possibly relevant, legal issues in the competency evaluation report. Opinions or conclusions regarding a defendant's future risk for violent behavior, or any other legal or psychological issue, have no place in a competency evaluation report. In many jurisdictions, competency evaluations and assessments of mental state at the time of the offense are often ordered simultaneously. In this situation, the evaluator may choose to prepare a separate report for each referral question or to address both referral questions within the same report. Legal consumers desiring two separate reports in this instance should make this clear to the evaluator.

Importance of Providing the Bases for the Opinion/Conclusions

The importance of delineating the linkages between mental illness, competence-related deficits, and functional abilities at trial (or for the purposes of

the defendant's proceedings) has been highlighted throughout this chapter but with good reason. In a survey of forensic diplomates of the American Board of Forensic Psychology (ABPP), Borum and Grisso (1996) found that 90% of respondents agreed that detailing the link between mental illness and competence-related deficits in competency reports was either recommended or essential. However, an examination of competency-to-stand-trial reports from two states indicated that only 27% of the reports provided an explanation regarding how the defendant's mental illness influenced his or her competence-related abilities (Robbins, Waters, & Herbert, 1997). Further, in another study, only 10% of competency-evaluation reports reviewed provided an explanation regarding how the defendant's psychopathology compromised required competence-related abilities (Skeem et al., 1998). In addition to the issue of the linkage between mental illness and competence-related deficits, the extant research also indicates that examiners rarely (Skeem et al.) or never (Robbins et al.) assess the congruence between a defendant's abilities and the specific case context. Thus, legal consumers should be aware of the necessity for evaluators to provide the bases for their opinions and conclusions through clear indication of these linkages in the written report.

Testimony

In the majority of cases where the issue of competency is raised, a legal determination is made without a competency hearing (both parties typically stipulate to the evaluator's report). When a competency hearing is necessary, the forensic evaluator(s) will be called to testify about the evaluation. If the evaluator was privately retained, as opposed to court-ordered, it is helpful for the defense attorney to conduct a pretrial conference to inform the evaluator about relevant issues, such as the theory of the case, how the attorney would like the evaluator's testimony presented, and any relevant information about what the opposing side may try to prove. During this conference (if not before), the evaluator should inform the retaining attorney about any possible weaknesses in his or her evaluation methods, opinions, or conclusions as well as any possible weaknesses with the opposing side's opinion (if known). It is helpful to the evaluator if defense counsel also share issues that may be subject to scrutiny or become the focus of cross-examination. In complex or high-profile cases the legal defense team may wish to ask the evaluator practice questions (both direct and cross-examination) to assist in preparing the evaluator for his or her testimony.

The evaluator should have provided a copy of his or her curriculum vitae to defense counsel (when privately retained) or the court (for court-ordered evaluations) prior to the day of the competency hearing, but he or she should also come prepared to testify with multiple copies of his or her CV. In cases where the evaluator was privately retained, the defense team may wish to go over the evaluator's CV with the evaluator ahead of time so the evaluator can highlight relevant experiences and qualifications to smooth the process of becoming qualified as an expert.

Regardless of whether the expert was court-ordered or privately retained, he or she is required to remain objective and neutral and to answer all questions in a straightforward manner. The evaluator should be well prepared to take the stand, having reviewed all relevant materials to the competency evaluation in addition to his or her written report.

SUMMARY

The purpose of this chapter was to present material relevant to legal consumers regarding the evaluation of competency to stand trial (adjudicative competence). The interested reader is directed to additional resources for further discussion of the information contained within this short chapter, including Grisso (2003); Melton, Petrila, Poythress, and Slobogin (2007); Pirelli, Gottdiener, and Zapf (2011); and Zapf and Roesch (2009).

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January 2013

STANDARDIZING PROTOCOLS FOR TREATMENT TO RESTORE COMPETENCY TO STAND TRIAL:

INTERVENTIONS AND CLINICALLY APPROPRIATE TIME PERIODS

The Washington State Institute for Public Policy (Institute) was directed by the 2012 Legislature to "*study and report to the legislature the benefit of standardizing treatment protocols used for restoring competency to stand trial in Washington, and during what clinically appropriate time period said treatment might be expected to be effective.*"

To conduct this work, the Institute contracted with a national expert in the field, Dr. Patricia Zapf. The attached report provides background on the types of interventions (treatments) used throughout the United States for the restoration of competency to stand trial, and research regarding the timelines for restoration. In addition, data on length of stay at Eastern State Hospital and Western State Hospital for incompetent defendants remanded for competence restoration are summarized.

For more information, contact Roxanne Lieb, (360) 586-2768, liebr@wsipp.wa.gov.

Suggested citation: Zapf, P. (2013). *Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods* (Document No. 13-01-1901). Olympia: Washington State Institute for Public Policy.

Standardizing Protocols for Treatment to Restore Competency to Stand Trial:

Interventions and Clinically Appropriate Time Periods

January 2013

Patricia Zapf, Ph.D.

The Washington State Institute for Public Policy (Institute) was directed by the 2012 Legislature to "*study and report to the legislature the benefit of standardizing treatment protocols used for restoring competency to stand trial in Washington, and during what clinically appropriate time period said treatment might be expected to be effective."*

Data from Western State Hospital and Eastern State Hospital were examined to determine typical length of stay for defendants deemed incompetent and remanded for restoration.

This report then summarizes the literature on treatment protocols used to restore defendants to competency throughout the United States and the literature on the time periods for restoration.

Finally, the report summarizes the 2011-12 recommendations of the National Judicial College's Best Practices Model.

The Washington State Institute for Public Policy (Institute) was directed by the 2012 Legislature to "*study and report to the legislature the benefit of standardizing treatment protocols used for restoring competency to stand trial in Washington, and during what clinically appropriate time period said treatment might be expected to be effective*."[1]

This report provides background on the types of interventions (treatments) used throughout the United States for the restoration of competency to stand trial. In addition, data on length of stay at Eastern State Hospital and Western State Hospital for incompetent defendants remanded for competence restoration are summarized.

Section 1: Background

The constitutional right to a fair trial includes several elements. An accused individual has the right to be present at the trial, must be able to understand the adversarial nature of the proceedings, and must be capable of helping present a defense. If the issue of competency is raised with respect to a particular defendant, the court must order a competency evaluation. The court may assign one or two experts to the evaluation and order the evaluation to take place in a jail, state hospital, or in the community. In Washington, state employees conduct the vast majority of these evaluations and the interviews occur in a jail.[2]

If, after receiving the evaluation report(s), the court finds that the defendant is competent, the case proceeds to trial. If the court concludes that the defendant is incompetent, a period of treatment may be authorized to restore the defendant to competency.

In Washington, most incompetent adult defendants are sent to Western State Hospital (WSH) or Eastern State Hospital (ESH) for competency restoration. The length of the initial treatment period depends upon the type of

[1] SSB 6492, Laws of 2012

[2] R. Lieb & M. Burley. (2011). *Competency to stand trial and conditional release evaluations: Current and potential role of forensic assessment instruments.* Olympia: Washington State Institute for Public Policy, Document Number 11-05-3401.

charge. Defendants charged with violent felony offenses are committed for an initial treatment period of up to 90 days.[3] Non-violent felony offenses qualify for an initial treatment period of 45 days.[4] Defendants charged with non-felony offenses are committed to an initial treatment period of up to 14 days for competency restoration. [5]

Felony defendants may be committed for a second 90-day period of treatment as long as their incompetence is not the result of a developmental disability.[6] In certain circumstances, felony defendants may be committed for a third period of up to six months (180 days).[7]

Defendants who are restored to competence proceed to trial or to the next step of the criminal adjudication process. Defendants who are not restored to competence have their charges dismissed without prejudice and are evaluated for civil commitment proceedings.[8]

Data from Washington's State Hospitals

The author requested data regarding time frames for competency restoration from the Eastern State Hospital (ESH) and the Western State Hospital (WSH). ESH provided 26 years of data, whereas WSH's data covered two recent years. Data from WSH did not include any information on non-felony defendants and was truncated in terms of the timeframe (with data only be provided from January 1, 2010 on). Additionally, the WSH data did not include variables such as admission dates, discharge dates, or legal status at discharge. These limitations call into question the reliability of the data from WSH, an issue noted in a recent JLARC report.[9]

Eastern State Hospital – Competency Restoration

Length of stay (LOS) data for 429 defendants admitted to Eastern State Hospital (ESH) for competency restoration between April 15, 1987 and October 31, 2011 were examined. Of the 429 defendants admitted to ESH for competency restoration, 373 were felony defendants and 40 were non-felony defendants.[10]

Felony defendants who were not restored to competence had longer LOS than those who were restored. Felony defendants who were restored to competency (n = 241) were hospitalized at ESH for an average of 89.2 days (SD = 53.2 days; range = 6 – 551 days).[11] Felony defendants who were not restored to competence (n = 132) spent an overall average of 153.6 days (SD = 568.8 days; range = 22 – 4372 days) at ESH, which included an average of 72.7 days on competency restoration status (SD = 68.0 days; range = 2 – 373 days).[12]

Non-felony defendants restored to competency (n = 23) were hospitalized at ESH for an average of 29.0 days (SD = 17.2 days; range = 16 – 100 days). Non-felony defendants not restored to competency (n = 17) spent an average

[3] RCW 10.77.086
[4] RCW 10.77.086 (1)(b)
[5] In addition to any unused evaluation time as per RCW 10.77.060, see RCW 10.77.088.
[6] Defendants whose incompetence is the result of a developmental disability are not permitted a second or third period of treatment if it appears that competency restoration is not reasonably likely, see RCW 10.77.086.
[7] RCW 10.77.086 stipulates that criminal charges of incompetent felony defendants shall not be dismissed (after a second period of treatment) if "the court or jury finds that: (a) The defendant (i) is a substantial danger to other persons; or (ii) presents a substantial likelihood of committing criminal acts jeopardizing public safety or security; and (b) there us a substantial probability that the defendant will regain competency within a reasonable period of time" at RCW 10.77.086 (4).
[8] RCW 10.77.084 (1) (c)
[9] JLARC report on Competency to Stand Trial: Phase I dated December 5, 2012.
[10] Data for 16 defendants were not included in the overall analyses as determined by the final legal authority on release: 13 defendants were NGRI (Average LOS for competency restoration = 132.1 days, Range = 7 – 365 days; Average total LOS = 2496.5 days, Range = 119 – 5182 days); 2 were voluntary (Average LOS for competency restoration = 192.5 days, Range = 88 – 297; Average total LOS = 249.5 days, Range = 100 – 399 days); and 1 was released on a competency evaluation status (LOS for competency restoration = 91 days; Total LOS = 98 days).
[11] The total LOS at ESH for this group of restored felony defendants was 97.3 days (SD = 56.3 days; Range = 9 – 551 days), which represented an average additional stay of 8.1 days (SD = 16.2 days; Range = 0 – 111 days). It should be noted that 65 (27%) defendants stayed at ESH beyond their competency restoration commitment status.
[12] These defendants spent an additional average of 80.9 days (SD = 43.2 days; Range = 9 - 210 days) at ESH on civil commitment status after the expiration of their competency restoration order.

of 76.2 days at ESH (SD = 21.1 days; range = 32 – 108 days). These defendants spent an average of 29.1 days (SD = 11.1 days; range = 3 – 51 days) on competency restoration status.[13]

Western State Hospital – Competency Restoration

Length of stay (LOS) data for all felony defendants admitted to Western State Hospital (WSH) for competency restoration after January 1, 2010 were examined.

A total of 272 felony defendants were admitted to WSH for competency restoration after January 1, 2010. The average LOS was 80.56 days (range = 1 – 354 days).

For the vast majority of felony defendants, competency restoration took 90 days or less. The breakdown and average LOS is shown below.

Exhibit 1
Length of Stay for Competency Restoration

	% (n)	Average LOS
≤ 90 days	77.57% (211)	60.46 days
91 – 180 days	19.12% (52)	136.06 days
> 180 days	3.31% (9)	231 days

Comparisons between ESH and WSH – Competency Restoration Timelines

The data supplied for ESH do not easily correspond to those from WSH. Thus, it is difficult to meaningfully compare time frames for competency. A comparison of the average length of time to restoration for felony defendants at ESH and WSH is included below. As mentioned earlier, ESH data cover the last 26 years and WSH data, the last two. Both hospitals appear to be restoring felony defendants to competence within the statutorily required time periods.

The data supplied by ESH and WSH indicate that approximately 35% of felony defendants sent to ESH for restoration were considered not restorable after an average of 73 days and were then civilly committed.

Section Summary

Most felony defendants treated for restoration to competency in Washington are restored to competency within 90 days. The available competency restoration research is summarized in the next two sections, with particular attention to treatment protocols and restoration timeframes.

[13] These defendants spent an additional average of 47.1 days (SD = 20.6 days; Range = 10 – 91 days) at ESH on civil commitment status after the expiration of their competency restoration order.

Exhibit 2
Average Days to Restoration

	ESH	WSH
Felony Defendants		
Average Days to Restoration	89.2 (n = 241)	80.6 (n = 272)
Average Days for Those Not Restored	153.6 (n =132)	N/A
Average Days on Restoration Status	72.7 (n = 132)	N/A
Non-Felony Defendants		
Average Days to Restoration	29.0 (n = 23)	N/A
Average Days for Those Not Restored	76.2 (n = 17)	N/A
Average Days on Restoration Status	29.1 (n = 17)	N/A
Time Frame of Data	April 15, 1987 - October 31, 2011	After January 1, 2010

Section II: Treatment Protocols

This section reviews the research literature on treatment protocols for the restoration of competency to stand trial.

The U.S Supreme Court established the current legal standard for determining competency to stand trial in *Dusky v. United States* (1960).[14] Every public jurisdiction in the United States has adopted or adapted this standard into their competency statutes. The issue of how to deal with incompetent defendants, however, was not addressed in *Dusky*.

Until the landmark case of *Jackson v. Indiana* (1972),[15] most states allowed the automatic and indefinite confinement of incompetent defendants. Many defendants were held for lengthy periods of time, often beyond the sentence that might have been imposed had they been convicted. In *Jackson*, the Supreme Court held that a defendant committed solely on the basis of incompetency "cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future."[16] The Court did not specify restrictions to the length of time a defendant could reasonably be held, nor did it indicate how progress toward the goal of regaining competency could be assessed.

The *Jackson* decision resulted in changes to state laws regarding confinement of incompetent defendants. Many states now place limits on the maximum length of time an incompetent defendant can be held and, if a defendant is determined to be unlikely to ever regain competency, the commitment must be terminated. Still, some states continue to allow long-term, and even indefinite, confinement of incompetent defendants.[17]

Although outpatient treatment is possible, most treatment continues to take place in residential forensic facilities.[18] Most incompetent defendants are returned to court as competent. This review examines treatment protocols developed for competency restoration.

Note: In this review of the literature, the term "incompetent defendants" is primarily used to refer to those defendants whose incompetence is a result of an Axis I mental disorder, as this represents the majority of

[14] Dusky v. United States, 362 U.S. 402 (1960).
[15] Jackson v. Indiana, 406 U. S. 715 (1972).
[16] Ibid at page 738.
[17] Miller, R. D. (2003). Hospitalization of criminal defendants for evaluation of competence to stand trial or for restoration of competence: Clinical and legal issues. *Behavioral Science and Law, 21*, 369 - 391.
[18] Ibid.

incompetent defendants.[19] When cognitively impaired or developmentally disabled defendants are being referred to, this will be explicitly stated.

Summary of Literature

The section below provides a detailed description of each of the studies from the available literature on treatment protocols for competency restoration for the interested reader. A summary table of the studies can be found on page 17 of this report.

The available literature examines five types of treatment protocols:

1) medication;
2) treatments for individuals with developmental disabilities;
3) educational treatment programs;
4) specialized/individualized treatment programs; and
5) cognitive remediation programs.

Treatment Protocols for Competency Restoration

Incompetence is predicated on two components: (1) a mental disorder or cognitive impairment and (2) a deficit in one or more competence-related abilities (i.e., understanding, appreciation, reasoning, assisting counsel) that occur as a result of the mental disorder or cognitive impairment.[20]

Treatment programs for the restoration of competence typically target mental disorder/cognitive impairment and competence-related abilities. Improvement in the underlying mental disorder or cognitive impairment often results in improvement in competence-related deficits. The most common form of treatment for restoration of competence involves the administration of psychotropic medication.

1) Medication

Most incompetent defendants consent to the use of medication. The possibility that an incompetent defendant refuses to consent has been tested in a number of court cases (e.g., *Washington v. Harper*, 1990;[21] *Riggins v. Nevada*, 1992.)[22] The U.S. Supreme Court held in *Sell v. United States* (2003)[23] that antipsychotic drugs could be administered against a defendant's wishes for the purpose of restoring competency, but only in rare, limited circumstances. Writing for the majority, Justice Breyer noted that a court "must find that medication is substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a defense."[24]

Although medication is the most frequent form of treatment, some jurisdictions have established educational treatment programs designed to increase a defendant's understanding of the legal process or individualized treatment programs that confront the problems that hinder a defendant's ability to participate in his or her defense (competence-related deficits).

Some jurisdictions have implemented treatment programs targeted to defendants found incompetent to proceed on the basis of mental retardation or developmental disability.

[19] Common Axis I disorders include depression, anxiety disorders, bipolar disorder, ADHD, autism spectrum disorders, anorexia nervosa, bulimia nervosa, and schizophrenia.
[20] Zapf, P. & Roesch, R.(2009). Best practices in forensic mental health assessment: Evaluating competency to stand trial. New York: Oxford.
[21] Washington v. Harper, 494 U.S. 210 (1990).
[22] Riggins v. Nevada, 504 U. S. 127 (1992).
[23] Sell v. United States, 539 U. S 166 (2003).
[24] Ibid at page 167.

2) Treatment Programs for Individuals with Developmental Disabilities

Two research studies and two commentaries regarding restoration protocols for defendants with developmental disabilities (mental retardation) were reviewed. All four articles underscored the difficulty in restoring developmentally disabled defendants. The two research studies indicated that about 1/3 of developmentally disabled defendants were restored.

Anderson and Hewitt (2002) examined outcomes of a competency restoration program in Missouri for defendants with mental retardation.[25] One-third of the defendants were restored to competency and two-thirds were not. Of those detained in a habilitation facility, 18% were restored, compared with 50% of those who were detained in a psychiatric hospital. The main difference between the two types of facilities was the wider availability of medications in the hospital facility. These researchers concluded, "for the most part, competency training for defendants with MR might not be that effective."[26] Other researchers and commentators have found similar results and have noted the difficulty in treating a chronic condition such as MR.[27,28]

Wall, Krupp, and Guilmette (2003) described a training program developed in Rhode Island for competency restoration for defendants with mental retardation.[29] This treatment program, called the *Slater Method* after the hospital where it was developed, includes five modules:

1. the purpose of the training, review of the charges, pleas, and potential consequences;
2. courtroom personnel;
3. courtroom proceedings, trial, and plea bargain;
4. communicating with the attorney, giving testimony, and assisting in defense; and
5. tolerating the stress of the proceedings.

Each module is presented in sequential order. Trainers meet with the defendants between one and five days a week for up to an hour. Each module is reviewed with the defendant a minimum of three times (the minimum number of times to ensure retention). The training/restoration program lasts for six months, with additional six-month increments provided as necessary. The authors did not present any data on average time to restoration but did indicate that five of 15 defendants had been restored to competency within an eight month to three year period of time.[30] Tables 1 through 4 provide further description regarding these modules.

[25] Anderson, S. D., & Hewitt, J. (2002). The effect of competency restoration training on defendants with mental retardation found not competent to proceed. *Law and Human Behavior, 26*, 343-351.
[26] Ibid at page 349.
[27] Appelbaum, K. L. (1994). Assessment of criminal-justice-related competencies in defendants with mental retardation. *Journal of Psychiatry and Law, 22*, 311-327.
[28] Pinals, D. (2005). Where two roads met: Restoration of competence to stand trial from a clinical perspective. *New England Journal of Civil and Criminal Confinement, 31,* 81-108.
[29] Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law, 31,* 189-201.
[30] Ibid at pages 194-198.

Table 1 Summary of Slater Method: Training Tool Rationale

MR Impairment	Phase I Knowledge-Based Training	Phase II Understanding-Based Training
Cognition	The client must learn: • the purpose of training sessions (1)* • the charges (1) • possible pleas (1) • potential consequences (1) • the role of courtroom personnel (2) • the purpose of going to court (3) • the purpose of going to trial (3)	The client must understand that: • this is an adversarial proceeding, and he/she is the accused (1, 3) • he/she cannot be punished just because he/she is accused (1, 3) • a plea is different from a finding (1, 3) • the case may go to trial, but it probably won't (1, 3, 4) • a plea bargain means giving up some rights (1, 3)
Communication	The client must learn: • the importance of speaking with his/her attorney (4) • the importance of listening in court (4) • the importance of not saying "yes" if he/she doesn't understand something (4) • how to testify appropriately (4)	The client must be able to: • understand that the opposing counsel may try to trip him/her up • tell his/her story without self-incrimination • tell all details of his/her story to the attorney • resist leading questions and appreciate and be able to stick to a defense strategy
Emotions and behavior	The client must learn: • to display appropriate behavior (5) • not to display inappropriate behavior (5)	• Role-playing sessions to assess ability to tolerate the stress of courtroom proceedings (1–5)

* Numbers in parentheses denote the main module number(s) where this information is reviewed (see Table 2).

Source: Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law*, *31*, 189-201.

Table 2 Module Training Topic Summary

Module 1:	Purpose of training: Review of charges, pleas, and potential consequences
Module 2:	Courtroom personnel
Module 3:	Courtroom proceedings, trial, and plea bargain
Module 4:	Communicating with attorney, giving testimony, and assisting in defense
Module 5:	Tolerating stress of proceedings

Source: Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law*, *31*, 189-201.

Table 3 Sample Questions from Each Module

Column A: Knowledge-Based Questions*	Column B: Understanding-Based Questions
Module 1: Purpose of Training: Review of Charges, Pleas, and Potential Consequences	
What did the police say you did? On what date did this happen? About what time? [*If client does not understand the concept of time, simply teach the date of the offense so it will be memorized for court.*]	**How come you're in trouble?** (Some people say I did something bad. They say I did a crime.)
What is a crime? (It's when you do something bad and break the law.)	**Just because you're in trouble, does that mean you go to jail?** (No) **How come?** (Because I have to tell them I'm guilty or they have to prove I'm guilty before they can punish me. They have to prove it first.)
	Is it a crime to steal a candy bar? (Yes) **Why?** (Because you didn't pay for it. Because it's against the law.) [*Another way to ask this line of questioning at a later time may be:* **Is it a crime to buy a candy bar?** (No) **Why?** (Because you paid for it.)]
Module 2: Review of Courtroom Personnel	
[*Show the photos of the courtroom and ask who sits where. As he/she names the judge, jury, lawyer, ask the following questions*]	**How come the other side's lawyer wants to make you look bad?** (His job is to try to make the judge or jury put me in jail.)
What is the job of the other side's lawyer? (Tries to convince the judge or jury that I did it.)	**Who is on your side in the court?** (My lawyer, my family [*depending on the charge*].)
Can you talk to the other side's lawyer? (Yes.) **When can you talk to the other side's lawyer?** (Only when he asks me a question when I am on the witness stand.)	**Who is not on your side?** (The other lawyer. The judge and the jury are neutral. Some witnesses may not be on my side.)
Module 3: Review of Courtroom Proceedings, Trial, and Plea Bargain	
Having a trial is different from just going to court. There is a trial only if you plead not guilty (innocent). If you plead guilty or *nolo*, there is no trial; instead, the judge just give you the sentence.	**How come you have to go to court?** (Because they say I did something wrong, and when they say you did something wrong, they give you a charge and they take you to court. Because that's how the law works to decide if I'm guilty or not guilty.)
If you say you're guilty, is there a trial? (No)	**Why don't you need a trial if you plead guilty or take a deal?** (Because they already have an answer to the question since I told them I'm guilty or that I did something bad.)
If you say (plead) innocent, is there a trial? (Yes)	
If you say [plead] *nolo*, is there a trial? (No)	
[*Because these are yes/no questions, repeat from a different perspective to make sure the client knows. e.g. What are your possible pleas? (Guilty, innocent and nolo). Which plea would cause the client to have a trial?*]	
Module 4: Review of Working with Attorney/Assisting in Defense	
If you don't understand what is being said about you in court, who can you tell this to? (My lawyer)	**Why is it important to tell your lawyer if you don't understand what is being said?** (Everybody is here in court to talk about me. My job is to make sure that I know what people are saying about my case. I might miss something.)
What do you say to him if you don't understand what is being said? (I say, "I don't know what is going on.")	**Let's talk about what you just told me** (*client's version of what happened*)**. What are the most important things that you told me? Why are these things important?** [*Take the client through several examples of leading questions. Try to get him/her to follow your lead, and then show how he/she is being led so that he/she will recognize the pattern. Then, work with the client to resist answering leading questions, and practice asking for clarification if he/she does not understand a question. The Forensic Service will go over specific examples with you before training.*]
What are the things you need to tell your lawyer? [*Ask the client to tell you his story of what happened. If important parts are left out, help to make it fluent, but don't add new material and don't write down incriminating information. If you don't know what happened, contact the Forensic Service, and we will discuss the police report.*]	
The other side's attorney may try to confuse you on the witness stand. When you are asked a question that you don't understand, what would be the wrong thing to say? (Yes, I understand.) **What will you say instead?** (I don't know what you are saying. Ask me again.)	
Module 5: Tolerating Stress of Proceedings	
How are you supposed to behave in court? (Be nice. Don't yell. Talk to my lawyer.)	**Why is it important to speak up in court?** (Because they are talking about me. Because I have to stand up for myself. Because I have to understand what is going on.)
Can you laugh in court? (No) [*Repeat yes/no questions from a different perspective.*]	**Why is it important to not stand up and move around when court is going on?** (It would make me look bad. I need to look good to help my case.)
Is it good to sit quietly in court? (Yes)	
Does that mean you can never talk in court? (No. I can talk in court sometimes.)	
Can you tell jokes, yell etc., in court? (No) [*Repeat yes/no questions from a different perspective.*] **Why not?** (Because going to court is serious. Because I have to look good.)	
Is it good to talk quietly in court? (Yes)	
Can you get mad in court? (Yes, but I can't yell or scream.)	

* Questions are examples; elaborate on them or add new questions to foster discussion. Samples of acceptable answers are in parentheses.

Source: Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law, 31*, 189-201.

Table 4 Flow Sheet for Using the Workbook

Step 1:	Phases I and II, Modules 1–5: Ask and record knowledge-based training (Column A) and understanding-based training (Column B) for all modules to obtain a baseline.
	Phase I: Knowledge-Based Training
Step 2:	Phase I, Module 1: Knowledge-based training only (Column A) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 3:	Phase I, Module 2: Knowledge-based training only (Column A) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 4:	Phase I, Module 3: Knowledge-based training only (Column A) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 5:	Phase I, Module 4: Knowledge-based training only (Column A) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 6:	Phase I, Module 5: Knowledge-based training only (Column A) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 7:	Call the Forensic Service to discuss results of Phase I training.
	Phase II: Understanding-Based Training
Step 8:	Phase II, Module 1: Knowledge-based understanding-based training (Columns A and B) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 9:	Phase II, Module 2: Knowledge-based and understanding-based training (Columns A and B) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 10:	Phase II, Module 3: Knowledge-based and understanding-based training (Columns A and B) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 11:	Phase II, Module 4: Knowledge-based and understanding-based training (Columns A and B) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 12:	Phase II, Module 5: Knowledge-based and understanding-based training (Columns A and B) **Go through this module a minimum of three times. When all answers are fair or good, move to the next step.**
Step 13:	Contact the Forensic Service when you believe that your client is ready for a "dress rehearsal" in mock court.

Source: Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law, 31*, 189-201.

3) Educational Treatment Programs

Five studies on educational treatment programs were reviewed. Educational competency restoration efforts were successful in all five studies but only one study used an experimental design that compared educational programming with no educational programming.

Pendleton (1980) described the treatment program for competency restoration at Atascadero State Hospital, California.[31] Incompetent defendants were administered the Competency to Stand Trial Assessment Instrument (CAI) to determine areas of deficit, which then formed the basis for an individualized treatment plan. Defendants attended a competency education class and were required to obtain a passing score of 70% on a written competency evaluation. Upon successful completion of the written test, defendants were required to participate in a mock trial, using real judges and attorneys. Once the defendant had successfully completed the written exam and the mock trial, a formal competency assessment was then conducted by a mental health professional.

[31] Pendleton, L. (1980). Treatment of persons found incompetent to stand trial. *The American Journal of Psychiatry*, *137*, 1098-1100.

Pendleton reported that 90% of the 205 defendants admitted in 1979 were restored to competency, and 97.5% of that group subsequently completed the trial process. The average length of stay for this group was 104 days.

Davis (1985) described the treatment program at a Columbus, Ohio, maximum-security forensic hospital, which used a problem-oriented individualized treatment plan for the restoration of competence.[32] Defendants were evaluated with respect to the following problems/issues— (a) knowledge of the charge, (b) knowledge of the possible consequences of the charge, (c) ability to rationally communicate with an attorney, (d) knowledge of courtroom procedures, and (e) capacity to integrate and efficiently use the knowledge and abilities outlined above in either a trial or a plea bargain—and then placed into one of five groups, with specific programming for each group:

- *Psychotic confused.* Perceptual and/or thought disturbances interfere with the defendant's understanding of how the legal process works or interfere with communication with the court and the defense attorney. Programming is focused on reality-testing skills and other standard treatment approaches of psychosis.
- *Low functioning.* Patients who have a low IQ or who have brain injury or developmental disability. These patients require didactic, remedial education techniques on the roles and functions of the courtroom participants, court procedures, and possible legal consequences.
- *Delusional-irrational.* Patients who have adequate knowledge about their charge and courtroom procedures, but who distort or misinterpret the reality of their situation because of paranoid or other bizarre delusions. Programming focuses upon enhancing non-delusional coping skills.
- *Disruptive.* Patients who exhibit attention-seeking, hyperactive, impulsive, uncontrollable, or belligerent behavior that impedes learning or the defendant's presence in the courtroom. Programming is focused on providing structure, reinforcement, and behavior management techniques.
- *Advanced maintenance.* Patients awaiting discharge to court; clinically believed to be restored to competence. These patients need to maintain their current competence and develop further coping strategies.

Defendants' progress in the group was monitored and a mock trial was used at the completion of programming. No data regarding restoration rates or length of time to restore competence was presented.

Siegel and Elwork (1990) evaluated the use of an educational program as part of the competency restoration process by comparing randomly assigned control (n = 20) and experimental (n = 21) groups.[33] The experimental group was taught legal concepts using a cognitive, problem-solving approach and psycho-educational components (videotape, courtroom model, and discussion of courtroom personnel/procedure) as well as group problem solving sessions in which problems arising from a defendant's actual legal case were presented and discussed. Results showed greater improvement on Competency Assessment Instrument scores for the experimental group and a greater number of staff recommendations of competent to stand trial; 45 days after treatment, 43% of the treated group, but only 15% of the controls were considered competent by staff.

Brown (1992) described the competency restoration program at Alton Mental Health and Developmental Center in Illinois.[34] This restoration program was described as didactic in nature and took place in a group format that met daily for 30-45 minutes per session and was organized into seven discrete modules, with each module lasting for several days and including written handouts, videotaped vignettes, a mock trial, video trials, and a written test. The modules addressed the:

[32] Davis D. L. (1985). Treatment planning for the patient who is incompetent to stand trial. *Hospital and Community Psychiatry, 36*, 268-271.

[33] Siegel, A.M., & Elwork, A. (1990). Treating incompetence to stand trial. *Law and Human Behavior, 14,* 57-65.

[34] Brown, D. R. (1992). A didactic group program for person found unfit to stand trial. *Hospital and Community Psychiatry, 43*, 732-733.

(a) nature of criminal charges and sentences,
(b) elements of specific charges,
(c) roles of participants in trial process,
(d) sequence of events in a trial, and
(e) consequences of pleas, verdicts, and sentences. No data was provided regarding restoration rates or the length of time to restoration.

Noffsinger (2001) described an overhauled competency restoration program at the Northcoast Behavioral Healthcare System in Ohio.[35] Prior to the overhaul, the program was educational in nature and consisted of 4 to 5 hours of weekly lectures on the court/legal process provided by the program social worker. The perceived criticisms of this earlier program were that it was one-dimensional and that it did not contain any format other than lectures. A multidisciplinary team was formed to develop a new competency restoration curriculum. The new curriculum consisted of approximately 15 hours weekly of contact time for each defendant and encompassed 7 modules, offered by different members of the multidisciplinary treatment team. The modules consisted of the following:

1. *Educational module.* This module replaced the didactic lecture previously conducted by the program social worker with an enhanced lecture series given by an increased number of clinical staff. A greater number of staff participating in this lecture module could make the lectures more effective in that varied lecturers would make the material more interesting and would result in better learning.
2. *Anxiety Reduction module.* Psychologists met twice weekly for one hour with incompetent defendants and focused on developing anxiety management/relaxation techniques that defendants may use in court. Guided imagery and self-hypnotic skills were also taught.
3. *Guest Lecture module.* Court personnel, such as judges, defense attorneys, prosecutors, and probation officers were invited on a weekly basis to speak to the incompetent defendants and answer questions.
4. *Mock Trial module.* A scripted mock trial was carried out, with defendants playing the roles of the various courtroom personnel.
5. *Video module.* Videotape of actual courtroom proceedings was presented to the defendants, followed by a discussion led by clinical staff.
6. *Post-Restoration module.* In a peer-led discussion, defendants who had previously been to court discussed their experiences with incompetent defendants.
7. *Legal Current Events module.* News stories involving criminal trials that were featured in newspaper articles or the local television news were reviewed and discussed.

Noffsinger reported that the average length of stay in the overhauled competency restoration program was approximately 80 days, which was noted to be shorter than the average length of stay in the earlier one-dimensional treatment program. The Ohio Revised Code provides for maximum competency restoration times, based on the severity of the offense, with defendants charged with misdemeanors and lesser felonies required to be restored within 6 months and those charged with major felonies required to be restored within 1 year. Noffsinger reported that defendants in the new program were restored to competency at the following rates: 81.5% for misdemeanors; 90.9% for lesser felonies; and 85.7% for major felonies. No other data were reported. Noffsinger's recommendations for the components of a competency restoration program are provided in Table 5 (next page).

[35] Noffsinger, S. G. (2001). Restoration to competency practice guidelines. *International Journal of Offender Therapy and Comparative Criminology, 45*, 356-362.

Table 5
Noffsinger's (2001) Proposed Elements of a Model Competency Restoration Program[36]

Objective competency assessment upon admission	Specific deficits that result in incompetence to stand trial should be identified upon entry to the competency restoration program. These specific deficits should then be listed individually on the individualized treatment plan and targeted specifically in the course of the defendant's treatment. As mentioned above, various factors can lead to incompetence, such as psychosis, mood symptoms, mental retardation, lack of information, and so forth. Not all defendants are incompetent for the same reason, and therefore, the underlying reason leading to each defendant's incompetence should be identified by an objective competency assessment upon admission to the program.
Individualized treatment program	Each defendant should have a treatment regimen tailored to his or her specific problems. Deficits identified in the competency assessment upon admission to the program should be listed in the individual treatment plan and addressed by specific treatment interventions.
Multimodal, experiential competency restoration educational experience	Defendants learn material best when it is presented in multiple learning formats by multiple staff. For this reason, learning experiences should involve discussion, reading, video, and role-playing. Learning is also enhanced by experiential methods of instruction, such as a mock trial.
Educational component	A mainstay of the competency restoration program should be education regarding the following: various charges; severity of charges; sentencing; pleas; plea bargaining; roles of the courtroom personnel; adversarial nature of trial process; evaluating evidence.
Anxiety reduction component	An anxiety reduction module can be instrumental in providing relaxation techniques to defendants who may become anxious while in court.
Additional education components for defendants with low intelligence	Defendants who are incompetent due to specific knowledge deficits caused by low intelligence can often be restored to competence but may require additional exposure to the educational material. This may be addressed by providing additional learning experiences through increased lecture time as well as individual instruction using simplified terminology.
Periodic reassessment of competency	Defendants should be periodically reassessed for their progress toward restoration to competence. Periodic assessment allows the treatment teams to measure whether their treatment interventions are working, and whether additional treatment elements need to be incorporated into patients' treatment plans.
Medication treatment	Because psychotic and mood disorders are a major cause of incompetence, underlying mood and psychotic disorders must be aggressively treated with biological therapies for restoration to competence to occur.
Capacity assessments / involuntary treatment	Defendants adjudicated as incompetent to stand trial may also lack the capacity to give informed consent for treatment/medication. Because an important component of restoration to competence is medication treatment of underlying mental disorders, it is essential that clinicians address incompetence for treatment decisions per their local hospital policy and state laws. Defendants who refuse medication treatment should be evaluated for competence to make treatment decisions. Defendants who consent to medication treatment but appear incompetent to make such decisions should also be evaluated for competence to make treatment decisions.

[36] Ibid at pages 360-361.

4) Specialized / Individualized Programs

Two studies on specialized or individualized treatment programs were reviewed. Both used an experimental design to examine the effectiveness of a specialized or individualized treatment program. One found no difference between legal and non-legal programming, but both groups engaged in problem-solving activities as part of treatment. The other study found that both deficit-focused remediation and legal rights education impacted competency in comparison with standard hospital treatment, but did not differ from each other in terms of this effect so concluded that legal rights education is a more cost-effective treatment.

Bertman and colleagues (2003) evaluated the effectiveness of individualized treatment for the restoration of competency.[37] Three types of treatment groups were compared: a deficit-focused remediation group (n = 8); a legal rights education group (n = 10); and a standard hospital treatment group (n = 8). The authors indicated that there were no significant baseline differences between the three groups. Each group was administered competency assessment instruments pre- and post-treatment and all three groups performed significantly better on these measures post-treatment. The deficit-focused remediation group and the legal rights education group both demonstrated higher post-treatment scores than did the standard hospital treatment group. The authors found that these two groups demonstrated approximately 50 percent more improvement on competency measures than the standard hospital treatment group. They found no significant differences between the deficit-focused remediation and the legal rights education groups. Thus, they concluded that given no significant differences between the deficit-focused (individualized) remediation and legal rights education groups, deficit-focused remediation may not be necessary when legal rights education appears to work just as well and is less resource-intensive (that is, does not require a different program for each individual). No data regarding restoration or the length of time to restoration were provided.

Mueller and Wylie (2007) examined the effectiveness of the Fitness Game, an intervention created for the restoration of competence to stand trial, in a sample of 38 defendants referred for competency restoration to Hawaii State Hospital to determine whether competency-specific programming would significantly contribute to progress toward competency restoration.[38] The MacArthur Competence Assessment Tool – Criminal Adjudication (MacCAT-CA) was administered to all participants both pre- and post-intervention. Both the experimental (n = 21) and control groups (n = 17) showed significant pretest to posttest improvements on the Understanding and Appreciation subscales of the MacCAT-CA; however, no significant differences were found between the experimental and control groups at posttest on the competency measures. The researchers concluded that the Fitness Game was no more effective at restoring competency than non-legal programming; "in other words, individuals committed to a psychiatric hospital for care and treatment were as likely to improve as those receiving additional specialized competency restoration treatment."[39] The average length of time from admission to posttest in this study was 72.4 days.

5) Cognitive Remediation Programs

One commentary on cognitive remediation programs was relevant to this review. These authors argue for the inclusion of a cognitive remediation component in competency restoration because it focuses on those exact abilities that are deficient in incompetent defendants.

In 2007, Schwalbe and Medalia argued for the use of cognitive remediation as an adjunct to competency restoration programs. They based their conclusion on evidence that cognitive remediation leads to improved cognitive functioning (e.g., improved attention, reasoning, memory, executive function), which not only improves

[37] Bertman, L. J., Thompson, J. W., Jr., Waters, W. F., Estupinan-Kane, L., Martin, J. A., & Russell, L. (2003). Effect of an individualized treatment protocol on restoration of competency in pretrial forensic inpatients. *Journal of the American Academy of Psychiatry and Law, 31*, 27-35.

[38] Mueller, C. & Wylie, A. M. (2007). Examining the effectiveness of an intervention designed for the restoration of competency to stand trial. *Behavioral Sciences and the Law, 25*, 891-900.

[39] Ibid at page 891.

the success of competency training but also improves the individual competence-related abilities required of a defendant (i.e., the specific prongs of the *Dusky* standard).[40,41]

Although they include no data, Schwalbe and Medalia provide a sound, rational argument for the inclusion of a specific treatment component that targets the exact abilities that hospitals attempt to restore in incompetent defendants. A flowchart depicting the way cognitive remediation leads to improved cognitive functioning, which in turn leads to better performance in competence-related abilities, is presented in Figure 1. This model is based on a rationale that is in line with current best practices in the evaluation of competency to stand trial and that attempts to specifically target those areas of deficit in incompetent defendants.

Figure 1
Cognitive Remediation Competency Flow Chart

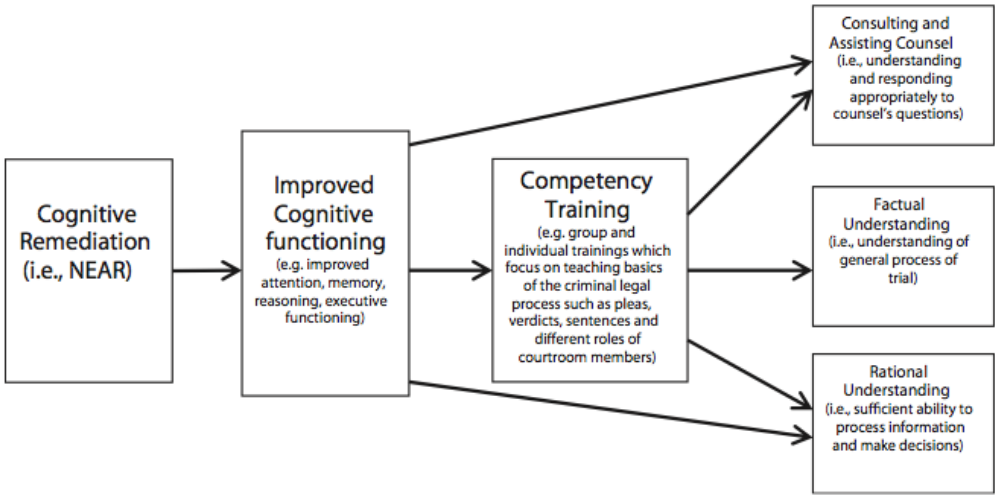

Figure 1. Cognitive remediation competency flow chart.

Source: Wall, B. W., Krupp, B. H., Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *The Journal of the American Academy of Psychiatry and Law, 31*, 189-201.

[40] Schwalbe, E., & Medalia, A. (2007). Cognitive dysfunction and competency restoration: Using cognitive remediation to help restore the unrestorable. *Journal of the American Academy of Psychiatry and Law, 35*, 518-525.

[41] A recent commentary on competency restoration called for further attention, in terms of development and testing, of this type of restoration protocol. Its sound logic and rationale and its focus on remediating cognitive deficits that, in turn, impact competence-related abilities is precisely where we need to be focusing our attention in this arena. See Zapf, P. A., & Roesch, R. (2011). Future directions in the restoration of competency to stand trial. *Current Directions in Psychological Science, 20*, 43-47.

The National Judicial College's Best Practices Model – Competency Restoration

Recently, the National Judicial College assembled a panel of experts[42] to develop a Mental Competency—Best Practices Model that would present "a body of practices deemed to be most effective and efficient for handling mental incompetency issues in the criminal justice and mental health systems."[43] The Best Practices Model with respect to restoration is summarized in the box below.[44]

National Judicial College's Best Practices Model: Competency Restoration

Best Practice: It is a best practice for the treating physician or primary treatment provider to determine the treatment regimen necessary for the defendant to be restored to, and maintain, competency. If the defendant is in need of psychoeducational training to gain competency to stand trial or plead, it is a best practice to provide psychoeducational training as part of the competency restoration. It is a best practice to rely on the opinion of the evaluating mental health professional as to what competency restoration interventions should be initially provided to the defendant.

Discussion: There is a debate as to whether psychoeducational training is effective in helping to restore competency to defendants who are not cognitively challenged. Many practitioners currently utilize some type of psychoeducational group training for competency restoration. However, to date, there does not appear to be scientific evidence to demonstrate that this type of training is essential to restore competency in persons who suffer from a mental illness; nor is there is evidence that these individuals will be restored faster with psychoeducational training.

Statistics show that approximately 90 percent of defendants referred for competency restoration are diagnosed with a mental health disorder, and approximately 10 percent are diagnosed with a cognitive disorder or developmental disability (these numbers may vary slightly from state to state). Of the roughly 10 percent of defendants who are diagnosed with a cognitive disorder or developmental disability, roughly 18-30 percent are rendered competent. For this group, psychoeducational training may be the only method available to render them competent.

Section Summary

The available research and commentary suggests that successful restoration is related to how well the defendant responds to psychotropic medications administered to alleviate symptoms of mental disorders. The addition of an educational component (either general or individualized) appears to offer some benefit for increasing a defendant's general legal knowledge and for increasing the level of competency in the defendant.

Research examining the efficacy of various educational treatment programs for defendants with mental retardation (developmental disability) was also reviewed. The converging conclusion across each of the studies reviewed was that competency training for these individuals does not appear to be very effective.

The Slater Method, described by Wall and colleagues, is a resource-intensive training program that resulted in one-third of the defendants restored to competency in a time frame of eight months to three years. Consideration must be given to balancing the benefit of the program and the amount of resources (i.e., time, staff) involved in offering such a program. As a general statement, it takes many more resources to restore a defendant with a developmental or cognitive disability to competence than it does to restore a mentally ill defendant, and fewer defendants with cognitive or developmental disabilities are ultimately restored.

[42] The panel includes judges, lawyers, policy makers, court managers, psychiatrists and psychologists, from academic, research, clinical and practice positions—all expert on various aspects of competency to stand trial. The authors this report, Patricia Zapf, was a panel member.

[43] More information about the panel or the Best Practices Model, as well as a copy of the complete Best Practices Model document and other helpful resources are available from the website www.mentalcompetency.org.

[44] Best Practices Model Section VI (B) available at http://www.mentalcompetency.org/model/model-sec-VI.html#VI

The available research on the efficacy of including an educational component to competency restoration for defendants with mental illness. provides some evidence for including an educational component with competency restoration. Siegel and Elwork (1990)[45] demonstrated that the use of an educational component that incorporated legal concepts using a cognitive, problem-solving approach and psycho-educational components (videotape, courtroom model, and discussion of courtroom personnel/procedure as well as group problem solving sessions in which problems arising from a defendant's actual legal case were presented and discussed) increased competency restoration rates. In addition, Noffsinger (2001)[46] presented a comprehensive model for competency restoration, that encompasses the same type of educational components as described by Siegel and Elwork, but that also includes additional aspects such as an anxiety reduction component. Noffsinger's model was included as a Table in this report as it might provide useful information for the State of Washington in this regard.

Additional studies that examined the specialized or individualized components in competency restoration concluded that the additional resources involved in individualized treatment plans might not be justified.

Finally, recent commentary[47] has indicated the potential utility of a competency restoration program focuses on improving the cognitive skills of incompetent defendants. This approach could provide some additional benefit to incompetent defendants in terms of both improving cognitive skills and functioning in general as well as with respect to the specific competence-related abilities required to proceed. More research in this area is needed.

Conclusions about Treatment Protocols

The available literature on treatment protocols for the restoration of competence in defendants who are not cognitively or developmental disabled does not provide strong scientific evidence for a preferred method for competency restoration, aside from pharmaceutical treatment. According to the National Judicial College's Best Practices Model, pharmaceutical treatment should be tailored to the specific needs and symptoms of each defendant.

The benefit of adding educational programs to medication protocols for competency restoration of non-developmentally disabled defendants has not been clearly established. There does appear to be some support for the inclusion of a general legal educational component and an opportunity for defendants to engage in problem solving about their own cases in a group format.

Cognitive remediation programs for competency restoration may hold some promise but scientific evidence is needed. This is certainly an area worthy of further investigation.

For defendants with developmental disabilities, educational treatment programs may be one of the only means for increasing the level of competence; however, there is limited scientific evidence for the overall efficacy of implementing these resource-intensive training programs.

The table below provides a brief description of each of the research studies reviewed.

[45] See note 32.
[46] See note 34.
[47] See notes 39 and 40.

Authors/Study	State/N	Study Population/ Success of Restoration Efforts	Timeframe for Restoration	Summary
		Treatment Protocols for Defendants with Developmental Disabilities		
Anderson & Hewitt (2002)	Missouri (N = 75)	1/3 were restored; 2/3 were not	No data on timeframes	Concluded that competency training for those with MR might not be that effective
Wall, Krupp, & Guilmette (2003)	Rhode Island (N = 15)	1/3 of defendants were restored	Restoration took between 8-months and 3-years	Full description of the Slater Method program for developmentally disabled; resource-intensive
Appelbaum (1994)	Commentary underscoring difficulty in restoring those with MR			
Pinals (2005)	Commentary underscoring difficulty in restoring those with MR			
		Educational Treatment Programs		
Pendleton (1980)	California (N= 205)	90% were restored	104 days	Most defendants were restored within 4 months
Davis (1985)	Ohio (N not provided)	No data provided	No data provided	Provided detailed description of program
Siegel & Elwork (1990)	No information provided (n = 20 controls; n = 21 experimental)	43% of those who received educational program were restored compared to 15% of controls	45 days	Educational, problem-solving approach was effective in restoring competency
Brown (1992)	Illinois (N not provided)	No data provided	No data provided	Described their didactic, educational approach and seven modules
Noffsinger (2001)	Ohio (N not provided; 40-bed facility)	81.5% of misdemeanants restored within 6 months; 90.9% of lesser felony D's restored within 6 months; 85.7% of major felony D's restored within 1 year	6 months or 1 year as defined by statute	Provided a detailed description of this restoration program
		Specialized/Individualized Treatment Programs		
Bertman et al. (2003)	Louisiana (n = 8 controls; n = 8 deficit-focused; n = 10 legal rights)	No data provided	No data provided	Compared deficit-focused remediation, legal rights education, and standard hospital treatment and found an effect for both deficit-focused remediation and legal rights education but no differences between the two types of treatments.
Mueller & Wylie (2007)	Hawaii (n = 17 controls; n = 21 experimental)	No data provided	72.4 days	Compared legal and non-legal programming and found no differences
		Cognitive Remediation Programs		
Schwalbe & Medalia (2007)	Commentary regarding the inclusion of a cognitive remediation component, which targets competence-related abilities (attention, memory, reasoning, executive functioning)			

Section III: Restoration Time Periods

The available research from 15 studies on timelines for restoration is reviewed in this section.

Summary of Literature

Research exploring the rates of competency restoration consistently indicates that the vast majority of defendants (80 – 90%) are eventually restored to competency.[48,49,50,51,52] Most defendants are restored to competency within 180 days and an even greater number are restored within one year.

Restoration Time Periods

Methodological issues with some of the earlier research in this area makes it difficult to determine the exact timelines for restoration. Some recent research has used more sound methodology, which allows for more specific information regarding how long it takes to restore certain types of defendants.

Pendleton (described in more detail in Section II above) reported that 90% of the 205 defendants admitted to the competency restoration program at Atascadero State Hospital in California in 1979 were restored to competency.[53] This group had a mean length of stay of 104 days and 97.5% of them subsequently completed the trial process.

Rodenhauser and Khamis (1988) examined restorability and length of stay in a sample of 376 patients who were court ordered to a maximum-security forensic hospital for competency restoration over a four-year period. Although these authors did not report overall rates of restoration, they did examine rates by factors such as medication refusal and diagnosis. The overall average length of stay was 153 days (SD = 164 days), with longer length of stay associated with a diagnosis of schizophrenia, lack of personality disorder, felony charges, medication refusal, involuntarily receiving medication, and requiring physical restraint[54].

Siegel and Elwork (described in more detail in Section II above) conducted a controlled study of a competency restoration program in the Philadelphia area and reported that 43% of the intervention group (versus only 15% of the control group) was restored to competency within 45 days.[55]

Bennett and Kish (1990) examined the relationship between length of treatment and demographic characteristics for 1090 incompetent defendants remanded to the North Florida Evaluation and Treatment Center between 1978-1984 for competency restoration to determine whether demographic characteristics influence length of time to

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[48] Cuneo, D. J., & Brelje, T. B. (1984). Predicting probability of attaining fitness to stand trial. *Psychological Reports, 55*, 35-39. (Found that 74.4% were restored within one year, 25.6% were not restored after one year.)
[49] Lamb, H. R. (1987). Incompetency to stand trial. *Archives of General Psychiatry, 44*, 754-758. (Found that 83.5% were restored after a median hospital stay of 4.5 months; did not describe the percent who were not restored.)
[50] Mowbray, C. T. (1979). A study of patients treated as incompetent to stand trial. *Social Psychiatry, 14*, 31-39. (Reported an 88.7% restoration rate, 7.2% not restored.)
[51] Nicholson, R., Barnard, G., Robbins, L., & Hankins, G. (1994). Predicting treatment outcome for incompetent defendants. *Bulletin of the American Academy of Psychiatry and the Law, 22*, 367-377. (Reported that 89.5% were restored, 10.5% not restored within 1 year.)
[52] Nicholson, R., & McNulty, J. (1992). Outcome of hospitalization for defendants found incompetent to stand trial. *Behavioral Sciences and the Law, 10, 371*-383. (Found 94.7% were restored, 5.3% not restorable.)
[53] See note 27.
[54] Rodenhauser, P., & Khamis, H. J. (1988). Predictors of improvement in maximum-security forensic hospital patients. *Behavioral Sciences and the Law, 6*, 531-542.
[55] See note 29.

restoration. These researchers concluded that length of treatment was not influenced by race, education, and marital status. The overall mean length of time to restoration was 174.96 days.[56]

Nicholson and McNulty (1992) reported on the restoration rates for 150 randomly selected incompetent defendants who had undergone restoration efforts in Oklahoma. These researchers reported successful restoration for 94.7% of these defendants; the an average length of stay for those restored was 63.7 days versus 234 days for those who were not restored. The average length of stay for the entire sample was 68.6 days and less than 6% had a length of stay greater than 6 months.[57]

Nicholson, Barnard, Robbins, and Hankins (1994) examined length of stay and restoration rates for 133 male defendants ordered to the North Florida Evaluation and Treatment Center as incompetent to stand trial. These researchers found that 89.5% of the defendants were restored to competency (10.5% were not restored) by the cutoff date for the study. On average, defendants were hospitalized for more than nine months (M = 283 days, SD = 272.2 days); however, the median length of stay was only 169 days. The proportion of defendants hospitalized for more than 3 months was 87.2%; 45.9% were hospitalized for more than 6 months, 30.8% for more than 9 months, and 24.1% for more than 1 year. Defendants considered not restorable remained in hospital significantly longer (M = 825.9 days, SD = 280.9 days) than those who were restored to competency (M = 219.2 days, SD = 187.4 days).[58]

Hoge and colleagues (1996) compared incompetent (n = 42) and competent (n = 42) defendants on a variety of measures of capacity to understand legally relevant information. The authors found that incompetent defendants were impaired in their ability to understand information relevant to assisting counsel, pleading guilty, and waiving a jury. The authors also reported an average timeframe for restoration of 97.9 days (SD = 50.5 days) for the 28 incompetent defendants who were restored to competency during the study period.[59]

Noffsinger (2001) reported on a competency restoration program consisting of seven modules delivered by a multidisciplinary treatment team (see Section II for more detail). The average length of stay in this treatment program was approximately 80 days. Noffsinger reported that 81.5% of defendants charged with misdemeanors were restored to competence within the required six-month timeframe; 90.9% of defendants charged with lesser felonies were restored within the required six-month timeframe; and 85.7% of defendants charged with major felonies were restored within the required one-year timeframe.[60]

Stafford and Wygant (2005) examined the outcomes of 80 competency evaluations conducted with defendants who were referred from a mental health court. Of the 80 defendants evaluated, 62 defendants (77.5%) were found incompetent and ordered to a competency restoration program. The incompetent defendants were given an average of 49 days of competency restoration treatment (SD = 23.8 days) in the state hospital and 47% were restored to competency during this timeframe.[61] It is important to note that this was a select group of referrals from a mental health court; thus, the lower rate of restoration is likely due to more severe psychiatric symptomatology.

Mueller and Wylie (2007) reported on the effectiveness of an intervention created for the restoration of competence to stand trial in a sample of 38 incompetent defendants (see Section II for more detail). They reported

[56] Bennett, G., & Kish, G. (1990). Incompetency to stand trial: Treatment unaffected by demographic variables. *Journal of Forensic Sciences, 35*, 403-412. (Note: n = 1019; SD = 137.07).
[57] See note 49.
[58] See note 48.
[59] Hoge, S. K., Poythress, N., Bonnie, R., Eisenberg, M., Monahan, J., Feucht-Haviar, T., & Oberlander, L. (1996). Mentally ill and non-mentally ill defendants' abilities to understand information relevant to adjudication: A preliminary study. *Bulletin of the American Academy of Psychiatry and Law, 24*, 187-197.
[60] See note 31.
[61] Stafford, K. P., & Wygant, D. B. (2005). The role of competency to stand trial in mental health courts. *Behavioral Sciences and the Law, 23*, 245-258.

an average of 72.4 days from admission to posttest but did not break this out by experimental and control groups, as there were no differences between the two groups at posttest on any competency measures.[62]

Herbel and Stelmach (2007) reviewed the cases of all incompetent defendants with the principal diagnosis of delusional disorder who underwent involuntary medication for competency restoration during a 13-year period at the Federal Medical Center in Butner, North Carolina (n = 22). The majority of these defendants (77%) were restored to competency within five months.[63]

Mossman (2007) examined the records of 351 inpatient pretrial defendants who underwent competence restoration at a state psychiatric facility in Ohio to determine whether certain variables available to forensic examiners could predict restoration outcome.[64] The variables of interest included demographic characteristics, diagnoses, symptom patterns, criminal charges, number of prior psychiatric hospitalizations, and cumulative prior length of stay. The overall rate of successful restoration reported by Mossman was 75% for felony defendants and 48% for misdemeanants. Length of restoration data were not presented but Mossman noted that Ohio statute requires that maximum restoration periods for felony defendants were 4–12 months (depending upon the specific charge) and 30–60 days for misdemeanants (again, depending upon the specific charge). Mossman found that "lower probability of restoration was associated with having a misdemeanor charge, longer cumulative length of stay, older age, and diagnoses of mental retardation, schizophrenia, and schizoaffective disorder."[65]

Mossman delineated two typical instances in which a defendant might be considered to have a low probability of restoration. First, if the basis for the defendant's incompetence was a longstanding psychotic disorder that resulted in lengthy periods of hospitalization. Second, if the basis for the defendant's incompetence was an irremediable cognitive disorder, such as mental retardation, that resulted in a limited grasp of the information that an examiner attempts to convey during an evaluation. Each scenario appears to result in a well-below-average chance of successful restoration.

Morris and Parker (2008) examined data from 1,475 admissions for competency restoration in Indiana between 1988 and 2005 to determine the factors associated with successful restoration to competence. These authors reported that 72.3% of the admissions were restored to competence within six months and 83.9% within one year.[66] In addition, those with mood disorders were significantly more likely to be restored to competence than those diagnosed with psychotic disorders. Defendants with mental retardation (either alone or in conjunction with a mental illness) were significantly less likely to be restored than defendants with any other psychiatric disorder. Those diagnosed with both mental retardation and a mental illness were significantly less likely to be restored than defendants with mental retardation alone. Regression analyses indicated that females and those with affective disorders were most likely to be successfully restored whereas older age, mental retardation, and a psychotic diagnosis were significantly related to a decreased chance of restoration.

Collwell and Gianesini (2011) reviewed the records of 71 incompetent male patients ordered for competency restoration and subsequently discharged from a maximum-security forensic hospital. The majority of defendants (75.7%) were restored to competency.[67] The mean length of stay for restored defendants was 98.92 days (SD = 54.54 days), which was significantly shorter than the mean length of stay for non-restored defendants (173.18 days; SD = 106.79 days). Non-restorable patients had more prior incarcerations, hospitalizations, and episodes of

[62] See note 34.
[63] Herbel, B. L., & Stelmach, H. (2007). Involuntary medication treatment for competency restoration of 22 defendants with delusional disorder. *Journal of the American Academy of Psychiatry and the Law, 35*, 47-59.
[64] Mossman, D. (2007). Predicting restorability of incompetent criminal defendants. *The Journal of the American Academy of Psychiatry and the Law, 35*, 34-43.
[65] Ibid at page 34.
[66] Morris, D. R., & Parker, G. F. (2008). Jackson's Indiana: State hospital competence restoration in Indiana. *Journal of the American Academy of Psychiatry and Law, 36*, 522-534.
[67] Colwell, L. H., & Gianesini, J. (2011). Demographic, criminogenic, and psychiatric factors that predict competency restoration. *Journal of the American Academy of Psychiatry and Law, 39*, 297-306.

incompetence as well as lower level charges, diagnoses of psychotic and cognitive disorders, lower global assessment of functioning (GAF) scores, and were prescribed more medications.

Advokat and colleagues (2012) examined archival data to determine the differences between incompetent defendants who were restored to competence (n = 43) and those who were not (n = 15).[68] No differences were found between the restored and unrestored groups with respect to demographic variables, intellectual capacity, offense type, diagnoses, substance abuse, or psychotic symptomatology. The restored group performed significantly better on the Georgia Court Competency Test (GCCT) and on the Global Assessment of Functioning scale (GAF), both at the initial evaluation period as well as at the final evaluation period. Severity of psychotic symptoms decreased significantly for the restored group, but not for the unrestored group, and the restored group was discharged significantly sooner (mean = 7.7 months; SD = 8.6 months) than the unrestored group (mean = 17.9 months; SD = 7.0 months).

Summary of Data

A summary table of the available research that provided time frames to restoration for incompetent defendant is provided below.

Exhibit 4
Time Frames to Restoration from the Research Literature

Study	N	Average time to Restoration
Pendleton (‘80)	205	104 days
Rodenhauser & Khamis (‘88)	375	153 days
Bennett & Kish (‘90)	1090	175 days
Nicholson & McNulty (‘92)	150	64 days
Nicholson et al. (‘94)	133	219 days
Hoge et al. (‘96)	28	98 days
Noffsinger (‘01)	n.r.	80 days
Stafford & Wygant (‘05)	38	72 days
Morris & Parker (‘08)	1475	72.3% within 6 mo 83.9% within 1 year
Collwell & Gianesini (‘11)	71	99 days
Average		153 days

Note: Reviewed studies that provided data on the average time to restoration are included in this table.

[68] Advokat, C. D., Guidry, D., Burnett, D. M. R., Manguno-Mire, G., & Thompson, J. W. Jr. (2012). Competency restoration treatment: Differences between defendants declared competency or incompetent to stand trial. *Journal of the American Academy of Psychiatry and Law, 40*, 89-97.

The National Judicial College's Best Practices Model – Length of Time for Competency Restoration

With respect to the issue of time frames for competency restoration, the 2011-12 National Judicial College's Best Practices Model is summarized in the box below.[69]

National Judicial College's Best Practices Model: Length of Time for Competency Restoration

Best Practice: For a person charged with a misdemeanor, it is a best practice for the initial competency restoration to be no more than 120 days, unless that period of time is longer than the maximum amount of time the defendant would have served if incarcerated for the pending charge(s). It is a best practice for the mental health professional to notify the court as soon as he or she believes the defendant is rendered competent, which may be less than the 120-day period. It is a best practice for the court to not criminally commit a defendant to be restored to competency (including pre-treatment detention) for a period that is longer than the maximum amount of time that he or she would have served if incarcerated for the pending charge(s).

For a person charged with a felony, it is a best practice for the initial competency restoration to be no more than 120 days. By or before the end of the 120-day period, it is also a best practice for the treating mental health professional to file a report with the court stating his or her opinion as to whether he or she believes there is a substantial probability that the defendant can be restored to competency in the foreseeable future, or no longer than by an additional 245 days. If the mental health professional believes there is a substantial probability that the defendant can be restored to competency in the foreseeable future, it is further a best practice for him or her to opine as to what additional time is needed to restore the defendant to competency; for the court to grant 60-day extensions up to the additional 245 days; and for the treating mental health professional to file additional progress reports at the end of each additional 60-day period. It is also a best practice for the mental health professional to notify the court as soon as he or she believes the defendant is restored, which may be less than the initial 120-day period. Finally, it is a best practice for the court to not criminally commit a defendant for restoration for a period that is longer than the maximum amount of time that he or she would have served if incarcerated for the pending charge(s) (including pre-treatment detention).

Discussion: The Supreme Court made clear in *Jackson v. Indiana*, 406 U.S. 715 (1972), that a person may not be criminally committed for purposes of rendering him or her competent to stand trial "more than the reasonable period of time necessary to determine whether there is a substantial probability that he [or she] will attain that capacity in the foreseeable future." *Id.* at 738. Further, if a physician determines that the defendant "probably soon will be able to stand trial," the defendant must be making progress toward that goal to justify his or her continued commitment.

[69] Best Practices Model Section VI (C) available at http://www.mentalcompetency.org/model/model-sec-VI.html#VI

Section Summary

The available literature on time frames to successful competency restoration indicates that the majority of incompetent defendants (80 – 90%) are restored to competency within six months.

Defendants that take the longest to restore to competence appear to be those with: (a) developmental disabilities, and (b) those with longstanding psychotic disorders that have resulted in lengthy periods of hospitalization. The available research indicates that these two categories of defendants also have the lowest probability of being restored.

In terms of the characteristics that are common to defendants who are ultimately not restored, these defendants tend to:

- be older;
- have more extensive histories of mental illness (as indicated by longer cumulative length of stay for inpatient admissions as well as more prior incidents of incompetence);
- have diagnoses of psychotic disorders (especially schizophrenia or schizoaffective disorder), mental retardation, or both mental retardation and a psychiatric disorder (putting these dually diagnosed individuals at the lowest probability for restoration); and
- have lower level charges (misdemeanors; although this might be an artifact of shorter statutory timelines for treatment).

Clinically, one would not expect to find a significant difference in the time it takes to restore felony and misdemeanor defendants. In recognition of the variation in sentence lengths, however, many jurisdictions have implemented different time frames for competency restoration by category of offense (felony v. non-felony). The National Judicial College's Best Practices Model's recommendations regarding time frames for restoration also take offense category into consideration.

Conclusions

This literature review concerns the clinically appropriate time periods for effective competency restoration.

The average time to restoration for incompetent felony defendants in the state of Washington, treated at either WSH or ESH, is less than 3 months (90 days), which is well within the allotted statutory time frames for the state (up to 360 days) and less than the initial period for restoration recommended by the National Judicial College (120 days).

Incompetent felony defendants who are not restored to competency spend an average of 154 days at ESH, including 76 days on competency restoration status before being civilly committed. The overall average length of time to restoration supplied by the available national research data was 153 days. Thus, it appears that 76 days (or even the statutorily required 90 days) might not be enough time to conclude that a defendant is not restorable. Data regarding the clinical characteristics of this group of defendants was not available. Similarly, it is not known whether any of these defendants went on to become competent. More information regarding these defendants would be helpful in ascertaining whether a longer initial statutory time frame for competency restoration would be beneficial.

With respect to the time frames for restoration of incompetent felony defendants, Washington State's statutes allow for a total time frame of up to 1 year (360 days) for restoration. This appears to be an adequate and clinically appropriate time frame for restoration to competency as indicated by the data reviewed in this report as well as the recommendations of the National Judicial College's Best Practice Model.

In terms of non-felony defendants, the available data for ESH indicate that this population is restored to competency within one month (30 days), presumably within the allotted statutory time frames for non-felony defendants in Washington (14 days plus any unused evaluation time) but well below the initial period for restoration recommended by the National Judicial College (120 days).

In addition, the data from ESH indicate that non-felony defendants who are found to be non-restorable are hospitalized for an average of 76 days, including an average of 29 days on restoration status before being civilly committed. Thus, it appears that the statutorily required initial 30-day period is not enough time to make a determination regarding whether these non-felony defendants are ultimately restorable. The available data on time to restoration appear to indicate that a lengthier initial time period might allow for more of these non-felony defendants to be ultimately restored and would reduce the number of non-felony defendants who become civilly committed.

Finally, given that one should not expect to find any differences—clinically—between incompetent felony and non-felony defendants, it appears reasonable to allow both types of defendants the same initial treatment period for restoration of competency.

Psychology, Public Policy, and Law
2016, Vol. 22, No. 3, 293–305

1076-8971/16/$12.00 http://dx.doi.org/10.1037/law0000088

Lookin' for Beds in All the Wrong Places: Outpatient Competency Restoration as a Promising Approach to Modern Challenges

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In response to consistently increasing numbers of individuals found incompetent to stand trial, some states have identified community-based or "outpatient" competency restoration programs (OCRPs) as a viable alternative to inpatient restoration. This study used a multistep approach to capture information about OCRPs nationwide. We reviewed states' competency statutes to determine which states have provisions that allow for outpatient competency restoration, and we then corroborated this review with a brief preliminary survey that was disseminated to each representative of the Forensic Division of the National Association of State Mental Health Program Directors. We received responses from 48 of 51 U.S. jurisdictions (47 states and the District of Columbia). We conducted in-depth interviews with forensic representatives in those 16 states that identified having operational OCRPS. The current study presents our analysis of state statutes and then compares and contrasts current OCRPs. In summary, OCRPs are a recent but rapidly developing alternative to traditional inpatient restoration. Through a comparison of existing OCRPs, we believe OCRPs show preliminary but promising outcomes in terms of high restoration rates, low program failure rates, and substantial cost savings.

Keywords: competency restoration, outpatient competency restoration, community-based

Localities across the United States are struggling with the growing number of individuals with serious mental health challenges charged with criminal offenses. Jail and state hospital administrators seek new ways to meet legal requirements and address the clinical needs of these individuals. State hospital bed capacity has not kept pace with the increasing rate of court-ordered forensic referrals (Colwell & Gianesini, 2011; Mossman et al., 2007), resulting in waitlists at local jails and decreasing hospital capacity for civil patients. The combination of burgeoning forensic populations, lean state mental health budgets, and successful lawsuits arguing for placements in "least restrictive settings" for forensic patients has led many states to develop community forensic programs as alternatives to correctional confinement and inpatient hospitalization (Bloom, 2012; DeMatteo, LaDuke, Locklair, & Heilbrun, 2013; Heilbrun et al., 2012; Wall, 2013). Examples of innovations that can decrease pressure on jails and state hospitals include pre- and postbooking jail diversion programs (Sirotich, 2009), mental health courts (Burns, Hiday, & Ray, 2013), increased services for insanity acquittees (Vitacco, Vauter, Erickson, & Ragatz, 2014), and specialized services for probationers or parolees with mental illness (Eno Louden et al., 2012). Much potential remains, however, for innovation around the significant portion of the forensic population found incompetent to stand trial (IST).

Robust Focus on Competency to Stand Trial Evaluations

Much scholarly and practical attention has focused on competency to stand trial. Competency to stand trial (CST) evaluations are the most common forensic evaluations ordered by the criminal courts (Edens, Poythress, Nicholson, & Otto, 1999; Golding, 1992; Melton, Petrila, Poythress, & Slobogin, 2007). Estimates range from 50,000 to 60,000 evaluations annually (Bonnie & Grisso, 2000; Skeem, Golding, Cohn, & Berge, 1998). Moreover, the number of evaluations is growing annually (Seaman & Johnson, 2008). The state of Colorado reported a 206% increase in the number of CST evaluations from 2005 to 2014 (Colorado Department of Human Services, 2015), whereas Los Angeles county reported a 273% increase from 2010 to 2015 (Sewall, 2016). An estimated 10,000 to 18,000 defendants are adjudicated as incompetent to proceed each year and remanded to competency restoration services (Warren, Chuahan, Kois, Dibble, & Knighton, 2013), with commensurate annual increases as the number of CST evaluations increases.

A great deal of research, litigation, and service provision has been dedicated to improving the competency process throughout the last 30 years, with the lion's share devoted to competency

This article was published Online First June 6, 2016.

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evaluation. Grisso's (1986) seminal book *Evaluating Competencies* ignited a great deal of complex and productive scholarship regarding competency evaluation. As a result, more than a dozen formal assessment measures currently exist to evaluate CST, and a large number of articles, chapters, and assessment measures have been developed for specific competency-related populations: juveniles, persons with intellectual disabilities, persons facing capital sentencing or death, and the like (Drogin, Dattilio, Sadoff, & Guntheil, 2011; Zapf & Roesch, 2009). The rich literature allowed the American Association of Psychiatry and the Law (AAPL) to create and adopt a comprehensive set of guidelines for CST evaluations (Mossman et al., 2007). The literature on defendants facing competency evaluation is so robust that an excellent meta-analysis (Pirelli, Gottdiener, & Zapf, 2011) was published in 2011, covering 68 competency evaluation studies and 26,139 defendants undergoing such evaluations from 1967 to 2008.

Moreover, states have consistently updated their policies and statutes regarding competency evaluations. A total of 37 states identify specific time frames to complete CST evaluations, and 35 of those delineate the various settings in which evaluations can be conducted (Gowensmith, Murrie, & Packer, 2015). The last 2 decades have seen a tremendous shift in where evaluations are conducted; for example, the state of Washington conducted 43.0% (n = 717 of 1,667 total) of CST evaluations in its state hospitals in 2001, compared with only 11.4% in 2013 (n = 336 of 2,939 total; Joint Legislative and Audit Review Committee, 2014). Most states have followed a similar trajectory, with most CST evaluations currently being conducted in local jails (Zapf & Roesch, 2009). In addition, 50% of states have formalized trainings or certifications for CST evaluators, a 90% increase since 1992 (Gowensmith, Pinals, & Karas, 2015). In short, CST evaluation has received a great deal of attention from researchers, service providers, and lawmakers alike—and as a result has continued to evolve and improve from both service provision and public policy standpoints (Melton et al., 2007).

Need for Focus on Competency Restoration

In contrast, less attention has been given to competency restoration—the treatment and service array required by persons adjudicated as IST. As a result, the historical trajectory of competency restoration has been comparatively stagnant. When a person is adjudicated as IST, legal proceedings are typically put on temporary hiatus and the person is remanded to competency restoration. Restoration usually involves some combination of psychiatric medication, mental health treatment, psycho-education about the legal process, and consistent evaluation regarding progress, although experts disagree about the relative importance of these approaches in various cases (National Judicial College, 2011–2012). Courtroom status hearings are usually held at regular intervals to gauge progress, often with the input of updated competency evaluations and/or progress updates from treating professionals. A person will typically remain in restoration until he or she is "restored" to competency or until the court is convinced that the person is unable or significantly unlikely to regain competency in the future.

Some research is available regarding competency restoration. A competency restoration meta-analysis by Pirelli and Zapf (a follow-up to their meta-analysis of CST evaluation mentioned previously) covered 51 studies and 5,856 persons in restoration services. They found that 81% of individuals were eventually restored to competency, and that it took an average of 90 to 120 days for most persons to be restored (Pirelli & Zapf, 2015). These results are consistent with other sources of restoration data (Melton et al., 2007; Zapf & Roesch, 2009). Factors that delineate those ultimately restored to competence versus those that are found unrestorable are becoming better understood (Warren et al., 2013). However, as Warren et al. (2013) stated, the amount of literature dedicated to investigating CST restoration is a fraction of that devoted to exploring CST evaluation.

Correspondingly, the field of competency restoration has seen fewer advances and changes than the field of competency evaluation. Although 48 states have identified specific time frames for competency restoration to occur, few states have updated those time frames during the last 2 decades (State of Hawaii Office of the Governor, 2008). Compared with the myriad assessments for CST evaluation, there are few proprietary models for competency restoration. Proposed restoration protocols have been offered (Bertman et al., 2003; Mueller & Wylie, 2007; Noffsinger, 2001; Wall, Krupp, & Guilmette, 2003), but few have undergone rigorous inquiry to assess their effectiveness (see Zapf, 2013 for an excellent review of these models). The State of Florida's restoration program (the "CompKit"), has been widely adopted by many states for their own restoration services; however, no known independent research has verified the effectiveness of this program. Although hospitals do seem to be increasingly adept at providing psycho-education services regarding competency (Mueller & Wylie, 2007), hospitals have traditionally been fairly slow in creating competency-specific treatments beyond the broad treatments available to all psychiatric inpatient populations (Miller, 2003).

Concurrently, states are mandated to restore a defendant's competency to stand trial in a "reasonable period of time" to meet the requirements of the landmark 1972 U.S. Supreme Court decision *Jackson v. Indiana* (1972). However, many states have difficulty meeting the spirit of this decision, given long hospital waitlists and overcrowded state hospital conditions (Gowensmith, Murrie, & Packer, 2014; Locklair, 2016; Morris & Parker, 2008; Pirelli & Zapf, 2015). This situation leaves many defendants to languish in hospitals and jails for long periods of time under a commitment due to trial incompetence, and leaves many states open to potential civil or class action lawsuits. The National Judicial College established standards for timeframes for competency restoration; these standards vary based on the defendant's clinical responsiveness, but are roughly 120 days for misdemeanants and no more than one year for felony defendants (National Judicial College, 2011−2012).

Consequently, many states are facing federal oversight regarding time frames for competency restoration. In *Oregon Advocacy Center v. Mink* (2003), a federal court ruled that defendants must be transferred to competency restoration within 7 days; a significant increase in Oregon's hospital capacity was realized in 2010 to manage the increasing number of IST defendants ordered to restoration. In 2015, a federal court replicated this time frame in the state of Washington (*Trueblood v. State of Washington Department of Human and Social Services,* 2015), and the state has opened new beds for restoration as a result. Several other states remain under litigation or settlement-type agreements for compe-

tency restoration or have begun exploring or adjusting time frames for the restoration services themselves (Locklair, 2016).

Competency restoration typically occurs in state hospitals (Pinals, 2005). A recent survey of state hospital administrators shows that the largest subpopulation of forensic patients in state hospitals is remanded for competency restoration (Parks & Radke, 2014) and that the overall percentage of forensic admissions for all state hospital patients has ballooned from 7.6% in 1983 to 36% in 2012. States consistently report that restoration cases comprise the largest proportion of forensic patients in their hospitals (Miller, Gowensmith, Cunningham, & Bailey-Smith, 2009). A few examples: Hawaii saw a 35.8% increase in persons found IST from 2005 to 2009 (Gowensmith, 2010), Wisconsin had a 34.8% increase between 2011 and 2013 (Wisconsin Department of Health Services, 2013), and Washington saw a 73% increase between 2010 and 2014 (Joint Legislative and Audit Review Committee, 2014). Although states have changed the typical location of CST evaluations from hospitals to outpatient settings, changes in restoration settings have been far less frequent (Gowensmith, Murrie, & Packer, 2015). In summary, hospital bed capacity falls far short of demand, while beds that do exist are increasingly being used for competency restoration services.

Outpatient Competency Restoration

Some states have identified community based (or "outpatient") competency restoration services as a partial solution to these issues. In these services, individuals who do not meet inpatient hospitalization criteria are treated in an outpatient setting, thereby reducing the hospitalization waiting list for others with more acute needs. Many individuals do not require an inpatient setting to be restored to competency (Miller, 2003; Pirelli & Zapf, 2015). Moving incompetent individuals out of the community and into an inpatient setting can be disruptive and in some cases may constitute an unnecessary infringement on their civil liberties.[1]

Miller (2003) emphasized the untapped potential of outpatient competency restoration programs (OCRPs). At the time of his article, 37 states permitted outpatient competency restoration; however, few states actually had programs in operation. Miller argued that OCRPs represented a cost-effective and least restrictive alternative to inpatient hospitalization. Since that time, shortages of inpatient beds have increased. However, little is known about the OCRPs currently in operation around the nation (Fitch, 2014; Miller et al., 2009). Many states are considering outpatient restoration as an option for IST defendants, yet little is known about how these programs work or how successful they are—if at all. What similarities (and differences) exist among current programs? What are typical restoration rates? Who tends to succeed in such programs? How much do they cost to operate, and are they ultimately a viable alternative to traditional hospital restoration settings?

This article updates and expands Miller's 2003 study. Like Miller, we review state statutes that address competency restoration settings, as well as review those states that currently operate alternatives to inpatient restoration. We then go beyond the 2003 study to analyze and compare existing programs, with a special emphasis on describing outcomes data from the programs. We will also provide more in-depth descriptions of four programs.

Method

This project used a multistep approach to capture information about OCRPs nationwide. First, we reviewed states' competency restoration statutes to determine which states had provisions that allow for outpatient competency restoration. We used the listing of competency statutes provided on the mentalcompetency.org website (http://www.mentalcompetency.org/resources/state-statutes/index.html) and supplemented those linked statutes with others in the same statutory sections to obtain information about settings for restoration. We then corroborated this review with a brief preliminary survey that was disseminated to each representative of the Forensic Division of the National Association of State Mental Health Program Directors (NASMHPD). Each state, as well as the District of Columbia, has a representative for the NASMHPD forensic division. A total of 48 directors out of 51 responded to the preliminary survey (representatives from Minnesota, North Dakota, and Vermont did not respond). This process generated a list of states with statutory allowances for outpatient restoration, and it identified states that currently operate OCRPs.[2]

Survey

Initial surveys were conducted in 2014, with a total of 16 states reporting that they had OCRPs in operation. A secondary 30-question survey was then created to obtain more detailed information about these state-specific OCRPs. The 16 secondary surveys were administered by telephone with either the forensic administrators overseeing the currently operating OCRPs or with the program directors of the OCRPs, and they lasted approximately one hour each. No information was provided to the respondents ahead of time, and respondents were given time at the end of the call to provide open-ended responses to strengths and barriers of OCRPs as well as ask questions of the interviewers.

The secondary survey was an open-ended, semistructured interview (see the Appendix), and it covered the following topics.

Size and longevity of OCRPs. This included items such as the numbers of participants and the inception date of the programs.

Demographics of OCRP participants. This included factors such as age, gender, ethnicity, and exclusionary and eligibility criteria (e.g., criminal charges, diagnoses, intellectual functioning, substance abuse).

Clinical status of OCRP participants. These survey items covered areas including the participants' psychiatric stability, adherence with treatment plans, and diagnostic issues.

Admission procedures for OCRPs. Admission procedures included topics such as referral sources, general preprogram trajectories, and coordination with hospitals and courts.

Jail-based competency restoration. Although not a primary focus of the current project, minimal information was collected

[1] It is important to note that scholars are beginning to explore jail-based competence restoration. Although it can be considered a type of outpatient restoration, jail-based restoration raises challenges and concerns that are quite different from restoration based in a hospital or in the community (Galen, Weitenheller, & Gowensmith, 2015; Kapoor, 2011; Rice & Jennings, 2014; Taylor, 2012). This article focuses exclusively on community-based restoration.

[2] For ease of reading, the term *states* in this article includes the District of Columbia, unless otherwise stated.

regarding jail-based competency restoration programs (e.g., which states operated jail-based restoration programs, numbers of participants, and different conceptual models of jail-based restoration).

Agencies providing OCRP services. Respondents were asked about supervisory authority for their programs, relationships with private versus public agencies, and the utilization of contracted agencies for specialized services such as housing or substance abuse treatment.

Location, staffing, and scope of restoration services. These survey questions included items such as the settings for restoration (e.g., community mental health centers, hospital day treatment offices), the types of professional staff and staffing ratios devoted to the programs, and treatment modalities (e.g., group vs. individual services). For information related to the conceptual scope of the programs, respondents were asked to describe the breadth of services afforded to the OCRP participants beyond competency restoration (if applicable).

Outcomes. Respondents were asked to provide several outcome markers: rates of restoration, rates of unrestorability, average lengths of stay for participants, rates of revocation or program dismissal, rates of violence and arrest, and daily operating costs.

Exclusionary Criteria

Several programs and/or program data were excluded from the analysis for this study. We chose not to aggregate data from jail-based competency restoration programs with data from community-based programs primarily because the conditions and settings are too distinct to make meaningful comparisons. However, we present preliminary findings regarding jail-based programs in a separate section.

We also restricted analysis to OCRPs serving adults. Juvenile programs may be effective and certainly merit further investigation; however, the distinctions in populations and settings between adult and juvenile OCRPs are too great to allow for useful comparison.[3]

Finally, we restricted our analysis to data from formal OCRPs and eliminated data from informal restoration services. Methods and structures for competency restoration vary widely within and between states, with some states offering informal or case-by-case restoration services in lieu of a formal program (and with some offering both types of services). Combining data from these two populations would have made the data from formal programs less reliable and valid. As an example, California's data for this study were drawn from their formal OCRP implemented in 2008; although individuals had been released to the community as IST under alternative auspices in California since 1986, data from this alternate population were not collected or analyzed. These issues are discussed in greater detail in the results section entitled "States Operating OCRPs as of 2014." Statutory analysis and survey responses were analyzed and are presented in the following paragraphs.

Results

First, we present an analysis of state statutes that address settings for competency restoration services. Second, we list those states with OCRPs in operation as of 2014. Finally, we compare and contrast those programs in detail.

Statutory Review

A review of state statutes provided data about the legal framework for OCRPs in each state and the District of Columbia. Table 1 lists statutory allowances or prohibitions for outpatient competency restoration. Statutes from 36 states (70.6%) allowed outpatient competency restoration, while statutes from seven states (13.7%) explicitly prohibited outpatient competency restoration. Eight states (15.7%) had "silent" statutes, meaning that the location of restoration is not explicitly addressed.

States Operating OCRPs

Table 2 lists the 16 states operating OCRPs as of 2014. According to the initial survey, of the 44 states and districts with statutes that allow outpatient competency restoration, 16 (36.3%) operated formal OCRPs in 2014, 19 (43.2%) did not, and 15 (34.1%) operated outpatient restoration in an informal and ad hoc manner (with some overlap across categories).

The second column in Table 2 ("States operating informal outpatient restoration") represents states that provided outpatient competency restoration outside of the guise of a formal program. In several states, the lack of a formal OCRP did not preclude individuals from being ordered to the community for outpatient restoration. These 15 states utilized a variety of informal or ad hoc restoration services. The numbers of individuals that received informal competency restoration services per year ranged from a handful in Washington and Colorado to more than 100 in New Hampshire, with Illinois, Rhode Island, and Wyoming serving approximately 10 to 15 per year (other states in this category did not have numbers to report). Some states (California, Colorado, Hawaii, Nevada, Ohio, and Virginia) had two concurrent populations of incompetent individuals in the community: those who received restoration from their state's formal OCRP, and those who were not participating in the formal OCRP but nonetheless received restoration from alternative restoration services (often from private providers).

Comparing and Contrasting Existing OCRPs

Unfortunately, OCRPs did not collect uniform data across all states, and several OCRPs collected very little data at all. Consequently, many survey respondents were only able to provide approximate numbers or percentages given their fledgling data collection abilities. (Data that was reported, however, was formally collected and did not represent educated guesses or approximations.) While presentation of complete data is of course preferable, we present incomplete data in this instance given that interested parties who are considering developing their own OCRPs would likely benefit from the available preliminary data. Examples from specific states and programs are provided throughout the results section to provide more specificity to data; in addition, incomplete data is noted in the sections in which it occurred.

Size and longevity of OCRPs. Table 3 summarizes programmatic data for the 16 formal OCRPs. Most OCRPs were relatively

[3] Arkansas, Connecticut, Louisiana, Ohio, and Virginia had juvenile OCRPs in operation. Colorado and Nevada also had juveniles released on an ad hoc basis to outpatient competency restoration, though neither state has a formal OCRP for juveniles.

Table 1
Comparison of State Statutes Referencing Settings for Competency Restoration

States with statutes allowing outpatient competency restoration		State with statutes prohibiting outpatient competency restoration
Alabama	Minnesota	Alaska
Arizona	Mississippi	Delaware
Arkansas	Montana	Kentucky
California	Nebraska	Massachusetts
Colorado	Nevada	Missouri
Connecticut	New Hampshire	New Mexico
District of Columbia	New Jersey	South Carolina
Florida	New York	
Georgia	North Dakota	States with "silent" statutes
Hawaii	Ohio	Michigan
Idaho	Oregon	North Carolina
Illinois	Pennsylvania	Oklahoma
Indiana	South Dakota	Rhode Island
Iowa	Texas	Tennessee
Kansas	Virginia	Utah
Louisiana	Washington	Vermont
Maine	West Virginia	Wyoming
Maryland	Wisconsin	

Note. Table reflects statutes as of 2014. Statutes that explicitly allowed outpatient competency restoration were placed in the "allowing outpatient competency restoration" category. Statutes that did not explicitly prohibit outpatient restoration or remained silent on the setting for restoration were placed in the "states with 'silent' statutes" category; some of these states made reference to placing the defendant in the custody of the state mental health authority or state-operated facilities, but outpatient settings were not explicitly delineated.

Table 2
Existence of Outpatient Competency Restoration Programs in States Without Statutory Prohibition

States operating formal outpatient restoration programs	States operating informal outpatient restoration	States without outpatient restoration in operation
Arkansas	California	Alabama
California	Colorado	Arizona
Colorado	Hawaii	Indiana
Connecticut	Idaho	Iowa
DC	Illinois	Kansas
Florida	Maryland	Maine
Georgia	Michigan	Minnesota
Hawaii	Nevada	Mississippi
Louisiana	New Hampshire	Montana
Nevada	New York	Nebraska
Ohio	Ohio	New Jersey
Oregon	Rhode Island	North Carolina
Tennessee	Virginia	North Dakota
Texas	Washington	Oklahoma
Virginia	Wyoming	Pennsylvania
Wisconsin		South Dakota
		Utah
		Vermont
		West Virginia

Note. Table reflects data as of 2014. Arizona offers competency restoration in local jails only, but not in the community. As the current study investigates community programs only, Arizona was not considered to have an outpatient restoration program. The table data represents only those states with statutory allowances for OCRPs.

new programs with small numbers of participants. Eleven of the 16 programs had been in operation for fewer than 10 years, with nine of those in operation for 7 years or less. Typically, these 11 programs had served a small number of jurisdictions or counties; over time, these programs expected to expand their reach statewide. Accordingly, these programs generally served fewer consumers; most served up to approximately 50 defendants per year. The Texas and Virginia, OCRPs were the anomalies within this group of new programs, as they each began serving more than 100 people per year statewide shortly after implementation. At the end of Fiscal Year 2013, the Texas OCRP had served 1,061 clients (Graziani, Guzmán, Mahometa & Shafer, 2015).

In contrast, Connecticut, Florida, and Ohio had OCRPs since 2001, 2002, and 1997, respectively. These three programs reported large numbers and a large statewide scope relative to most of the newer programs. For example, Florida's OCRP served approximately 600 participants, significantly more than any other state, though many of their programs operated individually. Each of these states offered their formal OCRPs in multiple locations statewide. The large number of participants reported by Texas and Virginia reflected their statewide implementation as well.

Demographics of OCRP participants. The demographic characteristics of OCRP participants mirrored local correctional populations in terms of ethnicity, age, and gender; typically, participants represented disproportionate percentages of ethnic minorities and tend to be younger to middle-aged males. Females accounted for about 20% of participants on average. The majority lived in urban areas.

Participants were typically charged with misdemeanor offenses or nonviolent felonies, did not have lengthy violent criminal histories, and did not present high risk for serious violence. Approximately half of all OCRP participants nationwide were charged with misdemeanor charges, while the other half were charged with nonviolent felonies.

Table 3
Comparison of Outpatient Competency Restoration Programs by State

State	Date of inception	Numbers of participants per year	Primary service provision	Juvenile program
Arkansas	2009	<20	State	Yes
California	2008	20–50	Private	No
Colorado	2013	<20	State	Yes
Connecticut	2001	20–50	State	Yes
DC	2005	20–50	State	No
Florida	2002	100+	Private	Yes
Georgia	2008	20–50	State	No
Hawaii	2007	20–50	State	No
Louisiana	2006	<20	State	Yes
Nevada	2003	<20	State	No
Ohio	1997	20–50	State	Yes
Oregon	2008	<20	State	No
Tennessee	2003	<20	Private	No
Texas	2008	100+	State	No
Virginia	2008	100+	Private	No
Wisconsin	2008	50–100	Private	No

Note. Table reflects data as of 2014.

Clinical status of OCRP participants. Clinically, OCRP participants tended to be psychiatrically stable and able to take medications voluntarily; 80% of states with formal OCRPs had policies requiring that participants must be clinically stable to be accepted into the OCRP. States reported that about two thirds of their OCRP participants were incompetent due to psychiatric impairment, whereas about one third were incompetent due to cognitive deficits and/or developmental disabilities. Two states excluded individuals with developmental disabilities from their OCRPs, whereas two others prioritized persons with developmental disabilities. Finally, while 13 programs provided substance use treatment as part of their scope of services, three states did not allow participants with prominent substance use diagnoses into their OCRP.

Admission procedures for OCRPs. Most prospective participants were first committed to a state hospital prior to entering an OCRP. Typically, state hospital and OCRP staff screened prospective participants' readiness for an OCRP prior to advancing the request to court. Ultimately court authorization was required prior to transferring participants from inpatient to outpatient settings, though state statutes and court practices determined the level of formal court involvement.

A smaller subset of participants was admitted directly from court or jail. For example, to reduce the number of individuals waiting in jail for hospital-level restoration, the Texas OCRP began mental health treatment and competency restoration in jail concurrently identifying individuals for admittance into their OCRP. Alternatively, Connecticut regularly admitted participants into their OCRP directly from court upon an initial finding of incompetence, thus averting the need for an interim hospitalization.

It is important to note that local criminal courts controlled which defendants were admitted into various OCRPs. Most states reported that referrals tend to originate from specific courts or judges with whom good professional working relationships had been established. In Hawaii, for example, every OCRP participant had been approved by two Honolulu courtrooms that operated mental health calendars. In Nevada, most referrals came from two urban courts (Reno and Las Vegas) that were staffed by public defenders familiar and comfortable with the Nevada OCRP. Although the state of Washington did not operate a formal OCRP, a close network of judicial and mental health professionals in King County (Seattle) developed a competency court for low-level offenders and had built a small network of outpatient restoration options. OCRPs typically operated in the jurisdiction of the urban courts; half of the OCRPs had started as pilot programs in their state's major metropolitan area (e.g., New Orleans, Portland, Milwaukee, and Little Rock).

Agencies providing OCRP services. A primary differentiating factor between OCRPs was the level of involvement of state government mental health agencies versus privately contracted providers (see Table 3). Some states relied heavily on state-operated and/or state-funded mental health agencies to operate the program, while other states tended to rely more heavily on privately contracted providers. Ultimately, funding was always provided through government mental health agencies, even if service provision was contracted to private providers. Eleven states (68.8%) used state resources as primary providers, whereas five (31.2%) relied primarily on private service provision. Overall, programs that were operated directly by state agencies tended to provide additional psychosocial services, increased structure for staff and participants, and more intense oversight and monitoring by OCRP administrators than programs relying primarily on private contractors.

Location, staffing, and scope of restoration services. In all instances, OCRPs provided their competency restoration programming in community mental health settings such as community mental health centers, outpatient treatment centers at state hospitals, private offices, or specialized group homes. Louisiana, for example, offered the bulk of its competency restoration programming at an aftercare clinic in the New Orleans metropolitan area. Arkansas began its OCRP as a day program at its state hospital, but later moved the location to an urban community clinic. Colorado's program was based in a day hospital setting in Denver. Texas had a number of locations at crisis respite facilities and one subsequently closed hybrid criminal justice facility (Graziani et al., 2015; Beard, 2014). Restoration programming for OCRPs was provided by certified or advanced-level practitioners, such as psychologists, psychiatrists, or forensically trained licensed social workers. OCRP services typically included, but were not limited to, education about the judicial process, medication management, psychotherapy, group and family therapy, psychological assessments and evaluations, and drug screenings. Some states provided housing and other psychosocial services, whereas others remained exclusively focused on restoration.

Jail-based competency restoration. Nine states (Arizona, California, Colorado, Florida, Georgia, Louisiana, Tennessee, Texas, and Virginia) offered restoration services in select local jails. Most jail-based competency restoration models provided a combination of mental health treatment and competency restoration programming to individuals who had been found IST and who are awaiting transfer to either a state hospital bed or community-based restoration slot. In many cases, jail-based competency restoration provided enough treatment such that defendants no longer required hospital-level care by the time a hospital bed was available. In other cases, states with OCRP counterparts used jail-based restoration activities as an avenue to screen possible participants for their state's OCRP, so that appropriate individuals could be released directly from jail and into treatment in the OCRP (thus bypassing an interim stay at the state hospital).

Alternatively, some of those states—Arizona, California, Colorado, Georgia, and Virginia—operated standalone competency restoration programs in jail, such that defendants were provided with a full complement of services designed to restore the individual to competence while incarcerated, analogous to the aims of an inpatient facility. Most of these programs were operated by private providers; however, Arizona's and Virginia's programs were operated by regional governmental departments. Given the different nature of these programs and the clients whom they serve, data from jail-based programs were excluded from our analyses.

Outcomes

Regardless of structural similarities or differences across OCRPs, NASMHPD forensic representatives reported strong outcomes across all programs. Again, outcome data was not consistently gathered across OCRPs, and some states had very little hard data to provide. When reported, the outcome data were based on average numbers of participants per year, from inception of that

state's program through November 2014. Data are summarized in Table 4.

Competency restoration. Primary indicators for any OCRP are the rates of restoration of competency and rates of unrestorability. Rates of competency restoration averaged 70.0% across the 13 programs that reported this data, ranging from 35% to 95%. Alternatively, participants in OCRPs may be determined to be unrestorable to competency after some period of time has passed. Of the 12 states reporting this data, the average rate of unrestorability was 20.3%.

Another key indicator for any OCRP is the length of time it takes to restore competency to its participants. States reported an average of 149 days for participants restored to competency. Interestingly, Texas reported an average of 70 days, but this average was comprised of two qualitatively different subgroups: participants residing in dedicated program housing (49-day average) versus participants who were not provided dedicated housing (90-day average). California and Louisiana's averages were significantly longer than other states (320 and 400 days, respectively), perhaps due to unique structural components of those programs (e.g., California's requirement that all participants be charged with felony charges). When removing California and Louisiana data, the average length of time to competency restoration was 111 days. In general, forensic directors reported that the length of time to restoration in outpatient programs was slightly longer than the time to restoration in their respective states' inpatient settings.

Public safety. Arrests, elopements, acute decompensations, and serious rule violations were defined as negative incidences in the survey. Twelve states responded with data in this category. The average rate of any negative incident was 16.7% across states. No incidences or arrests for serious violence were reported by any OCRP. An average of 27.0% of the negative incidents were due to rule violations, whereas 73.0% were due to acute decompensations or clinically driven problems that necessitated a return to an inpatient setting. Most (78.4%) negative incidents were found in programs with more than 20 participants.

Financial costs. Finally, each state reported significant financial savings from its OCRP. While calculating exact figures and cost savings is beyond the scope of this article, some preliminary numbers can be estimated. Forensic administrators reported daily costs for standard OCRPs between $101 to $500 per day. States that contracted with private providers for restoration paid between $40 to $75 per hour for restoration, though other state resources were used while these defendants live in the community. On average, total daily costs for OCRP restoration averaged approximately $215 per defendant (though this figure may be underestimated given the likelihood that some ancillary resources and costs are not included).

Administrators reported costs for inpatient competency restoration between $300 to $1,000 per bed day, with an average of $603 per bed day. This nets an estimated difference between average daily costs of an OCRP slot and an inpatient bed of $388 per day. Using an average length of stay for OCRPs of 149 days, this translates into an overall estimated average of approximately $57,800 in savings per OCRP participant (when excluding California and Louisiana's data due to long lengths of stay, the average estimated savings per participant decreases to approximately $43,000).

We present two illustrative examples. First, the Texas OCRP reported a cost of $140 per day for an OCRP participant as compared to $401 for an inpatient defendant, for a savings of $21,409 per defendant even after the longer lengths of stay were accounted for (Horton, Kidder, & Borel, 2011). Wisconsin reported a cost difference of $199 versus $674 in their OCRP, saving $41,290 per OCRP participant (Wisconsin Department of Health Services, 2013).

Comparative results of four different OCRPs (Wisconsin, Texas, Miami-Dade County, and Arkansas) are presented in Table 5. The

Table 4
Outcomes of Outpatient Competency Restoration Programs by State

State	Percentage restored to competency	Percentage determined unrestorable	Percentage of negative incidents	Average number of days to restoration of fitness	Average per participant savings per day
Arkansas	79	16	2	90	$150
California	35	12	30	320	$425
Colorado	Not reported	Not reported	Not reported	Not reported	Not reported
Connecticut	75	15	10	180	$600
District of Columbia	77	28	21	115–120	$400
Florida[a]	Not reported	Not reported	Not reported	146	$111
Georgia	77.5	22.5	16	Not reported	$50
Hawaii	95	5	5	100	$600
Louisiana	55	10	28	400	$300
Nevada	50	30	20	90	$315
Ohio	80	15	5	60	$450
Oregon	67	33	0	90	Not reported
Tennessee	Not reported	Not reported	Not reported	180	$850
Texas	77	Not reported	19	49–90	$261
Virginia	64	36	Not reported	Not reported	$450
Wisconsin	79	21	6	100	$475
Average	70.0	20.3	16.7	149/111[b]	$388

Note. *Negative incidents* are defined as criminal activity, violence, or clinical decompensation resulting in termination from OCRP.
[a] Florida data come from the Miami-Dade County Forensic Center's program. Statewide data were unavailable for review, aside from average per participant savings which increased to $122 as a statewide average. [b] 111 days is the average length to restoration when California and Louisiana are removed from the analysis, given their outlier average restoration time frames. When they are included, the average length to restoration is 149 days.

Table 5
Comparison of Wisconsin, Arkansas, and Miami-Dade County OCRPs

OCRP Elements Inception date	Wisconsin 2008	Texas 2008	Miami-Dade County 2009	Arkansas 2012
Setting of program launch	Milwaukee, WI	Bexar, Dallas, Tarrant, and Travis Counties	Miami, FL	Little Rock, AR
Statewide versus county program	27 counties	12 localities around the state	County (though other counties in Florida also had OCRPs)	13 localities
Number of participants through 2014	200	1061 (through Fiscal Year 2013)	167	50
Type of provider	Contract providers	Local mental health authorities	Contract with hospital	Community mental health centers
Initial barriers	Funding, statutory restriction, public safety concerns, low workforce capacity	Buy-in from judges and district attorney relationships with law enforcement/jail, housing, substance use treatment	Low funding, public safety concerns	Low workforce capacity, low levels of trust among partners
Referral process	All persons undergoing CST evaluations are screened	Referral from court based in part on recommendation from evaluator	Initial inpatient hospitalization	Most are hospitalized initially, but some are referred directly from court
Eligibility criteria	Low violence risk	Criminal history, clinical judgment, violence risk assessment, prior hospitalization	Minor charges	Misdemeanant and felony defendants
	Clinical stability Stable housing Interest in OCRP		Low violence risk	Other criteria unknown
Ancillary services	Case management	Case management, peer support, medication management	Case management, benefit acquisition	Case management, drug screening, family therapy, medication management
Outcomes	Comparable restorations rates; Outpatient cost $25,000 per case vs. $63,000 per inpatient case	Comparable restoration rates; LOS related to restoration up to 21 weeks; people with 2 to 3 prior hospitalizations less likely to restore	Cost of $33,667 per outpatient case versus $74,419 per inpatient case; fewer subsequent jail bookings	Comparable restoration rates; reduced wait lists; low recidivism; cost savings

Note. OCRP = "outpatient" competency restoration programs; CST = competency to stand trial; LOS = length of stay.

table provides a brief comparison of the four programs, their approaches to OCRP, and their outcomes.

Discussion

OCRPs are a recent but rapidly developing alternative to traditional inpatient competency restoration. High hospitalization costs and limited hospital capacity have forced many state mental health administrators, correctional administrators, and legislators to consider OCRPs as alternatives to traditional inpatient approaches to competency restoration. Through a comparison of existing OCRPs, we believe OCRPs overall show preliminary but promising outcomes.

Scope of OCRPs

While 44 states' statutes (86.3%) either explicitly or tacitly allow outpatient competency restoration, only 16 (31.4%) states had OCRPs in operation. In other words, while most states can do outpatient competency restoration, most states do not.

This number is expected to grow, however. Eleven of the 16 programs had been operational for fewer than 10 years. Given the rise in the number of community-based forensic programs nationwide over the last several years, the development of OCRPs is hardly surprising. States are looking for viable alternatives to resource-intensive forensic hospitalizations (Bloom, 2012; DeMatteo, LaDuke, Locklair, & Heilbrun, 2013; Heilbrun et al., 2012). Although the idea for outpatient competency restoration is not new, many states are increasingly forced to explore alternatives to inpatient restoration as hospital resources and state mental health budgets fail to meet the needs of growing populations, and as federal oversight and legal challenges continue to mount. Several states without OCRPs surveyed in this project mentioned that they are actively planning OCRPs for the future; Washington has identified a facility and is recruiting personnel for such a program, for example.

Efficacy of OCRPs

Do these outpatient approaches to competency restoration work? Although such an answer depends on one's definition of success, this study seems to indicate that OCRPs show generally positive results, including financial savings, increased inpatient bed capacity, maintenance of public safety, and high rates of restoration. A researcher for the Miami-Dade County Forensic Alternative Center described its outcomes this way:

> A patient admitted to the MD-FAC has double the chances of staying out of jail the year following discharge, at half the cost and 2/3 the

length of inpatient stay, in comparison to a patient admitted to a state hospital. (Qureshi, Liefman, Coffey, & Carney, 2015)

Although other states may have different statistics, these types of outcomes were generally echoed by other OCRP administrators.

Restoration to competence. In this study, rates of competency restoration for outpatient programs were found to be slightly lower than reported rates for inpatient restoration programs (70.0% compared to inpatient restoration rates of 70% to 80%; Warren et al., 2013). Why this discrepancy? One might expect that outpatient rates to be higher than inpatient rates, since most OCRPs screen out participants who are clinically unstable. While this study did not identify any definitive reasons, some possible explanations exist. First, several programs reported that many of the cases for OCRP participants were dismissed after a demonstrated period of adhering to treatment and obeying the law. Rather than finding the OCRP participant competent to stand trial, courts instead dismissed the individual's charges. It seems that some courts view OCRPs as a chance for participants to establish a track record of stability in the community, albeit with enhanced structures and services, before releasing them from criminal commitment.

Second, OCRPs on average reported higher rates of court determinations of unrestorability to fitness than inpatient programs (20.3% vs. 10%, respectively). The 12 OCRPs that reported unrestorability rates stated that these individuals were released to the OCRPs because of a lack of dangerousness rather than the lack of intractable impairments to competency. That is, OCRPs accepted IST patients based on programmatic criteria—clinical stability, manageable dangerousness, ability to withstand the program demands—and not necessarily their likelihood of regaining competence. Program representatives reported that their primary responsibility in identifying appropriate OCRP candidates was to find incompetent patients who no longer needed hospital-level care. Accordingly, OCRPs anecdotally reported higher proportions of participants with head injuries and developmental disabilities as compared to corresponding inpatient units. This may be a partial explanation of the differing restorability rates. It is unclear whether the full difference is due to factors related to the individuals selected for OCRPs or risk factors associated with community-based restoration (e.g., weaker participation in programming, access to drugs).

The broad variability in the length of time to restoration raises interesting challenges for policymakers. It is unclear whether there is an optimal length of stay in an OCRP or whether that metric varies based on the needs of the individuals and the approach of the OCRP. The few existing studies propose an optimal stay anywhere from 45 days to 21 weeks (Graziani et al., 2015; Johnson & Candilis, 2015). Nationally, inpatient lengths of stay for individuals who are restored to competency average around 89 days (Colwell & Gianesini, 2011; Stafford & Wygant, 2005), but these time frames may not be realistic or appropriate for individuals in outpatient settings. Perhaps idiosyncratic variables of outpatient participants—inconsistent appointment compliance, rule violations, medication nonadherence—could lengthen the expected time frames for attainment of competency.

Financial savings. This study indicates that, not surprisingly, OCRPs are less expensive than inpatient restoration programs. States reported saving nearly $400 per defendant per day by using OCRPs. As is typical, community mental health resources are less expensive than hospital resources; competency restoration seems to be no exception. Although some states report that inpatient capacity remained unchanged even after implementing an OCRP (due to waitlists and demand for restoration that outpaces OCRP capacities), costs had nevertheless been reduced as new hospital beds, overflow units, and potential lawsuits had been averted.

Increased hospital bed capacity. Capacity has increased in many states after OCRP implementation. Moving incompetent defendants from a hospital restoration program to a community restoration program can free limited hospital beds for individuals who may be in greater need. States with waiting lists for hospitals must often resort to confining these "hospital-ready" individuals in jails or overflow units until bed space opens up (Colwell & Gianesini, 2011; Gowensmith, Murrie, & Packer, 2014). This study indicates that OCRPs are one way states have found to improve the turnover in their hospital beds, by preserving beds for people with more acute mental health needs that can be addressed quickly in an inpatient setting.

Several states provide an innovative approach to addressing shortages of hospital beds. Like many other states, Texas and Arkansas had waiting lists of IST hospital-ready individuals in jail awaiting transfer to a hospital. These states found multiple benefits in providing a measure of competency restoration to these individuals even while incarcerated. Some people were returned to competency while in jail, thus avoiding the need for transfer to a hospital. Others were assessed for direct admission into an OCRP in lieu of an interim hospital setting. In a metaphorical sense, this approach to identifying potential OCRP participants in jail reduces the census of the state hospital population at the "front door," rather than waiting for appropriate discharges to OCRP at a hospital's "back door." Analogously, the Colorado jail-based competency restoration program has opened its services to other individuals in the correctional facility who have been referred for a competency evaluation, in the hopes that early treatment services could ultimately reduce the numbers of defendants found incompetent.

Maintenance of public safety. This study produced no data suggesting that OCRPs compromise public safety. No program identified any serious criminal or violent activity by any participating defendants. It is likely that the conservative program eligibility standards and the demographic makeup of the OCRP participants may be largely responsible for the low recidivism rates. Program administrators discussed the importance of selecting participants carefully, and screening out defendants with a moderate to high level of violence or recidivism. After screening for the "least risky" participants, participants were typically placed in a program with high levels of structure, further minimizing risk. Outcome data supported these efforts, showing that only 27% of participants were terminated from their OCRPs because of rule violations; most were terminated as a result of acute clinical needs arising that necessitated inpatient-level care.

Program administrators talked frankly about the importance of carefully growing a successful program. OCRPs are alternatives to traditional inpatient restoration, and plans to develop an OCRP can make many stakeholders uneasy. One significantly bad incident could seriously derail efforts to launch an OCRP. Administrators encouraged jurisdictions considering OCRPs to start small, ensure success, minimize negative outcomes, and develop an excellent track record that can be shared with courts, prosecutors, and other

potential stakeholders. After this track record has been built, the program is likely to be met with less resistance and the program allowed to expand in scope and size. Hawaii's program, for example, was initially housed in a secure, fenced area on the state hospital grounds with exclusionary criteria for felony defendants; however, the program now allows some felony defendants, and participants are housed in a standard group home in urban Honolulu.

Public Policy and Ethical Considerations

Despite the advantages that OCRPs may have over inpatient programs, they raise some important policy considerations. In general, OCRPs face the same basic challenge that all forensic programs and policies face: balancing individual freedoms and mental health recovery with the need to maintain public safety. Understandably, program administrators report being conservative when assessing potential participants, typically screening out individuals who present moderate risks for dangerousness in the community.

Eligibility criteria. However, could OCRPs be *too* conservative when it comes to eligibility standards? The fact that no program reported any incidences of serious recidivism or violence gives some support to the notion that the programs might be screening out candidates who could succeed in an outpatient setting. Perhaps instead of flatly denying any candidate with a violent charge, for example, programs might consider adding program elements to mitigate risk (e.g., increased monitoring, multiple reporting sources, individualized risk assessment and management planning, or increasing participants' criminogenic insights) to enhance safety. Again, data collection on this population will be critical to determine the success of such defendants in OCRPs; current data does not exist.

Scope of mandated services in OCRPs. A second issue concerns the scope of OCRPs. Participants are ordered to OCRPs for competency restoration; however, some programs include (or require) other services beyond competency restoration. These can include particular treatment modalities, housing options with particular rules or restrictions, or psychosocial rehabilitation services. While perhaps well-intended, these services—if categorized as program requirements—can begin to resemble a judicial workaround to involuntary outpatient commitment (Fitch, 2014). However, many individuals in OCRPs are unlikely to meet legal standards for involuntary outpatient commitment. OCRP participants may run the risk of not being able to "graduate" from the program until they have completed program elements that go beyond the restoration of competency. Clearly this can be problematic. This is borne out to some degree in our study, as the average length of time spent in OCRPs exceeded the length of stay for the same state's inpatient restoration commitments. In some ways, OCRPs run the risk of resembling an involuntary outpatient mental health commitment under the guise of competency restoration (Fitch, 2014). On the other hand, advocates for the OCRPs might argue that even with the additional program requirements that some OCRPs include, the restrictions on liberty are far fewer than the participant would otherwise experience in a hospital or a correctional facility; additionally, more intensive mental health services could assist participants in mental health recovery and reduce their risk for future criminal involvement.

Funding sources. Finally, unlike other treatment services, many OCRP interventions are not reimbursable by Medicaid or private insurance. Competency restoration classes and sessions are usually best coded as "psycho-educational," negating the possibility for reimbursement. This poses a serious barrier to many agencies who might be interested in providing such services. As a result, all of the formal programs in this study were funded from state dollars; nonreimbursed costs were still less expensive than analogous hospital costs for restoration services. Still, accessing funding for such services could create opportunities for private agencies or providers to operate OCRPs more effectively. Alternatively, graduate-level psychology programs with training clinics could offer OCRP services, since such clinics are typically operated as training clinics rather than for-profit clinics. As an example, a recently launched OCRP housed in the University of Denver's Forensic Institute for Research, Service and Training (Denver FIRST) provides an additional restoration option to those operated by the Colorado Office of Behavioral Health (the Denver FIRST OCRP is in its infancy; outcome data were not available for inclusion in the present study).

Limitations

The current study indicates that OCRPs, as a general rule, show promising and positive outcomes. However, data for some outcome variables were missing from some states. This study should be, in part, a call to data-collecting action: states with OCRPs must collect adequate data to gauge the effectiveness of the programs, in terms of both positive outcomes (e.g., cost savings) as well as negative outcomes (e.g., participant terminations). We suggest that OCRPs collect data on rates of restoration to competence, unrestorability, rehospitalization, arrest, terminations, as well as financial costs and average numbers of days to both competency restoration and unrestorability.

We were only able to access and review programs provided to us by respondents. It is possible that other programs exist, or that the programs described at the time of the surveys have since undergone significant changes. Ongoing research into these programs would help identify longitudinal changes and effects beyond the "point in time" focus that our study used.

We were not able to investigate the epidemiological reasons for OCRP effectiveness; in other words, there is not enough data available to evaluate which outpatient programmatic components are most (or least) effective in promoting restoration. Further research is needed to identify the most important factors in such programs.

Future Directions

Future research directions could include comparing the effectiveness of formal OCRPs to informal outpatient restoration programs. Additionally, research should be done to investigate why the average length of time to restoration for outpatient programs is longer than that found in analogous inpatient programs, and what implications those differing lengths of time may have on participants. Given the ethical dilemmas addressed earlier in the Discussion section, it would seem prudent to explore how certain programmatic elements in various OCRPs (e.g., housing, case management) correlate with program outcomes (e.g., length of

stay, restoration rates, negative outcomes). Finally, investigation into jail-based competency restoration programs should occur across programs to determine the effectiveness and limitations of such programs.

On the basis of this study's results, outpatient competency restoration seems to have a promising future. It seems nearly certain that additional programs will be developed and implemented in the next several years. Programs in the planning stages should learn from programs currently in operation, including both successes and challenges, so that new programs continue to advance the effectiveness of outpatient competency restoration. All current and future programs should collect program and outcome data. Of course, all programs should be aware of the public policy issues and ethical dilemmas posed by outpatient approaches to restoration, and take steps to rectify them in their own programs and jurisdictions. Finally, programs should ensure that staff are trained well and allocate appropriate time and resources to providing competency restoration; ancillary services (case management, housing, etc.) should serve only as adjunctive roles in restoring competence, if used at all.

In summary, OCRPs show great promise in addressing the challenges many states face regarding ever-increasing numbers of forensic referrals and commitments. OCRPs seem to provide an innovative outlet that can relieve state hospital capacity pressures at both the "front door" and "back door," maintaining public safety, saving taxpayer dollars, and improving the efficiencies of both the criminal justice and mental health systems while concurrently promoting recovery and community reintegration of the participants themselves.

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Appendix

Survey Questions for States With Outpatient/Community-Based Fitness Restoration Programs

Overall Description of Program

1. Do you have an identified program, or is it just that statutes allow for outpatient restoration?
2. What is the supervising agency (i.e., type of agency providing treatment, and who assumes responsibility if things go wrong)?
3. Scope of program (statewide? Who does the program serve? Is it county by county decision, jail by jail, etc.?)
4. When did the program start?
5. Where does the restoration take place (housing, jail, etc.)?
6. Daily cost?
7. Daily bed cost of inpatient restoration alternative?
8. Maximum number of current slots?

Target Population

9. Legal status of participants (i.e., bail, supervised release, released on conditions)
10. Any special characteristics of participant population (juveniles, adult, DD, etc.)
11. Criminal profile of population (felonies vs. misdemeanors)
12. Overall description of population (gender, ethnicity, age, dx)
13. Admission/exclusionary criteria
    a. Charges
    b. Diagnosis
    c. Clinical stability
    d. Rent or other money needed?
    e. Other
14. How many people have participated?

Operations (What Does the Program Do?)

15. Is housing provided?
16. Case management provided?
17. Psychosocial rehab provided?
18. Access to medication? Is medication required, forced, voluntary, prompted?
19. Individual versus group restoration?
20. Other components?

Outcomes

21. Average length of stay?
22. Percentage of those found fit?
23. Percentage found unrestorable?
24. Are these percentages similar to inpatient restoration program percentages?
25. Percentage terminated from program because of clinical reasons (i.e., returned to hospital)?
26. Percentage terminated from program because of rule breaking (i.e., elopement from housing, not following house rules, etc.)?
27. Percentage terminated from program because of criminal behavior?
28. Other outcomes?

Wrap-Up

29. What is/are the primary strengths to community-based fitness restoration in your program?
30. What is/are the primary barriers to community-based fitness restoration in your program?

Qualitative Comments

Received May 29, 2015
Revision received March 23, 2016
Accepted March 24, 2016 ■

Alternatives to Inpatient Competency Restoration Programs:

Community-Based Competency Restoration Programs

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ARTICLE INFO

Article history:
Published: October 31, 2018

Keywords:
Competency Restoration
Outpatient Competency Restoration

AUTHOR'S NOTE

Many states are in the process of developing and/or implementing new methods for handling IST defendants who do not require hospital level care. Outpatient competency restoration (OCR) were created to treat IST defendants who do not require hospital level care and who can be safely treated within the community.This paper reviews the states that have implemented OCR programs.

Overview

Over the past two decades there has been an increase in the number of forensic patients at state psychiatric hospitals. The largest increase has been seen among defendants who have been court ordered to receive competency evaluations[i] or restoration services[ii] at state psychiatric hospitals.[1] This has led to a decrease in the number of beds available for both civil and forensic patients. One result has been that many state psychiatric hospitals are having trouble meeting the increased demands for beds for forensic defendants; particularly defendants found incompetent to stand trial

[i] Evaluations used to determine if an individual is able to understand court proceedings and/or assist his/her attorney (*See below for more information on competency evaluations*).

[ii] Services that are designed to facilitate a patient's capacity to understand court proceedings and/or assist his/her attorney yin his/her case (*See below for more information on competency evaluations*).

(IST)[iii] who have been court ordered to receive inpatient[iv] competency restoration services at a state psychiatric hospital. Many states have created waitlists to manage the number of individuals awaiting admission. Lengthy wait times have led to some states having been held in, or threatened with being held in, contempt.[1,2,3,4,5,6,7,8]

Many states are in the process of developing and/or implementing new methods for handling IST defendants who do not require hospital level care, and many states are utilizing outpatient competency to stand trial (CST) evaluations[v] in an effort to reduce the number of defendants being referred to state psychiatric hospitals for inpatient services.[9,10,11]

Over the past three decades a variety of programs have been developed across the nation (some are state-specific) to reduce the burden being placed on state psychiatric hospitals by forensic patients. Programs that have been developed to divert IST defendants requiring competency restoration services who do not need hospital level care include: outpatient competency restoration services, and jail-based competency restoration services. Some states have also developed state-specific programs (e.g. aftercare services). Each program has its own benefits and drawbacks. Nonetheless, evidence suggests that these programs can lower the amount states spend on treating IST defendants and reduce the number of state psychiatric hospitals beds occupied by IST defendants.[4,7-11, 12,13,14,15,16,17,18,19,20] This paper focuses on a community-based outpatient competency restoration (OCR) programs . Information from existing resources will be utilized to describe the effectiveness of these programs and their limitations. A separate paper, titled "Alternatives to Inpatient Competency Restoration Programs: Jail-Based Competency Restoration", was developed to discuss jail-based competency restoration programs.

[iii] In some states these defendants are also referred to Incompetent to Proceed.
[iv] This term will be used to refer to services conducted within a state psychiatric hospital setting.
[v] Outpatient CST evaluations are CST evaluations that are conducted outside of the state psychiatric hospital setting. They are typically conducted in community or jail/correctional settings.

Background Information[vi]

Competency Evaluations

In court, a defendant's capability to understand the charges that he/she is accused of, and/or the defendant's capability of assisting his/her defense attorney may be questioned. Most states allow this issue to be raised by the prosecutor, defense attorney, and/or judge.[1,2,6] Once the defendant's competency has been questioned, the court makes the final decision on whether or not the defendant should be ordered for a competency evaluation.[2,6 21-22] If the judge places an order for a competency evaluation, then the case is suspended until the results from the evaluation are able be presented to the court. [2,6,21-22]

Competency evaluations can be conducted in an inpatient setting (e.g. a state hospital), or an outpatient setting (e.g. at the jails by an evaluator).[10,12-13, 21-22] As noted above, inpatient competency evaluations have become less common in recent years. In order to decrease the number of forensic clients being admitted to state hospitals for inpatient competency evaluations, states have begun to conduct more competency evaluations on an outpatient basis.[10-11]

Competency Restoration

Once a defendant has been evaluated, the results of the evaluation are presented at a competency hearing. At the hearing the judge will make a determination on whether or not the defendant is competent to stand trial, incompetent to stand trial but restorable, or incompetent to stand trial and unlikely to be restored in the foreseeable future[vii].[21-22] Defendants who are found IST but restorable are typically court ordered to undergo inpatient competency restoration services since competency restoration programs are primarily conducted on an inpatient basis.[10-11,13,23]

[vi] The background information provided is very brief. It is not intended to be a comprehensive review of competency evaluations and competency restoration services. For instance, the summary does not provide information on the nuances between states statutes on the competency evaluation and competency restoration process. Readers that are interested in learning more about competency evaluations and competency restoration services should review the referenced materials for more comprehensive information.

[vii] In this paper, defendants found incompetent to stand trial and unlikely to be restored in the foreseeable future are also referred to as "unrestorable". In regards to this paper, this means that it was determined that it was unlikely that the defendant was ever going to be able to achieve, or regain, the functional capacity required to understand the court proceedings and/or assist his/her attorney in his/her defense. Depending on the state, defendants found to be untrestorable may have their charges dropped and either be released or undergo other court procedures to determine if they are meet their state's eligibility criteria for civil commitment (American Bar Association, 2016; Mossman et al., 2007).

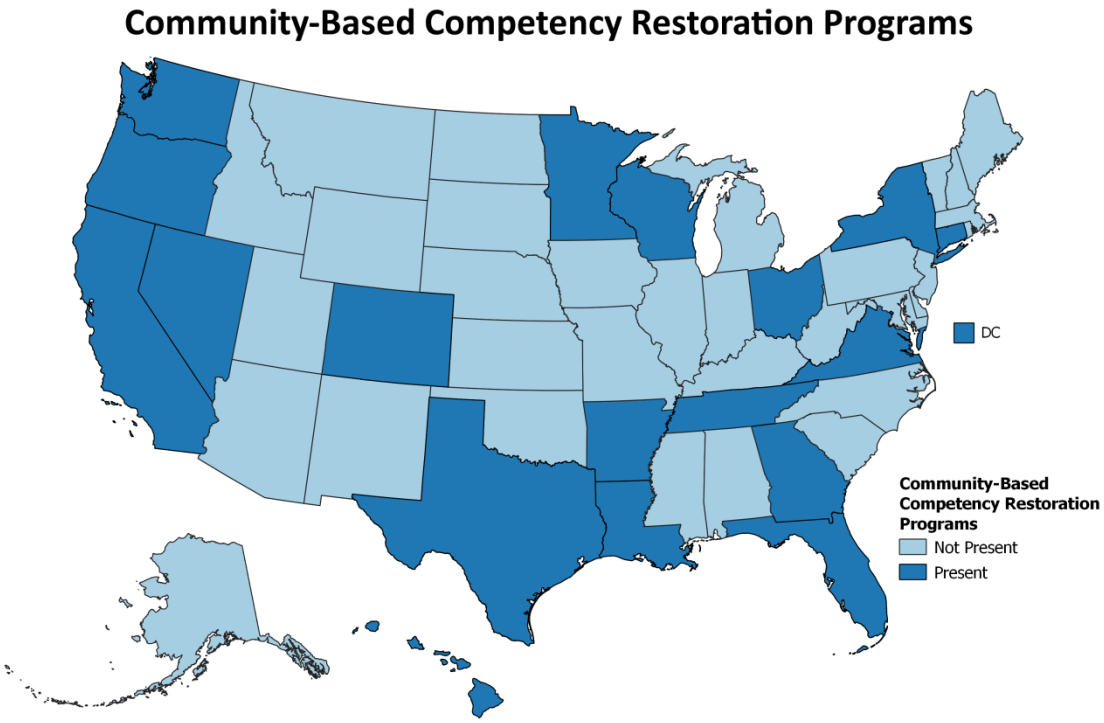
As noted above, outpatient competency restoration service programs have become increasingly popular. States have begun to develop these programs to reduce their waitlists and bed capacities since they are experiencing such a high influx in the number of forensic patients being court ordered to receive inpatient services at their state psychiatric hospitals.[2,4,6,9,11,23-24] The purpose of this paper is to provide an overview of outpatient competency restoration program models being implemented by states.

Outpatient Competency Restoration Programs

In its broadest sense, because traditional competency restoration programs have been primarily focused on psychiatric inpatient settings and especially state hospitals, the term "outpatient" competency restoration programs refers to restoration programs provided within any community setting, including within a jail/correctional setting.[12-13] Jail-based competency restoration programs have their own unique structures and challenges. These programs are distinguishable from those programs set up in a traditional outpatient community setting. Thus, this paper will focus *solely on community based* non-jail outpatient competency restoration (OCR) programs.

Statutes in at least 35 states allow for outpatient competency restoration services to be considered as alternatives to inpatient restoration programs. [10-13,23] Out of these 35 states, at least 16 states have developed formal competency restoration programs that are based outside of a an institutional or other hospital setting: Arkansas, California, Colorado, Connecticut, DC, Florida, Georgia, Hawaii, Louisiana, Nevada, Ohio, Oregon, Tennessee, Texas, Virginia, Wisconsin.[11-13]

The main purpose of this paper is to highlight which states are developing such programs and to present an overview of restoration rates for various OCR programs. This paper also serves to expand upon the research conducted by Gowensmith, Frost, Speelman, Therson's study (2016) in order to present information on states that have recently (between 2016 and 2019) developed OCR programs or that are in the process of developing OCR programs.[12]



Community-Based OCR Programs

Arkansas

Arkansas' refers to both its community- and jail based competency restoration programs as part of its over-arching Forensic Outpatient Restoration Program.[25,26] This paper solely focuses on the data that has been collected on the *community-based* portion of this program[viii]. Arkansas developed its outpatient competency restoration program in 2009.[12-13] The data that has been collected on Arkansas' community-based restoration services demonstrates that the program has restored 79% of its defendants. Of the remaining 21%, approximately 17% of the defendants were determined to be unrestorable[ix].[12-13] For those who were restored, most defendants were restored within two to three months.[12-13]

California

California's outpatient competency restoration program was developed in 2008. Data compiled by Gowensmith, Frost, Speelman, &Therson (2016) suggest that California's OCR program has a restoration rate of 35% and the average time that it takes to restore a defendant is 11 months. In total, 12% of defendants who were admitted to the program were found to be unrestorable.[12]

Colorado

Colorado developed an OCR program in 2013.[12] It appears that this program was a community-based OCR program since the authors defined outpatient competency restoration program and jail-based competency restoration programs separately in their study. Gowensmith, Frost, Speelman, &Therson (2016) were able to collect a limited amount of information on the program.[12] It should be noted that this does not mean that information is not being collected on the program. On the other hand, it does suggest that limited information on the program has been made available to the public. The author of this paper investigated whether or not new information had been made publically available on the program; the author was unable to find such information.

Connecticut

Connecticut developed its outpatient competency restoration program in 2001.

[viii] Please refer to the "Jail-Based Competency Restoration Paper" for more details on the jail-based services provided in Arkansas.

[ix] In this paper, a defendant being found unrestorable means that it was determined that the defendant was unlikely to be restored in the foreseeable future. Depending on the state, this could result in the defendant's charges being dropped and him/her being released or undergoing the process to determine if he/she is eligible for civil commitment.

The restoration rate and length of stay for the program is similar to that of inpatient competency restoration programs. The program has a restoration rate of 75% and most defendants are restored within six months. Approximately 15% of Connecticut's OCR defendants were found to be unrestorable.[12]

District of Columbia

The District of Columbia's outpatient competency restoration program was developed in 2005.[27] Once a defendant enters the program they receive competency restoration services at an outpatient clinic every two weeks[x]. The jurisdiction has reported that the program has a restoration rate of 77%.[12-13,23] During the period(s) for which data are available, most of the defendants participating in the program were restored within one to four months. Out of the 33% of the defendants who had not been restored, the percentage of defendants who were found to be unrestorable was 28%.[12-13]

Georgia

Georgia developed its outpatient competency restoration program in 2008. Limited information on the program has been made publically available, but based on the information that has been made public, it appears that the program has a restoration rate of 77.5%. The remaining 22.5% of defendants were unrestorable.[12]

Hawaii

In 2007 Hawaii developed an outpatient competency restoration program in a community mental health center. The program is run by Hawaii's Department of Health.[13] Defendants charged with misdemeanor offenses or non-violent felonies are eligible to participate in the program.[13] Approximately 95% of the defendants admitted to the program have been restored and most have been restored within 3 months. The remaining 5% of defendants were unrestorable.[12-13]

Louisiana

Louisiana's outpatient competency restoration program was developed in 2006 to admit defendants found incompetent to stand trial, are not dangerous, and who do not require the level of care provided in an inpatient settings.[14] According to Louisiana's Department of Health (2010), outpatient competency restoration programs tend primarily to get referrals for defendants who are non-dangerous and have been convicted for or accused of a misdemeanor offense(s) or a minor drug offense(s). The

[x] Information on the location of the services (e.g. outpatient clinics) and the frequency that the defendants receive these services (e.g. twice a month) will be reported when the data is known and/or available.

only other way defendants can receive these services is if they are referred by a District Forensic Coordinator[xi]. [14] Defendants who are eligible to participate in competency restoration services on an outpatient basis may be released to the community providing they adhere to certain conditions imposed by the court. Outpatient competency restoration services are provided by Louisiana's Department of Health.[14] Over the years, Louisiana's OCR programs have restored 55% of their defendants. These defendants are typically restored within a year. Only 10% of Louisiana's OCR program defendants have been found unrestorable. [14]

Minnesota

Minnesota has implemented several pilot OCR programs. The most recent was developed in Olmsted County. In 2016 the county received grant money from Whatever it Takes initiative to develop a pilot OCR program.[28,29,30] Minnesota's OCR programs are still being piloted. As a result, information on their effectiveness has not yet been made available to the public.[30]

Nevada

Nevada's outpatient competency restoration program was developed in 2003.[12] Results suggest that the program has helped defendants regain competency**.** The restoration rate for Nevada's outpatient competency restoration program is 50%. Approximately 30% of defendants who have been admitted to the program have been found to be unrestorable. [12-13,28] On average, the program restores defendants within three months. [12-13,28]

New York

In 2012 New York's Criminal Procedure Law was amended to allow for outpatient competency restoration.[31] Offenders under temporary orders of observation or under commitment orders may be admitted to an outpatient competency restoration program. Defendants who are put under these orders have committed felony crimes. [32]According to the New York Office of Mental Health (2013) the amendment to the Criminal Procedure Law does not place any restrictions on the types of felons that can be referred for outpatient competency restoration. There are, however, certain criteria that make defendants more optimal candidates. These criteria include: not being dangerous, having stable housing and/or

[xi] In Louisiana, part of the role of the District Forensic Coordinators is to provide competency restoration services within outpatient settings (jail and community-based settings) and to regularly update the court on the status of their IST defendants (Louisiana's Department of Health, 2010).

community supports, not having a substance use problem, not having a severe medical disorder or unique medical needs, and willingness to cooperate.[32] The effectiveness of New York's OCR program(s) has not been published.

Ohio

Ohio developed its Outpatient competency restoration program in 1997.[12] Data suggests that Ohio's OCR program has a restoration rate of 80%.[12] Of the remaining 20% of defendants who have been admitted to the program, 15% were unrestorable. Data collected on the program indicates that the average time that it takes to restore a defendant is roughly 2 months.[12]

Oregon

In 2008 Oregon developed its outpatient competency restoration program. The program has demonstrated success in restoring enrolled defendants over a short period of time. The restoration rate for Oregon's OCR program is 67%. The remaining 33% were found to be unrestorable. Of those restored, most of the defendants were restored within 3 months. [12]

Tennessee

In 2003 Tennessee developed its outpatient competency restoration program.[12] Limited information has been made publically available on this program. Of the information available, the average length of time that it takes to restore defendants has been reported to be approximately six months.[12]

Texas

In 2008 Texas piloted its outpatient competency restoration program by developing four outpatient competency restoration programs in four urban counties. [12-13,24] Since 2007 Texas has developed another eight programs. [12-13,24] Each program is unique and all are located in different counties. The state does not provide the counties with any uniform standards related to the development of the outpatient restoration programs.[13] [33] As a result, each outpatient competency restoration program uses different criteria to determine whether or not a defendant is an eligible candidate.[24] The most common criteria used across these programs are criminal history, clinical judgement, risk assessments for violence, and number of prior hospitalizations.[9,12,24,34] There are other factors that can influence the selection process. These factors include: the charges against the defendant, whether or not the defendant was willing to participate in the program, results from the competency evaluation, medication compliance, medical history, housing status, whether or not they had support from their family, and the

likelihood that they would commit another offense while in the program.[9,24,35]

Just like with the criteria used to determine eligibility, Texas' outpatient competency restoration programs also vary in the types of services that they offer. The specific services provided at each outpatient competency restoration program are based on the needs and resources of the county.[13,34] To illustrate, one of the OCR programs allocates funding to assist defendants with housing, while another OCR program uses its resources to provide its defendants with an extensive variety of non-competency related mental health services.[13,24]

The differences between Texas' OCR programs make it difficult to compare them. Aggregate data on the OCR programs suggests that their restoration rate is 77%. Lastly, these OCR programs typically restore defendants in four months.[9, 12-13,24,28]

Virginia

Virginia implemented its outpatient competency restoration program in 2008.[12] OCR services are provided to defendants who are released on bond. The services are typically provided in the Community Service Board building or the defendant's residence.[13,35] Since the development of its outpatient competency restoration programs, Virginia has tried to create uniformity among its programs through the development of a centralized forensic office. Originally, the outpatient competency restoration programs lacked standards for practice and varied on the types of services that they offered. In order to standardize training, Virginia's forensic office developed a standardized curriculum that it uses to train its forensic clinicians/counselors. Uniformity among the outpatient competency restoration programs was also fostered through the forensic office's development of standardized competency restoration tools.[13,36] Limited information has been made publically available on the program. Data that is available on the program indicates that 64% of defendants admitted to Virginia's program were restored while the remaining 36% were unrestorable.[9, 12-13,24,28]

Wisconsin

Wisconsin developed its outpatient competency restoration program in 2008 in Milwaukee. The program originally was designed to serve defendants in Milwaukee County, as well as those from neighboring counties.[12] Recently, the program has spread to another 27 counties. Wisconsin accepts defendants who are not dangerous, are stable enough to be released into the community, are willing to participate/cooperate, and

have a place to live.[12-13] Having transportation and avoidance of drug or alcohol use are additional criteria that can also increase eligibility a defendant's for outpatient treatment services.[36, 37]

Information collected on the program indicates that the program has been very successful. Since Wisconsin's outpatient competency restoration program was developed, 79% of defendants have been restored, most in less than four months. A little over 20% of the remaining defendants who were admitted to Wisconsin's outpatient competency restoration program were found to be unrestorable.[12]

Residential Rehabilitation OCR Programs

While OCR programs are typically characterized as community-based programs, there are other types of OCR programs. One of these types includes residential rehabilitation programs. The structure of these programs varies between states.

Louisiana

Louisiana has two Forensic Supervised Transitional Residential and Aftercare (FSTRA) programs that are designed to accept forensic patients who have been ordered by the court to receive treatment/restoration services or who are on conditional release.[15] Incompetent to stand trial (IST) defendants are typically referred to these programs by the state psychiatric hospital.[38,39] Each program accepts a different type of IST defendant[xii]. One residential program is located in Baton Rouge.[15] This program has 40 beds and admits IST defendants who have been found to be unrestorable and is designed to help them learn: daily living skills, how to manage their mental health symptoms, what their legal rights are, and how to manage their medications.[15] The second program, based in New Orleans, is a 28 bed program (22 beds dedicated to male patients, 6 beds that can be used by male or female defendants) designed to admit pre-trial defendants who have been found IST but are believed to be restorable.[15] These facilities are still relatively new and as a result, there is limited information on the IST populations that these facilities serve (e.g. restoration rates). [15,38]

Texas

In 2011 Texas' Department of Human Services opened up residential rehabilitation units in three of its state

[xii] Based on the CST evaluation, a judge can rule that an IST defendant is restorable (a.k.a. it is believed that the defendant can regain his/her competency to stand trial) or unrestorable (a.k.a. the defendant is believed to not bel able to regain his/her competency).

psychiatric hospitals.[9] In regards to IST defendants, the units were designed to treat/restore IST defendants who were unlikely to be restored in the foreseeable future but had not had their charges dismissed by the court.[9] The main difference between these residential rehabilitation units and the inpatient units were that the residential rehabilitation units had lower security levels and fewer staff workers.[9] Individuals placed in these units were typically perceived to not be a danger to themselves or others, unlikely to flee/escape, able to handle their own basic needs, did not require constant care by a skilled nurse, and willing to adhere to a treatment plan.[9]

Washington

In Washington, defendants found incompetent to stand trial can be diverted from state psychiatric hospitals by being placed in a residential treatment facility. Washington has two residential treatment facilities dedicated to competency restoration services Yakima and Maple Lane.[5,7-8] The residential treatment facility in Yakima can accommodate approximately 24 defendants.[5,7] The Maple Lane facility is slightly larger and can accommodate up to 30 defendants.[5]

Defendants are admitted to these facilities for 90 days. After 90 days have passed they are re-assessed to determine if they have regained their competency to stand trial. Very few defendants are believed to be unrestorable within the foreseeable future.[5,7-8] If a defendant[xiii] is not restored but is believed to be restorable he/she may be re-admitted to the program for an additional 90 days. Defendants can occasionally be transferred from the residential treatment programs to a state psychiatric hospital if they require more intensive services or supervision. Data from 2018 indicate that very few defendants were found to be unrestorable, recommended for additional restoration periods, or transferred to a state psychiatric hospital. [5,7-8] Most defendants are restored at these residential treatment facilities within 45 days. Data from 2016 indicates that the average length of stay for a patient at Yakima was 1.37 months and 1.12 months for Maple Lane.[5]

Wisconsin

In Wisconsin, defendants who have been found incompetent to stand trial who could be served through an outpatient treatment program but who have not had their charges dismissed can be admitted to the Wisconsin Resource Center for

[xiii] This, in particular, pertains to defendants accused of felony crimes. In Washington, defendants accused of misdemeanant crimes are not required by law to undergo additional restoration services.

competency restoration services. The Wisconsin Resource Center admits defendants who have been transferred from the Department of Corrections.[16-20] While information has been collected on the Wisconsin Resource Center, limited information is available regarding the number of defendants in the competency restoration program and the outcomes of the program.

Other Types of Alternative Programs

In 2009 a new program was developed in the state of Florida for handling IST cases. The program has multiple components. A separate section has been dedicated to this program because of its uniqueness.

Florida

Between 1999 and 2007 Florida saw a 72% increase in the number of forensic defendants being sent to its state psychiatric hospitals.[3,4] In response, the Miami-Dade Forensic Alternative Center was developed in 2009. To be eligible for this program a defendant must be found incompetent to stand trial, over the age of 18, have committed a minor felony, and must not have a previous history of committing violent offenses and/or have a prior first degree felony charge. Defendants admitted to the Miami-Dade Forensic Alternative Center are placed in an inpatient facility, where they are provided with treatment and restorations services, until they are stabilized.[3] Upon stabilization these defendants are transferred to a secure residential treatment facility.[3] Once their competency is restored measures are taken to develop a treatment plan that will allow them to be placed/moved into the community. [3]

The Miami-Dade Forensic Alternative Center has reported many benefits. One is its low recidivism rate. Data on the program suggest that, since 2009, only a small number of defendants who have been placed in the program have been re-arrested.[4] Another benefit is that the Miami-Dade Forensic Alternative Center provides defendants with a continuum of care. Most importantly, the program is designed to help defendants access their federal benefits. This is crucial because accessing these benefits will allow these defendants to receive treatment services and housing once they are discharged from the program. [3] Lastly, the program offers tools to assist defendants in refining their living skills, establishing community relationships and

supports, and developing certain levels of autonomy. [3]

Limitations

As noted previously, laws regarding OCR programs, the, exclusion/inclusion policies of OCR programs as well as the structure of these programs may differ across, and within, states. [9,12,14,23-24,26,34] This complicates both between-state and in-state comparisons. Some of the differences between programs may be attributed to program differences such as: patient population size, inclusion/exclusion criteria (e.g. allow misdemeanants and felons, only misdemeanants), and patient population composition (e.g. types of disorders, severity of disorders). [9, 12-13,24,33-35,37-38]

These differences between OCR programs are important to consider when comparing OCR programs to inpatient competency restoration programs. A state's OCR program may have a higher restoration rate but that may be related to the fact that it serves a smaller number of defendants. This statistic, as well as the average length of time until restoration, may reflect the differences in who is being admitted to the OCR programs. If IST defendants accused of committing low level offenses who do not pose a risk to the public are being sent to the OCR programs, than that would mean that IST defendants accused of more serious crimes and/or who pose a threat to the public are being admitted to the state's inpatient competency restoration program(s). [12-13,23-24,26,28] These types of differences increase the complexity of the situation and make it difficult to compare the effectiveness of OCR program to inpatient programs. This is especially true when attempting to compare the cost effectiveness of OCR programs.

Many states with OCR programs report saving money. However, it is difficult to ascertain if these cost-saving analyses are looking at all the components required to sustain an individual in the community (e.g. cost for housing, food, transportation) or if the costs are solely those associated with the amount that states are spending on the restoration services themselves. [9,12,14,23-24,26,34] Additionally, comparing costs savings of OCR program to inpatient programs is difficult since OCR programs can vary from inpatient competency restoration programs (as well as other OCR programs) on components such as: the education level of staff members, hours spent providing restoration services, and whether or not restoration service are provided in a group or individual setting. [9,12,23] There appears to be a limited number of publically available studies that provide a detailed examination

into the cost-effectiveness of one or more OCR programs. As a result, it is hard to estimate how much money OCR programs, as a whole, save their states annually.

Conclusion

The purpose of this paper was to provide a current, comprehensive list of states that have developed, or are developing, OCR programs.[12] While a dedicated effort was made to identify every state with an OCRP program, it is possible that other OCR programs exist and/or are being developed.

With the exception of Gowensmith, Frost, Speelman, Therson's (2016) study, there appears to be limited research comparing OCR programs at a national level. As noted previously, the lack of standardization between OCR programs (both between and within states) makes comparing this information difficult. Despite these limitations, the data that has been collected on OCR programs appears to suggest that they are successful. Most of the OCR programs restored over 60% of defendants. Though each program may vary by state law, policy and practice on certain parameters regarding the provision of restoration services (e.g. in terms of time to have repeated evaluations, time to court adjudication), the data that has been made available on OCR programs demonstrates their effectiveness in restoring IST defendant over short periods of time. Most of the OCR programs for which data is available have been able to restore their defendants within half of the time of inpatient programs.[9,12-13,23-24,26,28] However, such findings may be impacted by eligibility criteria. In essence, the criteria used to determine if a patient can be accepted into the program (e.g. lack of serious medical disorders) defendants admitted to these programs may impact the likelihood that the individual will be restored and the time that it takes to restore the defendant. Defendants who are excluded from the program, on the other hand, may have predispositions (e.g. more serious mental health disorders, medical disorders) which reduce the likelihood that they will be restored and/or complicate the restoration process.[12-13,24,33-35,37-38]

Information that has been collected on these programs also suggests that they are cost-effective.[9, 12-13,23-24,26,28] Despite this information, the lack of standardization amongst these programs strengthens the need for additional research on the effectiveness of these programs. This is especially warranted as more states with

access to different resources are considering implementing these programs.

In the end, the data collected on existing programs suggest that they may be a good resource for restoring IST defendants who do not require inpatient level of care and can be treated within the community. Nonetheless, the differences between the state/counties that have these OCR programs (e.g. laws on the development of OCR programs, and availability of resources) and the OCR programs themselves (e.g. exclusion/inclusion criteria and their structure) should be considered when determining if the development of an OCR program is an appropriate for a specific state or county. [9,12,14,23-24,26,34]

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Competency Restoration for Adult Defendants in Different Treatment Environments

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The optimization of trial competency restoration is a topic of growing interest and controversy in the fields of forensics, psychology, criminal law, and public policy. Research has established that adult defendants who have severe psychotic disorders and cognitive impairments are more likely than defendants without these conditions to be found incompetent to stand trial and are less likely to be restored to competency thereafter. Research has also identified some of the benefits of attempting restoration in hospitals, jails, or outpatient settings for defendants with different diagnoses or levels of cognitive functioning. Rates of restoration, length of stay necessary to achieve restoration, and, in some cases, how quickly defendants are found non-restorable are primary indicators of positive outcome. We sought to review the extant literature on competency restoration, with the goals of identifying implications for current practice and generating inquiries for future research. We found that there are significant advantages and disadvantages of attempting restoration in a hospital, jail, or outpatient setting on rates of restoration, length of stay necessary to achieve restoration, or length of time necessary to determine non-restorability, while controlling for several relevant factors (e.g., diagnosis, cognitive limitations).

J Am Acad Psychiatry Law 47(1) online, 2019. DOI:10.29158/JAAPL.003819-19

Since the early 1960s, requests for evaluations of competency to stand trial for adult criminal defendants have increased from approximately 25,000 to 36,000 annually to 50,000 to 60,000 in recent years.[1–4] Competency is now the most common subject of a forensic evaluation.[2] Surveyed public defenders have reported concerns about competency in 10 to 15 percent of their cases, with competency to stand trial evaluations occurring in 2 to 8 percent of all felony cases.[1,4] Given the frequency of evaluation requests, understanding the legal parameters and challenges related to competency determination and restoration is necessary for attorneys, judges, legislators, evaluators, and forensic mental health practitioners. A pertinent history of this topic will first be reviewed to provide context for a critical review and discussion of the relevant psycholegal literature.

History

Challenges of trying mentally ill defendants date back to the medieval period.[5] It has been reported that questions about competency may have first been raised in response to defendants who were mute and did not enter a plea of guilt or innocence.[6] In those cases, courts used juries to determine whether the defendant was mute in an obstinate way, or whether "he be dumb *ex visitation Dei* (by visitation of God)" (Ref. 6, p 3). Defendants determined to be obstinate were subjected to *peine forte et dure*, a process of placing increasingly heavy rocks on top of them as a form of coercion.[5,6] Defendants found to be mute *ex visitation Dei* were not subjected to *peine forte et dure* and (along with "idiots" and "lunatics") were spared trial proceedings altogether.[6] By the late 18th century, common law began to recognize that individuals needed to understand the charges against them and be at least somewhat capable of participating in their own defense.[5,6]

Published online February 8, 2019.

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Disclosures of financial or other potential conflicts of interest: None.

In the case of *Dusky v. United States* (1960), the U.S. Supreme Court established a Constitutional standard for competency applicable in all criminal cases at the federal or state level.[7] Henceforth, individuals accused of crimes needed to possess a factual as well as a rational understanding of the legal circumstances at hand and to be capable of consulting rationally with their attorneys.[4] In the years since this standard was established, the number of referrals for evaluation has increased significantly, in part reflecting increases in the number of criminal prosecutions.[8]

In the aftermath of *Dusky*, there were growing concerns about incompetent defendants being hospitalized for significantly longer periods of time than if they had gone through traditional criminal proceedings.[7,8] Before the early 1970s, incompetent defendants could be hospitalized and receive more general forms of treatment, regardless of whether restoration was likely to occur.[9]

Deinstitutionalization in subsequent years resulted in fewer civil hospital beds being available.[8,10] However, beds for incompetent defendants were not necessarily decreased and, in fact, were increased in some jurisdictions.[11]

In 1972, the U.S. Supreme Court, in the landmark case of *Jackson v. Indiana*,[12] ruled that competency-related hospitalization required that restoration be likely to occur in the foreseeable future.[3] Thereafter, states were incentivized to provide services tailored to competency restoration.[3,8,13,14]

However, the *Jackson* ruling did not further specify or define the foreseeable future.[5,9,14] As a result, subsequent state court interpretations of *Jackson* varied considerably, though led to shortened commitments in many cases and placement of some incompetent defendants in less restrictive settings.[5,8,14] Many states now place limits on the maximum length of time an individual may be committed for restoration purposes and require termination of the proceedings when competence cannot be restored.[14] Some states permit charges to be dropped and re-filed to get around statute-specified end dates, whereas other states allow commitments without predetermined end dates for individuals charged with murder and sex offenses. Still others grant indeterminate commitments (typically under procedures governing insanity acquittee commitments) for individuals found not likely to be restored in the near future and "factually guilty" of the offense(s) in question.[15]

Dusky and *Jackson* continue to have significant implications for current forensic practice.[7,14] Whereas *Dusky* provides a legal definition of competency, *Jackson* clarifies the limitations of commitment.[7,13,14] The *Dusky* standard requires a functional analysis of a defendant's current capacities, so that deficiencies can be targeted for intervention in furtherance of restoration.[5,7] Generally, when a defendant cannot be restored to competency, a *Jackson* hearing is called.[5,14] Depending on the jurisdiction, if the individual is found non-restorable, he or she will be released from the competency restoration commitment, the charges may be dismissed (although this was not specifically required by *Jackson*), and civil commitment proceedings may be initiated.[5,14]

Unfortunately, growing resource problems in some states have delayed defendants' transitions from jail to hospital after a finding of incompetency (and commitment for restoration).[16,17] As a result, defendants found incompetent to stand trial may spend considerable counterproductive time in jails awaiting the availability of a hospital bed.[2] In such cases, state governments may face civil action (e.g., contempt of court for delay in responding to a court's commitment order).[8,14,16,17] Within the following literature review are proposed strategies to redress such limitations of policy and practice, secondary to the larger aims as follows.

Prior Research

The purpose of this article is to substantially review the extant research on competency restoration, identify implications for current practice, and generate inquiries for future research. Historically, research has been focused more on evaluation than on restoration.[2] Well summarized by Pirelli *et al.*,[18] a majority of restoration research focused largely on identifying the common factors among competent/incompetent and restorable/non-restorable defendants. Zapf and Roesch[14] offered the perspective that future research should focus on identifying maximally effective treatment approaches and identifying areas of competency-based deficiency or particular symptoms that frequently complicate the restoration process.

Supporting the latter potential course of research, the few available empirical studies on effective treatment approaches had samples that were too small to allow for generalizability of findings or reliable analyses of between-group differences, or they were outdated (frequently 10–20 years old).[9,13,14,19–21] The

time lapse is significant given publication of the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which advanced a new understanding of psychiatric symptomology and diagnostic criteria.[22] This understanding is based on contemporary research, which should inform the mental health basis of all findings regarding competency to stand trial and guide treatment approaches.

Research has progressed from focusing on treatment methods to the various settings in which restoration is attempted for incompetent adult defendants presenting with different diagnostic, cognitive-functional, and criminogenic features, as discussed later in this article. Some prior treatment research focused on improving psycho-educational teaching of courtroom knowledge and expectations for behavior.[24] Researchers frequently expressed concern that the benefits of these approaches may be limited because defendants are frequently cognitively impaired and desperate to escape confinement, and may therefore memorize and parrot back information they do not truly or rationally understand.[3,13,16,23,24]

The literature suggests potentially differential benefits of attempting restoration in hospitals, jails, or outpatient settings, which is the primary subject of this article. As follows, the competency and restoration literature suggests the possibility that the setting in which restoration is attempted may help to improve the restoration process in the manner suggested by Zapf and Roesch.[14]

Variables of Interest

This review of the literature identified variables warranting consideration in future restoration research. This review not only identified treatment setting as an independent variable of interest, but also length of restoration (LOSR) and days necessary to determine non-restorability as outcome/dependent variables. Diagnosis and cognitive limitations also warrant consideration; these were studied extensively as independent variables in other studies, and thereby should be considered as mediators or moderators in future research. This multi-level relationship has yet to be studied intensively.

Crime type was identified in the literature as a potential mediator or moderator. Multiple literature reviews consistently identified defendants charged with violent crimes as being significantly more likely to be found competent.[5,24] However, we have deprioritized crime type in this article because it is not necessarily or fundamentally relevant to a determination of incompetence or restorability.[24]

Converging points in the following literature review will suggest one of the next major directions of competency restoration research. An emerging direction is the extent to which placement in a hospital, jail, or outpatient setting may have different effects on overall rates of restoration, average LOSR, and, at least in some cases, rates of non-restorability for incompetent defendants with different diagnoses, levels of cognitive functioning, and criminogenic features. Applied to practice, the current research will also identify common features among defendants restored and not restored in each setting, which may in turn offer a helpful guide for placement decisions.

Methods

We first conducted a keyword search of the PsycINFO database for relevant articles without a specific research question in mind. Based on prior experience, we anticipated that a paper topic would flow from this relatively unstructured approach. Keywords yielding the highest number of selected articles were competency to stand trial, restoration of competency, competency, and restoration.

Because there was not an abundance of recent studies on competency or restoration, articles were initially considered for inclusion if they were clearly related to the subject matter and published within the last 15 years. This initial search yielded 33 potential articles, including five dissertations. The abstracts were then scanned for common themes and limitations that might converge in a manner suggesting a future direction for competency restoration research.

Within the initial pool of articles, eight were excluded because they were mostly focused on identifying common diagnostic features, a subject already comprehensively addressed in prior meta-analyses. We subsequently reviewed the remaining 25 articles and organized key points under headings, which eventually became the headings of this article. Thereafter, 13 additional articles were selected based on follow-up consultation with colleagues and determination that they offered partial answers to limitations identified in the initial pool of articles. Meta-analyses and papers published within the last five years were prioritized. Dissertations were retained as adjuncts to primary sources given the inclusion of more data on the aforementioned variables of interest

(e.g., diagnosis, cognitive limitations, rates of non-restorability, etc.). As initially anticipated, from this process flowed the research question alluded to previously and fully articulated in the concluding section of this article.

Incompetence and Restorability

It is important to begin with a brief review of the national results of competency-restoration efforts. Research suggests that restoration attempts have been generally successful. Pirelli *et al.*[18] conducted a meta-analytic review of 68 studies conducted between 1967 and 2008. Their results indicated that approximately 81 percent of individuals across studies and diagnostic categories were eventually restored, usually within 90–120 days.[18]

The most common disorders associated with being found incompetent to stand trial were primarily psychotic, secondarily cognitive (sometimes as associated features of psychosis), and to a lesser extent, affective.[4,5,8,9,16,17,24,25] Pirelli *et al.*[18] found that evalueees with psychotic disorders were approximately eight times more likely than evalueees without psychotic disorders to be found incompetent. Consistent with Pirelli *et al.*,[18] Schwalbe and Medalia[5] reviewed several older meta-analyses and concluded a finding of competence was most often associated with non-psychotic affective disorders among defendants found to carry a psychiatric diagnosis. Consistent with prior research linking psychosis and cognitive limitations with findings of incompetence, research on defendants with schizophrenia indicated a finding of incompetence was correlated with severity of cognitively related symptoms, including disorientation, hallucinations, behavioral disturbance, impaired memory, lack of spontaneity and flow of conversation, difficulties in abstract thinking, and stereotyped thinking.[5,20]

Structured-interview and psychological-testing studies have attempted to identify symptoms and impairments associated with longer LOSR or non-restorability. There has been some indication that longer LOSR may be associated more with the severity of negative symptoms of schizophrenia than with positive symptoms.[20] A study with a smaller sample size indicated a preliminary relationship between longer LOSR and higher global psychiatric symptomology, as measured on the Brief Psychiatric Rating Scale-Expanded (BPRS-E).[26] There were mixed findings regarding the possibility of a relationship between LOSR and indicators of verbal learning and memory.[27,28] Treatment factors associated with a higher likelihood of being found non-restorable have included higher numbers of psychiatric hospitalizations and lower responsiveness to medications.[5,14]

Prominent vulnerability, sociodemographic, and treatment factors have also been identified in the research on competency and restoration. Some studies,[24] though not all,[25] have demonstrated a significant relationship between a finding of incompetence and not having completed high school. A finding of trial incompetence has also been found to associate significantly with being unemployed,[18] receiving a social security disability income, or being unmarried, though without controlling for potential covariance with diagnosis.[5] Older age was frequently identified as a correlate of both incompetence[5,24] and non-restorability,[14,25] even after controlling for dementia diagnosis.[21] Most studies suggested that African Americans and members of other minority races are more likely to be found incompetent, whereas findings on gender have indicated no significant difference.[5,19,24]

Ross and colleagues[25] conducted a neuropsychological study on restoration for 288 forensic inpatients in a state hospital facility in California who were restored within 36 months of admission. The mean age for the sample was relatively young at 39.9 years (i.e., suggesting a potentially better prognosis), while mean years of education was approximately 11.2 (i.e., indicating a potentially poorer prognosis). Most defendants/participants were diagnosed with psychotic disorders ($n = 169$, or 58.7%) and scored, on average, between two and three standard deviations below the mean on index scores of attention, language, multiple indicators of memory, and global performance; average LOSR was 7.2 months. The authors concluded that defendants scoring three to four standard deviations below average on the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) were nearly three times more likely to require a greater-than-average LOSR.[25] Crime type was not reported. Additionally, it is noteworthy that the mean number of days to restore was significantly longer than the national average data reported by Pirelli *et al.*[18] Thus, particular areas of cognitive dysfunction identified in the study by Ross *et al.*,[25] as well as global cognitive impairment, may cue hospital administrators and forensic practitioners to the likelihood of longer LOSR and a higher-

than-normal likelihood of being found non-restorable. These findings were also consistent with previously noted pilot research findings.[27,28]

Location of Restoration Efforts

We reviewed research on the programmatic designs, benefits, and drawbacks of restoration programs in hospitals, jails, and outpatient settings. In each reviewed study, available data on psychotic disorders, cognitive functioning, crime type, LOSR, non-restorability, malingering, and medication adherence were presented and compared across treatment environments. The purpose of these comparisons was to inform the reader about how outcomes in different treatment settings are affected by potential mediator or moderator variables discussed in previous sections of this article. Absences of such data were identified as limitations, which should be better accounted for in future research.

Competency Restoration in State Hospitals

Throughout history, most defendants found incompetent have been committed to state hospitals.[2,8] Defendants undergoing competency proceedings make up the largest group of psychiatric patients remanded to hospitals by the criminal justice system.[5]

Review of Programmatic Strategy

To illustrate the potential benefits of hospital-based care, Wolber *et al.*[29] reviewed the methodology and outcomes of the restoration program at Central State Hospital in Virginia. Representatives from Central State Hospital described a highly specialized treatment team and approach. The four-person evaluation team involved professionals experienced and trained in competency standards, restoration interventions, courtroom procedures, and expert testimony. A therapist was assigned to guide treatment-team coordination, monitor medication effectiveness, observe defendants' interactions, and consult with designated evaluators. Symptoms and impairments interfering with progress toward competency were identified in treatment plans. Meaningful improvement led the restoration therapist to coordinate a follow-up competency evaluation.

Wolber *et al.*[29] concluded with an informative discussion of how restoration outcomes were measured and perhaps should be measured in other settings. Central State Hospital reported an average LOSR of 73 days, though with a wide range of 1–560 days. The range was interpreted as an indication that the general usage of a measure of central tendency may be misleading and, therefore, may be less useful. As an alternative, the authors indicated that the number of defendants either restored or found non-restorable within specified time frames may be a better measure of outcome because the multi-level measure would account for multiple ways in which competency proceedings are resolved. Under this system, Central State Hospital reported that 27 percent of defendants were restored or found non-restorable within 30 days, 48 percent within 60 days, and 89 percent within 180 days, with less than 2 percent remaining in the restoration process after one year. A limitation of this study was that data on participants' demographics, diagnoses, cognitive functioning, and crime type were not reported.

Research

Anderson's dissertation[23] included 75 participants found incompetent to proceed/stand trial, diagnosed with intellectual disability (IQ less than two standard deviations below average), and housed and treated in either state hospitals or community-based settings (the number of patients in each setting was not reported). The purpose of this research was to determine whether restoration outcomes differed depending on the extent of participant's cognitive limitations and the treatment setting in which they were housed. Suggesting a better prognosis for restorability, the sample was composed mostly of younger adults (approximate mean age of 32 years) who committed violent/sex crimes (64% of the sample in community-based settings, 72% of the sample in hospitals). IQ scores for the entire sample were on average between two and three standard deviations below the mean, and the number of prior psychiatric hospitalizations ranged from one to two (i.e., significant psychiatric history), suggesting a potentially poorer prognosis for recovery. Only 5 percent of defendants in community-based settings had psychotic disorders, whereas 47 percent of participants in hospitals had psychotic disorders. IQ scores were similar across settings.

Results from Anderson's dissertation[23] were later revised and presented in a peer-reviewed article by Anderson and Hewitt.[19] The follow-up research determined (through additional statistical analyses) that placement in either a state hospital or a community placement did not significantly predict a greater

likelihood of restoration. However, this null finding should be considered in light of the hospital subsample having almost 10 times the number of participants with psychotic disorders, hospitals generally servicing much more severely ill/compromised and dangerous defendants, and the combination of severe cognitive limitations and psychotic disorders suggesting, per prior research, a higher likelihood of non-restorability. Consistent with research reviewed in earlier sections of this article, Anderson and Hewitt[19] found that restored defendants had significantly higher IQs (approaching the borderline range of functioning) and were more likely to have been accused of violent crimes. Among the limitations, major outcome variables noted in prior research (i.e., LOSR and number of defendants found non-restorable) were neither reported nor controlled for.

Theorized Advantages and Disadvantages

Among the advantages of attempting restoration in a hospital is the humanity of remanding individuals with mental illnesses to facilities oriented primarily to their treatment as opposed to a primarily custody-oriented jail setting. When incompetent defendants are placed in hospitals, they receive multiple needed services in addition to competency restoration, including medications that help address psychiatric and medical conditions that are less related to competency, greater resources to maintain adherence, rehabilitative interventions, and discharge resources related to housing and outpatient care. The provision of intensive and multi-faceted services may better prepare defendants to return to the community in a more functional state. Similarly, the extent of available treatment has been argued to be the major difference between a hospital and a jail.[30]

An additional advantage of attempting restoration in hospitals is that provider expertise and resources are typically more specialized and diversified. This consolidation of resources is often necessary to identify, diagnose, and differentiate severe and complex psychotic, personality, dissociative, or factitious disorders that may otherwise complicate restoration efforts.[8] A multitude of surveyed hospitals have attributed 80 to 90 percent restoration rates not only to their greater support for medication adherence and competency-related psycho-educational instruction, but also to a greater number of therapeutic and rehabilitative services, mock trials and role plays with actual attorneys and judges, classroom environments with written competency exams, and anxiety-management training specific to courtroom contexts and scenarios.[2,3,5,13]

The main disadvantages of hospital-level care are higher expenses and bed resource considerations. Greatly exceeding the costs associated with attempting restoration in jail or in community-based settings, costs of restoration in hospitals range from $401 to $834 per defendant per day, according to research studies.[16] It is difficult to determine the overall quality of hospital care, although it is noteworthy that by August 2002, 137 of 149 state mental hospitals (92%) were accredited by The Joint Commission.[8]

One of the ways that Florida State Hospital in Chattahoochee, Florida, optimizes scarce public resources is to hire not only licensed practitioners, but also to hire new graduates from doctoral psychology programs as well.[31] Florida State Hospital places new graduates directly into full-time competency evaluator roles where they receive formal and on-the-job training, as well as supervision from highly regarded state-certified evaluators and founders of widely used malingering measures. Thereafter, postdoctoral residents are afforded opportunities to progress in their independence, licensure acquisition, and professional advancement relative to their commitment and growing skill set, which promotes retention and longevity.

Medication Considerations

Although some jails have procedures for involuntarily medicating adult inmates with mental illnesses on the basis of safety concerns (in accordance with *Washington v. Harper*, 1990), the administration of involuntary medications solely for restoration purposes occurs nearly exclusively in hospitals.[32] Medications are the primary treatment strategy for many incompetent defendants, particularly those with psychotic disorders, often despite their objections.[33] Since the landmark case of *Sell v. United States* (2003), a defendant may be involuntarily medicated solely for the purpose of restoration, provided that there is a compelling government interest in prosecuting the case; there is a reasonable likelihood of restoration occurring in the future and that medication side effects will not interfere with the defendant's ability to exercise his or her trial rights; medications are the least intrusive option for treatment; and medications are medically appropriate.[34] Since

Sell, there have been lingering questions regarding the ethics of medicating patients primarily for legal purposes and despite evidence supporting the necessity in many cases.[24,34,35]

Herbel and Stelmach[33] conducted a retrospective chart review on 22 defendants diagnosed with treatment-refractory delusional disorders and receiving involuntarily administered antipsychotic medications. Of the 22 defendants, 19 (87% of the sample) were between 34 and 57 years old, 18 (82%) were arrested for violent crimes, and 14 (64%) were rated as having average intelligence. As noted earlier, relatively younger age, violent charges, and average (i.e., not lower) intelligence are suggestive of a marginally better prognosis for restoration. Of the 22 defendants, 15 (or 68%) were of Caucasian ethnicity. Among these involuntarily medicated defendants, 17 defendants (77%) were ultimately restored to competency, despite longstanding assumptions that delusional disorders do not improve with medications. This study was limited by the sample size being too small to conduct reliable between-group analyses. In addition, LOSR and the number of defendants eventually found non-restorable were not reported.

Competency Restoration in Jail

In most states, after an initial evaluation, defendants can continue to be evaluated for competency and restored in jails.[2] Although hospitalization is significantly more common, interest in jail-based restoration has grown due to concerns about the high cost of hospitalization, the higher risk of attempting restoration in the community, and jail-based competency programs' reporting of noteworthy rates of restoration. In an age of managed care and scarce public resources, optimization of resources is necessary to preserve the extent of available forensic mental health services in many jurisdictions.

Review of Programmatic Strategy

Several authors have described the parameters and potential benefits of jail-based restoration programs currently in operation.[36–38] Some programs, such as those in Fulton County Jail in Georgia and The Liberty Program (i.e., Liberty Healthcare) in California, service defendants in pod-based/dormitory-style housing, provide a daily group schedule, and individualized treatment.[36,38]

The Liberty Restoration of Competency program (ROC) provides twice daily one-to-one restoration services, as well as daily groups in which defendants receive knowledge-based instruction in the major domains of competency. In accordance with the *Dusky* standard, the domains include defendants' factual understanding and rational appreciation of their charges, possible sentences associated with those charges, the adversarial nature of the justice system, an ability to rationally assist an attorney in their defense, behave approriately in court, and testify relevantly if called upon to do so.[7]

A jail-based restoration program in Texas goes a step further in seeking to provide as many treatment hours in jail as are typically provided in hospitals. To this end, the Texas program strives for a low defendant–staff ratio (3.7:1) and employs a psychiatrist. However, this program was put forth as a pilot due to various resource challenges.[37]

Research

Rice and Jennings[17] reviewed the findings from a ROC program in a California jail and compared them to the findings from a ROC program in a Virginia jail. The ROC programmatic approach in both locations was theoretically consistent with a multidisciplinary hospital approach in terms of being holistic, motivational, and recovery-focused; tailoring interventions to competency-based deficiencies; and adjusting for defendants' cognitive limitations. Defendants in competency proceedings were also placed in specialty pods away from the general population.

At the time of manuscript submission, ROC programs had been piloted in Virginia and had been in operation for 29 months in California, serving 192 defendants. Defendants in the California ROC program were mostly of cultural minority backgrounds ($n = 109$, or 56.8%) and were diagnosed with psychotic disorders ($n = 126$, or 65.6%). Supporting a potentially better prognosis for restoration, the published rate of defendants with psychotic disorders appeared lower than what is typical of a state hospital census, while average age was relatively younger at approximately 37 years.

Whereas aforementioned hospital costs ranged from $401 to $834 per day with an 80–90 percent restoration rate, the jail-based ROC programs had a cost of approximately $42 per day with an 86 percent restoration rate in Virginia, and a cost of roughly $222 per day with a 55 percent restoration rate in California. In California, the remaining 45 percent of incompetent defendants were eventually transferred to the state hospital

for more intensive treatment. Regarding LOSR in the California program, 55 percent of the sample was restored within an average of 57.4 days, while 40 percent were transferred to the hospital within 90 days. These numbers are comparable with the average LOSR noted in prior meta-analyses.

Results from the California ROC program suggest positive implications for jail-based restoration efforts. It can be concluded that jail-based programs are less costly than hospitalization. Jail-based restoration may be a reasonable first step in the process toward restoration, prior to initiating hospitalization, and possibly even in cases of psychosis (if jails were sufficiently resourced and authorized to administer medication over objections).

Differences in the findings from jail and hospital-based competency programs may also be explained as a function of the greater severity, complexity, and complications usually associated with defendants who require hospitalization. Efficacy between treatment environments would be difficult to determine because the more severely ill, dangerous, and treatment-refractory cases of mental illness are typically referred from jails to hospitals. Consistent with this assertion, Rice and Jennings reported that 69 of 126 ROC program inmates with psychotic disorders (55%) were transferred to state hospitals, which is significant because a psychotic disorder diagnosis was found in prior research to suggest a poorer prognosis.[17] It was also reported that 85 percent of defendants in the California ROC program were fully adherent to medication, with basic rewards for adherence such as candy bars, chips, and soup, an incentivizing structure typically discouraged if not outright prohibited in hospitals.

Consistent with the limitations of previously reviewed hospital studies, ROC program research did not report LOSR for defendants transferred from jails to hospitals, numbers of defendants eventually found non-restorable, or sample demographics related to cognitive functioning and crime type. Recurring limitations in available data better permit theoretical comparisons of jail and hospital studies than statistical comparisons. Therefore, future research must account for and control for such recurring limitations.

Theorized Advantages and Disadvantages

Jail-based restoration programs are much less expensive than those in hospitals, with state government agencies reporting that jail-based programs have yielded cost savings of 50–80 percent.[16] In addition, offering restoration services in jails may reduce the time necessary to initiate restoration, given the potential for treatment to begin nearly immediately after incarceration. In some jurisdictions, there are relatively long wait times for defendants to be admitted to state forensic hospitals. Thus, not starting restoration services in jails and waiting for a hospital bed could significantly delay treatment and, in many cases, exacerbate symptoms of mental illnesses.

There may be additional treatment advantages associated with the jail environment. The increased supervision, monitoring, and relative discomfort defendants usually ascribe to jail may motivate some defendants to participate more gainfully in restoration services and progress toward regaining their opportunity for trial,[17] as will be discussed in more detail in the section on discouraging malingering below. While there is no question that jails are not designed for mental health care, there is much that a skilled jail-based treatment team can do to improve the quality and effectiveness of services.[17] Thus, it should not be assumed that jail-based restoration is necessarily inferior to hospital-based restoration. However, due to insufficient resources, it is unlikely that jails could provide the same level of medication support, classroom-based competency instruction, mock trials, symptom management, and rehabilitative services typically provided in hospitals and associated with impressive outcomes, as summarized earlier.

Kapoor[16] provided an informative summary of the theorized drawbacks of jail-based restoration services as inverse to the ethical positives of attempting restoration in hospitals. Within this summary, it was noted that there may be concerns about patient rights and further criminalizing the mentally ill when an individual is kept in jail for restoration, hospitalization is avoided at least partially for public policy reasons, and mental illness is so severe that a strong relationship between the individual's illness, impairments or problematic behavior and trial incompetence has been determined by a judge.

Given the limitations in the research, total efficacy is not known, although there may be good reason to think hospitalization would produce better results, particularly for severely psychotic adults. It is also possible that jail inmates with severe psychotic disorders may experience symptom exacerbation and perform even more poorly in competency evaluations if their mental health crises are addressed via standard

correctional system interventions. With regard to initiating jail-based restoration, it is of further concern that medications are the primary intervention (particularly for defendants with psychotic disorders), defendants are often resistant to taking medications, and, in some jurisdictions, jails lack the statutory authority to administer medications over objections.

For such reasons, jail-based restoration may be preferred for non-psychotic or less severely and blatantly psychotic individuals who need shorter-term treatment, with state hospital beds reserved for more seriously ill inmates requiring longer-term hospital-level care.[17] With such reasoning in mind, some statutes (e.g., VA statute 19.2–169.1 and CT general statute 54–56d(i)) require that an evaluator, who may be uniquely situated to know the challenges affecting a defendant's competency, make a recommendation to the court regarding whether restoration should be provided on an inpatient or outpatient basis. In such cases, statutes could permit jail-based restoration as a third option for defendants deemed inappropriate or too dangerous for outpatient restoration or not in obvious need of hospitalization.

Discouraging Malingering

Jail-based restoration, in some cases, may lower rates of malingering. Forensic experts have estimated the base rate of malingered trial incompetency to be approximately 15–20 percent.[1] However, rates may be significantly higher in serious felony cases where longer prison sentences are foreseeable. Malingering is of particular concern because it diverts scarce hospital and treatment resources away from individuals who are sincerely compromised and potentially more receptive or responsive to intervention.[1,16]

Researchers offer perspectives on whether jail placements may or may not discourage malingering. Kapoor[16] hypothesized that providing competency restoration services in jail, essentially because of the relative discomfort, may in some ways incentivize sincere participation. Specifically, it is often the case that hospitals are relatively more comfortable than jails and afford defendants greater privileges, provisions, and of course, the absence of correctional officers. Thus, a defendant participating in hospital-based restoration services, when found competent in a hospital and returned to jail (as is customary), would essentially be participating in furtherance of what would usually be a less desirable immediate outcome. In contrast, defendants in hospitals who successfully malinger would be maintaining a relatively more comfortable placement. In many cases, jails are often so discomforting and absent of provisions and recreation services that malingering defendants (who may learn or accept that hospitalization is not an option) may eventually become willing to demonstrate their competency, take their chances in court, and hope for a favorable outcome. In either setting, motivation to return to court and potentially face a prison sentence may be low, though possibly marginally higher in jails. Miller[8] added that inpatient hospitalization essentially exposes defendants to peers with a broad range of mental illnesses and mental health terminologies, so that they may learn to malinger more effectively. In addition, hospitals are often more adept at detecting malingering given opportunities for a larger network of professionals to observe the defendant over time on the ward, rather than only during an interview in jail, with additional consultation with jail staff.

Competency Restoration in Outpatient Settings

Outpatient programs have gained popularity in recent history as a cost-effective alternative to attempting restoration in hospitals. As described by Miller,[8] an outpatient program was piloted in Tennessee soon after the *Jackson* case was decided and inspired considerable interest among policy makers and practitioners.[14] Tennessee court officials and sheriff's department officers reported that outpatient restoration was a major success in terms of high (although unspecified) rates of restoration, significant reduction in transportation costs and coordination problems, cost savings associated with less reliance on hospitals, and local university students gaining opportunities to receive mental health training.[8,14]

Programmatic Strategy

The following review of outpatient strategy and best practices is based on co-author Dr. Apryl Alexander's experiences within the Denver Forensic Institute for Research, Service, and Training (or Denver FIRST) Outpatient Competency Restoration Program. This program provides court-ordered outpatient restoration for lower-risk adults and juveniles found incompetent to proceed in Colorado and subsequently released to the community. Defendants typically have developmental delays, head or traumatic brain injuries, or serious mental illnesses that can be managed in a less restrictive level of care than

hospitalization. Defendants may pay for their care on a sliding-scale basis, which may go down to zero (i.e., pro bono) in cases of indigence and with services paid for by state funding. Most referrals come from attorneys or courts. At the time of manuscript submission, the program could work with a maximum of approximately 35 defendants at a time. Similar to strategies utilized by Florida State Hospital, Denver FIRST also trains and employs students from a master's degree program in forensic psychology. Defendants typically receive additional and coordinated mental health services from community mental health providers.

Educational classes and individual restoration services tend to occur only once or twice a week, whereas such services are typically provided more frequently in hospitals (and possibly jails). Outpatient providers must coordinate their schedules with psychiatrists, case managers, and substance-abuse treatment providers. In jails or hospitals, providers are likely to be more accessible to defendants due to closer physical proximity. These communication difficulties can be particularly problematic in cases of outpatient restoration where resources for psychiatrists are minimal and medication adherence and abstinence from drugs and alcohol cannot be achieved as a function of a controlled environment (as in the case of a jail or hospital). Thus, poor medication adherence and access to drugs and alcohol are often stand-alone barriers to effective outpatient restoration, particularly for more severely and comorbidly ill defendants.

There is indication that policy makers and the public may be at least marginally more supportive of outpatient restoration efforts than the judiciary. Up to 2003, 33 states permitted different forms of outpatient restoration.[8] By 2009, this number had increased only slightly to 35.[15] From 2011 to 2016, only 16 states had active outpatient programs.[2,16] Researchers emphasize the need for improved education and dissemination of literature describing the results of such programs, with particular attention to rates of restoration and acknowledgment of public safety concerns.[2,29]

In addition, outpatient restoration may grow in availability and acceptance if programmatic strategies and arguments in support of those strategies more convincingly suggest how to optimize the balance between safety concerns, less restrictive treatment mandates, and increased usage of potentially effective and cost-saving treatment. As a sign of one locale moving toward acceptance of outpatient restoration, and in support of the prior theory, local judges seem generally in support of Denver FIRST, with referrals increasing based on growing concern about jail overcrowding, the complications of housing the vulnerable individuals with mental illness in jail settings, and hospital bed resource considerations.

Gaps in implementation of outpatient programs may also be explained, in part, by insufficient resources. Miller[8] indicated that successful outpatient programs in the 1970s and 1980s utilized evaluators and treatment providers who were highly trained in competency and restoration, which may be challenging for resource-starved community mental health agencies to facilitate. An additional resource consideration is that, while restoration primarily occurs via medications, psycho-educational interventions are also important and are less likely to be reimbursed by insurance companies.[2]

Research

Gowensmith *et al.*[2] reviewed the results of outpatient restoration programs and confirmed support for major cost savings, as well as the position that a majority of appropriately selected, less dangerous defendants could be safely treated in the community. Forensic administrators surveyed by Gowensmith *et al.*[2] reported daily costs of $101–$500 per day, with an average of $215 per day (not accounting for additional outpatient resource coordination), which was about $388 less per day than hospitals.[2] Wolber *et al.*[29] indicated similar transportation and cost benefits noted by Miller,[8] adding that defendants permitted to remain housed in their communities or counties of origin were consistently better able to get to court on time, communicate directly with their attorneys, and access local resources.

Recent research explored the potential benefits and drawbacks of attempting restoration in different outpatient settings. The dissertation by Tang[39] was a retrospective study of 208 adult defendants in southern Florida deemed incompetent to stand trial or proceed. They were housed either in independent living or drug treatment facilities, and restored within three years. Most defendants and participants across treatment settings were relatively younger adults (mean of approximately 39 years), indicating a potentially better prognosis. A slight majority of the

sample were accused of violent crimes ($n = 106$, or 51.0%). Defendants were disproportionately from cultural minority backgrounds ($n = 98$, or 47.1%), and single or never married ($n = 148$, or 71.1%). Suggestive of a poorer prognosis, high numbers of participants were diagnosed with psychotic disorders ($n = 108$, or 52.0%), had IQ scores between one and two standard deviations below the mean ($n = 74$, or 35.6%), were psychiatrically hospitalized one or more times ($n = 96$, or 46.2%), and had an approximate mean of 11 years of education, which was also consistent with the mean education of the sample in the neuropsychological study by Ross *et al.*[24]

Across treatment groups, the mean LOSR was roughly six months. This number is greater than the national average indicated in prior meta-analyses, although it is fairly consistent with LOSR reported in prior hospital studies. In a manner consistent with recommendations from Wolber *et al.*[29] regarding a multi-level outcome measure, Tang[39] reported that 122 (58.7%) individuals regained competency, 28 (13.5%) were rearrested, 21 (10.1%) had their charges dismissed, 25 (12.0%) were committed to inpatient hospitals, and 8 (3.8%) were found non-restorable.

A survey and interview study of forensic practitioners in 48 U.S. jurisdictions offered further evidence in support of the potential benefits of outpatient programs. Outpatient restoration was attempted within 16 jurisdictions in 2014, with between one and 100 cases per jurisdiction per year around this time.[2] Approximately half of outpatient restoration cases involved defendants who were charged with misdemeanors, while the other half were charged with nonviolent felonies. Relatively lower risk was indicated by defendants tending not to have lengthy criminal records and being relatively psychiatrically stable, medication-compliant on a voluntary basis, and younger. These factors were noted in prior research to suggest a relatively better prognosis for restoration. It was noted that outpatient cases involved defendants who were disproportionately of cultural minority background. In total, and across jurisdictions, outpatient restoration was achieved in 70 percent of cases, with an average of 20.3 percent of cases being found non-restorable, and an average of 149 days necessary to restore competency. Information on the remaining 10 percent of cases was not made available. The number of individuals diagnosed with psychotic disorders or presenting with significant cognitive impairment was not reported.

Citing the study by Gowensmith *et al.*,[2] and with limitations of previously published research convergent with their aims, Mikolajewski *et al.*[40] examined the characteristics of defendants successfully restored in outpatient settings. The authors collected data on 80 incompetent adult defendants in Louisiana and accounted for a multitude of the mediator, moderator, and outcome variables not reported or accounted for in other studies.[40] Of the 80 defendants, 65 (81.3%) were African American, while 69 (86.3%) were single or never married, which is consistent with prior research on incompetent defendants on the whole. Most outpatient restoration defendants were male (54, or 67.5% of the sample). Whether defendants in this study were found incompetent or competent was not significantly associated with age differences, nor were there significant differences depending on multiple income and employment variables. Supporting the prior mentions that crime type need not be highly prioritized in future research, Mikolajewski *et al.*[40] found no significant association between a determination regarding competency or restoration and multiple criminogenic variables (e.g., history of juvenile offense, number of previous arrests, and whether the current charge was homicide, or other and unspecified forms of violence).

Analyses of clinical variables and a finding regarding competency are noteworthy.[40] Consistent with prior research, defendants who were restored to competency were significantly more likely to have graduated high school, while defendants who were diagnosed with intellectual disability plus mental illness were less likely to be restored. Whereas prior studies found that longer LOSR was associated with higher BPRS-E scores (a structured interview tool), the study by Mikolajewski *et al.*[40] found no significant difference in restoration depending on higher/lower Global Assessment of Functioning (GAF) scores. This difference may be explained more as a function of the unreliability of unstructured and non-standardized clinical ratings, such as the GAF, than of genuine difference. Surprisingly, there was not a significant difference in findings of competency or incompetency depending on whether defendants were diagnosed with a psychotic disorder or the number of prior hospitalizations, which would ordinarily indicate symptom chronicity (and poorer restoration prognosis). There were significant differences depending on whether defendants had violated their pretrial conditional release for court-mandated out-

Table 1 Attributes of State Hospital, Jail and Outpatient Restoration Programs

Treatment Setting	State Hospitals*	Jails†	Outpatient‡
Costs	$300–$1,000 per day	$42–$222 per day	$100–$500 per day
Rates of restoration	80–90%	55–86%	54–70%
Mean LOSR (per research)	73 days	57.4 days, usually followed by transfer to state hospitals	149–207 days
Patients served	High % of defendants with psychotic disorders	Moderate % of defendants with psychotic disorders	Moderate to low % of defendants with psychotic disorders
Crime type/risk	Moderate to high level of dangerousness	Moderate to high level of dangerousness	Moderate to low level of dangerousness
Medication considerations	High % of adherence, largely due to greater resources to administer involuntary medications	Limited resources for involuntary medication administration	High % of adherence, largely based on screening
Malingering considerations	May teach defendants how to malinger more convincingly	Theoretically ideal for malingerers	Setting less likely to affect malingering either way

* Data on hospital-based restoration obtained from References 2, 3, 5, 8, 13, 16, 19, 23, 29.
† Data on jail-based restoration obtained from References 1, 16, 17, 36, 37, 38.
‡ Data on outpatient-based restoration obtained from References 2, 8, 16, 17, 29, 39, 40.
LOSR = length of stay necessary to achieve restoration.

patient restoration, had significant behavioral incidents soon after starting outpatient restoration, had more total behavioral incidents, and were re-arrested or re-hospitalized during community-based restoration. Multivariate analyses incorporating a multitude of these demographic and clinical variables explained 26.5–35.4 percent of the total variance, thereby underscoring the need to consider and incorporate these and other similar variables in future studies.

Theorized Advantages and Disadvantages

Outpatient restoration is typically and understandably reserved for defendants facing less serious or nonviolent criminal charges.[17] Prime candidates for outpatient restoration tend to have less extensive criminal histories and better track records regarding medication adherence, effectively utilizing services to prevent full decompensation, and appearing in court as ordered. As reviewed previously, and in addition to cost savings, research is increasingly suggesting the possibility that greater numbers of incompetent defendants might be safely housed and restored in the community. Although research suggests that outpatient defendants are generally less impaired and yet restored somewhat less frequently (see Table 1), it is also reasonable to suspect that defendants accused of less serious crimes and who seem more amenable to treatment may be more likely than hospitalized defendants with more serious charges and criminal records to have charges dropped or resolved via diversionary sentences.

Of additional consideration, defendants deemed incompetent to stand trial have been discussed in the literature as typically being of lower socioeconomic status. Therefore, they may have limited access to resources, including transportation. As a result, prior positions on the transportation benefits of outpatient restoration should be clarified to reflect the possible shifting of the burden from understaffed and overcrowded jails or hospitals to defendants who are often impoverished and living with severe mental illness. Additional oversight and supports may be needed to effectively manage individuals in the community and maximize restoration efficacy, particularly in cases of psychotic, cognitively limited, or brain-injured defendants who often do not have family members or friends available to help them navigate and coordinate public transportation. Also, defendants in outpatient restoration are often homeless and without phones. Thus, scheduling sessions and follow-up visits is more difficult than when defendants are confined in jails or hospitals.

Expanding Outpatient Services as a Balanced Alternative

Pressure for cost saving and less restrictive levels of care may be balanced via expanded usage of outpatient restoration services. This would require tolerance of at least a marginally higher level of risk for at least some defendants in criminal proceedings. Outpatient restoration would be a reasonable first step for defendants accused of nonviolent or lesser forms of violent crime (such as simple assault not resulting in major injury), without significant histories of serious violent crime, and not clearly meeting criteria for civil commitment.

To this end, supportive housing placements with a restoration component, case-management services, and assigned mental health probation officers with authority to return non-compliant defendants to jail settings may be advantageous. The latter strategy, however, may raise ethics questions about outpatient restoration effectively serving as a kind of probation without adjudication (i.e., sentencing prior to trial and conviction), especially if these arrangements became dispositional in terms of a focus on longer-term services enforced by court order. However, granting defendants the opportunity to remain in the community and out of institutions, even via involuntary measures, may optimally balance individual freedom and public safety concerns. Diversional options, with additional and purely voluntary services, would show even more respect for a defendant's self-determination.

Table 1 presents data from multiple studies of hospitals, jails, and outpatient settings. Data are presented on cost per day, restoration or non-restorability, diagnosis, crime type/dangerousness, medications, and malingering considerations. Within Table 1, quantitative research findings and qualitative perspectives are synthesized in an attempt to present the sum total of available research and to compensate for many studies not reporting quantifiable data in each category.

Conclusions

A review of the extant competency and restoration research suggests a future course of study and even the major variables within its design. Within the literature, there is growing interest in the potentially differential benefits of attempting restoration in hospitals, jails, and outpatient settings (i.e., the independent variable) for defendants of varying diagnostic categories, levels of cognitive functioning, and crime types (i.e., mediators or moderators), with rates of restoration and non-restorability as primary indicators of outcome (i.e., the dependent variables). Empirical research on this topic could address gaps in previously reviewed studies, including those studies not reporting all of the major competency and restoration variables even as descriptors, let alone controlling for potentially significant interaction effects.

From this review, as summarized in Table 1, implications for practice can be formulated. It appears that hospital beds used for competency restoration might be best reserved for defendants facing serious and violent charges, with psychotic disorders, cognitive impairment, medication non-adherence, and lesser concern about malingering. Defendants whose competency may be more tied to suspected malingering may be best served in jail. Under this system, it is expected that primary barriers to restoration for genuinely psychotic defendants would usually be psychiatric in nature and would flow into other secondary barriers related to behavioral disturbance, lack of rational understanding, and possibly deficits in factual-legal knowledge. Jail-based competency may be optimal for defendants who may have mental health issues, though primary barriers to competency are volitional-behavioral in nature. More specifically, if defendants are suspected of malingering, refuse to participate in hospital-based services, or show that volitional, antisocial, or aggressive behavior is clearly the major impediment to restoration, jail may be more appropriate and, in some cases, incentivizing.

Outpatient placements may be ideal for defendants charged with nonviolent crimes or possibly with lesser violent crimes (i.e., simple assault not causing significant injury and with less apparent likelihood of victim tampering or retaliation), who do not meet criteria for civil commitment, who do not have as significant a history of substance use, who are at least marginally more likely to be medication adherent, who show up to court as ordered, and who do not have as great a need for hospital-based services. Confirming these hypotheses through the previously proposed research may affirm clinical sensibility and improve placement decisions. As a result, defendants may be afforded the least restrictive level of care relative to restoration and public safety concerns, their constitutional rights may be maximally respected, and scarce public resources may be used as efficiently as possible.

Moreover, the prior review of research suggests that erring on the side of more restrictive (and therefore more expensive) placements in hospitals when mental health need and dangerousness are at least somewhat in question may become less acceptable over time. Expanded availability of jail-based and outpatient restoration would permit judicial systems, potentially upon the recommendation of competency evaluators, to consider a wider range of less restrictive options that may in turn be appropriate and effective in more cases than ordinarily assumed. Further establishing the need for the expansion of options, there are growing public and political de-

mands for cost-saving and less restrictive care, and for dangerous offenders to be more closely supervised, controlled, and swiftly returned to court to face their charges. This places the criminal justice and forensic mental health systems in a challenging conundrum. Empirical research for the furtherance of these hypotheses would be an important first step and a useful guide to better address these challenges in policy and practice.

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Psychology, Public Policy, and Law

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Online First Publication, August 22, 2019. http://dx.doi.org/10.1037/law0000210

American Psychological Association

Psychology, Public Policy, and Law

ISSN: 1076-8971

http://dx.doi.org/10.1037/law0000210

Treatment for Restoration of Competence to Stand Trial: Critical Analysis and Policy Recommendations

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The capacity of a criminal defendant to stand trial in the United States has been addressed in a sizable legal and scientific literature over a period of nearly 6 decades since the U.S. Supreme Court's landmark decision in *Dusky v. United States* (1960). Much less attention has been devoted to the topic of the restoration to competency of defendants who have been adjudicated incompetent to stand trial, however. This article reviews the relevant law, the current status of litigation in a number of states regarding restoration, and the scientific and clinical evidence on the restoration of individuals in 4 populations: adults with severe mental illness, adults with intellectual disability, adults with cognitive deficits, and juveniles. Current law and scientific evidence are considered in a critical analysis yielding recommendations for policy. This analysis is particularly timely considering the major problems currently being experienced (and sometimes litigated) in the United States involving lengthy waiting periods for hospital-based restoration services.

Keywords: competence to stand trial, restoration, treatment, policy, practice

There are important implications to the question of whether a criminal defendant is competent to stand trial. In the United States, the legal definition provided by the U.S. Supreme Court regarding whether an individual charged with a criminal offense is competent to stand trial (CST) is "whether he has sufficient ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him" (*Dusky v. United States*, 1960, p. 402). Since *Dusky* and its progeny (see, e.g., *Pate v. Robinson,* 1966; *Drope v. Missouri,* 1975), it has been established that it is unconstitutional for the government to conduct most criminal proceedings against a defendant who is not CST.

Accordingly, the construct of CST is an important consideration in criminal proceedings. It is particularly important when behavioral health problems potentially interfere with a defendant's capacities to assist counsel and understand the proceedings. Such individuals must be afforded swift access to competency restoration treatment so they can proceed to disposition of charges. Within the last decade, however, there has been a growing problem with the timely delivery of restoration services for defendants adjudicated incompetent to stand trial (IST). In some jurisdictions, IST defendants who are committed to state hospitals for competency restoration treatment are not admitted within a reasonable period. This results in significant waiting lists for hospitalization within this group. This can be particularly problematic if they are incarcerated in jail prior to hospital admission. A primary goal of this review is to provide guidance for present policy and practice

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The authors do not report any conflicts. The ideas expressed in this article do not represent an official position of the Philadelphia Department of Behavioral Health and Intellectual disAbility Services. An earlier version of some of these ideas was presented in Christy Giallella (Chair; 2019, March). *Addressing forensic waitlists in policy and practice.* Symposium presented at the Annual Conference of the American Psychology-Law Society/APA Division 41, Portland, Oregon.

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considering the empirical data that are available in this area. This will involve three steps. First, we review the current legal context and data broadly relevant to CST restoration. Second, we consider the empirical evidence for the effectiveness of CST restoration for different populations and in different settings. Third, we integrate these two domains through a critical analysis that yields recommendations for policy and practice, illustrated by individual- and system-level decision trees.

Competence to Stand Trial Restoration

This section reviews the current legal context involving legal action affecting a number of states involving the timely delivery of CST restoration services. It then provides a review of various intervention approaches and relevant data, setting the stage for a more specific review of empirical evidence on CST restoration interventions provided in the following section.

Legal Context

Class action lawsuits in the United States contending that IST criminal defendants were subjected to unconstitutional delays in competency restoration treatment have now been brought in a number of states, including Arkansas, California, Colorado, Georgia, Florida, Louisiana, Nevada, Oregon, Pennsylvania, Texas, Utah, and Washington (Shannon, 2017). Typically, these suits have resulted in outcomes requiring states to provide competency restoration treatment—usually by admitting the IST defendant to a state hospital within a specific period of time ranging from 7 to 30 days after the finding of incompetency (Locklair, 2016). Plaintiffs in some of these states have initiated further proceedings, claiming that the states have not complied with the terms of the original decisions and agreements.

Waitlists for IST restoration dispositions, accordingly, are now a widespread problem throughout the United States. One self-report survey of state psychiatric hospitals described numerous challenges to timely CST evaluation and delivery of IST restoration (Wik, Hollen, & Fisher, 2017). Specifically, 20 states reported having a waitlist for inpatient competency evaluations. Average time spent on the waitlist ranged from 7 to 252 days, with the majority of states endorsing a wait time between 21 and 79 days. Furthermore, across 26 states surveyed, a 72% increase in the number of defendants adjudicated IST was observed between 1999 and 2014; average wait times for transfer to treatment ranged between fewer than 7 days (endorsed by two states) and up to 1 year (endorsed by two states), with the majority of states endorsing an average wait time of 29 to 90 days (Wik et al., 2017). At the higher end of these average waiting times, the time spent "waiting for treatment" may actually exceed the duration of treatment itself. According to a recent meta-analysis that included 51 independent competency restoration samples published over a 38-year period (1975–2013), including 12,781 defendants, the average length of stay for CST restoration ranged from 42.7 to 1,108 days, with a median of 146.9 days (Pirelli & Zapf, 2015).

Delays in providing restoration services have resulted in states facing backlash, including litigation and contempt citations. In Pennsylvania, the American Civil Liberties Union (ACLU), in association with a Washington, DC-based law firm, filed a lawsuit alleging various violations of due process related to lack of access to restoration services, resulting in a settlement with the Commonwealth in early 2016 to reduce the jail waitlist. Despite this settlement, the restoration waitlist actually rose from 215 defendants (in January 2017) to 251 defendants (in July 2017). Furthermore, for these defendants, time spent on the waitlist varied significantly, ranging from 2 days to 429 days and averaging 138 days across sites (Steadman & Callahan, 2017).

Similarly, the ACLU and Disability Rights Washington brought a class-action lawsuit against the State of Washington alleging violation of a state law requiring that defendants begin treatment within 7 days of being adjudicated IST. The deadline to conduct a competency evaluation following a court order was extended to 14 days upon appeal, with a "performance target" of 7 days (Behavioral Health Administration, 2017, p. 4). Up to 87% of those awaiting treatment for restoration had been on waitlists for longer than 7 days (Bellisle, 2015). Time spent on restoration waitlists at various state hospitals throughout Washington had waits ranging from an average of 0.3 to 11.83 days for transfer to a hospital and from 3 to 107 days for the provision of restoration services (Behavioral Health & Service Integration Administration, 2014).[1]

California has also experienced difficulty with restoration waiting periods, with a monthly waitlist of between 200 and 300 defendants who have been adjudicated IST. In the course of litigation stemming from delays in providing restoration services, the Second District Court of Appeal (in *Freddy Mille v. Los Angeles County,* 2010) held that transfer from jail to a hospital following IST adjudication must occur within a "reasonable amount of time," which has since been interpreted by California state courts as a recommended maximum of 30 to 35 days (Francis, 2012). From 2009 until 2010, the average wait for defendants to be transferred to a hospital for evaluation was 68 days, with a range of 33 to 87 days; approximately 73% of those adjudicated IST waited longer than 35 days to be transferred into treatment (Francis, 2012). Other states have faced litigation and court sanctions as well due to delays in the initiation of restoration treatment. There has been increasing attention to these delays across the country as a result.

There may be various influences exacerbating this problem. An increased number of adjudications as IST, an insufficient number of available hospital beds and/or staff to provide restoration services at previous levels, and the use of competence to stand trial to obtain behavioral health services and/or housing that may not be available to defendants at earlier stages of the standard process of arrest and prosecution—all may have some part in contributing to the present problem. In part because it implicates constitutional rights, the issue of trial competence can be raised at any time by either party or the court, with a relatively low threshold for making a good faith motion, and such motions are rarely refused by the court (American Bar Association [ABA], 2016; Melton et al., 2018). This constitutional requirement and low threshold may contribute to the present situation in the United States regarding the large number of defendants who are IST and in need of restoration.

[1] These data suggest that there was a gap between the time individuals were admitted to a hospital and the time they began receiving services. This seems odd, but we cannot provide an alternative explanation.

Possible influences contributing to such delays and waitlists have recently been discussed in greater detail (see Gowensmith, 2019). Whatever the causes of this problem, it should be clear that there is now a premium placed on the timely delivery of restoration services. The present analysis focuses on individuals who have been adjudicated IST and are awaiting the delivery of restoration services—but not on cohorts who are awaiting (a) evaluations following the raising of CST, (b) return from a treatment program following a clinical recommendation that competence has been regained, (c) a hearing on unrestorability per *Jackson v. Indiana* (1972), or (d) placement following adjudication of such unrestorability. (Although we do not review these cohorts in the present article, they undoubtedly contribute to the larger problem of waitlists for forensic beds.) Toward that end, we review the theoretical and empirical evidence regarding services used in restoring defendants' competence to stand trial in four categories: medication, psychoeducation, cognitive remediation, and specialized combinations of services. We consider such evidence as it applies to adults with severe mental illness, adults with developmental disabilities, and juveniles. Three contexts are reviewed involving the delivery of services: forensic and civil state hospitals, jails, and outpatient programs based in the community.

Approaches to CST Restoration

The literature addressing defendants' CST has broadened considerably during the last two decades. One influence has been the growth of problem-solving courts to address defendants with mental illness (e.g., DeMatteo, Heilbrun, Thornewill, & Arnold, in press), with the assumption that a defendant with significant behavioral health problems rendering him or her IST might be placed under the jurisdiction of a "competency court," a specialized unit within a larger mental health court. One such proposal (Finkle, Kurth, Cadle, & Mullan, 2009) has suggested that the same judges, attorneys, and mental health professionals provide services in both courts. This could allow them to use their expertise in competency law and procedures, as well as their experience working with defendants with mental illness and providers of mental health services, to improve the efficiency of the process and reduce the unnecessary time that IST defendants spend in jail.

There has been comparable enthusiasm for community-based outpatient services for IST defendants who are selected for such services, often on the basis of appropriateness for remaining in the community during the restoration process. Earlier recommendations for establishing and operating such programs (e.g., Miller, 2003) have been supplemented by a more detailed recent review of state statutes combined with interviews of those operating outpatient competence restoration programs (OCRPs; Gowensmith, Frost, Speelman, & Therson, 2016). This review led Gowensmith and colleagues to describe OCRPs as a recent but rapidly developing alternative to traditional inpatient restoration, showing promising preliminary outcomes: high restoration rates, low program failure rates, and substantial cost savings.

There has also been growing interest in delivering competence restoration services in jails. Although the implementation of jail-based restoration services is sufficiently recent so that no large-scale effectiveness data are available (Kapoor, 2011), there are several relevant considerations. Most defendants adjudicated IST and awaiting transfer to a secure hospital for restoration are already in jail. It is well-established that jails and other correctional facilities have substantial legal and policy obligations to provide physical and behavioral health care to the individuals in their custody, including treatment to control active symptoms of severe mental illness and to prevent suicide and self-harm (Cohen & Dvoskin, 1992).

But within this general obligation, there appears to be fairly wide variation across states and counties. Some jails are required under relevant law or policy to transfer IST inmates to state hospitals for treatment, whereas others can administer involuntary psychotropic medication to address urgent mental health needs among inmates who refuse treatment (Torrey et al., 2014). On a national level, the Civil Rights of Institutionalized Persons Act (CRIPA; 1980) was created to protect the rights of institutionalized populations, including individuals with mental illness who are housed in jails. The absence of adequate mental health care provided in correctional settings has been cited as a potential violation of CRIPA (Morehart, 2014). Some IST defendants waiting in jails appear to be restored after receiving basic services such as specialized housing and psychotropic medication. This has been observed in Philadelphia, for example, where 53% of defendants who were removed from a competence restoration waitlist during a 10-month period appeared to have been restored without hospitalization (Steadman & Callahan, 2017). In some of these cases, the duration of time spent on the waitlist may have allowed other forms of intervention (e.g., medication) to promote such restoration. Indeed, high rates of restoration observed elsewhere are consistent with this possibility, including the noted restoration rate of 81% across 19 nonmatched samples, representing 2,616 out of 3,214 defendants who engaged in restoration procedures (Pirelli & Zapf, 2015).

Although the implementation of jail-based restoration services is recent, research suggests that this approach may hold promise for competence restoration. Jail-based restoration may include intensive, individualized programs using a multidisciplinary framework and vary with regard to how these services are provided (e.g., separate housing units for inmates adjudicated IST; Wik, 2018b). One model, restoration of competency (ROC), has been implemented in various states since its development in the late 1990s. A 5-year evaluation of 1,400 inmates treated in a jail in Virginia documented a restoration rate of 83%, with a mean of 77 days required to restore competence (Jennings & Bell, 2012). An ROC program implemented in California showed restoration rates between 55% and 58% over a mean duration of 57.4 days, compared to 180 days in California state hospitals (Carabello, 2013; Rice & Jennings, 2014).

Additional jail-based restoration programs have emerged throughout the country. In Arizona, an 84% restoration rate, with a mean treatment time of 82.5 days, was observed in one jail-based program in Pima County between 2007 and 2011, and an 86.7% restoration rate, with a mean treatment duration of 4 months, was observed among 187 defendants admitted to another Arizona-based program between 2011 and 2014 (Morenz & Busch, 2011; Stewart, 2015). In Colorado, an evaluation of a jail-based restoration program revealed that 71% of 106 patients treated were restored between 2013 and 2015, with the majority restored within a 2 to 3-month treatment period (Colorado Department of Human Services, 2015). In Georgia, jail-based restoration rates differed as a function of the setting in which inmates were housed, with 34%

of male inmates housed in an IST-specific unit restored and 9% of male and female inmates housed in the general population restored; the mean duration of treatment was 4 months regardless of housing setting (Georgia Department of Behavioral Health and Developmental Disabilities, 2014). Finally, in Louisiana, fewer than 33% of defendants adjudicated IST were restored in a jail-based setting within a 90-day treatment period (Wik, 2018b). In recent years, jail-based competency restoration programs have been developed in Arkansas, New York, Utah, and Texas, but at present no outcome data exists for these sites (Wik, 2018b).

In addition, the adaptation of specific kinds of services such as cognitive remediation may have promise for the restoration of defendants whose incompetence is primarily due to cognitive deficits. This may be most appropriate for individuals who are intellectually disabled (e.g., Wall, Krupp, & Guilmette, 2003), or those with severe mental illness or neurocognitive impairment accompanied by significant difficulties in understanding and processing information. Such remediation may be valuable when provided to a population with co-occurring clinical problems, including intellectual and developmental disabilities, traumatic brain injury, dementia and related disorders, and substance abuse (including active detoxification and substance-induced psychosis). There may be limits to how well such "cognitive enhancement" approaches apply, however, when the limitations result from developmental immaturity or intellectual disability (ID) in adolescents (Viljoen & Grisso, 2007).

Given this expanded perspective on restoration services to IST individuals, varying across age, behavioral health symptoms, and setting, it is important that a current review and analysis be comparably broad. We first consider the relevant empirical evidence generally, after which we move more specifically to relevant groups, clinical conditions, and settings in the next section.

In all states, the majority of the treatment for restoring defendants' CST was provided in 2014 through admission to state hospitals, with Arkansas (treating the majority of IST defendants in the community) the only exception (Fitch, 2014). Arkansas developed a Forensic Outpatient Restoration Program that provides competency restoration services during a 6-month period either in jail or in a community mental health center for those who posted bond (Arkansas Department of Human Services, 2017). As of 2017, 40% received services in the community after posting bond (Arkansas Department of Human Services, 2017). Those who were not restored in a 6-month period through Forensic Outpatient Restoration Program were then transferred to a state hospital for additional treatment (Arkansas Department of Human Services, 2017).

The larger tendency toward hospital-based restoration may be changing somewhat. One study identified six states that appear to have shifted in the direction of providing community-based IST restoration, with the remainder maintaining their historical trend of providing primarily hospital-based restoration services (Wik et al., 2017). It has been estimated that about 75% of IST defendants who are treated in hospital settings for restoration appear to have regained relevant capacities and thus are returned to court within 6 months (Zapf & Roesch, 2011). A meta-analysis describing the characteristics of those adjudicated IST (Pirelli, Zapf, Gottdiener, & 2011) concluded that the variables most strongly distinguishing IST defendants from those not adjudicated IST were the presence of a psychotic disorder (67% vs. 22%), unemployment, and a history of psychiatric hospitalization.

A second meta-analysis, this one addressing the restoration of IST defendants, was also conducted (Pirelli & Zapf, 2015). Incorporating the literature in this area between 1975 and 2013, the investigators reported that most of their included studies used correlational designs involving either a single restoration group or a comparison to another group that was unquestionably CST, with only five studies comparing restored versus nonrestored defendants. Specialized measures of CST capacities were used in fewer than one third of the studies, and other psychological tests in fewer than one fourth. This meant that it was often impossible to obtain meaningful quantitative data. They concluded that the available evidence did not enhance our knowledge regarding the mechanisms associated with IST restoration, nor empirically inform our awareness of which interventions are more effective.

In light of the empirical status of CST restoration highlighted by this meta-analysis, some (e.g., Gowensmith et al., 2016) have suggested that the limited available research on IST restoration means that the field cannot yet establish empirically supported "best practices" in this area. Although this is undoubtedly accurate, we would offer an even more fundamental criticism of the research to date: it has not consistently been theoretically sound, legally relevant, and operationalized using reliable measures. For any number of reasons, it is difficult to use true experimental designs in a criminal justice context. But the research to date has rarely reflected even the incorporation of widely used compromises in research design, such as comparing a well-developed, theoretically sound, legally relevant programmatic intervention with a "treatment as usual" comparison group. It is unlikely that the empirically informed aspect of competence restoration will improve substantially as long as these fundamental questions of relevance and measurement are unresolved. Having reviewed the existing system-level data on CST restoration, we now consider the available empirical data on restoration of CST in different populations and settings.

Competence to Stand Trial Restoration: Treatment Effectiveness

This section provides a review of evidence on the nature and effectiveness of various interventions delivered with the goal of competence restoration. It includes four populations: adults with severe mental illness, adults with ID, adults with cognitive deficits, and juveniles.

The primary types of treatment protocols for competence restoration include medication, psychoeducational treatment, specialized/individualized treatment programs, treatment for individuals with developmental disabilities, and, more recently, cognitive remediation programs (Zapf, 2013). Within these broad approaches, interventions vary significantly—often with little relevant empirical research on effectiveness available for support.

Adults With Severe Mental Illness

We first consider adults with severe mental illness. Relevant interventions for this population include psychotropic medication, educational treatment, and specialized/individual treatment programs.

Psychotropic medication. Medication is the most common form of treatment for individuals with severe mental illness. In the context of CST restoration, it may be accompanied by individual or group therapy targeting competence-related deficits and may also be combined with psychoeducation or cognitive remediation. It is challenging to gauge the impact of any of these interventions separately, as research designs rarely isolate them. Accordingly, any measure of the impact of separate interventions is most likely to be determined through statistical techniques such as covariate analysis. Research has strongly supported the effectiveness of antipsychotic medication in restoring the CST of individuals with severe mental illness who decline medication and have it administered under the terms of *Sell v. United States* (2003), with restoration observed for 79% of the 132 defendants in the federal system treated under *Sell* over a 6-year period (Cochrane, Herbel, Reardon, & Lloyd, 2013). Across this sample of defendants, the use of first-generation antipsychotics was associated with higher rates of restoration (84.4%) relative to the use of second-generation antipsychotics (73.5%), although this difference was not statistically significant and the effect size was small. In addition, involuntary treatment with antipsychotic medication demonstrated high rates of treatment responsiveness across diagnoses, including delusional, cognitive, substance use, and psychotic disorders (Cochrane et al., 2013). This rate of restoration is comparable to that seen for IST individuals with delusional disorder who are treated with antipsychotic medication, with 77% reportedly restored in one study (Herbel & Stelmach, 2007) and 74% (contrasted with 26% who did not receive antipsychotic medication) in another (Kassen, 2016).

Unsurprisingly, there is apparently no empirical evidence on whether the clinical-legal deficits of individuals with active symptoms of severe mental illness respond favorably to approaches that do *not* include psychotropic medication. The use of such medication to treat individuals with these symptoms is so widely accepted within the mental health field that it approaches foundational: absent justification for not administering psychotropic medication, the use of such medications with individuals who are IST should be seen as an essential component of the restoration process.[2] How skillfully such medication is managed by the prescribing physician will, accordingly, affect many of the symptoms that are directly related to competence-relevant clinical-legal deficits and impact the overall effectiveness of competence restoration efforts. Although the impact of physician skillfulness on restoration outcomes has not been directly evaluated, recommendations have been set forth regarding clinical competencies that support effective psychotropic treatment and promote agency among patients with serious mental illness (Young, Forquer, Tran, Starzynski, & Shatkin, 2000). Furthermore, the effectiveness of medication-based competency restoration efforts can be bolstered by efforts to promote medication adherence (e.g., contingency management programs; Danzer, Wheeler, Alexander, & Wasser, 2019).

Educational treatment programs. Educational programs vary in specific content depending on the program, but often include components such as competence education training and participation in a mock trial. Research conducted between 1980 and 1992 found restoration rates between 43% (vs. 15% among controls; Siegel & Elwork, 1990) and 90% (with an average length of stay of 104 days; Pendleton, 1980). Siegel and Elwork used an experimental design to compare group-based treatment focusing on specific functional-legal deficits with "treatment as usual" group therapy focusing on general psychiatric needs; both interventions were provided to patients as supplements to their baseline forms of treatment (e.g., medication, art therapy) in the facility. The experimental condition included (a) a videotape and courtroom model designed to instruct patients on courtroom procedures and (b) a structured, problem-solving orientation during group discussions that focused on IST and followed a learn-discuss-integrate model. The 21 participants in the experimental condition were significantly more likely to be recommended as CST (43%) than were the 20 in the treatment as usual group (15%), $\chi^2(1, N = 41) = 3.84$, $p < .05$, $\varphi = 0.31$ (medium; Siegel & Elwork, 1990).

A descriptive study (Noffsinger, 2001) has provided some information on one competence restoration program in Ohio, involving about 15 contact hours weekly in 7 modules: educational, anxiety reduction, guest lecture (from court personnel), mock trial, video, postrestoration, and legal current events. Restoration rates ranged from 81.5% for those charged with misdemeanors, to 85.7% for those having major felony charges, to 90.9% for defendants with lesser felony charges (Noffsinger, 2001). Because the article is entirely descriptive and does not even cite the number of participants, it is not possible to determine whether these differences are statistically significant or calculate the effect size. We refrain from offering possible explanations for such differences, therefore, as they might not be meaningful. According to the Ohio Revised Code in effect in 2001, the maximum duration permitted for restoration efforts differed as a function of the type of crime. Therefore, the differential restoration rates observed may reflect a 60-day maximum for misdemeanors as compared to a 6-month maximum for lesser felonies and a 1-year maximum for major felonies.

Except for the Siegel and Elwork (1990) study, however, there is virtually no research that compares "treatment as usual" (e.g., psychotropic medication plus case management and group therapy) versus specialized treatment (e.g., psychotropic medication plus case management plus rehabilitation directly targeting functional-legal deficits). Simply put, we know little about whether enhanced treatment cost or intensity leads to higher restoration rates. However, when designing a program, it is possible to prioritize certain educational and therapeutic interventions that are "treatment as usual" (typically provided to patients but not designed specifically for CST restoration) when they focus on areas such as communication, reasoning, and decision-making. These are functional-legal capacities that are theoretically and legally relevant to attaining CST (Melton et al., 2018).

Specialized/individualized treatment programs. Two sets of researchers have developed and evaluated novel restoration protocols. Results were modestly encouraging for the first, but less so for the second.

[2] This does raise several important questions. What is the likelihood of restoration without the provision of psychotropic medication to those who need it? Is such medication "necessary but not sufficient," or could it stand alone? In this article, we particularly note when there is empirical evidence relevant to the second question. It is not likely that there will be such empirical evidence relevant to the first, however, because of the widely accepted role of medication in the treatment of individuals with actively psychotic symptoms.

Deficit-focused remediation. Bertman and colleagues (2003) reported that a deficit-focused remediation group—that emphasized the defendant's charges and associated consequences, as well as the defendant's competence-related deficits as evidenced by the Georgia Court Competency Test-Mississippi State Hospital and *Bennett* criteria—and a legal rights education group performed better than treatment as usual for competence restoration, with approximately 50% greater improvement on posttreatment competence measures. However, no significant differences emerged between the deficit-focused remediation, which was developed by the researchers and individualized to target unique deficits, and the legal rights education group, which provided individual sessions in legal rights education (in addition to group-based legal rights education, which was provided to all three groups; Bertman et al., 2003).

Fitness Game. An examination of the Fitness Game (a board game used to teach individuals about the legal system according to eight criteria of competence suggested by *Wieter v. Settle*, 1961) as compared to a control condition (receiving a "Healthy Behaviors" board game or receiving "non-legal programming") was implemented (Mueller & Wylie, 2007). It included a total of 28 participants who completed either the experimental intervention (Fitness Game; $n = 21$) or control intervention (Healthy Behaviors Game, a board game that covered content including symptom management, medication management, conversation skills, recreational activities, and substance abuse issues; $n = 17$) at Hawaii State Hospital. Both groups were held for approximately 1 hr 3–4 times per week for 4–6 weeks. Participants in both groups were able to receive treatment as usual restoration services from the hospital, including psychopharmacological interventions; weekly sessions with social workers; recreational, occupational, or milieu therapy; or other psychosocial rehabilitation programming. Results indicated that both groups had significant pretest to posttest improvements on the Understanding, $F(1, 26) = 15.48$, $p = .001$, $\eta^2 = 0.37$ (large), and Appreciation, $F(1, 26) = 10.24$, $p = .004$, $\eta^2 = 0.28$ (large), subtests of the MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA). However, there was no statistically significant difference between groups on competency measures (Understanding, $p = .84$, $\eta^2 = 0.002$ [very small]; Reasoning, $p = .77$, $\eta^2 = 0.003$ [very small]; Appreciation, $p = .73$, $\eta^2 = 0.005$ [very small]), suggesting that the Fitness Game was not significantly more effective at restoring recommended competency than nonlegal programming (Mueller & Wylie, 2007).

Individuals With IDs

Intellectual functioning has been found to be significantly related to determinations of IST (e.g., Bonnie, 1992; Burnett, Noblin, & Prosser, 2004; Colwell & Gianesini, 2011), but there has been limited research focusing on the restoration of developmentally disabled persons who are IST. In one study (Grabowski, 2017), the investigator considered defendants' characteristics (demographic information, prior criminal justice involvement, psychiatric history, intellectual functioning, and comorbid mental disorder diagnosis) and their association with competency restoration outcomes and length of hospitalization for restoration. Although demographic factors were unrelated to competency restoration outcomes, the investigator did identify a measured-IQ cutoff (FSIQ = 63.5), above which it was more likely that an IST defendant would be restored to competency (Grabowski, 2017).

In a second study with individuals with ID, investigators (Anderson & Hewitt, 2002) reported that among a population of defendants in Missouri with ID, there were significantly fewer individuals restored than not restored. Treatment setting served as an additional variable, with 18% of those detained in a habilitation facility (tailored to the needs of those with ID) restored as compared to 50% of those in a psychiatric hospital. It may be noteworthy that the hospital setting afforded greater access to psychotropic medication, as 78% of those treated in a hospital setting met criteria for schizophrenia or substance use disorder as compared to 18% of those treated in the habilitation center (Anderson & Hewitt, 2002).

The Slater Method, a training program developed in Rhode Island for use with defendants with ID in a state hospital setting, consists of five modules covering the following: a review of the charges, pleas, and potential consequences; courtroom personnel; courtroom proceedings, trial, and plea bargain; communicating with the attorney, providing testimony, and assisting the defense; and tolerating stress associated with proceedings. The Slater Method was developed to be administered in either an inpatient or community-based setting, with flexibility in frequency of delivery; sessions may last from a "few minutes to an hour" and occur anywhere between 1 to 5 days per week (Wall et al., 2003, p. 197). Of note, each module is presented to the defendant on at least three separate occasions to facilitate retention. A review of the use of the Slater Method between 1997 and 2003 revealed a restoration rate of approximately 33% (Wall et al., 2003). A later study of the Slater Method, used for competence restoration between 2001 and 2006, found that significantly more defendants with ID who were exposed to the Slater Method attained recommended restoration (61.1%) than did those who received treatment as usual (16.7%; Wall & Christopher, 2012). This does suggest some promise to using the Slater Method with an ID population.

Individuals With Cognitive Deficits

Cognitive remediation has gained attention as a potential approach to competence restoration resulting from improvements in cognitive functioning. Cognitive remediation consists of behavior-based training to improve cognitive functioning among individuals with average-range premorbid intelligence who have demonstrated a decline in neuropsychological functioning. Training may consist of exercises (specific drills/exercises using computerized software, paper tasks, and group activities) to address attention, memory, and problem-solving. Cognitive remediation emphasizes cognitive abilities and the process, rather than content, of thoughts (Schwalbe & Medalia, 2007). An unpublished dissertation revealed that cognitive remediation, when compared to treatment as usual, resulted in significant improvement in Reasoning ability (measured by the MacCAT-CA), but not in Understanding or Appreciation abilities (Wilson, 2015). This randomized controlled trial involved 33 male patients from an inpatient forensic hospital, including those who (a) had been adjudicated incompetent to stand trial, (b) were awaiting an inpatient evaluation of competence to stand trial, or (c) had been adjudicated not guilty by reason of insanity. The study compared a control group receiving standard hospital treatment to an experimental group receiving a supple-

ment of 5 weeks of cognitive remediation using the Neuropsychological Educational Approach to Cognitive Remediation model. Cognitive remediation consisted of 1-hr individual sessions twice weekly and another 1 hr of group sessions per week. The investigator compared pre- and posttreatment data for changes in verbal memory, problem-solving, and CST capacities as measured by the MacCAT-CA. Results indicated that cognitive remediation significantly improved the Reasoning ability measured by the MacCAT-CA as compared to treatment as usual, $U = 76$, $z = -2.196$, $p = .028$, $r = .38$ (medium). Changes on the two other factors (Understanding, $p = .43$, $r = .14$ [small]; Appreciation, $p = .73$, $r = .06$ [small]), however, were not significant. Patients who benefitted most from cognitive remediation were those exhibiting greater need for treatment, including patients with lower scores on a baseline measure of CST, with greater severity of mental illness, and who were diagnosed with schizophrenia or another psychotic disorder. Successfully treated participants tended to have more active symptoms of severe mental illness and show poor performance on a pretest measure of CST.

Treatment Settings

Treatment for competence restoration has traditionally been provided in secure psychiatric hospitals. As of 2016, 35 states primarily used inpatient services for this purpose (Wik et al., 2017). This means that a substantial minority of states have implemented competence restoration primarily or partially in outpatient and/or jail settings. However, few empirical studies have examined the effectiveness of such outpatient or jail-based approaches to competence restoration, and few treatment models have been described.

Hospital

Most IST restoration occurs in state hospitals (Pinals, 2005; Wik et al., 2017). Restoration practices appear to vary across states, but there are a few common practices that have been documented: use of psychotropic medication, legal education (e.g., information on charges, description of the trial process, consequences if convicted), specific programming for individuals with developmental disabilities, individualized treatment programming, and cognitive remediation (Zapf, 2013). Zapf reached several conclusions based on this review. First, psychotropic medication in forensic hospitals appears to provide CST restoration benefit. Legal education also seems to offer some benefit, although there is less information available on this point. More specific and highly individualized programming offers less benefit, however, and programs generally report higher restoration rates for IST defendants with mental illness, as contrasted with those with developmental disabilities.

One of the descriptive studies noted earlier (Noffsinger, 2001) offered several recommendations for competency restoration curricula that had been used in the Ohio hospital system. These psychoeducational modules—legal education, anxiety reduction strategies for court, guest lectures from court personnel (e.g., judge, attorney), mock trials, video viewing of actual trial footage, conversation with defendants who had been successfully restored about their experiences, and review of current events relevant to the legal system—may have had a favorable impact on restoration, as Noffsinger noted that their implementation was associated with a mean time-to-restoration of 80 days within this Ohio hospital. He added that restoration rates were high, with between 80% and 90% of defendants recommended as restored. The challenge, of course, is gauging how much each of these components contributed to the restoration outcome, and whether some combination of medication, inpatient structure, and less intensive psychoeducation might have yielded comparable success rates. Such questions cannot be answered without either methodological or statistical control of various contributing influences.

Some states have adopted/adapted curriculum developed by Florida State Hospital (the CompKit), although there appears to be little empirical research on outcomes using the CompKit (see Gowensmith et al., 2016). The CompKit includes curriculum for legal education, including information on the court; the defendant; the roles of the defense attorney, prosecutor, and jury; the plea process; witness testimony; the bailiff; the clerk; sentencing and possible outcomes; and appropriate courtroom behavior (Florida State Hospital, 2011). In addition to information modules, the CompKit requires that the participants complete quizzes after each module to demonstrate competence in that area.

In the Pirelli and Zapf meta-analysis (2015) that considered the effectiveness of competency restoration programs, it is noteworthy that most of the included studies were hospital-based programs; another two studies used a mixed inpatient/outpatient model, and one study used an outpatient model. Given the inconsistencies in available research across program practices, certain planned analyses could not be conducted. The authors concluded that there is relatively little information available regarding specific restoration practices, with "virtually no" published data identifying specific practices that result in successful restoration. They noted that the mean rate of competency restoration was 81%, with a median length of stay of 147 days (Pirelli & Zapf, 2015).

OCRPs

OCRPs apparently began in 1997 in Ohio, with Connecticut and Florida adopting similar models in 2001 and 2002, respectively (Gowensmith, Murrie, & Packer, 2017). Most states ($n = 36$) have statutory authority to provide outpatient competence restoration, but as of 2015 only 16 states were operating OCRPs (Gowensmith et al., 2017). There is substantial variability among OCRPs, with little empirical data regarding effectiveness. The majority of OCRPs are located in urban settings and serve groups that are comparable in a number of ways: demographically (primarily racial/ethnic minorities, 80% male, and young/middle-aged), criminally (approximately 50% misdemeanors and 50% nonviolent felonies), and clinically (psychiatrically stable; able to voluntarily adhere to medication; approximately 67% with psychiatric impairment and 33% with cognitive/developmental deficits; majority substance abusing; Gowensmith et al., 2017). Services offered typically include education regarding the judicial process, psychotherapy, group and family therapy, medication management, drug screenings, and psychological assessments/evaluations. A recovery model is emphasized, with minor transgressions and setbacks not punished, but hospitalization occurring in some cases.

There are differences across OCRPs in the level of involvement of state governmental mental health agencies and privately contracted providers. In addition, some programs use an outreach model, with services provided wherever the participants are lo-

cated (e.g., residential program, remote areas). Finally, different restoration curricula are used, with no presently available research on effectiveness that would inform curriculum selection (Gowensmith et al., 2017).

OCRP outcome data collected to date provide mixed results. Some have found that restoration rates are similar to, or lower than, inpatient rates (although lower OCRP restoration rates may reflect the higher rates of intellectually disabled defendants accessing OCRPs). Significant cost savings have been described; however, the measurement of outcomes such as rehospitalization and rearrest are unusual (Gowensmith et al., 2017). Across 13 OCRP programs with available outcome data, the rates of recommended restoration averaged 70%, with mean time to restoration of 149 days; all OCRP programs in this review were operating less expensively than inpatient restoration programs (Gowensmith et al., 2016).

Johnson and Candilis (2015) found an evaluator-recommended restoration rate of 32% (55 of 170 participants) over a 4-year period of one OCRP's operation, with 76% of those recommended as restored achieving this status within the first 45 days of their participation in the program. Other research has documented higher rates of recommended restoration among those participating in OCRP, however. In Texas, the rates across 11 OCRPs in 2013 ranged from 62% to 94%, with increases in restoration observed until about 21 weeks (Graziani, Guzman, Mahometa, & Shafer, 2015). In Louisiana, investigators reported an adjudicated restoration rate of 54% for defendants receiving outpatient restoration services from a single program consisting of intensive case management, treatment provided by forensic psychiatrists, attendance at group-based legal rights education sessions, 12-step meetings, home visits, ongoing monitoring of the home environment, and random drug testing (Mikolajewski, Manguno-Mire, Coffman, Deland, & Thompson, 2017).

The Denver, Colorado Forensic Institute for Research, Service, and Training (FIRST) has an OCRP providing participants with individual and group sessions led by doctoral students in the Denver Graduate School of Professional Psychology. The observed rate of recommended restoration was 18%, with a mean duration of 226 days, for the first 50 participants served (Musgrove, Gowensmith, Hyde, & Wallerstein, 2018). Of note, participants did not receive medication through the Denver FIRST program, and adherence to medication provided by other clinicians could only be assessed through participant self-report; therefore, the authors suggest that the 18% restoration rate may in part be accounted for by medication nonadherence, although this was not directly considered. A different OCRP model is used in Hawaii, with psychiatric, case management, and peer support services provided to individuals who are housed in a group home in the community during the restoration process. Using materials and procedures similar to those employed during inpatient restoration, this program was both cost-effective and highly efficient—reporting a restoration rate close to 95% (as cited in Wik, 2018a). The wide range of restoration rates among OCRPs in this section—as low as 18% and as high as 95%—raises important questions about the influences that might account for such discrepant results. Among the possibilities are differences in populations, medication practices, nature and intensity of nonmedical treatment, and operationalization of restoration outcome (e.g., evaluator-recommended, court-adjudicated). Research to date has not yielded answers, and it is important to avoid going beyond the data. But one intriguing possibility is that when services do not include medication monitoring, housing, and case management, particularly in the community, that results are less favorable.

A discussion of the advantages and disadvantages of OCRP (see Danzer et al., 2019) noted that because it is typically used with defendants facing less serious charges, with better records of using treatment services and appearing in court as ordered, there is less risk to public safety than would otherwise be the case. Further, such defendants may be more likely to have charges dropped or diverted from standard prosecution, providing more support for using OCRP with its associated cost savings. However, such defendants may also be challenged by poverty, housing instability, unemployment, and transportation difficulties—so the structure of a successful OCRP program must address these challenges. This observation is consistent with the suggestion at the end of the last paragraph: monitoring, housing, and case management are likely to be important. Finally, there is the possibility that expanded outpatient services could provide an alternative to criminal prosecution through diversion. This would mean that many OCRP services, if presented to those diverted from prosecution, might strengthen such diversion without increasing risk to public safety or enhancing costs through unnecessary criminal justice involvement.

Jail-Based Competence Restoration

Jail-based competence restoration has developed as a supplement to the use of state hospitals for restoration services. Most jail-based programs are intensive, individualized treatment programs, involving a multidisciplinary approach that consists of a forensic psychiatrist, psychologist, social worker, rehabilitation therapist, and nurse (Graziani et al., 2015). These services may be provided by state psychiatric hospital staff or independent contractors and often are provided in a jail unit developed solely for providing restoration services (Wik, 2018b). Lastly, these defendants may be housed either in distinct units dedicated for IST defendants or in the general population (Wik, 2018b).

The ROC model. The ROC approach (Jennings & Bell, 2012), developed by the for-profit organization Liberty Healthcare, uses a recovery model focused on individual strengths and targeting competence-related abilities (i.e., deficits and acute symptoms). Goals include (a) resolving psychosis, if present, to promote general thinking abilities; and (b) educating patients about the legal/court process to increase capacities to better understand the legal process, to make informed decisions relevant to one's defense, and to cooperate with counsel. Psychotropic medication, rehabilitative activities, and multimodal cognitive, social, and physical activities, with the assistance of a multidisciplinary team, are incorporated. Use of the ROC model of jail-based restoration developed in Virginia demonstrated a restoration rate of 83% (1,162 participants) over a 5-year period, with an average of 77 days to restore recommended competence (Jennings & Bell, 2012).

Another ROC program in California found a more modest recommended restoration rate (55%), with an average duration of 57 days to restoration (Rice & Jennings, 2014). This duration was shorter than the average period of hospitalization for inpatient restoration (180 days). The study presented a useful hierarchy of goals associated with this program: (a) resolve the psychosis, when

present, to enable the patient to regain general thinking abilities; (b) educate the individual about the legal/court process to promote meaningful cooperation with counsel in the defense process; and (c) if there is a failure to achieve either of the first two goals, compile documentation relevant to possible unrestorability. The ROC team described in this study combined the use of psychotropic medication, rehabilitative activities, and multimodal cognitive, social, and physical activities.

A jail-based ROC program in San Bernardino, California reported overall statistics regarding restoration rate and duration. This rate was described as 58%, with a mean duration of 56 days (Carabello, 2013). These jail-based ROC programs were associated with reduced costs compared, with the Virginia and California ROC programs costing $42 and $222 per day, respectively, as compared to hospital costs ranging from $401 to $834 per day (Danzer et al., 2019).

Additional restoration models. Treatment outcomes of jail-based restoration programs in Arizona, Colorado, Georgia, and Louisiana have been evaluated as well. A jail-based program developed in Pima County, Arizona consists of a unit that is dedicated to treating IST defendants through a multidisciplinary team, involving psychiatrists and social workers. These inmates are housed either in the IST-specific unit or in the general population (Morenz & Busch, 2011). An 84% restoration rate was observed between 2007 and 2011, with an average length of treatment of 82.49 days (Morenz & Busch, 2011). An additional jail-based program was developed in Yavapaid County, Arizona in 2010 and demonstrated similarly high rates of restoration (86.7%) across 187 defendants treated between 2011 and 2014 (Stewart, 2015). This program consists of telepsychology provided by a psychologist and in-person restoration services provided by counselors in a group or individual setting (Stewart, 2015).

The Restoring Individuals Safely and Effectively (RISE) Program was developed in 2013 in Arapahoe County, Colorado and consists of assessment and evaluation, individual and group therapy, and medication management, among other services, to promote restoration in a multidisciplinary jail-based treatment setting (Colorado Department of Human Services, 2015). The RISE Program demonstrated a 71% restoration rate across 106 defendants treated between 2013 and 2015, with the majority restored within a 2 to 3-month treatment period (Colorado Department of Human Services, 2015).

Another jail-based competency restoration program was developed in 2011 in Fulton County, Georgia. This program provides restoration services to males who are housed in a dedicated unit for IST defendants ("pod") as well as males and females who are housed with the jail's general population (Georgia Department of Behavioral Health and Developmental Disabilities, 2014). Services are provided by a multidisciplinary team, including social workers, psychiatrists, and psychologists, and consist of group-based competency training, social skills groups, and cognitive rehabilitation. Across 317 defendants adjudicated IST, 20% were restored within a 4-month period on average, with higher restoration rates observed among those housed in the pod (34%) as compared to those housed in general population (9%; Georgia Department of Behavioral Health and Developmental Disabilities, 2014).

Lastly, outcome data for Louisiana's jail-based restoration program, a 90-day program, revealed that fewer than 33% of defendants adjudicated IST were restored within 90 days (Wik, 2018b). As a result, the majority of these defendants were transferred to an inpatient restoration program to continue treatment (Wik, 2018b).

Juvenile Settings

Juvenile competence to stand trial is not specifically addressed in statute in many states, which may have limited the relevant research that has been conducted in this area (Riggs Romaine, Kemp, & DeMatteo, 2010). The complexity of CST is increased in juveniles because of the influence of developmental immaturity (Kruh & Grisso, 2008), so restoration efforts must incorporate many of the same considerations as in adults (e.g., serious mental illness, ID, cognitive deficits) as well as considering the limitations associated with a youth's developmental immaturity. This section will summarize the available literature on restoration of juvenile competence, much of which is descriptive only.

Surveying the members of the National Association of State Mental Health Program Directors (Forensic Division), one investigator (Langley, 2015) asked respondents about juvenile competency evaluation and restoration, durations, and outcomes. About two thirds of the responding jurisdictions ($n = 18$) indicated that restoration services were provided to juveniles who had been adjudicated incompetent to stand trial. Such restoration services included psychotropic medication, individual and group therapy, and legal education. Two jurisdictions also reported providing restoration services to youth whose incompetence was based on developmental immaturity. Across the entire survey, a total of 57% of youth were recommended as restored following services delivered in 2012 (Langley, 2015).

There are apparently only a small number of outcomes studies on juvenile competency restoration, which are described in this section. As with adults, it appears that restoration rates are higher for juveniles with mental illness (84%) as contrasted with ID (47%), with the highest restoration observed in those with neither mental illness nor ID (91%; Warren et al., 2009).

There have also been several studies focusing on restoration services for IST juveniles in different states. Virginia, for instance, has developed a community-based model for restoring IST-adjudicated youth; investigators considered the satisfaction of such youth ($N = 130$) with the services provided. Very strong levels of overall satisfaction were reported, with some problems cited by a small percentage of individuals in learning specific concepts such as plea bargaining (12%), the expectations for court procedures and roles of participants (11%), and other proceedings such as opening and closing arguments (21%; Jackson, Warren, & Coburn, 2014). Restoration services in Virginia are delivered in various locations in the community, including school, home, detention centers, and hospitals, and are provided in an individualized fashion that uses case management particularly (Jackson, 2018). Legally relevant psychoeducation is offered using computers and related tools, as well as role-playing. Mental health services, when needed, are obtained from providers outside the program. Outcome data suggest that about 70% of juveniles are recommended as restored, with community-based programming considerably less expensive than inpatient restoration (Larson & Grisso, 2011).

A comparable community-based model for juvenile CST restoration has been developed in Florida, using case management and legal education as the primary tools. (As in Virginia, mental health

services are coordinated through case managers rather than provided specifically as a part of CST restoration services.) Services are focused on specific needs and deficits rather than provided in highly structured form (Florida Department of Children & Families, 2018). There is also a residential option for restoration, based at a youth camp and using both standard mental health treatment (e.g., medication, therapy) and legally focused psychoeducational approaches (e.g., mock trials, video games). Research on this specific residential program suggests that about 85% of youth are recommended as restored, with a mean restoration period between 5 and 6 months (Larson & Grisso, 2011).

Discussion

The use of CST as part of a traditional model involving standard prosecution of all criminal defendants is working poorly in the United States at present. Although there is a constitutional requirement that a criminal defendant have certain capacities in order to stand trial or otherwise dispose of such charges (ABA, 2016; *Dusky v. United States*, 1960), there are additional considerations. These include individual liberty, societal cost, public safety, and the timing, efficiency and effectiveness of behavioral health treatment. This review has considered the process of IST adjudication, traditionally including jail incarceration, transfer to a secure hospital for restoration services and ongoing clinical-legal evaluation, and return to the jail in the jurisdiction of the committing court when the individual appears (as reflected in a forensic evaluation of CST) to have been restored. Using this model appears to contribute to lengthy periods of jail incarceration experienced by some defendants adjudicated IST while waiting for transfer to a bed in a secure hospital. More efficient and effective alternatives must be considered.

Unfortunately, there is little outcome research available to guide this effort. Discussed in this review (see Table 1), the studies that are available are mostly descriptive, delineating components of treatment, duration, and rates of restoration (sometimes failing to distinguish whether such restoration is "recommended by an evaluator" or "adjudicated by the court"). Important policy decisions such as these would be particularly well-informed by the results of controlled studies comparing settings (e.g., hospital, jail, community, juvenile placement) and forms of treatment delivered to defendants of different ages and behavioral health challenges. The use of random assignment would make such controlled studies even more informative. Until we have the benefit of considering data from such studies, we must rely on the descriptive and single-group studies that comprise most of the empirical literature in this area.

There are common elements across various approaches to CST restoration that have been developed. Whether delivered in a secure inpatient setting, an outpatient setting, a jail, or a specialized juvenile program, these components include assessment, medication management, case management, and interventions focusing particularly on skills and capacities relevant to trial competence (e.g., knowledge, communication, decision-making). Individuals with severe mental illness tend to respond more quickly and favorably to appropriate medication; those with ID respond more slowly (if at all), with interventions including rehearsal of knowledge and practice of relevant skills. Cognitive remediation approaches have been described for those with degenerative disorders or brain injuries. Developmentally appropriate skills-based training and medication management appear prominently in juvenile restoration programs. It would appear, therefore, that programming delivering competence restoration services should include these elements, conduct regular screenings and subsequent full evaluations, and gather outcome data for program evaluation purposes. However, not all such services would be needed for all defendants, so identifying what works most often with most clients in a particular population is important in designing the most effect and efficient restoration services.

In particular, researchers in this area can provide valuable information by conducting controlled studies comparing restoration outcomes from OCRP and jail-based restoration programs with treatment as usual (typically hospitalization). Among the variables of most interest: rate of restoration; time to restoration; nature, intensity, and dosage of services; cost; and satisfaction of various actors (clients, attorneys, judges, and providers). An independent, validated measure of CST capacities would also be valuable, as expert forensic evaluations of trial competence are uneven in quality but highly concordant with subsequent CST adjudications by the judge (Melton et al., 2018).

We propose two decision trees based on this review. The first (see Figure 1) summarizes a series of decisions relevant to system-level change, while the second (see Figure 2) outlines decisions made at the level of the individual defendant. When considering system-level functioning, it is helpful to use the structure of the Sequential Intercept Model (see, e.g., Griffin, Heilbrun, Mulvey, DeMatteo, & Schubert, 2015; Munetz & Griffin, 2006) to determine whether there are diversionary alternatives earlier in the criminal justice process. Such alternatives would focus specifically on the identification of and intervention for behavioral health needs before the individual has been arrested (Intercept 1), after arrest and during initial detainment and/or initial hearing (Intercept 2), or when they are detained in jail prior to trial (Intercept 3; Griffin, Munetz, Bonfine, & Kemp, 2015). To the extent that the issue of competence to stand trial is raised because a defendant simply needs treatment for symptoms of severe mental illness, the provision of such treatment through earlier diversion from standard prosecution should reduce the frequency of subsequent CST motions.

The system-level decision tree (see Figure 1) next focuses on the question of whether there is currently a waiting list comprising individuals adjudicated IST and awaiting placement for restoration. This helps determine whether the system is approaching an overload crisis. If it is not, then some of the alternatives such as OCRP and jail-based restoration may be desirable to pursue for other reasons—but this can be done without the pressures stemming from a waitlist crisis. Finally, the decision tree identifies the importance of gathering (or reviewing) information on reoffense risk and criminal charge for those who are currently on a waitlist. The development of OCRPs with individuals who are not at high risk of reoffending, and who have less serious charges, is justifiable both from an actual risk perspective (clearly community-based programs have an interest in minimizing the number of defendants in treatment who commit another offense) and a perceived risk perspective (serious criminal charges are sometimes treated as a proxy for risk, although this is not empirically justifiable). Those appraised at higher risk, and with more serious charges, would be better candidates for a jail-based competence

Table 1
Description of Competency Restoration Programs Reviewed

Program name (*treatment type*)	Location	Patient population (*n*)	Program setting	Restoration rate (%)	Mean restoration duration (days)	Authors (year) for empirical data	URL for additional information
(*psychotropic medication, first-generation antipsychotic*)	U.S. Federal Court System	Adult SMI ($N = 64$)	Prison psychiatric hospitals	84.4%	$M = 144.4$	Cochrane, Herbel, Reardon, and Lloyd (2013)	https://www.jstor.org/stable/43587443
(*psychotropic medication, second-generation antipsychotic*)	U.S. Federal Court System	Adult SMI ($N = 68$)	Prison psychiatric hospitals	73.5%	$M = 144.4$	Cochrane et al. (2013)	https://www.jstor.org/stable/43587443
(*psychotropic medication*)	Butner, North Carolina	Adult SMI ($N = 22$)	Federal prison psychiatric hospital	77.3%	—	Herbel and Stelmach (2007)	https://pdfs.semanticscholar.org/13cd/02b00558cba81ce50ff2227502e1975df4b3.pdf
(*psychotropic medication*)	Butner, North Carolina	Adult SMI ($N = 96$)	Federal medical center	73.6%	120.0	Kassen (2016)	https://academicworks.cuny.edu/gc_etds/689
(*group-based educational treatment*)	Philadelphia, Pennsylvania	Adult SMI ($N = 21$)	State hospital (forensic units)	43.0%	45.0	Siegel and Elwork (1990)	https://link.springer.com/content/pdf/10.1007/BF01055789.pdf
(*educational treatment*)	Atascadero, California	Unspecified ($N = 205$)	State hospital	90.0%	$M = 104.0$	Pendleton (1980)	http://dx.doi.org/10.1176/ajp.137.9.1098
(*educational treatment*)	Cleveland, Ohio	Unspecified	State hospital	81.5%–90.9%	$M = 80.0$	Noffsinger (2001)	http://ijo.sagepub.com/content/45/3/356
(*deficit-focused remediation treatment*)	Jackson, Louisiana	Adult unspecified ($N = 8$)	Maximum security hospital	—	—	Bertman et al. (2003)	https://www.researchgate.net/publication/10698212
(*educational treatment*)	Jackson, Louisiana	Adult unspecified ($N = 10$)	Maximum security hospital	—	—	Bertman et al. (2003)	https://www.researchgate.net/publication/10698212
Fitness Game (*specialized/ individualized treatment*)	Kaneohe, Hawai'i	Unspecified ($N = 21$)	State hospital	—	—	Mueller and Wylie (2007)	https://onlinelibrary.wiley.com/doi/abs/10.1002/bsl.775
CST Education Program (*educational treatment*)	Missouri	Adult ID ($N = 75$)	State psychiatric hospitals + Habilitation centers	33.3%	—	Anderson and Hewitt (2002)	https://link.springer.com/content/pdf/10.1023/A:1015328505884.pdf
The Slater Method (*specialized treatment*)	Cranston, Rhode Island	Adult ID ($N = 15$)	State hospital	33.3%	—	Wall, Krupp, and Guilmette (2003)	http://www.concept-ce.com/wp-content/uploads/2013/10/Wall-Krupp-Guilmette-2003-Restoration-of-MR.pdf
The Slater Method (*specialized treatment*)	Cranston, Rhode Island	Adult ID ($N = 30$)	State hospital	61.1%	—	Wall and Christopher (2012)	http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.1034.4289&rep=rep1&type=pdf
(*cognitive remediation*)	Tuscaloosa, Alabama	Adult SMI ($N = 16$)	Inpatient forensic hospital	—	$M = 319.2$	Wilson (2015)	https://ir.ua.edu/bitstream/handle/123456789/2414/file_1.pdf?sequence = 1
Florida State Hospital CompKit (*educational treatment*)	Chattahoochee, Florida	Unspecified	State hospital	—	—	—	https://docplayer.net/1263202-Florida-state-hospital-compkit.html
(*mixed*)	Virginia	Juvenile ($N = 563$)	Mixed	72.3%	—	Warren et al. (2009)	http://fmhac.org/uploads/1/2/3/9/123913996/2009developingaforensicservice.pdf
Virginia DBHDS competency program (*individualized treatment*)	Virginia	Juvenile ($N = 130$)	Unspecified	—	—	—	https://heinonline.org/HOL/Page?collection=journals&handle=hein.journals/juvfc65&id=100&men_tab=srchresults
(*educational treatment*)	Twin Oaks, Florida	Juvenile (N unspecified)	Juvenile forensic facility	~85.0%	$M = 155.0–185.0$	As cited in Larson and Grisso (2011)	http://modelsforchange.net/publications/330
(*individualized educational treatment*)	Virginia	Juvenile ($N = 563$)	Community-based	72.0%	—	As cited in Larson and Grisso (2011)	http://modelsforchange.net/publications/330
(*individualized/ specialized treatment*)	Twin Oaks, Florida	Juvenile (N unspecified)	Community-based	60.0%	—	Christy, Otto, McClaren, and Petrila (2001)	https://scholarcommons.usf.edu/mhlp_facpub/251
(*mixed*)	Mixed	Unspecified	Community-based	70.0%	$M = 149.0$	Gowensmith, Murrie, and Packer (2017)	https://doi.org/10.1037/law0000088

(*table continues*)

Table 1 (*continued*)

Program name (*treatment type*)	Location	Patient population (*n*)	Program setting	Restoration rate (%)	Mean restoration duration (days)	Authors (year) for empirical data	URL for additional information
DC OCRP (*educational treatment*)	Washingotn D.C.	Adult (N = 170)	Community-based	32.0%	—	Johnson and Candilis (2015)	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4473494/
(*unspecified*)	Texas	Unspecified (N = 644)	Community-based	74.7%	—	Graziani, Guzman, Mahometa, and Shafer (2015)	http://utw10282.utweb.utexas.edu/wp-content/uploads/2015/09/EvaluationReport_091815.pdf
(*mixed*)	New Orleans, Louisiana	Unspecified (N = 80)	Community-based	54.0%	M = 207.0	Mikolajewski, Manguno-Mire, Coffman, Deland, and Thompson (2017)	https://doi.org/10.1002/bsl.2287
(*unspecified*)	Denver, Colorado	Unspecified (N = 50)	Community-based	18.0%	M = 226.0	Musgrove et al. (2018)	—
(*mixed*)	Hawai'i	Unspecified (N = 50)	Community-based	95.0%	—	As cited in Gowensmith, Murrie, and Packer (2014)	http://app.leg.wa.gov/ReportsToTheLegislature/Home/
ROC Model (*unspecified*)	Prince George, Virginia	Unspecified	Jail-based	83.0%	M = 77.0	Jennings and Bell (2012)	http://cdn.intechweb.org/pdfs/25947.pdf
ROC Program (*unspecified*)	San Bernadino, California	Adult (N = 192)	Jail-based	55.0%	M = 57.0	Rice and Jennings (2014)	https://doi.org/10.1177/1078345813505067
ROC Program (*unspecified*)	San Bernadino, California	Unspecified	Jail-based	58.0%	M = 56.0		https://www.leg.state.nv.us/Session/77th2013/Exhibits/Senate/JUD/SJUD623F.pdf
(*unspecified*)	Pima County, Arizona	Unspecified	Jail-based	84.0%	M = 82.5	Morenz and Busch (2011)	https://www.aapl.org/docs/newsletter/AAPL%20Newsletter%20January%2011.pdf
Yavapai RTC Program (*unspecified*)	Yavapai County, Arizona	Unspecified (N = 187)	Jail-based	86.7%	M = 120	Stewart (2015)	https://www.researchgate.net/publication/311190356_Restoration_To_Competency_in_Arizona
RISE Program (*unspecified*)	Arapahoe County, Colorado	Unspecified (N = 106)	Jail-based	71.0%	60–90	Colorado Department of Human Services (2015)	http://www.ahpnet.com/AHPNet/media/AHPNetMediaLibrary/White%20Papers/OBHNeeds-Analysis-Report,2015-pdf.pdf
(*unspecified*)	Fulton County, Georgia	Adult (N = 317)	Jail-based	9.0%–34.0%	M = 120	Georgia Department of Behavioral Health and Developmental Disabilities (2014)	https://www.nasmhpd.org/sites/default/files/NASMHPD%20GA%202014_0.pdf
(*unspecified*)	Louisiana	Unspecified	Jail-based	<33%	90	As cited in Wik (2018b)	https://www.nri-inc.org/media/1500/jbcr_website-format_oct2018.pdf
Utah Attainment Curriculum for Trial Competence (*educational treatment*)	Utah	Juveniles	—	—	—	Holt, Gold, Sheen, Hammond, and Notwell (2013)	—

Note. SMI = severe mental illness; ID = intellectual disability.

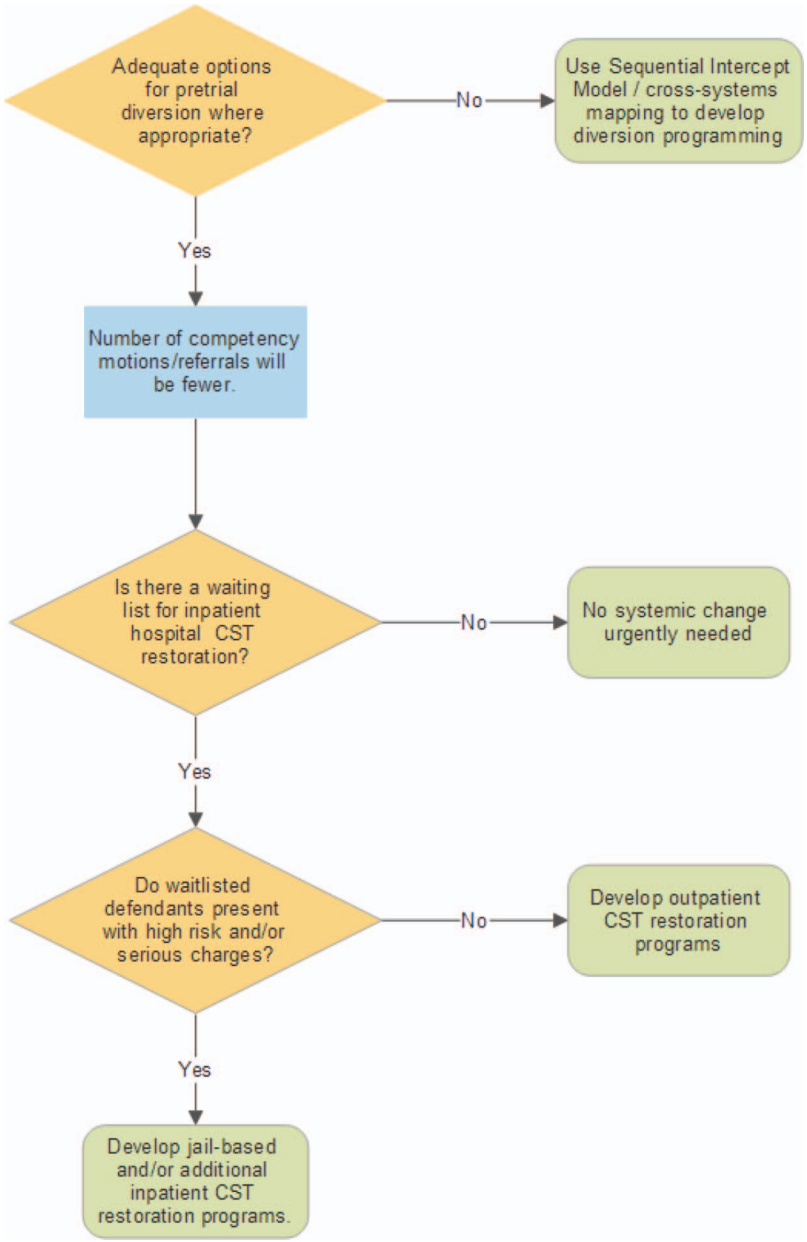

Figure 1. System-level decision tree for restoration services to criminal defendants adjudicated incompetent to stand trial (IST). See the online article for the color version of this figure.

restoration program. Community-based and jail-based restoration are not necessarily mutually exclusive, however. For jurisdictions operating both, it is possible to deliver services using the same providers. Such services might include psychotropic medication and case management—and even psychoeducation—delivered to individuals in the community who are appropriate for pretrial release, and to individuals in the jail who are not.

The individual-level decision tree (see Figure 2) reflects the current empirical evidence that psychotropic medication is strongly related to restoration accomplished with IST individuals with severe mental illness (Zapf, 2013), so should be a prominent part of restoration services to SMI individuals in hospitals, OCRPs, and jail-based programs. Careful attention to medication is likely to facilitate restoration in a substantial proportion of IST defendants *even in the absence of other services* (see, e.g., Steadman & Callahan, 2017). This is, of course, not a justification for designing restoration services using only psychotropic medication, but a reflection of the importance of this particular intervention in restoring many individuals as quickly as possible. Other clinical challenges, such as ID and neurocognitive deficits, require different interventions. When IST populations contain substantial proportions of individuals for whom these are primary or co-occurring disorders, the decision tree prioritizes the development and delivery of psychoeducation and cognitive remediation, targeted toward the deficits

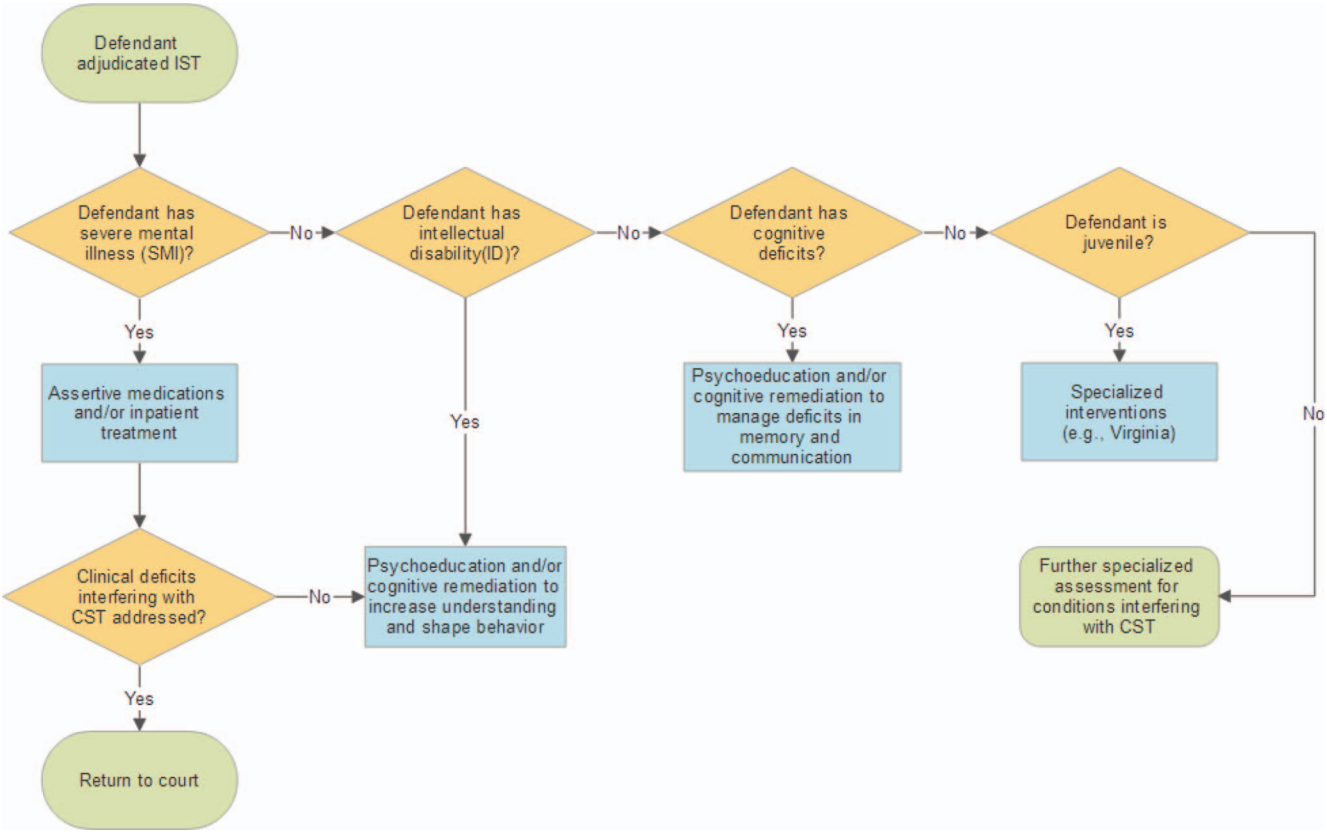

Figure 2. Individual-level decision tree for restoration services to criminal defendants adjudicated incompetent to stand trial (IST). See the online article for the color version of this figure.

most associated with each. The existing evidence suggests that successful remediation of these deficits occurs much less frequently than does improving actively psychotic symptoms, underscoring the importance of multiple interventions delivered in the restoration process while considering possible unrestorability (see *Jackson v. Indiana*, 1972) if all are unsuccessful.

The evidence reviewed in this article on restoration outcomes for community- and jail-based programs suggests that most of the successful restoration occurs within the first 6 months. After that, there are at least two possible alternatives for subsequent restoration interventions: (a) build and document more intensive, additional treatment into the process and document results for *Jackson* unrestorability consideration at a designated time specified under state law or (b) arrange for transfer to a secure inpatient facility after 6 months for this purpose. Using the latter would adjust the mission of the forensic hospital from restoration of a wide range of IST individuals to restoration of a smaller (but more challenging) cohort, and the careful documentation of the impact of interventions. This approach would need to be modified for IST defendants who need intensive and acute-level hospital care prior to 6 months post-IST adjudication. Perhaps a triage system, assessing clinical need, would allow a system to safely and effectively distinguish between IST defendants in need of immediate hospitalization and those who would be better candidates for OCRP or jail-based restoration. In addition, it is important to consider how liberty interests and disability rights are served by participating in a jail-based restoration program for 6 months, for instance, as compared with the alternative of an involuntary hospital stay for that period. Any jurisdiction considering this model would need to weigh restoration effectiveness, disability rights, clinical need, and *Jackson*-based unrestorability (e.g., for those charged with misdemeanors) in deciding how the model would work in that particular jurisdiction.

Even considering this complexity, however, there could be significant advantages to this model. First, it could reduce the number of IST individuals awaiting hospital-based restoration services and allow the restoration of an estimated 50–80% of individuals within the first 6 months in an OCRP or jail-based program. Second, it could decrease the overall duration of confinement for IST individuals, considering that some treatment toward restoration would begin as soon as the individual was incarcerated in jail rather than waiting for a hospital bed to become available. In some cases, when IST defendants are involved in OCRP, it could avoid confinement altogether. Third, it could be less expensive. Community-based treatment has consistently been shown to be less resource-intensive than residential treatment; effective outpatient restoration might halt or reverse the expansion of inpatient beds to address waiting lists. Fourth, it could be more easily integrated into existing problem-solving courts (especially mental health courts, or other problem-solving courts such as "competency courts"—see

Finkle et al., 2009) than other alternatives. Fifth, it could promote "resource sharing"—restoration staff could cover both outpatient and jail clients when the two are integrated. Sixth, it could promote greater specialization (and hopefully mastery) in *Jackson* unrestorability assessment by hospital staff if there is a transfer after 6 months of unsuccessful intervention in the community or jail. Seventh, it would require an open discussion of cost-sharing. To the extent that CST restoration has been a responsibility of the state rather than counties, such counties might well be reluctant to take on the added burdens of providing restoration services in the community and jail. When cost-sharing has become part of an integrated model of restoration services involving both state resources (secure forensic hospitals) and county resources (outpatient and jail-based services), then the overall financial burden should not increase—but it should not be disproportionately placed on counties by an unfunded expectation to deliver these services.

CST is sometimes used as a mechanism for accessing treatment for individuals with mental illness. In the larger context of services to justice-involved individuals with behavioral health needs, this is inefficient at best. Evaluations and cross-systems planning should consider the use of CST in the larger context of criminal justice and mental health. Access to high quality treatment and early diversion should be emphasized to reduce the number of unnecessary IST adjudications, which then require competence restoration. Rather, jurisdictions should consider criminal justice system reform models (e.g., Stepping Up) that can reduce the number of individuals with mental illness and co-occurring substance use disorders in jails and connect them with appropriate community-based services. Such services, when delivered in the context of diversion or a problem-solving court, can more easily encompass a wider range of services because they are not constrained by the uncertainty of whether a defendant will be returning to the community or incarcerated following a criminal conviction. For example, access to affordable housing is rarely discussed in the context of competency restoration programs, but it can have a significant impact on community-based adjustment and the risk of further justice involvement (Gowensmith et al., 2017; Ollove, 2015). Prioritizing stable, affordable housing as a component of treatment is easily justifiable in the context of a mental health court or specialized probation. It is more difficult to prioritize when it is unclear whether the defendant will be living in the community in the immediate future.

It also appears that broader diversion efforts can reduce the number of individuals who are prosecuted and subject to conviction and incarceration, and hence may be adjudicated IST. Consider the approach taken in Miami/Dade County, Florida, in which the Criminal Justice Mental Health Project initiated by Judge Steve Leifman employs both prebooking and postbooking strategies. The latter include diversion of individuals charged with misdemeanors, but also of others charged with nonviolent felonies. The impact of this project has apparently included both an expansion of mental health and related services to recipients, and a reduction in criminal recidivism—suggesting the value of selectively employed diversion of individuals with mental illness from traditional prosecution, when accompanied by collaboration among judges, defense attorneys, prosecutors, and mental health personnel (Iglehart, 2016).

The kind of changes seen in Dade County, and those proposed in our decision trees, would require the collaboration of those representing multiple systems across law and behavioral health. Typically these would include judges, prosecutors, defense attorneys, police, parole and probation officials, hospital administrators, community mental health staff, and housing authorities. This kind of cross-system collaboration has been promoted through "cross-system mapping," which brings together representatives from these different systems, allowing them to establish priorities and agree upon an action plan (see Griffin et al., 2015). Funding is frequently a major challenge to implementing and sustaining such changes, so creativity, determination, and persuasion are important components for success (see Leifman & Coffey, 2015).

It is clearly time to reconsider how our justice system uses the construct of competence to stand trial. Further developing alternative restoration treatment sites outside of secure forensic hospitals could improve efficiency and effectiveness without sacrificing public safety, while promoting diversion and other alternatives outside the standard prosecution process, in cases that were appropriate considering reoffense risk and criminal charges, could have the same effect while improving integration of this population into systems of community-based care. This could help resolve one crisis—waiting for beds—while improving services to defendants, the legal system, and our larger society.

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Received June 3, 2019
Revision received July 10, 2019
Accepted July 12, 2019 ■

Attachment 10

PRTF	Daily Rate
Avalonia - Hampton PRTF	$ 305.55
Carolina Children's Home	$ 305.55
Excalibur - Venice PRTF	$ 305.55
Generations Residential Programs (Pathways)	$ 305.55
Lighthouse Care Center of Augusta	$ 291.00
Lighthouse Care Center of Conway	$ 307.28
New Hope Carolinas (Rock Hill)	$ 305.55
Palmetto Lowcountry (Charleston)	$ 288.53
Palmetto Pee Dee (Florence)	$ 301.62
Palmetto Pines (Summerville)	$ 319.63
Pinelands RTF	$ 305.55
Sprinbrook Behavioral Health	$ 307.28
Three Rivers Bheavioral Health	$ 307.28
Three Rivers Midlands	$ 307.28
Willowglen Academy	$ 305.55
Windwood Farm	$ 305.55

SC PRTF Avg Daily Cost = **$ 304.64**

PRTF	Daily Rate
Coastl Harbor Treatment Center	$ 351.62
Devereux Advanced Behavioral Health	$ 407.00
Hillside Inc	$ 407.00
Laurel Heights Hospital	$ 363.57
Lighthouse Care Center of Augusta	$ 318.14
Youth Villages Inner Harbour	$ 407.00

GA PRTF Avg Daily Cost = **$ 375.72**

ONIT: OFFICE OF NETWORK & INFORMATION TECHNOLOGY
South Carolina Department of Mental Health

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

ABBEVILLE	Total
MOOD DISORDERS	194 43%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	83 19%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	74 15%

AIKEN	Total
MOOD DISORDERS	750 42%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	377 19%
ANXIETY DISORDERS	230 13%

ALLENDALE	Total
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	36 36%
MOOD DISORDERS	23 24%
ANXIETY DISORDERS	16 16%

ANDERSON	Total
MOOD DISORDERS	673 40%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	499 28%
ADJUSTMENT DISORDERS	185 11%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

Author: Business Intelligence Crystal Reports Group
File Name: Clients - Active Clients - Top Three Diagnosis by County

ONIT: OFFICE OF NETWORK & INFORMATION TECHNOLOGY
South Carolina Department of Mental Health

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

BAMBERG	Total
MOOD DISORDERS	87 31%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	71 27%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	66 23%

BARNWELL	Total
MOOD DISORDERS	127 39%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	71 21%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	41 13%

BEAUFORT	Total
MOOD DISORDERS	550 41%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	288 20%
ANXIETY DISORDERS	183 14%

BERKELEY	Total
MOOD DISORDERS	607 38%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	302 18%
ADJUSTMENT DISORDERS	296 19%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

CALHOUN	Total
MOOD DISORDERS	65 39%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	36 23%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	36 20%

CHARLESTON	Total
MOOD DISORDERS	1,346 32%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	971 21%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	702 17%

CHEROKEE	Total
MOOD DISORDERS	231 36%
ADJUSTMENT DISORDERS	151 25%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	122 18%

CHESTER	Total
MOOD DISORDERS	149 39%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	113 27%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	45 12%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

ONIT: OFFICE OF NETWORK & INFORMATION TECHNOLOGY
South Carolina Department of Mental Health

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

CHESTERFIELD	Total
MOOD DISORDERS	163 40%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	108 24%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	60 15%

CLARENDON	Total
MOOD DISORDERS	349 40%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	193 23%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	181 19%

COLLETON	Total
MOOD DISORDERS	171 37%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	125 26%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	54 12%

DARLINGTON	Total
MOOD DISORDERS	188 31%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	170 26%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	97 17%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

DILLON	Total
MOOD DISORDERS	227 43%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	146 26%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	76 15%

DORCHESTER	Total
MOOD DISORDERS	624 34%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	355 20%
ANXIETY DISORDERS	290 16%

EDGEFIELD	Total
MOOD DISORDERS	105 44%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	58 22%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	36 15%

FAIRFIELD	Total
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	87 31%
MOOD DISORDERS	86 33%
ADJUSTMENT DISORDERS	37 15%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

FLORENCE	Total
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	436 32%
MOOD DISORDERS	397 31%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	209 17%

GEORGETOWN	Total
MOOD DISORDERS	295 39%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	185 22%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	178 25%

GREENVILLE	Total
MOOD DISORDERS	2,445 33%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	1,366 19%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	1,258 16%

GREENWOOD	Total
MOOD DISORDERS	530 44%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	206 16%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	170 15%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

HAMPTON	Total
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	79 30%
MOOD DISORDERS	77 30%
ANXIETY DISORDERS	39 16%

HORRY	Total
MOOD DISORDERS	1,119 51%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	502 22%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	187 9%

JASPER	Total
MOOD DISORDERS	125 40%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	73 22%
ANXIETY DISORDERS	44 14%

KERSHAW	Total
MOOD DISORDERS	503 48%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	165 15%
ADJUSTMENT DISORDERS	160 15%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

LANCASTER	Total
MOOD DISORDERS	279 41%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	159 22%
ADJUSTMENT DISORDERS	84 13%

LAURENS	Total
MOOD DISORDERS	406 45%
ADJUSTMENT DISORDERS	145 16%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	126 13%

LEE	Total
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	116 34%
MOOD DISORDERS	114 35%
ADJUSTMENT DISORDERS	30 9%

LEXINGTON	Total
MOOD DISORDERS	1,379 40%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	506 14%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	504 15%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

MARION	Total
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	113 27%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	93 26%
MOOD DISORDERS	93 24%

MARLBORO	Total
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	122 29%
MOOD DISORDERS	110 27%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	92 24%

MCCORMICK	Total
MOOD DISORDERS	72 43%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	40 26%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	26 15%

NEWBERRY	Total
MOOD DISORDERS	210 43%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	113 22%
ANXIETY DISORDERS	74 16%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

OCONEE	Total
MOOD DISORDERS	221 42%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	120 21%
ANXIETY DISORDERS	70 14%

ORANGEBURG	Total
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	404 30%
MOOD DISORDERS	378 30%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	213 18%

OUT-OF-STATE	Total
MOOD DISORDERS	15 44%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	10 30%
ADJUSTMENT DISORDERS	3 10%

PICKENS	Total
MOOD DISORDERS	515 51%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	266 25%
ANXIETY DISORDERS	80 8%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

RICHLAND	Total
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	1,523 37%
MOOD DISORDERS	1,407 35%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	306 8%

SALUDA	Total
MOOD DISORDERS	53 40%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	40 29%
ADJUSTMENT DISORDERS	15 12%

SPARTANBURG	Total
MOOD DISORDERS	1,486 40%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	945 24%
ADJUSTMENT DISORDERS	399 11%

SUMTER	Total
MOOD DISORDERS	766 41%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	539 27%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	257 15%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

UNION	Total
MOOD DISORDERS	267 36%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	170 24%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	98 13%

UNKNOWN	Total
MOOD DISORDERS	39 47%
ADJUSTMENT DISORDERS	16 20%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	12 14%

WILLIAMSBURG	Total
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	223 34%
MOOD DISORDERS	155 26%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	129 22%

YORK	Total
MOOD DISORDERS	851 44%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	409 20%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	238 13%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

ONIT: OFFICE OF NETWORK & INFORMATION TECHNOLOGY
South Carolina Department of Mental Health

Clients - Active Clients - Top Three Diagnosis by County

Run Date: 8/27/2019
Run By: SMG91

ALL COUNTIES	Total
MOOD DISORDERS	21,022 38%
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	12,850 22%
ATTENTION DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	7,406 14%

Record Selection Criteria:not IsNull ({_clients.pdsm}) and {_clients.adminact} = "N" and IsNull({_clients.dischrgdat}) and not ({_clients.dmhfacil} in ["54", "53", "3V", "30"])

Author: Business Intelligence Crystal Reports Group
File Name: Clients - Active Clients - Top Three Diagnosis by County

SAMHC Employee Survey

June 30, 2019

Spartanburg Area Mental Health
250 Dewey Ave.| Spartanburg, SC 29303
864-585-0366
www.samhc.org

Introduction > Survey Background

The 2019 Spartanburg Area Employee Survey was conducted on-site in Spartanburg, Cherokee and Union.

59 out 137 employee responded to the survey (43% response rate). Clinical employees (33% response rate), non-clinical employees (64% response rate).

Survey questionnaire had 14 statements, employees indicated their level of agreement with each statement on a 1-4 scale, “definitely disagree” to “completely agree.”

Definitely Disagree 1	Somewhat Disagree 2	Somewhat Agree 4	Completely Agree 5

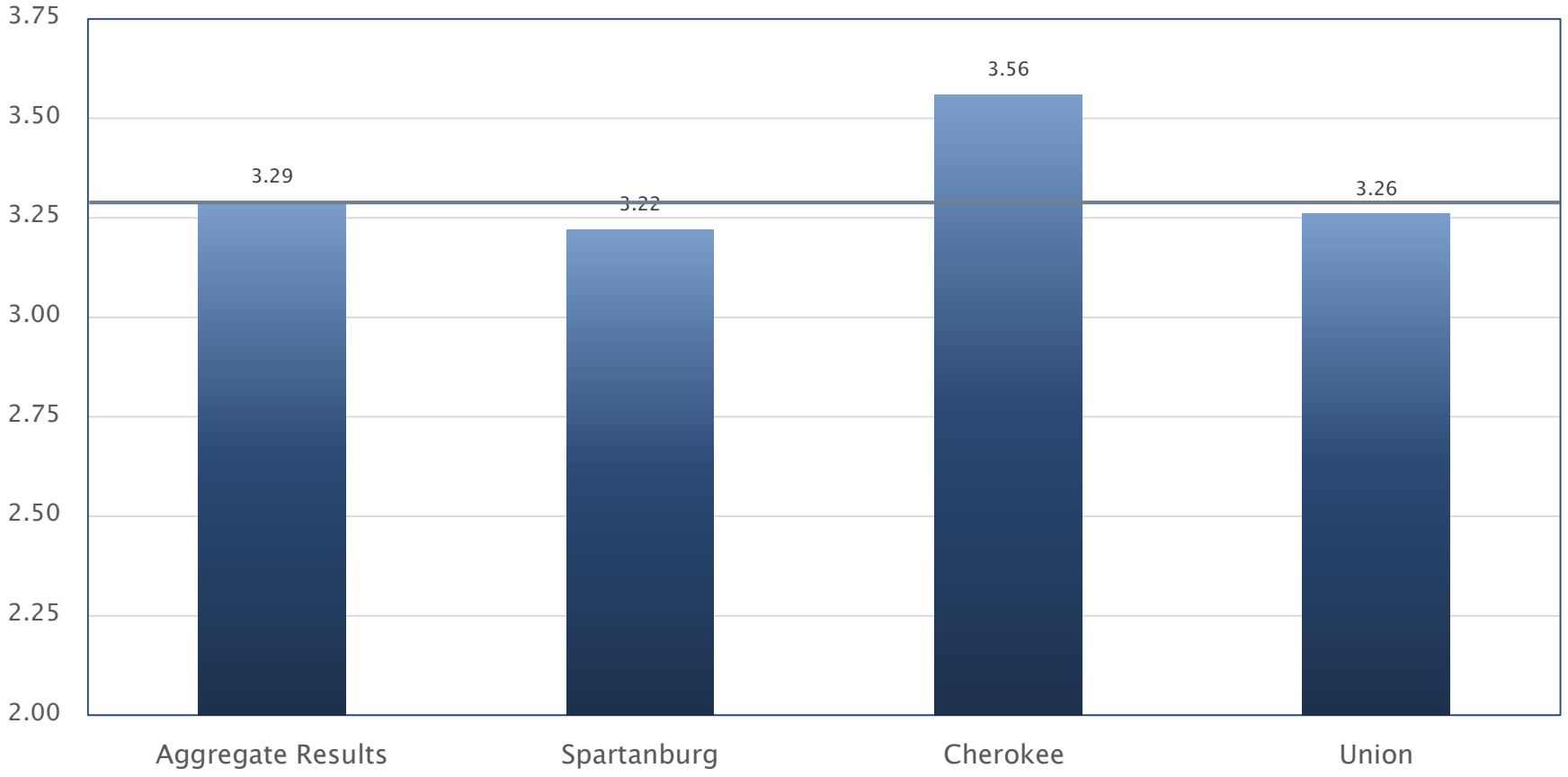
Introduction > Survey Indicators

- My work is meaningful
- I get the recognition that I deserve for the work that I do
- I have adequate opportunities for training and professional development
- I am satisfied with advancement opportunities here
- Performance appraisals are conducted fairly
- My work environment is one in which I feel I can be successful
- Supervisors are supportive in ways that help me to do my job
- I believe that SAMHC's top administration (Center Director and Administrator) wants to know how I feel
- Decision-making processes adequately involve persons affected by the decision in most cases
- Staff are adequately informed about the outcomes of suggestions/recommendations made to supervisors or members of the Executive Committee
- Staff are adequately informed about the outcomes of surveys and other outcome studies
- There is appropriate inter-departmental communication/cooperation

Agenda

- **Survey Overview**
- **Aggregate Results**
- **Segment Analysis**
- **Conclusions/Recommendations**

Aggregate Results > Performance



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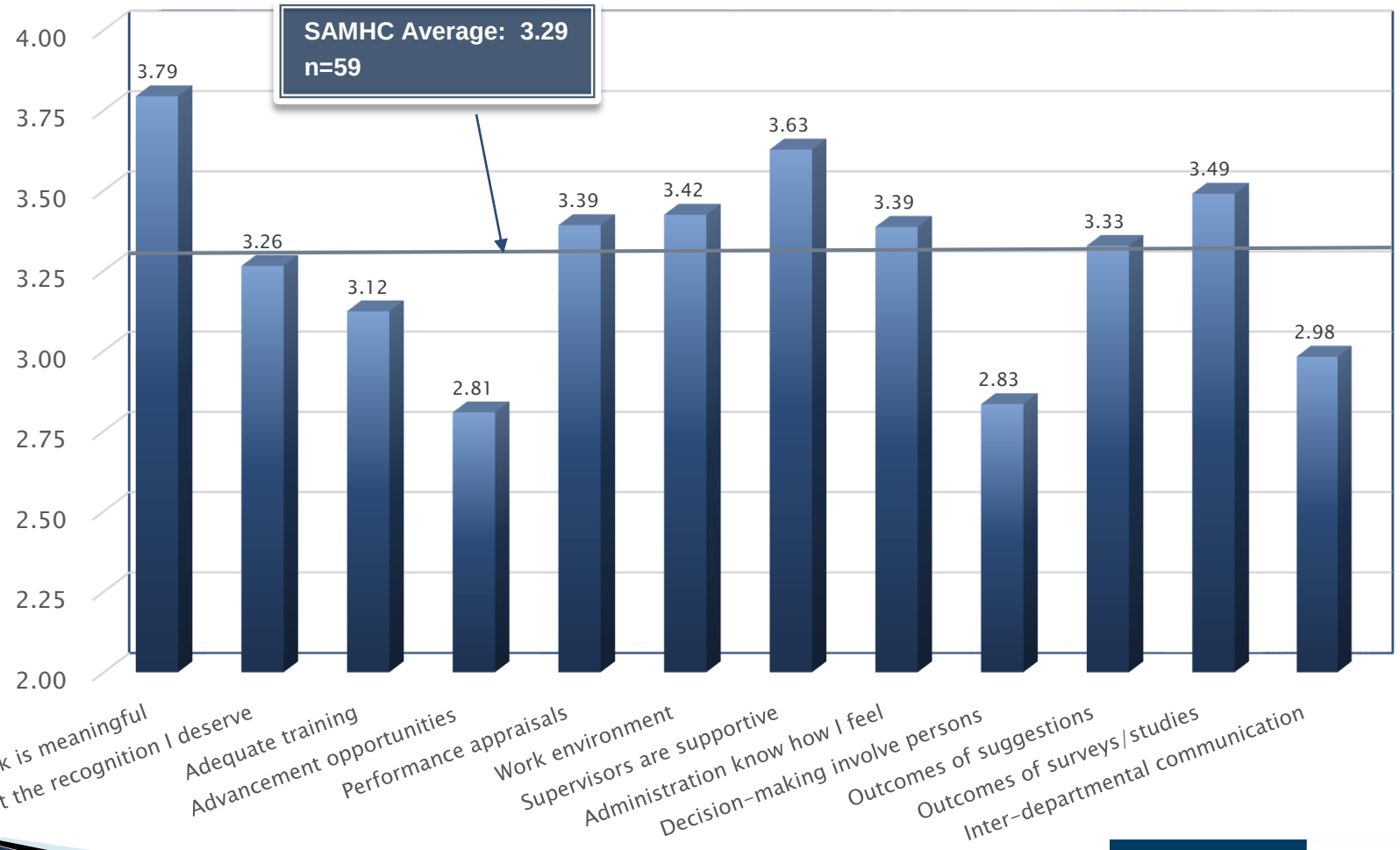
Aggregate Results > Performance



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South Carolina Department of Mental Health

Aggregate Results > Importance > Background

What is Importance?

Importance identifies the impact or influence that each attribute has on patients' overall perception of your office or group.

Importance can be measured in two ways – by asking directly or by inference. Asking a respondent to rate importance directly is straightforward but tends to result in high importance values for all attributes and little differentiation between attributes. Deriving importance, on the other hand, results in a more accurate assessment. Respondents have a difficult time articulating shades of difference in importance, but since derived importance does not ask importance directly, the result provides a truer measure of what is important.

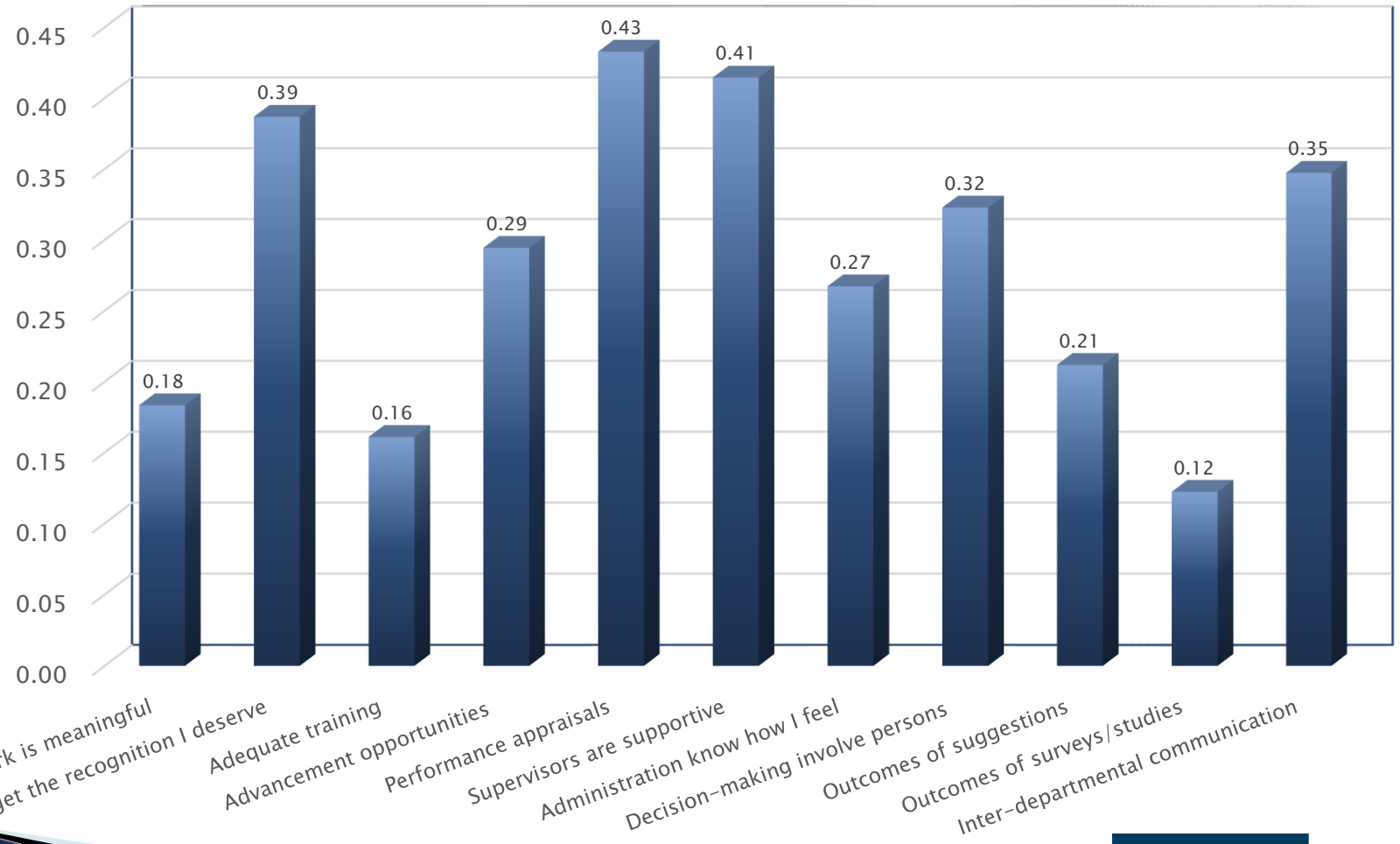
How is Importance calculated?

The correlation is essentially a simple linear regression of one independent variable and one dependent variable. The correlation score can range from 0 to 1, with a 0 indicating no relationship and a 1 indicating a perfect or lock-step relationship. The higher the score, the more important the attribute is in determining the patient's overall satisfaction.

The dependent variable attribute used to calculate the correlation is "Q7. My work environment is one in which I feel I can be successful".

Aggregate Results > Importance

***Note: dependent variable use to calculate importance is "Q7. My work environment is one in which I feel I can be successful"



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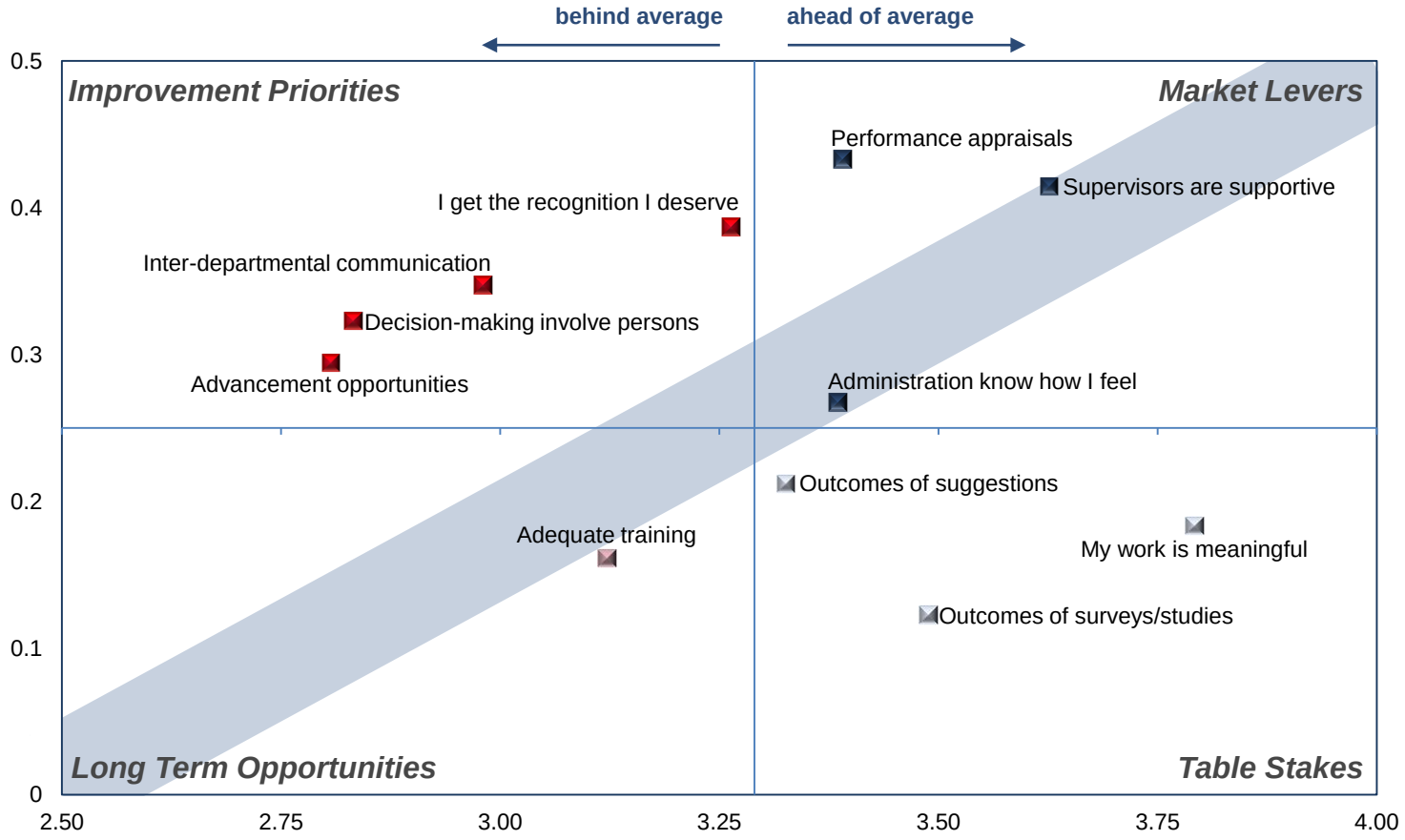
Aggregate Results > Improvement Map



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South Carolina Department of Mental Health

Aggregate Results > Improvement Map > Comments

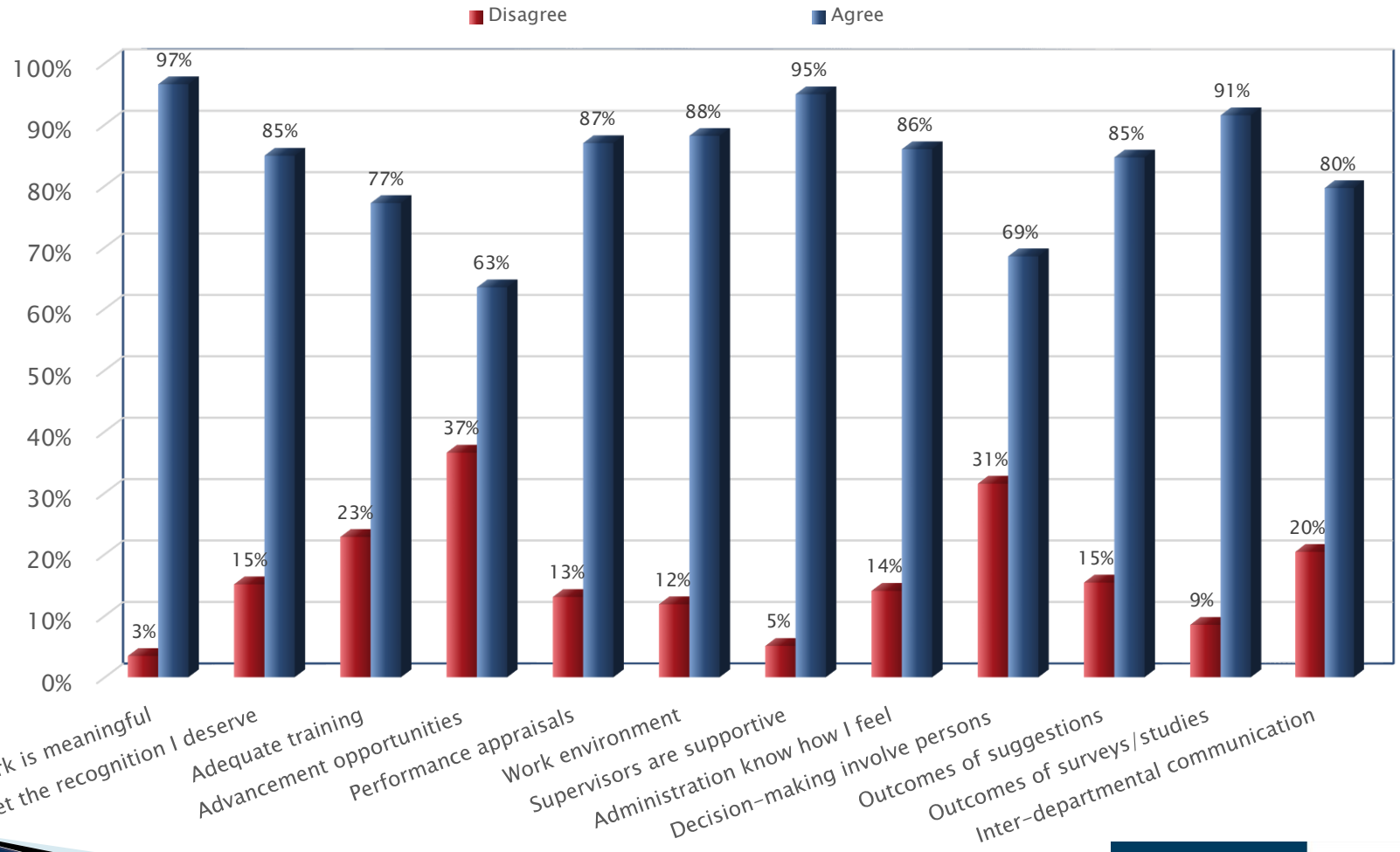
I get the recognition that I deserve for the work that I do.
- From supervisor but not Administration/3rd floor.

I am satisfied with advancement opportunities here.
- I feel like there is no growth here.
- I believe there are opportunities available here but only if you are what they consider advancement material.
- In my area of work I don't really know of any advancement opportunities.
- Limited advancement after MHCIII, esp. if you don't want to supervise.
- Flatten that org chart No where for staff to move up or have career worse than 1 ½ ago
- I do not feel there are any opportunities for me to advance currently.
- I do not feel there is room for advancement in a satellite office.

Decision-making processes adequately involve persons affected by the decision in most cases.
- This is not always the case. Sometimes you get a lot thrown at you with no warning.
- Not entirely sure about the word "affected" proactively, I would like decisions from people who are "engaged"
- A lot of important things and decision that you should be included in you aren't. That's one of the major problems here everyone knows your business before you.
- I have not seen this. Director & HR make all the decisions.
- Decisions about programs are made & staff are not adequately informed.
- Things such as employee of the year - real peers Really Know who is doing the Work.

There is appropriate inter-departmental communication/cooperation.
- Dept. need to keep everyone in loop about meetings using rooms on site.
- Not at all. It appears there is a lot of "not my job, not my problem."
- Needs improvement. Not saying it isn't getting better. But…it could be better.
- No one knows how to communicate properly here.
- Counselors and medical staff need better communication/cooperation. Really like all staff meetings-wish docs would attend.
- Sometimes.

Aggregate Results > Performance



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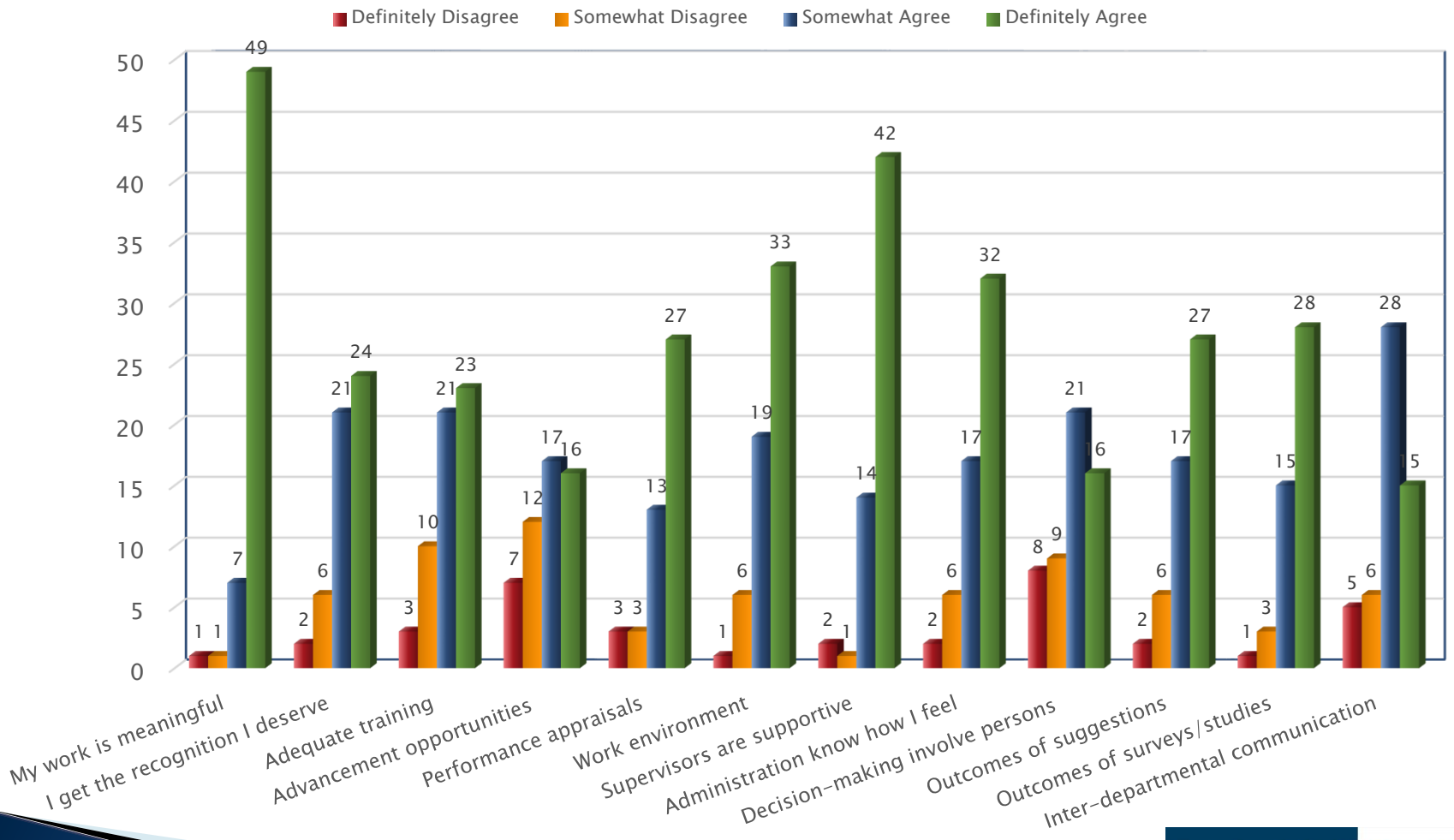
South Carolina Department of Mental Health

Aggregate Results > Performance



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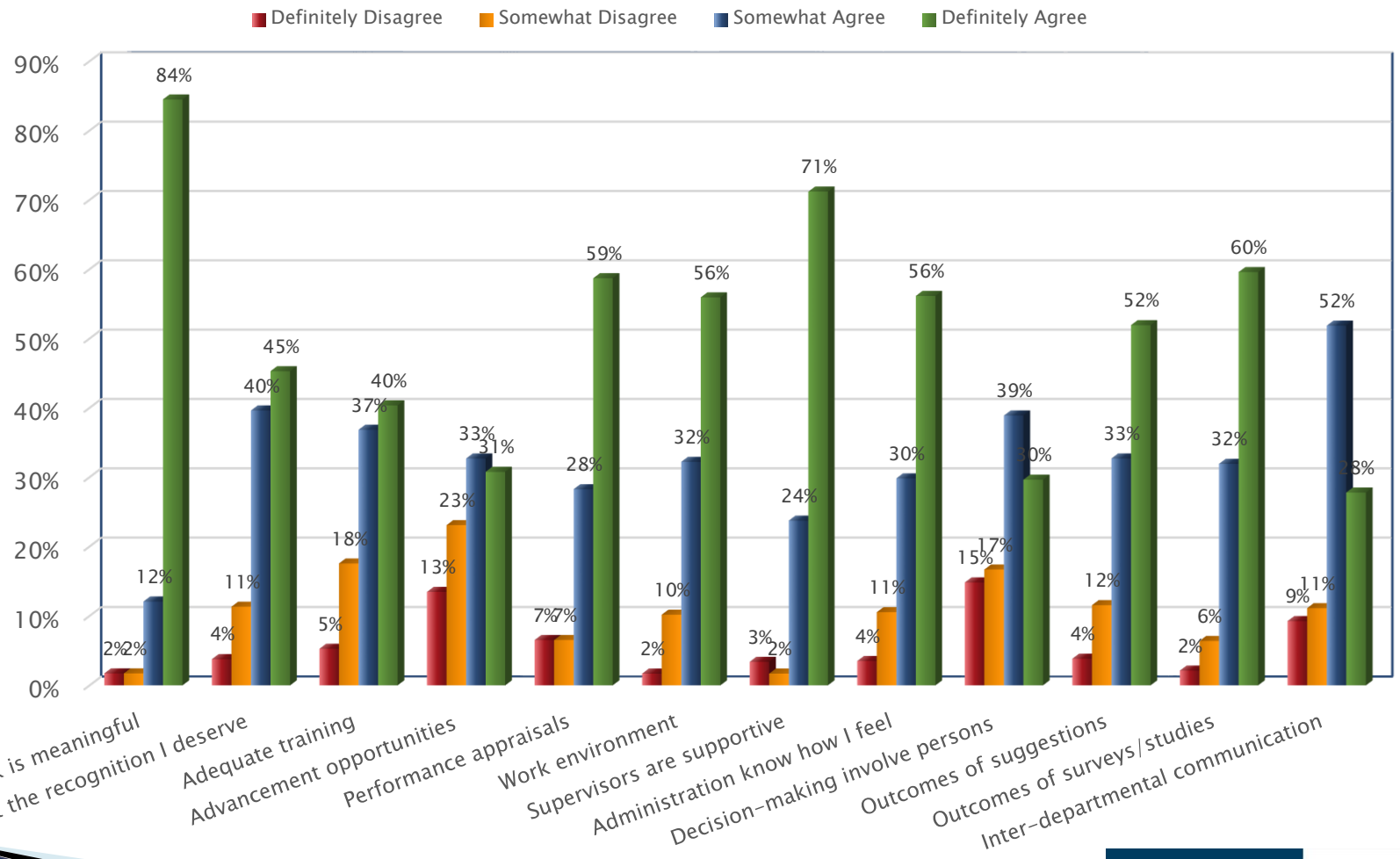
Aggregate Results > Performance



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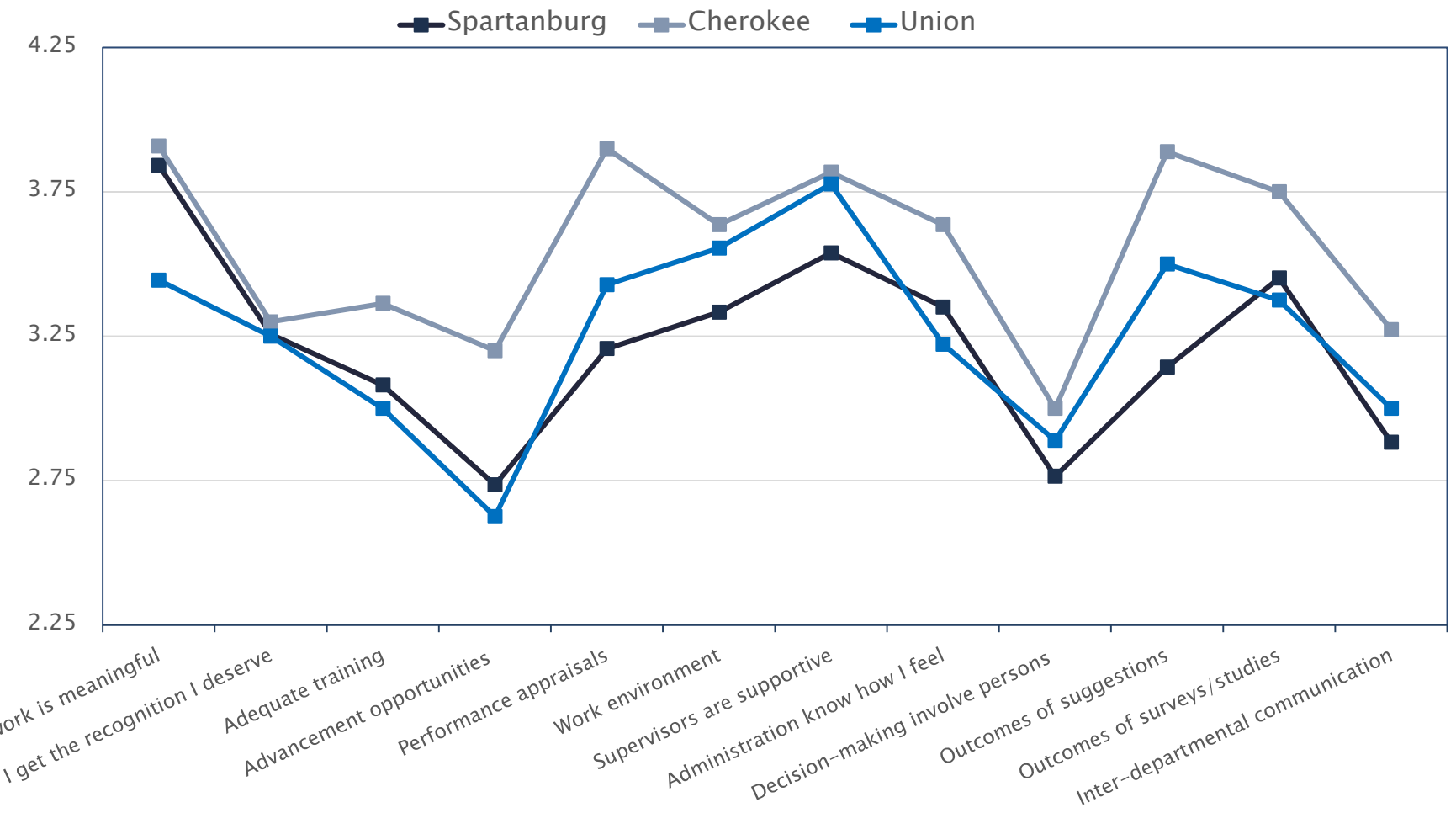
South Carolina Department of Mental Health

Agenda

- Survey Overview
- Aggregate Results
- Segment Analysis
  - By County
  - Clinical Vs. Non-Clinical
- Conclusions/Recommendations

Aggregate Results > Performance Comparison



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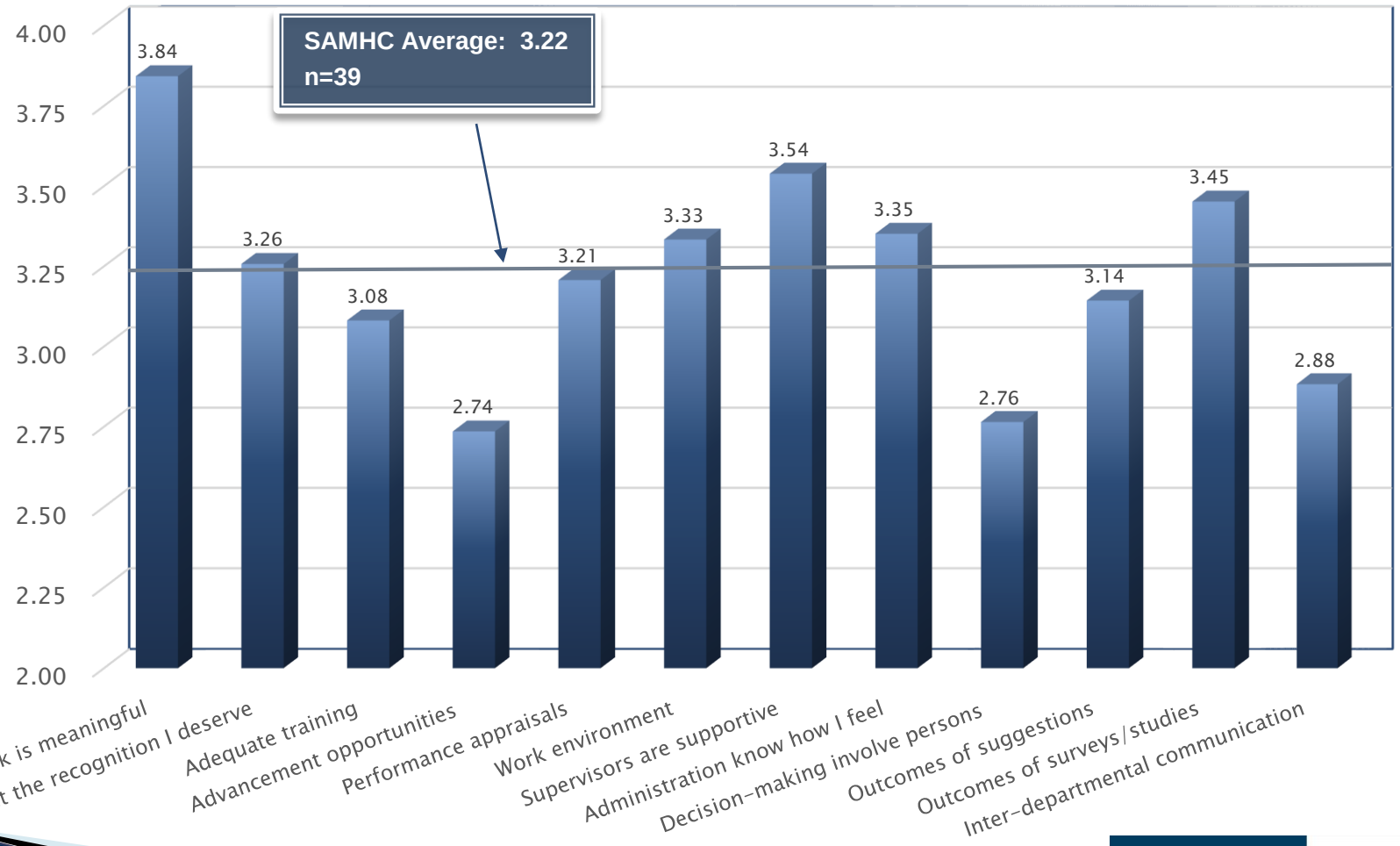
South Carolina Department of Mental Health

Aggregate Results > Performance > Spartanburg



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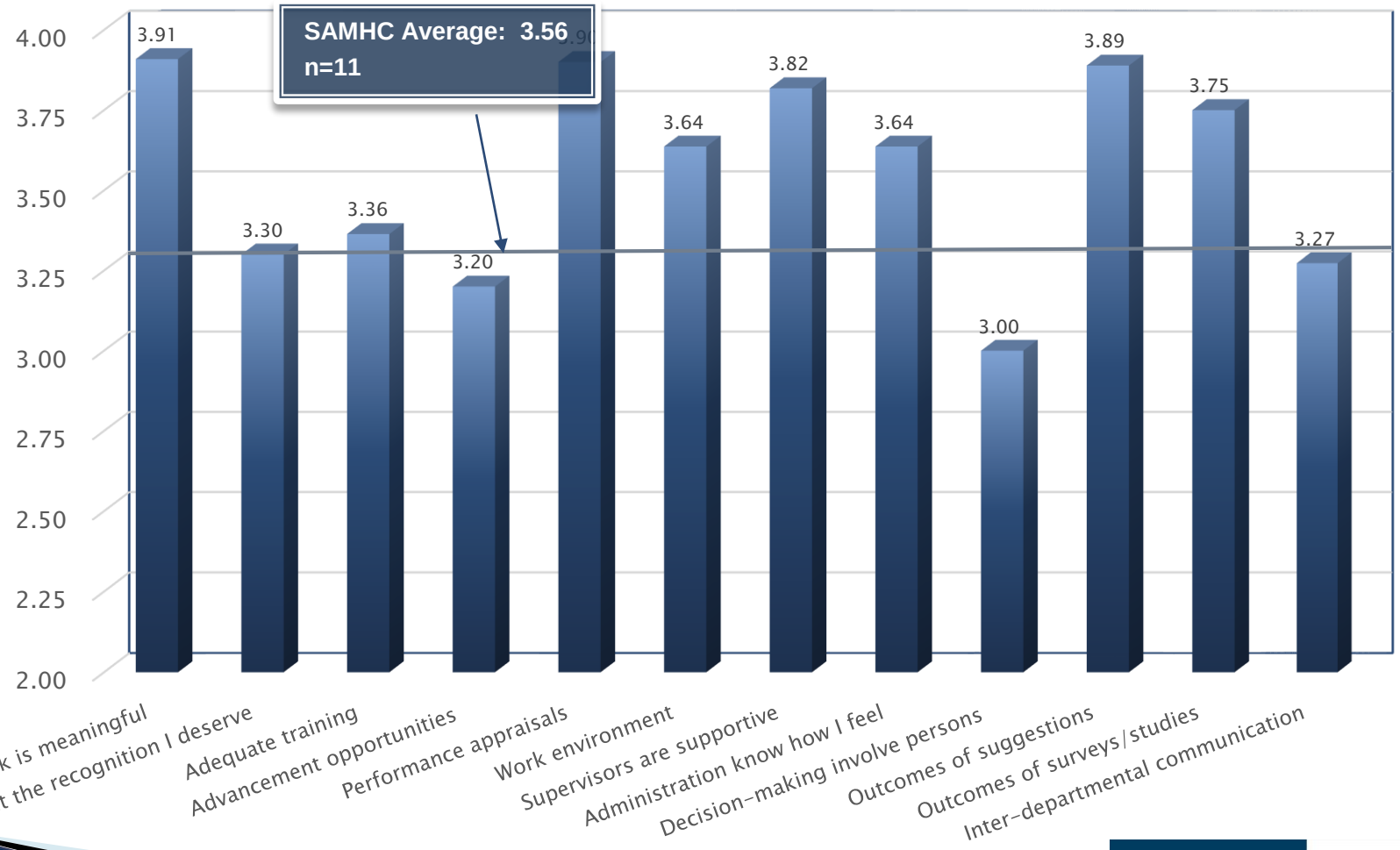
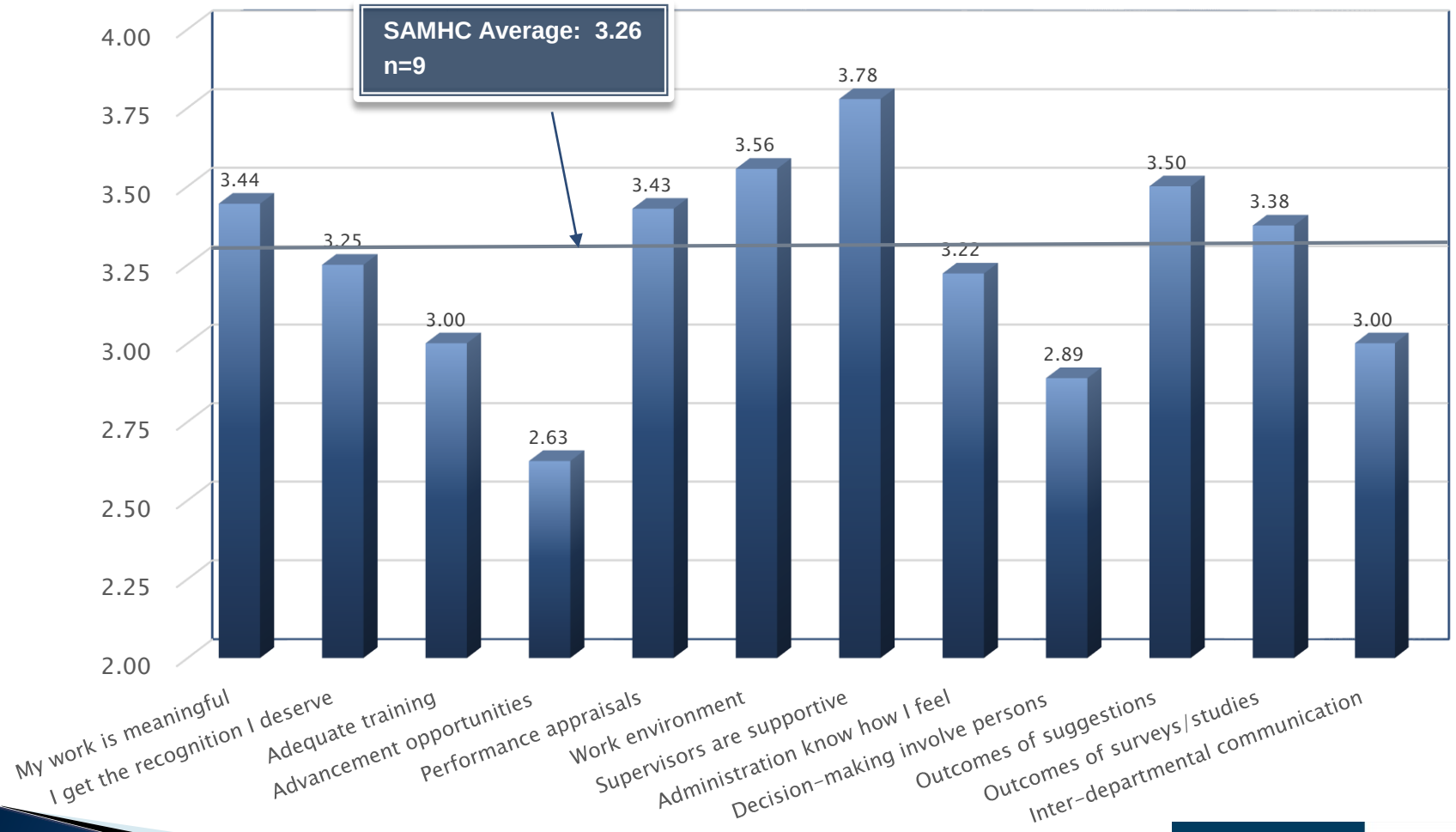
South Carolina Department of Mental Health

Aggregate Results > Performance > Cherokee



DMH Spartanburg
South Carolina Department of Mental Health

Aggregate Results > Performance > Union

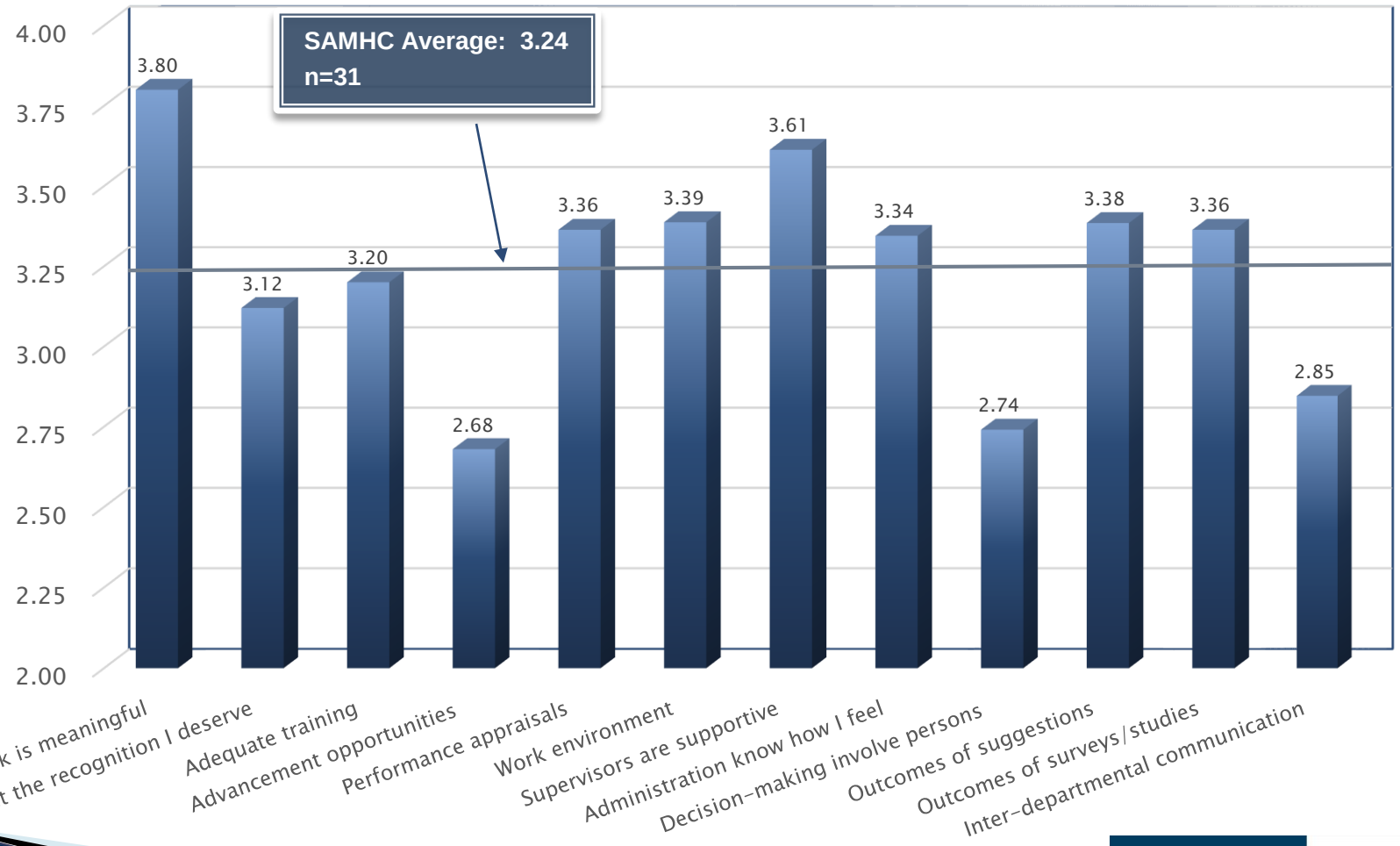


DMH Spartanburg
South Carolina Department of Mental Health

Agenda

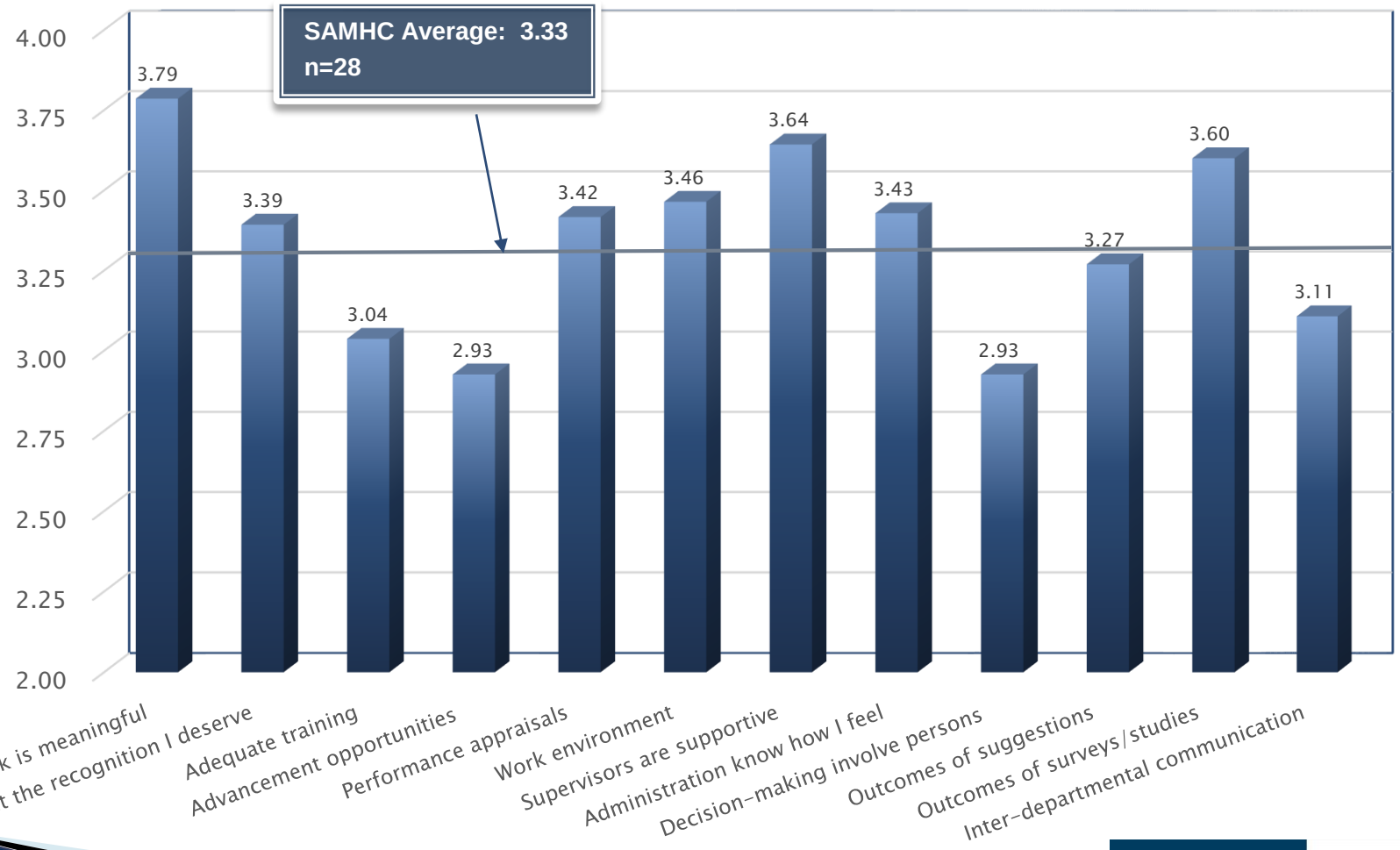
- Survey Overview
- Aggregate Results
- Segment Analysis
  - By County
  - Clinical Vs. Non-Clinical
- Conclusions/Recommendations

Aggregate Results > Performance > Clinical



DMH Spartanburg
South Carolina Department of Mental Health

Aggregate Results > Performance > Non-Clinical



DMH Spartanburg
South Carolina Department of Mental Health

Agenda

- Survey Overview
- Aggregate Results
- Segment Analysis
- Conclusions/Recommendations

Conclusions

The average score of SAMHC is 3.29 on a 4 point scale. In general, employees view SAMHC as good employer. They indicate that their work in meaningful and that they get all the support from their supervisors.

SAMHC employees identified the following as key strengths:

- My work is meaningful.
- Supervisors are supportive in ways that help me to do my job.
- Staff are adequately informed about the outcomes of surveys and other outcome studies.
- My work environment is one in which I feel I can be successful.
- Performance appraisals are conducted fairly.
- I believe that SAMHC's top administration (Center Director and Administrator) wants to know how I feel.
- Staff are adequately informed about the outcomes of suggestions/recommendations made to supervisors or members of the Executive Committee.

Attributes scoring relatively low:

- I am satisfied with advancement opportunities here.
- Decision-making processes adequately involve persons affected by the decision in most cases.
- There is appropriate inter-departmental communication/cooperation.

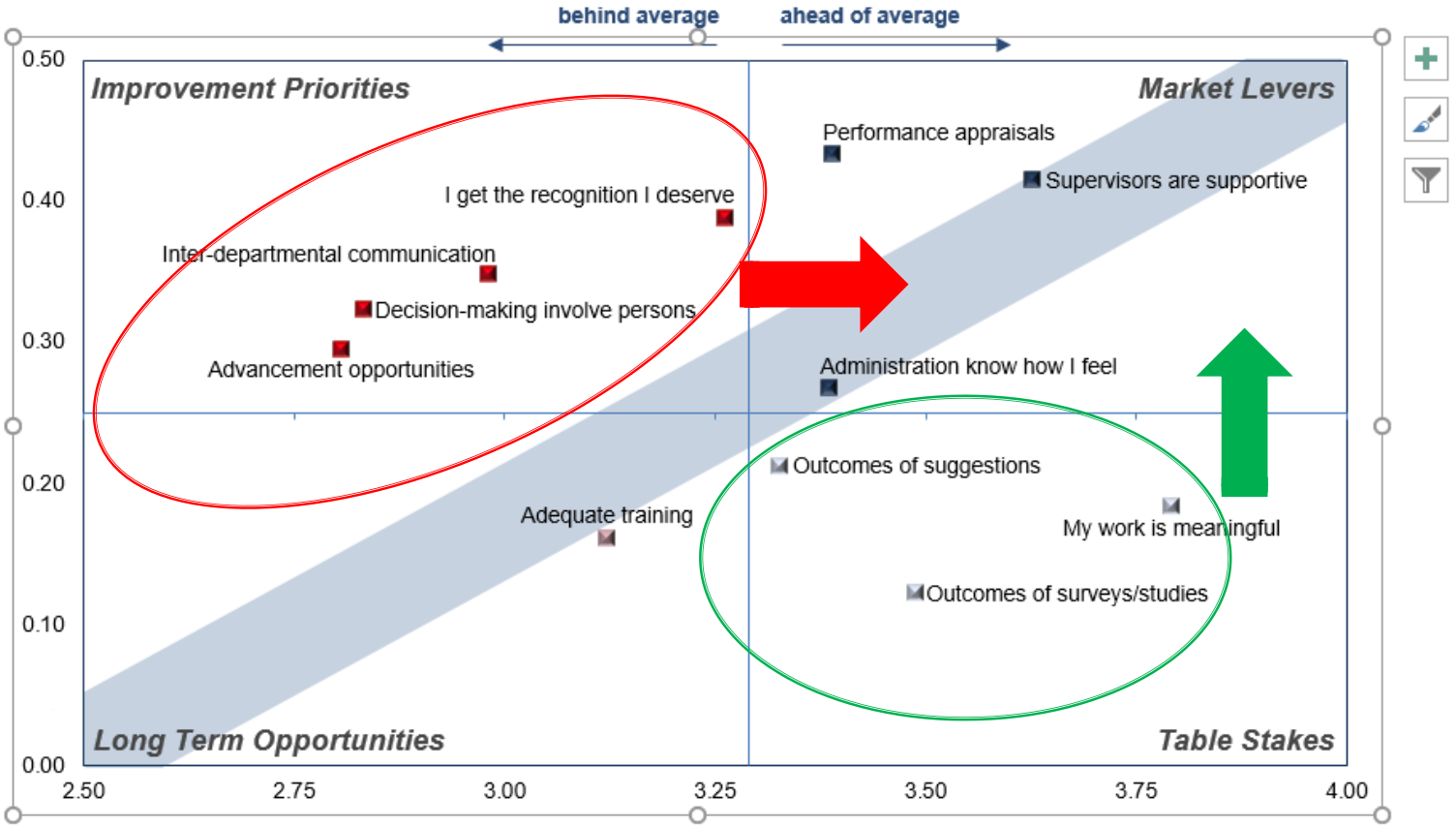
Conclusions

Comparing performance with importance, four attributes stand out as opportunities for improvement:

- I get the recognition that I deserve for the work that I do.
- Decision-making processes adequately involve persons affected by the decision in most cases.
- I am satisfied with advancement opportunities here.
- There is appropriate inter-departmental communication/cooperation. (see next page)

Three attributes in the performance map are in the sector titled “table stakes.” These are areas where SAMHC performs at a high level but employees do not see the attributes as important in creating satisfaction or feel successful at work. These attributes could be the focus of targeted efforts to communicate with employees. (see next page)

Conclusions

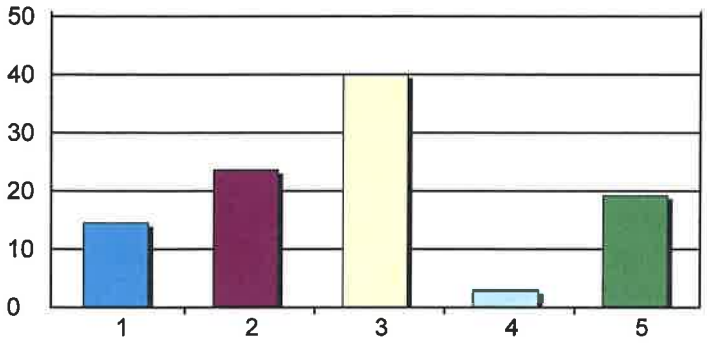


DMH Spartanburg South Carolina Department of Mental Health

South Carolina Department of Mental Health
Division of Evaluation, Training and Research
Survey for DIS Staff

Creation Date: 5/14/2018
Time Interval: 4/19/2018 to 5/14/2018
Total Respondents: 324

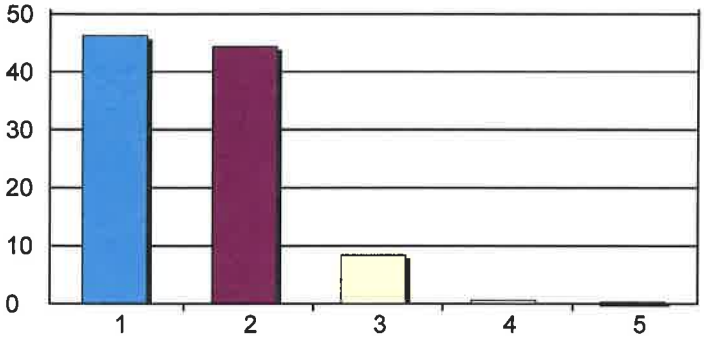
1. SCDMH should revise the SCDMH mission, vision, and values.



1. Strongly Agree	46	14%
2. Agree	75	24%
3. Neutral	127	40%
4. Strongly Disagree	9	3%
5. Disagree	61	19%
Total Responses:	318	

Mean: 2.89 Standard Deviation: 1.27

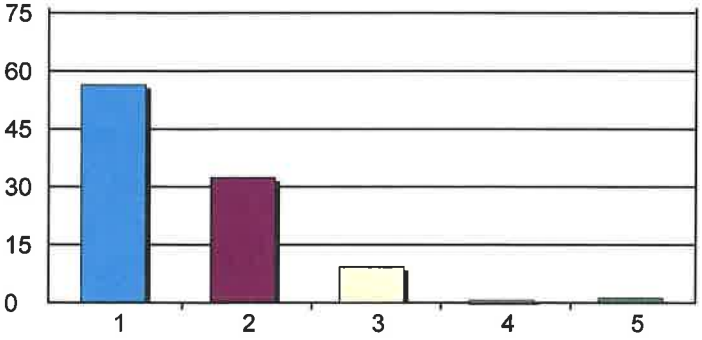
2. SCDMH should allow all employees to contribute to improvements.



1. Strongly Agree	149	46%
2. Agree	143	44%
3. Neutral	27	8%
4. Strongly Disagree	2	1%
5. Disagree	1	0%
Total Responses:	322	

Mean: 1.64 Standard Deviation: 0.69

3. SCDMH should improve its communication process.

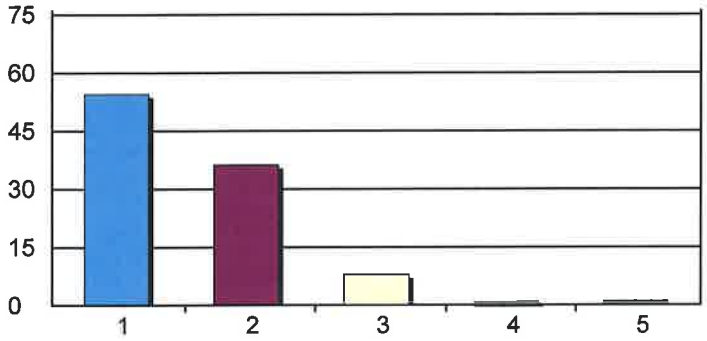


1. Strongly Agree	181	56%
2. Agree	104	32%
3. Neutral	30	9%
4. Strongly Disagree	2	1%
5. Disagree	4	1%
Total Responses:	321	

Mean: 1.58 Standard Deviation: 0.79

South Carolina Department of Mental Health
Division of Evaluation, Training and Research
Survey for DIS Staff

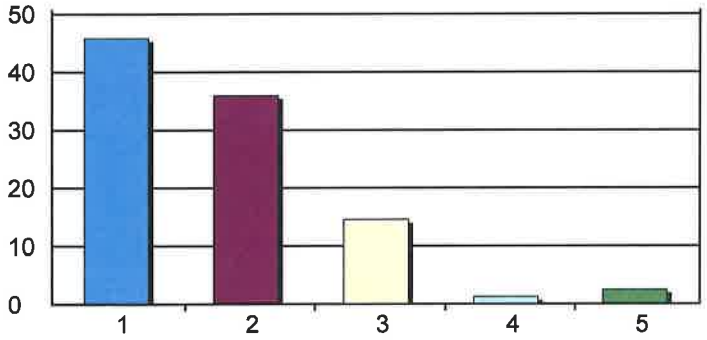
4. SCDMH should improve teamwork within the agency.



1. Strongly Agree	176	54%
2. Agree	117	36%
3. Neutral	25	8%
4. Strongly Disagree	2	1%
5. Disagree	3	1%
Total Responses:	323	

Mean: 1.57 Standard Deviation: 0.74

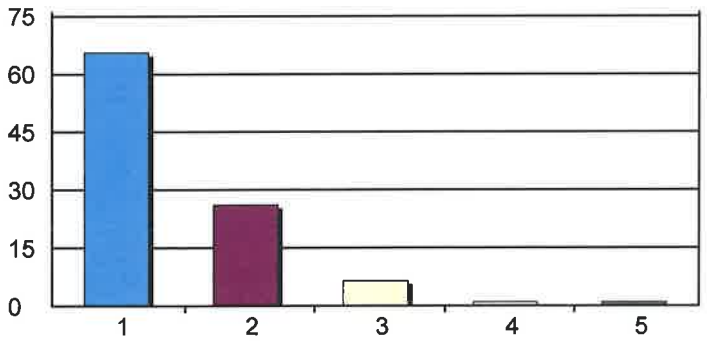
5. SCDMH should improve supervisory support to employees.



1. Strongly Agree	148	46%
2. Agree	116	36%
3. Neutral	47	15%
4. Strongly Disagree	4	1%
5. Disagree	8	2%
Total Responses:	323	

Mean: 1.79 Standard Deviation: 0.91

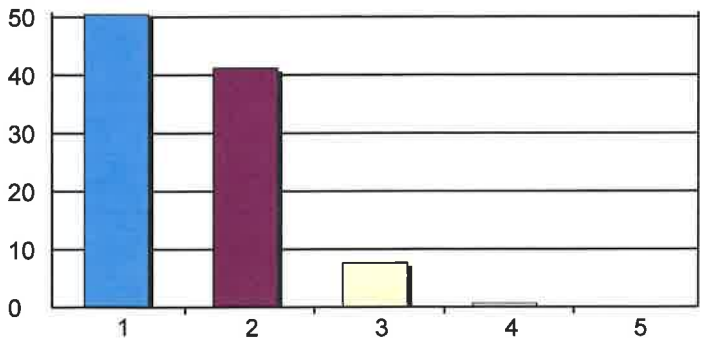
6. SCDMH should increase employee opportunities for professional and personal growth.



1. Strongly Agree	211	66%
2. Agree	84	26%
3. Neutral	21	7%
4. Strongly Disagree	3	1%
5. Disagree	3	1%
Total Responses:	322	

Mean: 1.46 Standard Deviation: 0.74

7. SCDMH should build and maintain leadership values.

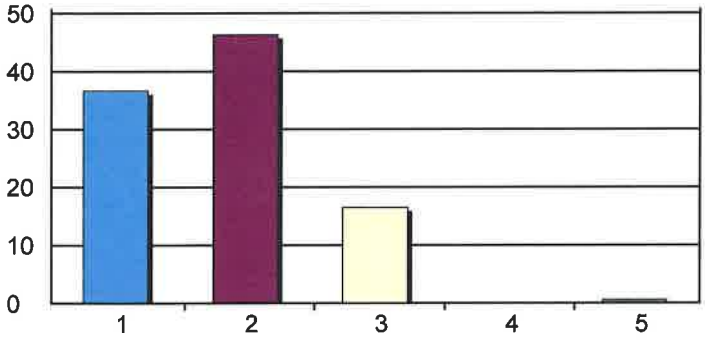


1. Strongly Agree	163	50%
2. Agree	133	41%
3. Neutral	25	8%
4. Strongly Disagree	2	1%
5. Disagree	0	0%
Total Responses:	323	

Mean: 1.59 Standard Deviation: 0.66

South Carolina Department of Mental Health
Division of Evaluation, Training and Research
Survey for DIS Staff

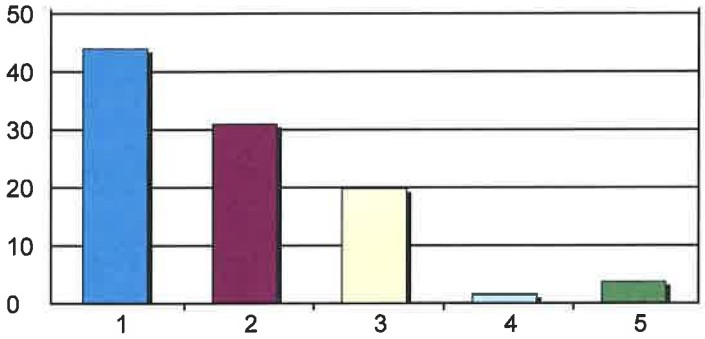
8. SCDMH should improve/expand treatment programs for clients, residents and patients.



1. Strongly Agree	118	37%
2. Agree	149	46%
3. Neutral	53	16%
4. Strongly Disagree	0	0%
5. Disagree	2	1%
Total Responses:	322	

Mean: 1.82 Standard Deviation: 0.75

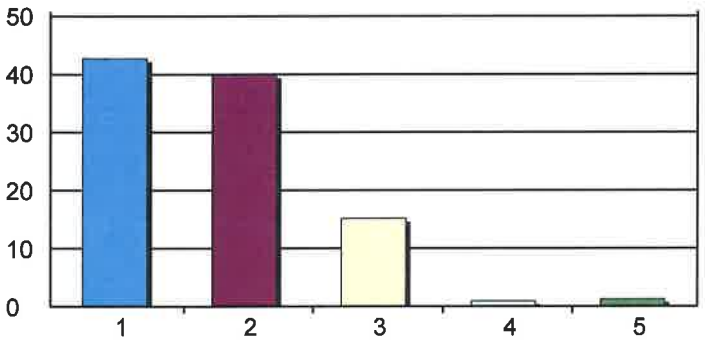
9. SCDMH should improve/expand orientation and training programs for its employees.



1. Strongly Agree	142	44%
2. Agree	100	31%
3. Neutral	64	20%
4. Strongly Disagree	5	2%
5. Disagree	12	4%
Total Responses:	323	

Mean: 1.90 Standard Deviation: 1.01

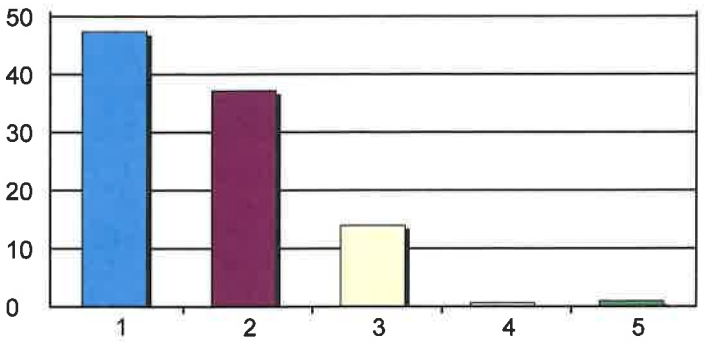
10. SCDMH should improve the physical environment for clients, residents and patients.



1. Strongly Agree	138	43%
2. Agree	129	40%
3. Neutral	49	15%
4. Strongly Disagree	3	1%
5. Disagree	4	1%
Total Responses:	323	

Mean: 1.78 Standard Deviation: 0.83

11. SCDMH should build upon the technology in the agency.

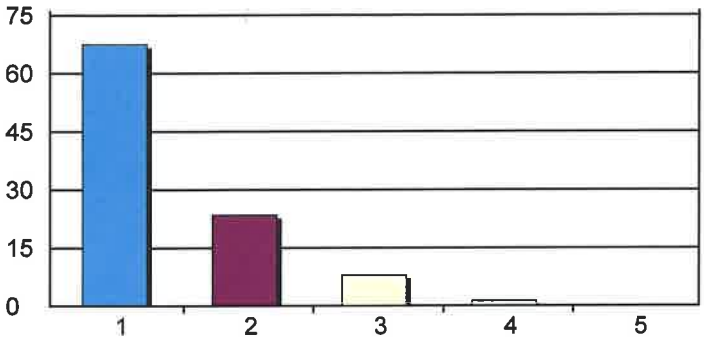


1. Strongly Agree	153	47%
2. Agree	120	37%
3. Neutral	45	14%
4. Strongly Disagree	2	1%
5. Disagree	3	1%
Total Responses:	323	

Mean: 1.71 Standard Deviation: 0.80

South Carolina Department of Mental Health
Division of Evaluation, Training and Research
Survey for DIS Staff

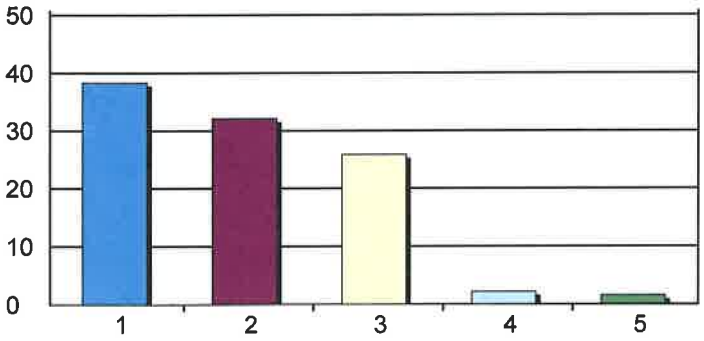
12. SCDMH should increase/enhance recruitment and retention incentives.



1. Strongly Agree	216	68%
2. Agree	75	23%
3. Neutral	25	8%
4. Strongly Disagree	4	1%
5. Disagree	0	0%
Total Responses:	320	

Mean: 1.43 Standard Deviation: 0.69

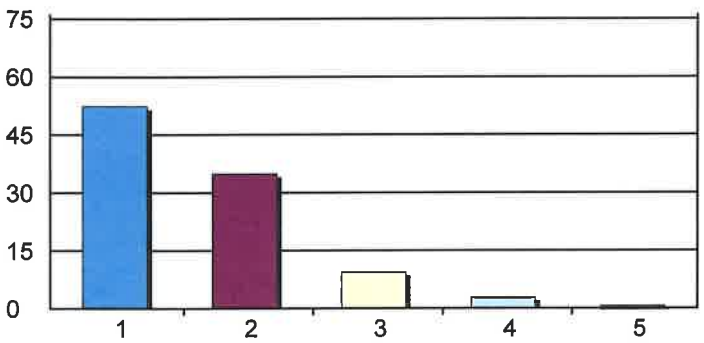
13. SCDMH should decrease paper-driven processes.



1. Strongly Agree	123	38%
2. Agree	103	32%
3. Neutral	83	26%
4. Strongly Disagree	7	2%
5. Disagree	5	2%
Total Responses:	321	

Mean: 1.97 Standard Deviation: 0.93

14. SCDMH should increase opportunities for employees to provide feedback.



1. Strongly Agree	168	52%
2. Agree	112	35%
3. Neutral	30	9%
4. Strongly Disagree	9	3%
5. Disagree	2	1%
Total Responses:	321	

Mean: 1.64 Standard Deviation: 0.81

Comment Report Title

17. The use of Technology in SCDMH.

Avatar is too old & ridiculously too complicated. Staff should have access tp laptops/mobile devices and screems/tvs on units, cottages to view or project the multitude of available learning opportunites i.e. youtube etc. for clients.

19. Employees both full-time, temporary, or contract staff.

1. Why is HR running everything? Hiring, raises, salaries should be determined by supervisors and directors. 2. PAY PEOPLE! Look at job requirements vs. salary offered-way unbalanced. Thats why wa cant find & keep people. We have a big agency but that is no excuse. Its 2018. Get in the game. It takes too long for decision making. Ultimately, its the patients that suffer-our first priority!

17. The use of Technology in SCDMH.

Afford staff opportunity for state of the art computer technology and furniture.

16. The SCDMH Budget.

Ergonomic office furniture needed(new).
(new) file cabinets needed.

17. The use of Technology in SCDMH.

Free online office workers software training classes, i.e., excel, powerpoint, word, access, project, etc.

15. The SCDMH Mission, Vision, and Values.

Are we maximizing on the promises and statements that are in place? Are we making statements that we are not keeping? Is there something in there that we cannot accomplish because of changes? What changes?

16. The SCDMH Budget.

Request that money be put in the budget for employee raises and incentives. If only .5% or 1% toward above average evaluations and and overall increase atevery year or every other year. Employees are asked to do more jobs daily in some departments, and that is okay but I also think that we need to be compensated. Some of us are struggling. Need increase.

17. The use of Technology in SCDMH.

Do we have a training lab at the dept. for people who need computer training? I think it would be wonderful if there was a computer lab where the staff could go and have a trainer there to assist them in their needs. Not on the unit or another campus but on the campus where they work. This could occur once a quarter but it would be helpful.

18. SCDMH Client, Patient, Resident Services.

I think that money is not always the thing that makes people happy or make them feel good. Doing things that make the staff feel good about themselves or about the job they are doing. Authority figure show up in the workplace and give word of appreciation to those staff that is here around the clock, in the trenches. Face time is sometimes better than 2 or 3 dollars when you feel unappreciated.

20. SCDMH Leadership/Supervisors.

Leadership and Supervisor roles-accountability is lacking in alot of areas. Are supervisors trained in how and what their duties are? Are managers supposed to be leaders?

I don't mean anything i said to be taken as negative thinking. I know we can do better

15. The SCDMH Mission, Vision, and Values.

still clear

16. The SCDMH Budget.

breakdown the budget so everyone can understand it. Feedback on where budget being spent

17. The use of Technology in SCDMH.

more classes

18. SCDMH Client, Patient, Resident Services.

?

19. Employees both full-time, temporary, or contract staff.

search for some new employee, people who already retired and terri should have to apply for these jobs just like a new person. we might can get new ideas in @ a cheaper cost

Comment Report Title

20. SCDMH Leadership/Supervisors.

Need better communication between dept.

15. The SCDMH Mission, Vision, and Values.

no comment

16. The SCDMH Budget.

employees should be paid more

17. The use of Technology in SCDMH.

outdated computers are down a lot

18. SCDMH Client, Patient, Resident Services.

should provide better care for pts

19. Employees both full-time, temporary, or contract staff.

should be treated just like regular staff

20. SCDMH Leadership/Supervisors.

supervisors should treat staff in a professional manner.

15. The SCDMH Mission, Vision, and Values.

na

16. The SCDMH Budget.

na

17. The use of Technology in SCDMH.

na

18. SCDMH Client, Patient, Resident Services.

na

19. Employees both full-time, temporary, or contract staff.

na

20. SCDMH Leadership/Supervisors.

na

15. The SCDMH Mission, Vision, and Values.

Include simple "standards of behavior". state regulations can be confusing and not always helpful.

16. The SCDMH Budget.

Show employees where we have waste, not just the leaders. Someone may have excellent ideas that can actually work.Keep language simple.

17. The use of Technology in SCDMH.

Move to the 21st century-too much paper. Many state and private organization use electronic processes. Lets go green dmh/dis.

19. Employees both full-time, temporary, or contract staff.

Show employee how the can grow in the organization-stop losing good employee to the private sector. build a ladder to show where/how they can enhance careers right with dmh.

20. SCDMH Leadership/Supervisors.

Provide ongoing "Mandatory Training" to the leaders of dmh/dis. Leaders must be lead by example!!

16. The SCDMH Budget.

I don't know if the budget needs to be increased but the staff surly need raises if crazy that for every yearly review(meets &exceeds) we should get raises WE DONT HAVE ANY INCENTIVE TO DO OUR BEST we should get raises yearly if we've done our job exceedingly well!

17. The use of Technology in SCDMH.

SCDMH needs to update its computers and go completely electronic this will illuminate paper cost & im sure decrease HIPPA vialations & DMH could interact with other agencies electronically(like the rest of the world does)

Comment Report Title

18. SCDMH Client, Patient, Resident Services.

I'm not sure if this goes along with client/pt./resident services but overworked, underpaid staff doesn't make for very attentive staff to pt. relationships.

15. The SCDMH Mission, Vision, and Values.

The current mission is appropriate; however, it seems appropriate to review any mission relative to changes which have directly impacted that mission, vision or values.

16. The SCDMH Budget.

Budgets need to be more integrated with appropriate feedback loops within the direct service areas. Patient needs and trends within services ie regulatory, accreditation requirements, community feedback, etc should drive decision making

17. The use of Technology in SCDMH.

more, more, more... the agency seriously imparied by lack of systems which can eliminate waste, paper and absence of data needed to drive business decisions. HR is overwhelming the SCDMH with paper and it further impacts recruitment

18. SCDMH Client, Patient, Resident Services.

More "active treatment" is needed across the system. The need requires a "2018" revision of how we provide rx to include 7 day/24hr plans and integration with families and community and inpatient. Creative thinking can lead to an improved contium of care.

19. Employees both full-time, temporary, or contract staff.

employee need more training-post etr general orientation (at their facility site. And employees need access to additional off site training opportunities. I would suggest that a major (integrated) scdmh think tank be developed to encourage all levels of staff participation and feedback is development of a plan-training online should be a part of that plan.

20. SCDMH Leadership/Supervisors.

leadership/supervisor ethics training & leadership excellance program should be a part of initial and ongoing across the system to include an "academy" program which would encourage, engage and sustain consistent leadership excellence in supervising skills, ethics, and behaviors and knowledge base.

16. The SCDMH Budget.

SW, AT, Psycology/counseling need raises

17. The use of Technology in SCDMH.

EHR needs import tab

15. The SCDMH Mission, Vision, and Values.

Addiction treatment should be included in mission, visoin, value

16. The SCDMH Budget.

The budget seems to cater to those at the top more than any other employees. For staff to still be making 15k annually and those over 50k continue to get raises make no logical sense/ Patient care is at all time low but top tier and middle level managers often see salary increases.

17. The use of Technology in SCDMH.

Other large entities in the state have transitioned from paper charting to technology/computers which leaves scdmh way behind in advancements and modern technology.

18. SCDMH Client, Patient, Resident Services.

Patient care seems to be decreasing. there should be more servicing to the elderly to help them while they are patients here.

19. Employees both full-time, temporary, or contract staff.

Staff are severly under paid and many employees have both experience and education, however, it is very hard to advance within. Very discouraging for potential employees and millenials. This is why the turnover rate is high.

20. SCDMH Leadership/Supervisors.

Leadership/supervisor don't seem to have much interest in getting to know or become personable with the lower tier employees. Other times they walk past nor do they even speak or acknowledge anyone who they aren't familiar with.

Comment Report Title

15. The SCDMH Mission, Vision, and Values.

na

16. The SCDMH Budget.

All departments(sections) should have access to sink, refrigerator, and fresh drinking water. Some of our building clearly have old pipes b/c the water comes out brown. Some section do not have break rooms.

17. The use of Technology in SCDMH.

I applaud SCDMH as I can see steps taken to update some tech(computer, time clocks, etc.). However, I believe security doors for our employees would be a good idea.

18. SCDMH Client, Patient, Resident Services.

I recommend having support services for staff. I'm sure that our staff who are occasionally hurt by our patients would benefit from better physical, psychological; really just overall support. Our agency depends on our nurses, bhas and cnas. They really deserve our support and daily prayers

19. Employees both full-time, temporary, or contract staff.

see box 18

20. SCDMH Leadership/Supervisors.

Excellent leadership at C.M. Tucker, NCC. The leadership/supervisors listen to staff, gather input, and respond in a timely manner. The stop light board is a way employees have a voice. There is a great deal of respect for the way Tucker treats their staff.

15. The SCDMH Mission, Vision, and Values.

Great value needs to be placed on more performance excellence. There is no merit based system at yearly evaluation and employees are not compensated is any way for an above and beyond performance. Likewaise, under performing employees are not disciplined or faced with any consequences. This results in an apathetic staff. The system needs to move towards performance based incentives/compensation similar to other work environments.

17. The use of Technology in SCDMH.

I think that an electronic medical records is essential for accuracy, safety, and efficiency. My facility does not have this technology and it is a major setback. Also, the technology support has been less than average. When my department has a technology problem it takes days to weeks to get it fixed and these are often urgent matters. The staff with IT is unresponsive or very slow to respond with no sense of urgency.

18. SCDMH Client, Patient, Resident Services.

I think our patients would greatly benefit from further activity therapies. They often are found wandering the halls and appear bored. Specifically our younger residents would benefit from more stimulating activities.

19. Employees both full-time, temporary, or contract staff.

The pay for employees needs to be equivalent and competitive to the outside work force in order to gain and retain qualified and quality employees. The compensation is much below the average national salary. For my position specifically about 40% under our national average. That makes it difficult to hire experienced and qualified individuals and retain employees.

20. SCDMH Leadership/Supervisors.

I think that leadership and supervisors should have more emphasis on performance excellence and should acknowledge employees for a job well done. It seems as though they do not care if you perform mediocre work or great work. At my previous job mediocre work was called out and called to a higher standard. That is not the case here.

16. The SCDMH Budget.

I think salaries need to be increased significantly in order to recruit and retain quality employees and compete with other companies.

17. The use of Technology in SCDMH.

There is not enough support from IT and their team is not reliable when they're needed.

20. SCDMH Leadership/Supervisors.

There needs to be a quicker turn around for leadership support and/or approval for things.

17. The use of Technology in SCDMH.

We need better support for the technology we currently have. It is a very slow process in getting a response for a request when having a problem. Our job depends on technology.

Comment Report Title

19. Employees both full-time, temporary, or contract staff.

The pay needs to be equivalent to the outside work force in order to get and retain quality employees

19. Employees both full-time, temporary, or contract staff.

DIS HR needs to expedite recruitment and hiring practices!!

15. The SCDMH Mission, Vision, and Values.

great

16. The SCDMH Budget.

not enough information provided

17. The use of Technology in SCDMH.

needs improvement

18. SCDMH Client, Patient, Resident Services.

ok

19. Employees both full-time, temporary, or contract staff.

not stuff enough

19. Employees both full-time, temporary, or contract staff.

I constantly hear complaints and negativism about start pound policy. is ther any way to develop a prn pool and do away with their practice which seems to be a hard stumbling block to employee retention

16. The SCDMH Budget.

Low paid employee need a decent salary increase. The cost of living never stops going up and state employees can't even begin to catch up because we are so far behind.

17. The use of Technology in SCDMH.

Technology needs to be supported by trained and available IT people.

19. Employees both full-time, temporary, or contract staff.

make an environment in which employees want to stay

16. The SCDMH Budget.

There should be more funds for treatment in the outpatient settings needs to increase the salaries of clinicians.

18. SCDMH Client, Patient, Resident Services.

Needs to improve funding for pt. with substance abuse in the community

19. Employees both full-time, temporary, or contract staff.

e,ployee are underpaid and are over worked

16. The SCDMH Budget.

Improve salaries and benefits to stay competitive with community stay utilizing spare equipment have little to no input into purchases or changes.

17. The use of Technology in SCDMH.

EHR is not user friendly. Also very slow to start up. cant retrieve necessary information on a patient in a code situation system taking too long to start. you dont know what mode. the pt. is on or their diagnosis. Dangerous.

18. SCDMH Client, Patient, Resident Services.

Nothing is consistent, random services, minnimumly staffed

15. The SCDMH Mission, Vision, and Values.

na

16. The SCDMH Budget.

I think if they have enough money in the budget for improvements, it should be enough money in the budget for a raise.

17. The use of Technology in SCDMH.

na

18. SCDMH Client, Patient, Resident Services.

na

Comment Report Title

19. Employees both full-time, temporary, or contract staff.

na

15. The SCDMH Mission, Vision, and Values.

need a pay raise

16. The SCDMH Budget.

need a pay raise

17. The use of Technology in SCDMH.

need a pay raise

18. SCDMH Client, Patient, Resident Services.

need a pay raise

19. Employees both full-time, temporary, or contract staff.

need a pay raise

20. SCDMH Leadership/Supervisors.

need a pay raise

15. The SCDMH Mission, Vision, and Values.

to provide a culture around the "whole" person and not just the problem. Create a culture based on diversity and constant care for "ALL" who enters the facilities. Show appreciation for the wonderful staff that provides constant care for patients daily

16. The SCDMH Budget.

change the salary for employees and their titles. cut out the paper so you can free up more money for employees

17. The use of Technology in SCDMH.

Move to newer systems that decrease the use of so much paper. Make task easier where people work smarter not harder. Send documents via email and require new hires to bring or electronically sign them.

18. SCDMH Client, Patient, Resident Services.

Get rid of the "star" "pound" system so employees can provide better care to their patients and plan their lives. Go to a 12 hour working schedule and provide flexibility for other support staff @ DIS location. A 24 hr. facility, you can still make it work!

19. Employees both full-time, temporary, or contract staff.

Provide incentives (better) for employees. The pay is not that great, so provide other things that are benefical and can help with the cost of living. Allow options for variations in schedules so people can have longer weekends. get ride of the star pound system so employees can plan their lives and provide better care to patients.

20. SCDMH Leadership/Supervisors.

supervisors should be trained once every 3 months on how to b4e a better supervisor, how to be and show compassion for their team, and stop treating some employees like their budies. be quick to listen and slow to speak! communication(good) goes to a long way.

15. The SCDMH Mission, Vision, and Values.

mission should include Respect. Culture is to not believe in holding individuals accountable to include mgmt.

16. The SCDMH Budget.

Budget should include annual training on certain topics.

17. The use of Technology in SCDMH.

Technology is the future of any business. to attract individuals to work at scdmh, need modern technology in clinical and administrative areas.

18. SCDMH Client, Patient, Resident Services.

Continue training for clinical staff. Establish a standard professional practice and hold manager, supervisors accountability when process and practices broke.

19. Employees both full-time, temporary, or contract staff.

na

Comment Report Title

20. SCDMH Leadership/Supervisors.

Supervisor and leadership are never held accountability you unprofessionalism. Allowed to do whatever they want.

15. The SCDMH Mission, Vision, and Values.

SCDMH should value their employees and you should hire within. Give your employees a chance because a person hold a title don't mean they can be a bullies to employees. Misusing their title. People that you can use or the one you give increases. there are quilify people that will never get a chance because you dont like the person. its not fair when you get a chance because you dont like them so you will not give them a chance. Bullies in the workplace is not good, misused authority is not good, preselected hires not good, talking about other employees to other employees not good. If you dont like me dont treat me different thats a problem. Start your clean up first with HR

17. The use of Technology in SCDMH.

google drice could help alot

16. The SCDMH Budget.

You dont put your money where you'll see it grow. never. so your employees keep leaving.

17. The use of Technology in SCDMH.

What Technology? We are so paper driven and so behind on technology its embarressing

20. SCDMH Leadership/Supervisors.

Ridiculous. Some here I wouldn't even call leaders. Its more a dictatorship and makes coming to work miserable. it needs a serious revamp. But it wont ever happen n/c its all about who you know, not what you know. it's sad.

16. The SCDMH Budget.

Need to include money for all lower paid employees making under 50,000 p/y instead of lining pockets of those making above that and not bused on if you are liked by your supervisor but on performance

17. The use of Technology in SCDMH.

need to come up to date with private sector

19. Employees both full-time, temporary, or contract staff.

employees should be offered the opportunity of a flex schedule in other departments beside nursing

20. SCDMH Leadership/Supervisors.

Supervisors need to be fair with all subordinates and not have favorites

17. The use of Technology in SCDMH.

Expand the use of video conferencing in all DIS facilities

15. The SCDMH Mission, Vision, and Values.

Need to expand mission statement -vision not located on internet page- for values do we also need to incorporate accountability, diversity, patient-family centered care? Do we need to add resource effectiveness?

16. The SCDMH Budget.

Need tools to see in real time revenue and expenditures at individual unit/lodge/center level

17. The use of Technology in SCDMH.

Need a single platform that communicate efficiently need to shift from paper to process utilizing technology

18. SCDMH Client, Patient, Resident Services.

need more attention to activities in inpatient services. Need more oversight with residential facilities post discharge

19. Employees both full-time, temporary, or contract staff.

SCEIS scheduling is not effective in a 24/7 environment- we can no longer depend on straight 8 hours shifts. Need to offer 12 hour shifts-focusing on work life balance to attract millenials.

20. SCDMH Leadership/Supervisors.

Many talented leaders. Love the mentor program.

16. The SCDMH Budget.

Each lodge unit should be its own cost center. manually operational and fte budget variance reports submitted. Access to comparision of how each cost center with other similar cost center to previous year.

Comment Report Title

17. The use of Technology in SCDMH.

Provide enough hardware in the patient care areas for the staff to do their job without a sign out process. Unlicensed staff need some type of tablets for documentation. laptops should probably be notebooks for providers at least. smaller, lightweight. Move to laptops with docking stations instead of pc workstations. Need voice dictation directly with eha. barcode med admin. Automated dispensing machines.

18. SCDMH Client, Patient, Resident Services.

alot of patients just sitting around not engaged in activitities. Patient areas are drab and depressing. Forensic(mcclendon) broken furniture, missing tiles, ugly overall.

19. Employees both full-time, temporary, or contract staff.

hopefully the goal is to increase full time staff. unclear to me if the issue is pay or working conditions. onbaording from interview until 1st day of employment is way too long. lose good candidates to other organizations because it takes too long to get an offer of employment.

20. SCDMH Leadership/Supervisors.

Need a concerted effort to change culture, break down siloes and get rid of the often used excuse of "thats how we do it here" or "thats how weve always done it" Need to adopt a culture of excellence and servant leadership.

17. The use of Technology in SCDMH.

computer system and charting needs to increase as paper decreases. Very little history or LPP notes.

15. The SCDMH Mission, Vision, and Values.

The world of healthcare is changing, and the societal recognition of mental health issues broad scale has increased. The mission, vision, and values should be reviewed to make sure it coincides with todays environment.

17. The use of Technology in SCDMH.

Technology is very limited in the current environment, compared to the advancement available in the industry. Better technology would improve effieciency and streamline many systems, providing better work environment and better, more efficient care to patients.

19. Employees both full-time, temporary, or contract staff.

full time or temporary staff may be more invested in their jobs that contract employees.

20. SCDMH Leadership/Supervisors.

Supervisors need to be empowered to do the right thing for the well being of the patients.residents and for the agency. Structure begins with leadership from the top and flows by example throughout the veins of division. Employees will follow strong leaders who do the right thing themseleves. Training opportunities should be strongly encouraged to improve leadership.

17. The use of Technology in SCDMH.

The EMR chosen for DIS is poor quality and not really a smart, adaptable system.

18. SCDMH Client, Patient, Resident Services.

Facilities are old and not suitable for psychiatric patients. Nursing staff are not consistent.

19. Employees both full-time, temporary, or contract staff.

Too much reliance on locums employees. Salaries are too low for full time staff.

16. The SCDMH Budget.

Provide raises to employees and yearly even if its a small amt. at least it shows the employee you appreciate their services.

18. SCDMH Client, Patient, Resident Services.

Provide more interaction/activitities for the residents/clients instead of on the lodges sleeping/watching tv.

20. SCDMH Leadership/Supervisors.

Be more supportive to staff on their units

17. The use of Technology in SCDMH.

Technology services currently offered are ineffective and time consuming due to poor planning, training, and support for IT issues. Limited resources(laptops) make use very difficult.

Comment Report Title

15. The SCDMH Mission, Vision, and Values.

There is a culture here at scdmh that works against itself. Although structure and leadership is vital to any organization; this "subordinate" "leadership" hierarchical system leads to staff feeling less than and unvalued.

16. The SCDMH Budget.

Employees should automatically recieve "cost of living increases" annually. retention will remain low unless you incentivize staff.

17. The use of Technology in SCDMH.

less paper driven

17. The use of Technology in SCDMH.

a must

19. Employees both full-time, temporary, or contract staff.

having enough coverage is critical

20. SCDMH Leadership/Supervisors.

leaders/supervisors must have backbone and be consistent with all employees.

16. The SCDMH Budget.

Strongly agree in an increase in pay for all staff. Unfortunately only nursing staff seem to be the department that receives an increase. I feel my position is vital and an access for the facility

20. SCDMH Leadership/Supervisors.

On the values of leadership and supervisors are should lead by example which im not 100% seeing in the DMH

17. The use of Technology in SCDMH.

The network goes down way too much. Newer and faster technology should be explored

16. The SCDMH Budget.

Employees should be given a short survey before fy budget requests are submitted. Their director should ask what they believe top 3 dept fiscal priorities should be. The 1 or 2 items that are common should be considered if within a reasonable cost to dept.

17. The use of Technology in SCDMH.

Many improvements have been made. The IT dept should be willing to and financially able to respond to problems quickly. Programs have to be purchased when a dept has probelm. It should be anticipating needs and ready to fix problems. More staff for IT.

19. Employees both full-time, temporary, or contract staff.

Employees should be able to expect opportunities for professional development. Ways employee can gain skills to contribute more to agency should be available at no cost to employee.

20. SCDMH Leadership/Supervisors.

SCDMH leadership should be more visible to employees. 1-2 times a year there should be an all staff mtg to allow leadership an opportunity to meet and greet staff not a gripe session but casual setting.

17. The use of Technology in SCDMH.

woefully inadequate and behind the times. It not only makes our processes inefficient but makes it difficult to recruit employees who are used to working with more advanced technology. It would be nice to see professional development webinars/training archived or access to these produced by other sources.

18. SCDMH Client, Patient, Resident Services.

Keeping up with advances on best practices serves us well as a department. Developing internal resources to research and disseminate info in a way that makes it easy for busy clinicians to digest is vital and will contribute to improved patient care and a culture of continous learning/improvement

19. Employees both full-time, temporary, or contract staff.

Professional development opportunities used to be a perk to state employment. These have been decimated due to budget cuts. Using technology could be a cost effective way to bring these things back. We need to find ways to help staff feel invested in DMH and it communicate dmh is invested in staff. Both serve improving patient care.

Comment Report Title

20. SCDMH Leadership/Supervisors.

DMH should seek to cultivate talented leaders not just good managers. Leadership and quality supervision are vital foir recruitement and retention. DMH should develop an ongoing leadership seminar/professional dev. program to improve personal/professional skill and improve teamwork and collarboration among leaders. DMH should be a leader in fostering a psychologically healthy workplace.

16. The SCDMH Budget.

Perhaps less supervisors would result in better pay for employees and less confusion. Also yearly pay increases corresponding to epms scores should be restarted to help retain a good working force, resulting in less turnover.

19. Employees both full-time, temporary, or contract staff.

SW staff should not be given so many duties. Many duties of inpatient sw's could be done by non-licesnsed staff-such as phone calls, packages,etc. so they can focus on treatment.

20. SCDMH Leadership/Supervisors.

The supervisors I have now are wonderful-very responsive to needs and questions. However, my recent past supervisors were very unsupportive, micromanaging and didn't listen to staff concerns. This has resulted in very high staff turnover and poor satisfaction in employees at that hospital.

15. The SCDMH Mission, Vision, and Values.

we each all of the following

19. Employees both full-time, temporary, or contract staff.

employees do not caring out their duties.

20. SCDMH Leadership/Supervisors.

we need leaders to know and care about the people ar scdmh.

16. The SCDMH Budget.

need more raises

17. The use of Technology in SCDMH.

ston

15. The SCDMH Mission, Vision, and Values.

na

16. The SCDMH Budget.

increased salary over time would be nice. It seems like unless you've been here 15 years you'll be stuck at the minimum of your pay bracket.

17. The use of Technology in SCDMH.

Avatar is nice but a newer, user-friendly systme would be even better.

18. SCDMH Client, Patient, Resident Services.

Morris village is old and all the patients feel like they're beds in jail when they first come in

19. Employees both full-time, temporary, or contract staff.

na

20. SCDMH Leadership/Supervisors.

Love Tammy Cleveland and Nakisha Lee to death. Best director and supervisor I've ever had.

16. The SCDMH Budget.

Better pay for bhs, at morris village

18. SCDMH Client, Patient, Resident Services.

the clients complain about the amount of food provided.

19. Employees both full-time, temporary, or contract staff.

nursing opportunities

Comment Report Title

16. The SCDMH Budget.

When asked why did we replace tube televisions for flat screens orhow can we afford cable for patients but no raise for staff, we were told that was a separate budget. Where is the budget for staff raises> We come to work only to endure possible attacks from patients, verbal abuse from patients, as well as mental abuse. Its sad that all surveys that come out only applies to patients. Morale for staff sucks!! We're equally important. Stop overlooking your staff!!

17. The use of Technology in SCDMH.

Happy about moving towards doing away with all this paper. It's difficult trying to find places to store all of it. Love the advancement towards technology.

18. SCDMH Client, Patient, Resident Services.

Were dated. Everything around us is old. We need to focus on using and applying budgets where they are needed other than kickbacks, bonuses, and raises for administrators. Think about us on the bottom for a change.

16. The SCDMH Budget.

More money needs to be allocated to paying competitive salaries and to conitnue to advance employee's salaries, especially in under appreciated ares like environmental services, food services, and bha/cnas. These groups are the life blood of the agency.

19. Employees both full-time, temporary, or contract staff.

Contract employees should no be paid more than dmh employees. There is no incentive for a dmh employee to remain a dmh employee if they can make more money as a contract employee doing the same job.

20. SCDMH Leadership/Supervisors.

The leadership and supervisors meed to be proactively engaged in the success and advancement of their employees.

20. SCDMH Leadership/Supervisors.

Need to hold employees accountable and use disciplinary methods.

15. The SCDMH Mission, Vision, and Values.

SCDMH mission, vision, and values should include and maintain integrity, truthful, and happiness.

16. The SCDMH Budget.

The SCDMH budget should include employees with financial gains. (promotions,incentatives,bonuses etc)

17. The use of Technology in SCDMH.

Technology should be improved, secured, and regularly accesible.

18. SCDMH Client, Patient, Resident Services.

Scdmh patient/client resident services should be cleaned, physically accessible, and allowing for health changes. (exercises, labortories, extra curricular activities.

19. Employees both full-time, temporary, or contract staff.

more pay!

20. SCDMH Leadership/Supervisors.

no issues

16. The SCDMH Budget.

Facilities are in bad conditions. Old buildings, inadequate space, poor work conditions for staff.

17. The use of Technology in SCDMH.

hire more IT staff

18. SCDMH Client, Patient, Resident Services.

More PT housing needed

16. The SCDMH Budget.

The budget should be equally capable of providing increases for employees accross the board and not just certain receiving increases each year and others go 2-3 years without any increase because you are being told there's no money in the budget.

Comment Report Title

19. Employees both full-time, temporary, or contract staff.

Tuition reimbursements should be extended to non-clinical staff certain positions should not be based solely on whether or not an individual possess a degree to qualify for the position.

15. The SCDMH Mission, Vision, and Values.

If the mission, vision, and values of SCDMH are to be fully realized, stronger measures must be implemented to secure community and legislative support and appropriate funding.

18. SCDMH Client, Patient, Resident Services.

Efforts should be made to ensure that resident living areas, to the extent possible, promote privacy and simulate the home environment.

19. Employees both full-time, temporary, or contract staff.

Temporary and contract employees should receive the same respect guaranteed to full-time employees. There should be guidelines for what constitutes a temporary employee. After a certain period of service, a temporary employee should be made permanent, if the position is still required. A temporary employees transition from temporary to permanent should not require the position to be advertised, if the position has not been vacated.

20. SCDMH Leadership/Supervisors.

When a supervisor violates the disciplinary code and the violation affects a subordinate, the supervisor, if not discharged, should forfeit the right to supervise the injured employee. All appropriate disciplinary policies should be followed to ensure that the supervisor receives appropriate disciplinary action. Any responsibel person(s) failing to ensure that this process is completed, should also be held responsible for the non-compliance with the disciplinary code.

19. Employees both full-time, temporary, or contract staff.

pay staff more for the job performance that they deal with on a daily basis. And maybe they will stay. I know I still have to work another job to maintain my every day living expenses.

20. SCDMH Leadership/Supervisors.

The same way you want to be spoken to give the same respect to your employees!!

16. The SCDMH Budget.

Pay increases for bha's and administrative staff.

17. The use of Technology in SCDMH.

More up to date equipment and faster service.

18. SCDMH Client, Patient, Resident Services.

More room on pt. lodges for pts. Need a covered walk way for pts. staff and visitors

15. The SCDMH Mission, Vision, and Values.

Where is SCDMH mission, vision, and values located? The DIS mission is on the DIS intranet but difficult to read. Black writing on a blue background. Some vision for years that has not been achieved.

17. The use of Technology in SCDMH.

Need to increase memory; increase access to IT supports. Do not receive response timely from DIS Help Desk, calls nor email. May receive response over a week later.

18. SCDMH Client, Patient, Resident Services.

Staffing levels does not support expansion of treatment and when services are expanded, the staffing/direct care is not there to provide great service. Staffing @ nursing home(tucker) is ridiculous.

19. Employees both full-time, temporary, or contract staff.

Need more emphasis on retention. More willing to pay better salaries to those entering the system than to those who have been in the system. No raises for a job well done, so why do well? You get the same thing as those who don't do well. No incentives/rewards. Can't pay bills with a paper award.

20. SCDMH Leadership/Supervisors.

Supervisors need support from directors. Leaders need to work better as a team and role model for staff. Too many expectations from staff below, more so than from above.

18. SCDMH Client, Patient, Resident Services.

Improve activities, communication

19. Employees both full-time, temporary, or contract staff.

FTE - Increase $

Comment Report Title

15. The SCDMH Mission, Vision, and Values.

inpatient services seek tjc accreditation as hospital but operate like long term care facility

16. The SCDMH Budget.

Environmental services is a under appreciated discipline that performs "critical service"- could easily remedy through expanding FTEs, salary increase, provide opportunity fro professional growth.

17. The use of Technology in SCDMH.

Electronic health record decision making has neglected to include health information in decision making.

18. SCDMH Client, Patient, Resident Services.

Client care has improved since 1981(when I started working at BPH)-medical/nursing care for the aging patients is more complicated and professional development is not keeping pace.

19. Employees both full-time, temporary, or contract staff.

Need less contract, agency staff; more full time

20. SCDMH Leadership/Supervisors.

Stuart Shields has singularly turned around BPH in the very short time he has been there- his leadership should be commended and extended! The new cno seems out of step.

15. The SCDMH Mission, Vision, and Values.

The service rendered to our patients should be individualized and holistic. Discharge initiative should include activities that support our clients being able to function in the community e.g ground pass, time management, bus/transportation and employment opportunities if applicable.

16. The SCDMH Budget.

Employee should be paid fair dollar amount relative to the economy/inflation in our country

17. The use of Technology in SCDMH.

Updated software recommened for the electronic health record comparable to other health care provider.

18. SCDMH Client, Patient, Resident Services.

The quality of hygiene, oral and foot care should be improved.

19. Employees both full-time, temporary, or contract staff.

Employee work-life balance should be viewed as a very important aspect of living. Unnecessary mandatory overtime should not replace staffing needs. Frequently used staffing star system should be discouraged. Agency contract for nursing staff should be review and to include but not limited to primarily providing coverage where there is need and not burn out the SCDMH employee.

20. SCDMH Leadership/Supervisors.

Interpersonal relationship with employee need some improvement. Fair $ just should be the rule of the game.

17. The use of Technology in SCDMH.

Technology is outdated and in some areas,cumbersome. Also, DIS Help desk employees lack motivation and enthusiasm. It would be nice if they put thought into what they deliver instead of doing bare minimum.

18. SCDMH Client, Patient, Resident Services.

It would be nice to document and reference the available services available to patients. Typically need to discuss with social workers to get these answers. EG, literacy development, GED books/classes, etc...

19. Employees both full-time, temporary, or contract staff.

Difficulties in ability to communicate with agency/contract staff. No available methods of contact. Difficult to follow up when agency/contract staff isnt here in person at the moment. No available email? For full time employees can we consistently get their info into the system by hire/start date? outlook, sceis,and other needed systems...

20. SCDMH Leadership/Supervisors.

I feel that we have exceptional leadership and management @ SCDMH

16. The SCDMH Budget.

Raises please

17. The use of Technology in SCDMH.

emr!

Comment Report Title

19. Employees both full-time, temporary, or contract staff.

Raise please-increase retention

20. SCDMH Leadership/Supervisors.

communication

16. The SCDMH Budget.

There is a budget for everything but raises for employees. If you do a good job and show leadership you should be rewarded.

20. SCDMH Leadership/Supervisors.

When you have supervisors who have never been in state government, they are not given enough training and when things happen they don't ask questions. They do things as though they are still in the private sector.

15. The SCDMH Mission, Vision, and Values.

Times have changed. People have changed. Society has Changed. It would be good to reevaluate mission, vision, values and goals.

16. The SCDMH Budget.

Needs to be increased obviously. The facility to keep up with private sector.

17. The use of Technology in SCDMH.

Needs to be increased and updated to keep up with private sector.

19. Employees both full-time, temporary, or contract staff.

Staffing definitely needs to be addressed! Too many contract personnel. Raise full time employees salaries and cut down on contract staff!

20. SCDMH Leadership/Supervisors.

Too many chiefs and not enough indians at my facility!

16. The SCDMH Budget.

Need Badly Increase in Pay For All Employees!!

17. The use of Technology in SCDMH.

All Employees need access to computers

20. SCDMH Leadership/Supervisors.

Needs to be very much nice or friendly to employees

16. The SCDMH Budget.

SCDMH employees work hard. It would be good if we could implement the merit system for increase pay yearly for all employees.

19. Employees both full-time, temporary, or contract staff.

All employees should receive the same amount of respect in their position including temp or contract staff

15. The SCDMH Mission, Vision, and Values.

Every new employee should have to memorize the mssion statement. Every current employee should be consistently encouraged by the mission, vision and values of the agency, through emails, metting, and pathlore.

16. The SCDMH Budget.

Nurses and other direct care staff should be able to earn merit raises and have regular cost of living increases.

17. The use of Technology in SCDMH.

Computer systems should be prepared and upgraded prior to changes with ehr. Also, the software chosen should not just be the cheapest, but also, the most user friendly for the lowest cost.

18. SCDMH Client, Patient, Resident Services.

We need to focus every departments mindset on how their services affect our clients/patients/residents. Care should be client driven.

19. Employees both full-time, temporary, or contract staff.

na

Comment Report Title

20. SCDMH Leadership/Supervisors.

I believe many of our top leaders are too far removed from what is ocurring on the units. There needs to exist better communication from direct care/front line employees and supervisors/department heads/program managers.

16. The SCDMH Budget.

All employee making below 30,000 should be given a 20% increase in pay.

20. SCDMH Leadership/Supervisors.

Supervisor should be require leadership training annually.

17. The use of Technology in SCDMH.

Electronic leave slips would be nice

15. The SCDMH Mission, Vision, and Values.

I am in agreement with the mission, vision and values. no changes at this time.

16. The SCDMH Budget.

The lowest paid employees salaries should be $15.00 per hour and this will start the domino effect, and will bring other employees salaries to a better living wage. For most emplyees the state wages are low and requires some state employees to work a second job to maintain a normal standard living.

17. The use of Technology in SCDMH.

enhance technology by having all employees Request for Leave and Time Sheet to be completed electronically

16. The SCDMH Budget.

If you can work 28 years and come up for retirement and not have made 28,000 something is very wrong with the budget.

17. The use of Technology in SCDMH.

do not have any

20. SCDMH Leadership/Supervisors.

not good

17. The use of Technology in SCDMH.

The agency would benefit by moving to a paperless filing system. Office space/filing space is limited, so when documents are purged there no where to put them. There a data tracking system that allows for an agency to copy,scan,track, and store files to a chip based system. It cuts down on paper and frees up filing areas.

18. SCDMH Client, Patient, Resident Services.

Residents, though they enjoy their regular activities, need more diversity. Things like painting, computer, labs for games, video games, dance offs, etc. could provide alot of stimulation for those that enjoy not only being creative but also interacting with others. Maybe even a resident/staff talent show or friendly competition between units to see who can make the best painting.

20. SCDMH Leadership/Supervisors.

Some supervisors could benefit from sympathy training and or take time to hold over a minute conversation with all their employees, not just a few. There been times certain employees are fearful of asking questions because the supervisors reaction over the top. Or theyre afraid of making mistakes for the very same reason, to the print their stomachs in knot and they dont want to come in.

15. The SCDMH Mission, Vision, and Values.

you do not have vision or values

16. The SCDMH Budget.

I work her for 17 years and can not get a RAISE

19. Employees both full-time, temporary, or contract staff.

They all need more money

20. SCDMH Leadership/Supervisors.

sorry as hell

17. The use of Technology in SCDMH.

Technology should be increase so that there will be less errors with charting/communication purposes

Comment Report Title

18. SCDMH Client, Patient, Resident Services.

There should be more activities for patient to be involved in really appreciate the new nail services that has been added to the facility.

19. Employees both full-time, temporary, or contract staff.

CNA work short or have to stay over frequently there should be incentives for retaining employees

20. SCDMH Leadership/Supervisors.

Nurse supervisors should better communicate with cna on the floor.

16. The SCDMH Budget.

More raises for housing or janitorial

19. Employees both full-time, temporary, or contract staff.

increase employee moral

16. The SCDMH Budget.

Retain personnell by keeping up with inflation. Better pay Better retention

17. The use of Technology in SCDMH.

Incorporate Dragon Dictate software in Avatar

16. The SCDMH Budget.

The budget should allor for salary raises so key staff can be retained(including nurses, social workers, and psychiatrists)

18. SCDMH Client, Patient, Resident Services.

We should do a better job of providing basis needs for patients(including clean clothes and healthy food)

20. SCDMH Leadership/Supervisors.

Supervisors should do more listening and actively follow up on the concerns of the staff.

15. The SCDMH Mission, Vision, and Values.

When full time employee exits, they must have opportunity to give reason for leaving prematurely. Retired staff must be recognized socially to show appreciation and motivate others.

16. The SCDMH Budget.

The budget for DMH should go higher to make staff salary competitive with other to higher and retain qualified staff.

17. The use of Technology in SCDMH.

The DIS is going electronics and needs sufficient, qualified IT staff to provide technological assistance. to staff especially-the direct patient care.

18. SCDMH Client, Patient, Resident Services.

Some facilities need overall structural repair for replacement for both participants and staff. e.g BPH landscape especially flooding when it rains bruiguy food trays to lodges for the cafetaria.

19. Employees both full-time, temporary, or contract staff.

employees especially the full time are the assets for the department and deserve adequate compensation. Adequate qualified staff both full time, temporary, or agency are needed to help.

20. SCDMH Leadership/Supervisors.

Leaders should set good examples for the followers and listen with good sense of judgement to be fair and professional. treat others the way you want you or your love ones be treated.

15. The SCDMH Mission, Vision, and Values.

I am not sure if Bryan is treated as a medical hospital or psych hospital since we are under joint commision as a medical hospital but we consider ourselves a psych hospital. Also I am not sure why the 2 bryans are one hospital now.

16. The SCDMH Budget.

It is difficult for the pts to receive enough food because they only get allotted 1 dollar per day for food. They have to fill up on non-nutritious items.

17. The use of Technology in SCDMH.

good

Comment Report Title

18. SCDMH Client, Patient, Resident Services.

I wish the pts could be more active and have volunteer chores, etc. in the facility. They get very bored when groups are not going on. They tend to just sit and watch tv.

19. Employees both full-time, temporary, or contract staff.

I wish contract staff were able to become employed at DMH if they decide to stay long term.

20. SCDMH Leadership/Supervisors.

Sometimes it is unclear who is in charge of what, and who we need to talk to about certain issues.

16. The SCDMH Budget.

We need to improve the budget in order to implement necessary changes to the physical, treatment, recruitment and retention activities.

17. The use of Technology in SCDMH.

We need to improve our utilization of technology as the fastest growing means of communication and business management. However we need competent IT staff to institute the necessary infrastructure and function.

18. SCDMH Client, Patient, Resident Services.

We need to provide more community integrative treatment programming, life skills, and improve transitions in care from i/p to o/p treatment. The two need to work together to support patients/clients stop blaming each other for areas in which we have failed a patient/client.

19. Employees both full-time, temporary, or contract staff.

We need better training on how to interact with mentally ill patients, recognizing empathy, fatigue/burnout to ensure better pt/staff interactions of the lowest salaries in the state and do nothing to support staff who are overwhelmed by covering multiple positions. Salary stagnation contributes-staff need cost of living, job well done, and annual standard raise opportunites that aren't stripped away by increased mandatory contributions to retirement.

20. SCDMH Leadership/Supervisors.

Leadership needs training on how to be effective leaders. too many of the departmental leaders are vindictive rather than supportive. They don't provide constructive feedback, are not honest with their subordinates. leadership needs to learn tact, compassion, honesty, and how to make decisions without putting everything off until a meeting can happen. Receive feedback from staff as well.

17. The use of Technology in SCDMH.

Improve on and add quality technology that takes less time so staff can spend most of time on patients and nurse monitoring, guide staff.

16. The SCDMH Budget.

non-competitive salaries contribute to loss of staff and difficulty recruiting and retaining

19. Employees both full-time, temporary, or contract staff.

Improve training. continue to work on retention and recruitment

15. The SCDMH Mission, Vision, and Values.

I would like to see it posted more.

17. The use of Technology in SCDMH.

I'm glad we are finally using EHR. I would love to see even more technology.

18. SCDMH Client, Patient, Resident Services.

More training and support for BHAs who may have the hardest jobs throughout Bryan.
Buildings at Bryan Adult and Forensics look worn down. A brighter, updated decore would help w/ employee morale and patients view of self.

19. Employees both full-time, temporary, or contract staff.

It would be great if we had more insentives for employees to go back to school, get licensed, get specialized training. (ec, tuition reimbursement, promise of raise after licensure, etc) Many work hard to go back to school, get licensed, etc. and leave DMh soon after. I wish we had more in place to encourage these employees to stay.

20. SCDMH Leadership/Supervisors.

Our leadership at BPH is great.

15. The SCDMH Mission, Vision, and Values.

na

Comment Report Title

16. The SCDMH Budget.

spend greatfully

17. The use of Technology in SCDMH.

I noticed legal aid still using type writers. needs improvement. updated.

18. SCDMH Client, Patient, Resident Services.

na

19. Employees both full-time, temporary, or contract staff.

Could use some new maintenence vans. current one smell really bad and barely run.

20. SCDMH Leadership/Supervisors.

Most leaders like evs, physical plant, hr, a&d, pso are amazing.

17. The use of Technology in SCDMH.

I think wi-fi should be provided for all employees.
I think all employees should have access to email in case you are out sick and need to forward something that needs immediate attention.
I do not think that technology should be used around patients unless it is work-related.
I think patients should have some access to technology to research their mental disorders(maybe limited to certain workers).

20. SCDMH Leadership/Supervisors.

i think leadership should involve subordinates more often; this would cut down on rumors, increase moral and make everyone feel important and make everyone feel like they are contributing to the recovery of our patients.

16. The SCDMH Budget.

more pay

17. The use of Technology in SCDMH.

is great

18. SCDMH Client, Patient, Resident Services.

more interaction with patients

19. Employees both full-time, temporary, or contract staff.

good

20. SCDMH Leadership/Supervisors.

could improve

15. The SCDMH Mission, Vision, and Values.

no change

16. The SCDMH Budget.

Increase pay for lower paying positions.
Increase effiency of agency to decrease costs.

17. The use of Technology in SCDMH.

Technology should be constantly updating

18. SCDMH Client, Patient, Resident Services.

improve update physical properties

19. Employees both full-time, temporary, or contract staff.

Decrease amount of redundant paper work to improve efficiency and worker satisfaction

15. The SCDMH Mission, Vision, and Values.

I think most of our HPH know what the mission is, vision and values I am not so sure of.

16. The SCDMH Budget.

I think very unfair how underpaid we are especially secretares. We do not have a liveable wage. I understand rasies for docs because of shortage, nurses shortage but if our clerical people work hard and are not rewarded.

17. The use of Technology in SCDMH.

No problems with technology.

Comment Report Title

18. SCDMH Client, Patient, Resident Services.

not sure what you are asking

19. Employees both full-time, temporary, or contract staff.

I believe DMH does not care enough about our HPH staffing. The hospital has been without an appropriate amount staffing and it takes too long to get permission to fill positions. This in some areas very dangerous.

20. SCDMH Leadership/Supervisors.

I am satisfied with my supervisor and read of hospital. I can speak for everyone in the hospital.

18. SCDMH Client, Patient, Resident Services.

HPH has a pt who has been hospitalized on acute lodge since 6/2010. dx of mr and ied. She has not progressed in her care. This is absolutely the wrong setting for her care. She has significantly declined b/c we are not equiped to care for this pt. DSS was repeatedly refused to aid and care of this pt. This is an absolute fail of SCDMH for this pt. Can anyone Help?

15. The SCDMH Mission, Vision, and Values.

The values could be changed to reflect more supportive lanquage. The mission could say "to support the recovery of people with mental health disorders" also, could add advocate in mission.

16. The SCDMH Budget.

Needs to be increased. There are not enough resources for patients to receive the services they need. Also, there is not enough compensation offered for employees.

17. The use of Technology in SCDMH.

Could be improved. We are behind in technology.

18. SCDMH Client, Patient, Resident Services.

I think client, patient, resident services has improved. Mostly, this is due to the patient advocates.

19. Employees both full-time, temporary, or contract staff.

no concerns

20. SCDMH Leadership/Supervisors.

Communication should be improved. Also, treating all DMH facilities and programs with the same respect would be great.

16. The SCDMH Budget.

Increase Pharmacy pay including techs

19. Employees both full-time, temporary, or contract staff.

full time

17. The use of Technology in SCDMH.

I had no idea that SCDMH site had moved. When I found a link to direct me. I found the Mission, Vision and Values.

19. Employees both full-time, temporary, or contract staff.

Employees are difficult to retain in a large part due to salary. Performance raises should be considered. I have had a "substantially exceeds" rating for 15 years working for DMH but never received a performance increase in pay! In addition, my working environment is noisy. I have complained that I cannot hear on the phone and parties on the other end cannot hear me but Admin, tells me I am the "meet and greet person" so I do not have office space or a divider. Slightly embarassing when Medicaid offices and ssa can not hear you.

20. SCDMH Leadership/Supervisors.

Supervisors should be "working" along with the staff that they supervise. When I schedule time-off there is no one to cover. My supervisor admits that she could not do my work. But when I ask for an increase I am told that my pay is "inline". Double Standard!

16. The SCDMH Budget.

Support staff low pay. should be upgraded.

15. The SCDMH Mission, Vision, and Values.

appropriate

16. The SCDMH Budget.

It is fixed by legislature

Comment Report Title

17. The use of Technology in SCDMH.

Disjointed and non-responsive central organization

18. SCDMH Client, Patient, Resident Services.

outstanding

16. The SCDMH Budget.

increase pay for employees

16. The SCDMH Budget.

Employees should recieve yearly raises based on merit. It would be an incentive to do a better job. Also, it would be nice to have a chance for advancement based on merit.

17. The use of Technology in SCDMH.

Our technology is very "behind the times" Upgrading technology could improve efficiency in work processes.

19. Employees both full-time, temporary, or contract staff.

Employees are very underpaid, which leads to a very high turnover rate. Nursing recently got a significant pay increase but the rest of us got nothing. It feels like we are not appreciated for the work we do.

16. The SCDMH Budget.

Should include raises for all employees, especially employees who have been with DMH for years and make less than new hires coming in. Incentive for staying with department, not using sick leave, etc.

17. The use of Technology in SCDMH.

Medication dispensing cabinets would be helpful for the nursing and pharmacy staff.

19. Employees both full-time, temporary, or contract staff.

Better pay for nurses would motivate nurses to apply and cut down on lodges being short staffed.

15. The SCDMH Mission, Vision, and Values.

They are fine. Should just be valued more by supervisors.

16. The SCDMH Budget.

We need access to more money!

17. The use of Technology in SCDMH.

My computer is extremely old. Would like iPad for assessments for those unwilling to leave room/pod.

18. SCDMH Client, Patient, Resident Services.

Good. More effective communication would make everyday work flow better. But some HPH specifically are pretention and unwilling to try.

19. Employees both full-time, temporary, or contract staff.

opportunities for overtime!!! (working a saturday when regular schedule is M-F) !!

20. SCDMH Leadership/Supervisors.

Some need training in being professional with other employees and how to respond and speak with their employees.

15. The SCDMH Mission, Vision, and Values.

They are made by administration with little communication to the majority of the hospital.

16. The SCDMH Budget.

The rate of pay for employees is harmful to the retention rate and is not equal to the amount of work required of employees.

17. The use of Technology in SCDMH.

All old computers should be replaced now that all treatment requires them.

18. SCDMH Client, Patient, Resident Services.

Some patients are left on a level zero for far too long and H lodge patients are never given level 4. This is unfair.
There are far too many people in most tx. teams and it is often overwhelming for the patients. There should be a maximum # of staff allowed.

19. Employees both full-time, temporary, or contract staff.

There should be improved communication within all clinical staff members. We all work with patients, but have poor grasp of what each of us do to treat them.

Comment Report Title

20. SCDMH Leadership/Supervisors.

Employees should have more opportunities to review their supervisors, especially in department with poor retention, without fear of backlash.
Supervisors are far too separated from treatment and rarely know what their employees are doing for their patients.

16. The SCDMH Budget.

More money needs to be added to budget for pay raises.

20. SCDMH Leadership/Supervisors.

Needs to focus more on having enough staff to provide safe and therapeutic care for patients and allow suppervisors in each department to focus on individual issues.

15. The SCDMH Mission, Vision, and Values.

review and update with "todays" wording

16. The SCDMH Budget.

Be more transparent

17. The use of Technology in SCDMH.

Maximize technology and provide patient, supportive and user friendly training

18. SCDMH Client, Patient, Resident Services.

continually improve any areas or concerns identified

19. Employees both full-time, temporary, or contract staff.

Temporary vs contract? Should some contract be temporary? Temporary and contract staff should benefit especially. From COLAS and 1 time bonuses

20. SCDMH Leadership/Supervisors.

Continue to strive to provide supportive, tolerant and family friendly leadership/supervisors as many, many employees have young families and/or elderly parents to care for.

19. Employees both full-time, temporary, or contract staff.

I would like for full-time employees to be able to work over in another department if you have been trained in it also.

15. The SCDMH Mission, Vision, and Values.

What we actually do is not reflected in our mission statement, vision, or values

17. The use of Technology in SCDMH.

A better EHR then Nutsmart

18. SCDMH Client, Patient, Resident Services.

More residential placements, less resistance form MHC's(columbia, sumter, orangeburg, pee dee, charleston) to patients from outside their areas.

19. Employees both full-time, temporary, or contract staff.

faster Hr decisions

20. SCDMH Leadership/Supervisors.

What leadership?

18. SCDMH Client, Patient, Resident Services.

More devices sharable added to come into the active treatment ..... eg., more groups and activities to keep patients busy. More resources are needed to help in this process with to certain populations proculing with developmental and cognitive disability

16. The SCDMH Budget.

Should include raises and bonuses for the employees when employees go over and beyound in their job duties there should be gift cards, petty cash for incentives, wellness for state incentitives.

17. The use of Technology in SCDMH.

Antiquated!! We are far behind. Computer training for staff and residents/patients/clients.

18. SCDMH Client, Patient, Resident Services.

We need to catch-up to what other states are doing to provide better services.

Comment Report Title

19. Employees both full-time, temporary, or contract staff.

A study of salary need to be done to help retain staff(please). More training is needed for all staff.

20. SCDMH Leadership/Supervisors.

LEadership and supervisors need much training. Supervisor training how to speak with their staff members. Leadership only look out for themselves(not all). Go back to the basics of learning good interpersonal skills.

15. The SCDMH Mission, Vision, and Values.

The mission, vision, values are great

16. The SCDMH Budget.

need to give raises if possible

17. The use of Technology in SCDMH.

none

18. SCDMH Client, Patient, Resident Services.

PT. should come first and they do

19. Employees both full-time, temporary, or contract staff.

needs more staff better coordination

20. SCDMH Leadership/Supervisors.

They should do better when it comes to the supervisor staff need to know who they are first

15. The SCDMH Mission, Vision, and Values.

What mission
What vision
What values

16. The SCDMH Budget.

We as CNAs all underpaid and over worked and think its disgusting for a state facility is the worst paying job in the state.

17. The use of Technology in SCDMH.

If you have staff

19. Employees both full-time, temporary, or contract staff.

What staff!!! I dont know where you all get your information from but Tucker center do not have staff. Not when I have to stay over at least twice a week.

20. SCDMH Leadership/Supervisors.

Need to come out of the office and on the florer and help since MRS Kemp left theres no help or leadership just bosses.

15. The SCDMH Mission, Vision, and Values.

Should be posted on the front hall entrance by the flag

17. The use of Technology in SCDMH.

Each employee should have an access to email message

18. SCDMH Client, Patient, Resident Services.

Need adequate staffing
Need better way of conflict resolution instead of moving staff from one unit to another

19. Employees both full-time, temporary, or contract staff.

Should receive same treatment

20. SCDMH Leadership/Supervisors.

Should work together for the betterment of DIS and their customers. Improved on communication instead of being judgemental.

19. Employees both full-time, temporary, or contract staff.

More diversity in high level positions

Comment Report Title

17. The use of Technology in SCDMH.

By not having access to scheduling electronically it creates more paper for the office. It is time consuming, we are not as efficient as we can be to do our daily jobs. With lack of access to systems, Having electronic medical records creates more efficiency and accuracy for recalling and accessing information in a timely manner. At the moment our office does not have our own electronic medical records system.

16. The SCDMH Budget.

Staff need raises for good work. Merit raises!!

17. The use of Technology in SCDMH.

Please!! Lets get digital! Why are we still doing all charting on paper.

19. Employees both full-time, temporary, or contract staff.

We need more Staff!! (DMH Staff) No more * & # if we hire enough staff to always have at least 1 extra on each unit for all shifts.

15. The SCDMH Mission, Vision, and Values.

Nobody follows the mission, vision, or values around here

16. The SCDMH Budget.

Need to be better, so things can work around here

17. The use of Technology in SCDMH.

sucks cause things barely work

18. SCDMH Client, Patient, Resident Services.

can improve more with more staff

17. The use of Technology in SCDMH.

more

18. SCDMH Client, Patient, Resident Services.

more team work

19. Employees both full-time, temporary, or contract staff.

no pound or star! 100

15. The SCDMH Mission, Vision, and Values.

na

16. The SCDMH Budget.

Their needs to be a supplemental budget for DIS IT staff since the demand for them is high. They have worked over hours to accomadate new technology issues and didnt get paid for it. A separate budget for overtime would be nice as well as shift diffrential.

17. The use of Technology in SCDMH.

Everyone needs to be on the same path for technology. Too many old software and hardware trying to work with new technology.

18. SCDMH Client, Patient, Resident Services.

na

19. Employees both full-time, temporary, or contract staff.

Employees that go way above and beyond are not being recognized. They are not being recognized as they should be. Some put their soul into working here are taken for granted.

20. SCDMH Leadership/Supervisors.

na

15. The SCDMH Mission, Vision, and Values.

na

16. The SCDMH Budget.

na

17. The use of Technology in SCDMH.

setup to communicate digitally cross the board. paperless

Comment Report Title

18. SCDMH Client, Patient, Resident Services.

na

19. Employees both full-time, temporary, or contract staff.

employee should receive pay raises according to policy and procedures.

20. SCDMH Leadership/Supervisors.

na

16. The SCDMH Budget.

SCDMH budget should be used to give employees a pay increase. Many employees are in areas where there is a staff shortage, they are performing multiple job duties, and they should be compensated for those duties.

17. The use of Technology in SCDMH.

Since the implementation of the EHR, technology in SCDMH is too slow. The Avatar program loads slowly and freezes often. There does not appear to be enough monitors/computers on hand for all staff. Many of the machines need to be upgraded.

18. SCDMH Client, Patient, Resident Services.

With regards to patients and their medical records, often times their final summary of treatment is unavailable upon their request or request from outside entities. This is a great disservice to them. Theri facesheet is incomplete upon discharge and that is unacceptable. Better care should be given to the patient to ensure their final summary of treatment is completed within 30 days of discharge and not several months/years later.

19. Employees both full-time, temporary, or contract staff.

oftentimes, current staff are not aware of all full time, temporary or contract staff. The facility should have an updated listing of current employees. In regards to temporary staff, their job duties should be clearly expressed to them as well as other staff. Policies should be in place regarding their supervision. Temporary staff have been left in areas unsupervised to "non" an area for which they have no knowledge of.

20. SCDMH Leadership/Supervisors.

Supervisors should be held accountabel for ensuring staff coverage in their areas. Often times when employees are out no one is aware. it appears dmh has instituted a policy of staff sending text messages to the supervisor stating they will not be in and this information does not get to other staff. Supervisors are sending text messages to contain staff stating lateness and absences, but this information is not revealed to all. Supervisors need to verbally speak with staff or send an email.

17. The use of Technology in SCDMH.

EMR!!!

16. The SCDMH Budget.

The SCDMH budget should put par raises in budget at least every three years or get bonuses every year.

16. The SCDMH Budget.

Increase incentive and salary of rn and cna(especially cna) for retention. Will reduce call outs.

17. The use of Technology in SCDMH.

EMR will be most helpful. It keeps etting delayed

18. SCDMH Client, Patient, Resident Services.

some days not enough cna staff. meds not given out in time because nurses ar busy, not enough activti people

20. SCDMH Leadership/Supervisors.

Stop promoting because of longevity and friendship

16. The SCDMH Budget.

New hires should not be brought in @ salary equal to an employee with over 20 years experience.

19. Employees both full-time, temporary, or contract staff.

supervisors, regardless of salary should complete timesheets. Everyone should be treated equally! A new employee should complete time shees, however vested employees with 5 plus years should not have to complete time sheets.

18. SCDMH Client, Patient, Resident Services.

Hospital patients need a work/vocational program. More freedom to roam around the grounds. More bus/van trips off grounds. Patients should have access to gardening, greenhouse, occupational therapy, music therapy, etc...

Comment Report Title

15. The SCDMH Mission, Vision, and Values.

ok with me

16. The SCDMH Budget.

I don't know anything about it. Supervisors handles all of it.

17. The use of Technology in SCDMH.

More the better.

18. SCDMH Client, Patient, Resident Services.

Need to be improved. Need more activities(variety) for clients.

19. Employees both full-time, temporary, or contract staff.

Contract staff is a good thing.

20. SCDMH Leadership/Supervisors.

I do not want to work at my facility anymore. Poor...Judgemental, be in cliques. Not fair to other staff. Staff not treated equal. No morale. Facility director is nice. Confidentiality here is terrible!

15. The SCDMH Mission, Vision, and Values.

We are not improving our client's quality of life, we are maintaining their quality of life. As a doctor said "we are making them comfortable. Improving is a far stretch.

16. The SCDMH Budget.

The budget does not support the need of the clients, staffing & upgrading our facility.

17. The use of Technology in SCDMH.

We still do not have EC at most facilities of SCDMH realm. The the problem will still be integrating all disciplines to a good program.

19. Employees both full-time, temporary, or contract staff.

The need for permanent staff is necessary for continuity of care for our residents. Improving salaries would bring higher level of care personal.

20. SCDMH Leadership/Supervisors.

Not sure who is leadership, but with present staffing it would be appropriate for supervisor to pitch in/assist instead of scrambling for hours to find coverage.

16. The SCDMH Budget.

The pay needs to be increased.

17. The use of Technology in SCDMH.

Very much so NEEDED

18. SCDMH Client, Patient, Resident Services.

needs a major improvement.

19. Employees both full-time, temporary, or contract staff.

Temp & contract has to much control & power. They have more say so than full-time employees.

20. SCDMH Leadership/Supervisors.

Need to be more involved with staff and residents. They feel as though patient care is beneath them & will look for cnas to changes residents instead of doing it themselves. Need to talk better to staff. Leadership needs an overhaul.

16. The SCDMH Budget.

The budgets seem to be favorable to certain departments. Public safety, physical plant-see lots of new vehicles. Other departments are using 96-98 vehicles that sometimes break down.

17. The use of Technology in SCDMH.

There should be easier access for all employees to be able to use a computer terminal.

19. Employees both full-time, temporary, or contract staff.

State employees are way under paid. Angency staff make better wages.

Comment Report Title

20. SCDMH Leadership/Supervisors.

Fire the HR Staff. They are ridiculous. Why does it take 3 months or more to hire people? Disciplinary actions take so long- that HR says that we cannot serve actions because it took too long-but HR is at fault.

If DMh was a publicly traded company it would be long gone to bankruptcy.

16. The SCDMH Budget.

Need a pay raise for employees

20. SCDMH Leadership/Supervisors.

Some need training

16. The SCDMH Budget.

Need a pay raise not enough money for employees

16. The SCDMH Budget.

Employees should be paid more

17. The use of Technology in SCDMH.

Computers would be useful in the cafeteria

19. Employees both full-time, temporary, or contract staff.

Temp staff should be able to become permanent quicker

18. SCDMH Client, Patient, Resident Services.

Resident services

19. Employees both full-time, temporary, or contract staff.

contract staff

15. The SCDMH Mission, Vision, and Values.

Mission-Teamwork to the same goal.

17. The use of Technology in SCDMH.

Its good to technology because of the world but nothing wrong with having paperwork for backup.

19. Employees both full-time, temporary, or contract staff.

full time

16. The SCDMH Budget.

Look more into doing for the employees with money and appreciate them. feel like some of the money get wasted.

19. Employees both full-time, temporary, or contract staff.

Should look into why employee do not stay or like working here.

20. SCDMH Leadership/Supervisors.

All supervisors need to be on the same page and support each other.

16. The SCDMH Budget.

Better finances for employee. More money for you employee in budget.

20. SCDMH Leadership/Supervisors.

Make sure all are on the same page and know their leadership at SCDMH.

16. The SCDMH Budget.

Need to have more money for individual departments to receive yearly raises.

17. The use of Technology in SCDMH.

Way to much paper work unnecessary

19. Employees both full-time, temporary, or contract staff.

Shouldnt take 6 months to be hired into a position

20. SCDMH Leadership/Supervisors.

Too many supervisors and not enough staff. In certain departments.

17. The use of Technology in SCDMH.

Could be better to much paperwork, need more computer work

Comment Report Title

19. Employees both full-time, temporary, or contract staff.

Should be paid more for the hard work we do everyday

15. The SCDMH Mission, Vision, and Values.

no comment

16. The SCDMH Budget.

The employees should make more than they do. Admin Employees.

17. The use of Technology in SCDMH.

good

18. SCDMH Client, Patient, Resident Services.

ok

19. Employees both full-time, temporary, or contract staff.

?

20. SCDMH Leadership/Supervisors.

ok

15. The SCDMH Mission, Vision, and Values.

The mission and vision are good but the SCDMH values have shifted. Not much value in the care of clients and their well-being and treatment due to pay. Hey you get what you pay for.

16. The SCDMH Budget.

The budget for SCDMH should be increased significantly so employees can get a decent salary and clients can get the adequate treatment without cutting corners due to lack of staff.

17. The use of Technology in SCDMH.

The technology needs to be up-graded with the times and get people that know how to fix-it when you have a problem.

18. SCDMH Client, Patient, Resident Services.

The clients should have Barber/Cosmetology services available to them. Re-evaluate the Nutritional Services. Clients complain about the food. Ex: taste,amount.

19. Employees both full-time, temporary, or contract staff.

Pay the full time employees what they deserve that way some of the temporary and contract staff will want to become full time employees.

20. SCDMH Leadership/Supervisors.

Leadership/supervisors stop the favoritism!!!!!! Don't listen to what others tell you about a person-know that person for yourself. Certain employees get just what they ask for and the one that's working hard, coming to work every day get nothing.

15. The SCDMH Mission, Vision, and Values.

na

16. The SCDMH Budget.

Counselors are unpaid for the treatment services we give to change and save lives

17. The use of Technology in SCDMH.

More updated system, we need access to youtube as update addiction videos and lectures for patrols.

18. SCDMH Client, Patient, Resident Services.

Patients need better food. A I work w meal @ complaints of portion size.

19. Employees both full-time, temporary, or contract staff.

Need to feel upper management care about staff giving direct care to patients. Compassion. Empathy. Genuiness.

20. SCDMH Leadership/Supervisors.

Promote staff from within agency.

Comment Report Title

16. The SCDMH Budget.

I feel thath employees should be paid more

17. The use of Technology in SCDMH.

I think a time clock needs to be permitted

18. SCDMH Client, Patient, Resident Services.

Need a better directed program. The children are returning too frequently and no change. Just need to improve the whole system.

19. Employees both full-time, temporary, or contract staff.

Its a good thing but need more.

20. SCDMH Leadership/Supervisors.

No support and our voices are unheard until things happen. They are not concerned about our life or health. We should not be in a place 16hrs back to back due to less staff. Thats bad on individuals life. Our Family misses us.

16. The SCDMH Budget.

Stop keeping BHA over. Burning out your employees and some just hanging in the nurses station doing nothing.

17. The use of Technology in SCDMH.

To make sure all employees have computer access.

18. SCDMH Client, Patient, Resident Services.

Stictor, rules if refusing treatment and abusing staff.

19. Employees both full-time, temporary, or contract staff.

All should be treated equally. Allow employees to sign up for overtime instead of mandating. Go to 12 hour shifts. You will have less call outs.

20. SCDMH Leadership/Supervisors.

Are not Fair. Alot of favortism and some supervisors are not good leaders talking about their staff.

16. The SCDMH Budget.

provide raises to staff

17. The use of Technology in SCDMH.

Computers need updating

18. SCDMH Client, Patient, Resident Services.

providing more clothing to patients

19. Employees both full-time, temporary, or contract staff.

provide more staff

16. The SCDMH Budget.

We really need a rise, bha

17. The use of Technology in SCDMH.

Need to be improvement computer being extremly slow.

18. SCDMH Client, Patient, Resident Services.

Need to increase clothing for pt whenever they first arrive, etc.

19. Employees both full-time, temporary, or contract staff.

Need to recruite more staff full-time or agency etc

20. SCDMH Leadership/Supervisors.

Need to have more empathy toward staff etc.

16. The SCDMH Budget.

Allow for more activities on the unit

18. SCDMH Client, Patient, Resident Services.

Employee safety should be just as important as pt safety.

19. Employees both full-time, temporary, or contract staff.

Recognition for work(e.g. employee of the month) staff appreciation.

Comment Report Title

20. SCDMH Leadership/Supervisors.

More help from the nurses and supervisors on the floor. This way they can have a understanding of what BHAs go through.

15. The SCDMH Mission, Vision, and Values.

Revisit and rewrite the mission. Stick to the mission rather pick and choose when to follow

16. The SCDMH Budget.

Expand offer incentives to keep employees, offer more money for BHAbs and c's. Improve advancement within company.

17. The use of Technology in SCDMH.

More laptops. We cant always leave unit to go to computer to write notes. Easier logons for computer.

18. SCDMH Client, Patient, Resident Services.

Focus on patient and safety. Get rid of patients always high. More things to do within the program. More Activities. Separation of the units especially boys and girls.

19. Employees both full-time, temporary, or contract staff.

Stop over working staff hire more people. Actually listen to staff and try to consider their inputs. Treat staff right with respect.

20. SCDMH Leadership/Supervisors.

We need to see the leaderships/supervisors more than once ever, three months. better communications.

16. The SCDMH Budget.

Do things cheaper for bigger bonuses is what I see. Not actually spending it to the benefit of patients

17. The use of Technology in SCDMH.

Computer are terrible-very slow
Avatar is terrible-cheap program

18. SCDMH Client, Patient, Resident Services.

They don't provide enough therapeutic opportunities or things for the patients to do especially on weekends. if you want them to just sit around and watch television then you're right on the money. They need more things to do.

19. Employees both full-time, temporary, or contract staff.

Under appreciated, under compensated and working their butts off. We need more staff. We have a hard time covering our census now when the new MD shows up we'll have an even harder time. People are leaving all the time because they are expected to work so much. Multiple 16 hour shifts each week are normal.

20. SCDMH Leadership/Supervisors.

Leadership just look at reports and don't really know what it is like on the unit, especially when it comes to Hall. They lead from afar and communication sucks. Everything takes too long to happen and when it does they cheap out so they can get a better bonus at end of year.

16. The SCDMH Budget.

Work something out so we can get paid more

20. SCDMH Leadership/Supervisors.

Needs more communication

15. The SCDMH Mission, Vision, and Values.

Treat patient and staff with dignity and respect at all times, and provide a safe environment for patient and staff.

16. The SCDMH Budget.

BHA, Housekeepers, Food Service all need a raise. Cost of living and insurance is going up not our pay check.

17. The use of Technology in SCDMH.

Need more and better computers.

20. SCDMH Leadership/Supervisors.

Too much favoritism supervisors should have a open mind and be fair.

16. The SCDMH Budget.

Focus on paying BHAs what they deserve so they don't leave. Other hospitals start out at $17.00

Comment Report Title

16. The SCDMH Budget.

The employees need a big raise.

16. The SCDMH Budget.

Seems to be more of "how can we save money so I can get a bigger bonus" rather than "how can we make this a place that actually HELPS patients"

17. The use of Technology in SCDMH.

Avatar SUCKS! It is obviously the absolute cheapest thing SCDMH could fint to be in state compliance. Even though we do most things on the computer we still do completely repetitive paperwork. that say the exact same thing that we just put in the computer and printed.

18. SCDMH Client, Patient, Resident Services.

There is very little for patients to do, especially on weekends, that is theraputic. Watching tv for hours on end, during the weekend especially is not helping patients at all! But they have literally nothing else to do.

19. Employees both full-time, temporary, or contract staff.

Are not appreciated at all. As long as everyone shows up to work and mgt doesnt have to get involved then no one above the charge nurses cares as long as it doesnt affect their money or chance for a bonus or vacation. Staff is miserable and are dropping like flies because of the way this place is run. this is even evident by the fact that we can't even hire a new MD that will actually show up on their first day not alone stay for more than a month.

20. SCDMH Leadership/Supervisors.

Like I said in my previous rant, anyone, except a very select few have anything constructive to do with the actual goings on of the units. They sit in their offices making decisions that effect, usually negatively, all the employees and patients on a unit just because it sounds good to them when in actuallity it is usually the dumbest crap that makes no sense to anyone else. But it is very rare that the suggestions of staff are actually taken into consideration.

15. The SCDMH Mission, Vision, and Values.

No problem in this area

16. The SCDMH Budget.

Many employees complain about their salaries.

17. The use of Technology in SCDMH.

Seem to be pretty good.

18. SCDMH Client, Patient, Resident Services.

Seems good.

19. Employees both full-time, temporary, or contract staff.

Salaries seem to be an issue.

20. SCDMH Leadership/Supervisors.

seem to be doing a good job

19. Employees both full-time, temporary, or contract staff.

I feel that everyone should have the same opportunities to work part time even if you're not in one of the higher up positions.

17. The use of Technology in SCDMH.

We don't have the resources ive need to eliminate paper driven processes. New user friendly programs not available. Updated computers not available for us and technical support for training on basic computer software. 0 intergrated system available to all to obtain needed information-only to a select few.

18. SCDMH Client, Patient, Resident Services.

Patients are not given the educational training and resources needed for discharge and success in a community setting.

19. Employees both full-time, temporary, or contract staff.

Employee rushed into areas without appropriate training and competency checks to assure success. Increased salaries with no accountability or knowledge or policy or procedures. More people coming in knowing less.

Comment Report Title

20. SCDMH Leadership/Supervisors.

Too many positions in leadership positions that do not adhere to mission, vision, and values with no vested interest in learning or providing service to patients we are supposed to serve.

19. Employees both full-time, temporary, or contract staff.

Could someone pressurize the legislature to vote on improving salaries of staff? We are surely last on the list of poorly paid workers nationally!

15. The SCDMH Mission, Vision, and Values.

neutral

16. The SCDMH Budget.

They should pay experience CNA more money I check the pay scale for other places, state we need to match everyone else. They should provide back braces for any employee who is doing alot of lifting.

17. The use of Technology in SCDMH.

never used it

18. SCDMH Client, Patient, Resident Services.

neutral

19. Employees both full-time, temporary, or contract staff.

They should recognize employee for their hardware like employee of month, and please let CNA know whats going on and stop having to or from one person to the next and never know whats going on. Communication not great at all.

20. SCDMH Leadership/Supervisors.

Leadership/supervisors should communicate and make sure they talk yto each other make good decision together not no one knows nothing.

15. The SCDMH Mission, Vision, and Values.

Need to be changed

16. The SCDMH Budget.

Provide raise after 1 year of service

17. The use of Technology in SCDMH.

need to become modernize. This is 21st century. Need to be computerized.

18. SCDMH Client, Patient, Resident Services.

Resident need upmost care.

19. Employees both full-time, temporary, or contract staff.

Full time employee should be pulled less, should be left in charge if working with part time or contract staff.

20. SCDMH Leadership/Supervisors.

Supervisors need to help out when short of nurses especially with medications,

15. The SCDMH Mission, Vision, and Values.

The mission, vision and values. We as employee need to do better as me.

16. The SCDMH Budget.

na

17. The use of Technology in SCDMH.

Please update computer and all employees should have access to computer. Lets go paperless.

18. SCDMH Client, Patient, Resident Services.

na

19. Employees both full-time, temporary, or contract staff.

They all should have raises.

20. SCDMH Leadership/Supervisors.

Employees have alot of free will to lease the job and be absent and still have a job when they decide to come to work???

15. The SCDMH Mission, Vision, and Values.

Great vision

Comment Report Title

16. The SCDMH Budget.

Pay raise for all employees

17. The use of Technology in SCDMH.

offer more training

18. SCDMH Client, Patient, Resident Services.

hire more staff to improve patient care

19. Employees both full-time, temporary, or contract staff.

pay raise

20. SCDMH Leadership/Supervisors.

Express how important it is to not show favoritism to one employee over others.

15. The SCDMH Mission, Vision, and Values.

na

16. The SCDMH Budget.

A pay raise for nursing staff should be considered. We are here to help improve life, pay us like we matter.

17. The use of Technology in SCDMH.

The nursing notes are becomming over cluttered in patients binders! I would suggest more employees to go paperless.

18. SCDMH Client, Patient, Resident Services.

Services are fine. It the patients who are becoming more and more uncooperative and acting as thought they're in need of full care who are making it harder to give care to those who actually NEED the help. This is a hospital.

19. Employees both full-time, temporary, or contract staff.

Certain nurses are not doing their job completely. Ex: BHA reports to charge nurse about resident in pain, bleeding, etc is not being looked in to. Also, each shift is becoming more picky about things not being done. Hipocrite (me) certain shifts leave oncoming shift with a large mess to clean up. EX: Residents left without certain items, clothes being left behind for oncoming shift. This wouldn't be a problem, but the simple fact that said shift is in the nurse's station, talking to staff, casually sitting, while trash is left in pods and clothes are left behind is getting to be too much.

20. SCDMH Leadership/Supervisors.

The supervisors are doing well. Although communication could be better about certain fields. Such as putting x amount of BHAs from one floor to the next, leaving the pulled floor with a stressful amount of patients to care for.

17. The use of Technology in SCDMH.

I feel SCDMH should have wifi available for employees. This would help those of us who are in shod, online. We would be able to do school work on our break.

16. The SCDMH Budget.

Im not sure what the budget is or what it covers. But I do know that the employees at the DMH @ patric B Harris is underpaid, especially in nutritional services. The NS department does not even get the same weekend incentive as the ones in Columbia. This is the new reason new employees won't stay. The employees at a fast food restaurant are paid more than we are.

17. The use of Technology in SCDMH.

Technology is fine if it benefits everyone and not just a few.

19. Employees both full-time, temporary, or contract staff.

There needs to be more one on one training. There are too many supervisors in NS @ Harris Hosp. and not enough workers. The morale is low here. One lead supervisor doesn't do his fair share, he spends more time in the stock room then anywhere else. One supervisor walks around each morning talking to other employees and talks on her phone anytime it rings, whether she is on the serving line or not. Other employees are prohibited from this.

Comment Report Title

20. SCDMH Leadership/Supervisors.

Our mile lead supervisor does not know the patients tickets or the amounts of food needed in each meal prep. Always short on the necessary items to prep with. Lead supervisor places the orders.

It would be nice if everyone follows the same procedures on the serving line, dish room and in the prep areas. It would save a lot of confussion on new employees.

15. The SCDMH Mission, Vision, and Values.

I looked up mission, vision, and values. They look good on paper, but I don't see these values in practice daily. Nor do I see staff valued or supported.

16. The SCDMH Budget.

This should include a sizeable increase to BHA salaries. I am not a BHA. Nursing salaries should also be increased to remain competitive with local markets. Salaries are probably the biggest barrier to employment retention.

17. The use of Technology in SCDMH.

Insufficient training before implementing EHR and what little training occurred took place 4-5 months before system implemented. System is slow, locks up frequently. SCDMH is far behind on properly implemented technology.

18. SCDMH Client, Patient, Resident Services.

Patients services need to be increased for intermediate to long-term care patients with more variety based on age, ability, personal interests and cultural sensitivity. CNAs should be hired for older, geriatric patients housed long term in acute care facilities with adequate, competitive salary compensation.

19. Employees both full-time, temporary, or contract staff.

All employees need to be held accountable to working assigned hours. Too many call offs without consequences; leads to unsafe staffing and ultimately compromised patient care.

20. SCDMH Leadership/Supervisors.

Leadership needs to respond more aggressively to staffing shortage replacements to Columbia. Process takes too long to hire new staff. This applies to DON & CEO. Nurse managers need additional support and effective leadership skills training for dealing with difficult issues with staff.

15. The SCDMH Mission, Vision, and Values.

helping people heal sums it up well

16. The SCDMH Budget.

I don't know enough about this area to comment other than to say there is room for improvement.

17. The use of Technology in SCDMH.

This area is improving slowly. I feel there should have been more studies done before choosing AVATAR as this program doesn't interact with any hospitals or labs in our area.

19. Employees both full-time, temporary, or contract staff.

I feel that contract staff has no "ownership" in SCDMH-their work ethic shows it. There are execptions to this of course.

20. SCDMH Leadership/Supervisors.

My immediate supervisor works tirelessly as a patient and nursing advocate. her job would be much easier if the upper management would not put such restrictions on her ability to discipline. The onboarding of new employees needs to be in-house in order to speed up the process.

17. The use of Technology in SCDMH.

Computer training for AVATAR was insufficient. A complete waste of time and left to figure it out after going live.

18. SCDMH Client, Patient, Resident Services.

There needs to be more activities for the long term care patients. A garden or pet-something.

19. Employees both full-time, temporary, or contract staff.

Patient safety is a priority, but staff safety should also be a priority. You are shamed, guilted, and even fired for protecting your own safety when you are in immediate threat or life-threatening contact. Feels like SCDMH values the patients life over the staff. After all other de-escaltion techniques have been used.

Comment Report Title

20. SCDMH Leadership/Supervisors.

Supervisors constantly get away with talking/yelling at staff, very disrespectful.

16. The SCDMH Budget.

Salaries of all employees need to increase to attract and keep quality employees. we are not competitive and the private sector.

17. The use of Technology in SCDMH.

improving

20. SCDMH Leadership/Supervisors.

Great supervisor-room for improvement some areas...

15. The SCDMH Mission, Vision, and Values.

Go the extra mile

16. The SCDMH Budget.

Go treat everyone fairly and give everyone raises.

17. The use of Technology in SCDMH.

Good as long as running smoothly

18. SCDMH Client, Patient, Resident Services.

na

19. Employees both full-time, temporary, or contract staff.

give everyone chances

20. SCDMH Leadership/Supervisors.

Great every fairly and with respect.

16. The SCDMH Budget.

Employees pay

17. The use of Technology in SCDMH.

The computer system needs to be faster and more accurate. Some days it takes to long to complete task due to computer being so slow.

16. The SCDMH Budget.

Would like to see more transparency with how salaries are computed due to the wide range of salary of people in same job description/title.

17. The use of Technology in SCDMH.

Need more than 2-3 days of instruction on bits and pieces of implanted technology

18. SCDMH Client, Patient, Resident Services.

Need agencies within the state to cooperative more for the mutual benefit of the patient.

19. Employees both full-time, temporary, or contract staff.

Need a more efficient way and better pay to 1) get people processed in a timely manner(3-5 days) currently 2-3 weeks. Be more competitive with pay.

20. SCDMH Leadership/Supervisors.

More and better communication, not last minute.

16. The SCDMH Budget.

more raises for employees

17. The use of Technology in SCDMH.

Every employee should have email access. This would allow for better communication.

18. SCDMH Client, Patient, Resident Services.

Intermediate patients should have a more "home like" feel integrated into their lodge activities.

19. Employees both full-time, temporary, or contract staff.

Orientation should be the same for all employees. Temporary and contract staff need to be aware of what this hospital is and how to protect themselves. All stuff should have some small amt. of training(info) on mental illness.

Comment Report Title

20. SCDMH Leadership/Supervisors.

leaders and supervisors should be more open to/with employees. I have seen too much information withholding from higher-ups that could help their employees.

16. The SCDMH Budget.

What budget? I barely make ends meet with my paychecks! The only reason I took this job is because I needed $$$, I'm working two jobs b/c this place can't pay me over $500 every two weeks for 80 hours.

17. The use of Technology in SCDMH.

All the papers and paperwork is CRAZY STUPID!!! Theres no need in all the use of paper we go through.

18. SCDMH Client, Patient, Resident Services.

I do not believe woman workers should be put on any male lodge for the fact that they can be very harmful.

19. Employees both full-time, temporary, or contract staff.

I have a cna certificate, going back to # 16. Can't hire ppl b/c of low pay. This is a state run hospital and youre telling me we cant get a good enough pay. Same reason why employees are leaving, not enough pay to deal w/ the bull.

20. SCDMH Leadership/Supervisors.

As far as leadership, its not right our time keeper threatens not to pay us if we do something wrong on our time card or dont fill out the 100 different slips if we come in early/leave early/leave late/don't come in at all. Few called SC Board of Labor, by law, whether ran by the state or not, yall have to pay us. When we get threatened like that, its not showing leadership.

15. The SCDMH Mission, Vision, and Values.

It's to the point. It serves its purpose.

16. The SCDMH Budget.

More input from individual lodges should be implemented.

17. The use of Technology in SCDMH.

Take in consideration, that the older generation may lack interest in technology and has to resort to short-cuts just to get by.

18. SCDMH Client, Patient, Resident Services.

Establish and maintain structure persisitently

19. Employees both full-time, temporary, or contract staff.

Seniority should be exercised; whereas employees with more years should be given more options.

20. SCDMH Leadership/Supervisors.

New comers should respect and be acceptable to guidelines and leadership presented by those before them.

15. The SCDMH Mission, Vision, and Values.

Nothing looks problematic about these policies, and i'm sure their regularly reviewed.

16. The SCDMH Budget.

I don't know enough about the to speak to the efficiency and efficieny of how SCDMH speaks their money.

17. The use of Technology in SCDMH.

Within reason, expansion of technology we within scdmh is very possible, and remaining paper documentation could mostly be negated to computer processes with some system/policy updates.

18. SCDMH Client, Patient, Resident Services.

This is too broad of a topic for me to comment on

19. Employees both full-time, temporary, or contract staff.

Staff conflict abounds, more frequently I assume related to stress of the work environment. Could benefit for a more active staff mediation program.

18. SCDMH Client, Patient, Resident Services.

patients need more to do than coloring. Patients that can should be allowed to do their laundry, etc for more autonomy, as well as responsibilities.

16. The SCDMH Budget.

Budget needs to include provide a safe, clean environment for pts. Budget needs to do market researches on all positions and increase salaries accordingly.

Comment Report Title

19. Employees both full-time, temporary, or contract staff.

If employees are not qualified to do their job, put someone in who can. Pay for qualified staff, not a warm buddy. Read some of the 24hr reports that are sent to upper mgt. Embarrassing those that are qualified leave due to salaries/work load.

16. The SCDMH Budget.

Give employees raises based on their work performance.

15. The SCDMH Mission, Vision, and Values.

According to the website, mission, vision and values statements were adopted by the sc mental health commision in 2002. To support the recovery of people with mental illness is a retroactive approach. Adopt a proactive mission for prevention.

16. The SCDMH Budget.

To expect the best results an organization must commit to hiring the most qualified professionals and that comes with a price. You get what you pay for.

17. The use of Technology in SCDMH.

Significant improvements needed froma bottom up approach. Trying to use systems that are outdated or not designed to perform the functions required is a waste of time and taxpayers money.

18. SCDMH Client, Patient, Resident Services.

Early intervention in the community, schools, etc may help to avoid the need for inpatient admission. Stop using the inpatient facilities simply to warehouse people with mental illness.

19. Employees both full-time, temporary, or contract staff.

Pay scale must keep up with pay in the community for like professionals. PTD instead of holidays for employees in 24/7 care facilities. Employees should have incentives for their dedication to the organization. loosing leave time at the end of the year must stop. Those working in 24/7 facilities cannot always use their leave time without affecting patient care. There are too many chiefs within the organization we need more front line caregivers, not managers.

20. SCDMH Leadership/Supervisors.

Both need to clearly understand how the fit/their role within the organization and be all over to perform at their maximum capability.

15. The SCDMH Mission, Vision, and Values.

Dress code clearly not followed, emplimented or recognized. Policies not enforced.

16. The SCDMH Budget.

Staff are overworked and underpaid. Preventitive issues not discussed. Seems like money wasterd on things not thought out.

17. The use of Technology in SCDMH.

Employees need ongoing training on the use of emails, minimizing, enlarging work computer screens and computer maneuvering.

18. SCDMH Client, Patient, Resident Services.

Patients are continually admitted to MV when our services can not benefit them.

19. Employees both full-time, temporary, or contract staff.

Employees need to be trained on all areas of each cottage and shifts to be able to perform all duties.

20. SCDMH Leadership/Supervisors.

Cell phones are becoming a disruption in areas. Leadership roles need to be clearly defined.

15. The SCDMH Mission, Vision, and Values.

These statements should have a direct link or icon on the main DMH intranet and internet pages. Needs easier access.

Comment Report Title

16. The SCDMH Budget.

Where is the budget available for all to see? This is an important part of transparency and a way to reduce corruption. It seems there are favorite departments in SCDMH and somehow funds are appropriated to items that aren't exactly high priority or for the benefit of the patients and employees but for the directors and supervisors higher up. The budget needs to be designed to allow for a section in each department budget for incentives and increases based upon performance appraisals. These department budgets also need to be transparent and posted for all the employees to view. This is to keep corruption in check and allow for a greater amount of communication and understanding. Keeps everyone accountable and help employees understand the limitations of money available due to budget constraints from the legislature down.

17. The use of Technology in SCDMH.

Too much paperwork or not enough electronic forms! This needs to be of critical importance as it will increase efficiency and reduce mistakes or misunderstandings. It would also be helpful with communication with outside medical offices and hospitals. Electronic medical and training records should be implemented. This has been common place in the private fields why not to help the government.

19. Employees both full-time, temporary, or contract staff.

Enforce retirements and quit this terry program. People need avenues of progression to the top. I understand certain licensed positions are a different story, but admin or support jobs don't have these same requirements. Provide a path towards promotion or alternate job positions and have a departmental job chart or diagram listing postions and bands so people can understand the chain of leadership and how the positions interact with each other and which positions are promotions or just lateral moves.

20. SCDMH Leadership/Supervisors.

Leaders need to be leaders not just bosses or rulers of their domains. leadership isn't about giving orders or direction, its about chipping in when the work gets tough, being there to support and guide your employees, getting to know them personally to learn their strengths and weaknesses and help develop them. That's what should be reinforced and shown to others.

16. The SCDMH Budget.

Employees that are dedicated and reliable should get some type of monetary incentive.

17. The use of Technology in SCDMH.

More classes on outlook, power point, excel, etc. Throw you in these systems with no books to refer to and minnimum training

19. Employees both full-time, temporary, or contract staff.

Some supervisor mis use their authority and get away with it. Have more training for supervisors!

16. The SCDMH Budget.

Definitely more access for funds to place patients in sober living environments following DIC to help them transition into the community.

17. The use of Technology in SCDMH.

It would be helpful to have access to youtube videos that can be shown during classes and groups that are relevant. More user friendly medical records system.

18. SCDMH Client, Patient, Resident Services.

Ability to keep patients longer in tx, more beds, less of a waiting list.

20. SCDMH Leadership/Supervisors.

Free LISW supervisor! in house CEUs!

17. The use of Technology in SCDMH.

The current system is only a grade above paper. Need a better, faster, more efficient system.

18. SCDMH Client, Patient, Resident Services.

Need more resources for our clients. Books, updated library, more outings, skills training program, etc.

19. Employees both full-time, temporary, or contract staff.

Need additional staff-preferably full-time employees who are invested in the system, care for and about the patients and are willing to work.

Comment Report Title

20. SCDMH Leadership/Supervisors.

We have administrators not leaders. Look at the turn over rates; the rates are astonishing for all disciplines. Department directors(several) received raises but refuse to advocate for subordinates to get increases. Need leaders.

15. The SCDMH Mission, Vision, and Values.

The SCDMH Mission, Vision, and Values is clear and concise. Don't believe changes are necessary at this time.

16. The SCDMH Budget.

The SCDMH Budget needs to dedicate funds to improve the physical environment for clients, residents, and patients.

17. The use of Technology in SCDMH.

The use of technology in SCDMH is lacking. Many upper management and their support staff are equipped with updated computers, mobile phones, etc., able to use Skype, have less limitations and newer equipment than those of line staff or the "workers'.

18. SCDMH Client, Patient, Resident Services.

SCDMH client, patient, and resident services need proper space to carryout missions and provide services. Space for proper treatment and/or functions is very limiting.

19. Employees both full-time, temporary, or contract staff.

Employees both full-time, temporary, or contract staff need more orientation and training on all facets of SCDMH with focused training on critical areas related to licensing and accreditation as well as other applicable regulatory requirements to ensure positive outcomes specific to their center or hospital to have ongoing compliance maintained. If funds appropriated for general salary increase, ensure those earning less than $50,000 receive general increase more so than those over $50,000.

20. SCDMH Leadership/Supervisors.

The SCDMH leadership/supervisors need to know how to do the jobs of those they supervise. Not use their position of authority to bully or intimidate staff or others but set the example. Hold accountable those that do not do their jobs and not delegate everything to others to pick-up someone else's slack (if unable to do the job, individual disciplined at time/point of onset). Too many individuals "allowed" to do nothing or little for a lot of pay and get by with it. Unfairness, treatment by management leaving other employees angry and resentful. Good employees leave because of this.

16. The SCDMH Budget.

Routine raise evaluations for long-term employees(based on performance and desire to stay)

17. The use of Technology in SCDMH.

Find more update and user friendly programs

20. SCDMH Leadership/Supervisors.

Be here and be consistent

15. The SCDMH Mission, Vision, and Values.

Too many patients are here for just housing. Not made to clean up after themselves. they will have to do it when d/cd to placement or return to the revolving door.

16. The SCDMH Budget.

Patients receive better care than staff can afford-even with insurance. Merit raises should be revisted.

17. The use of Technology in SCDMH.

Current computer system is inadequate! Edducational opportunities

18. SCDMH Client, Patient, Resident Services.

Drug and alcohol patients should be separate from the truly mental patients. They have entitlement issues and rather do nothing but complain about "3 hots and a cot".

19. Employees both full-time, temporary, or contract staff.

More money!!! Lunch Breaks!!! Same benefits for all shifts. Opportunity for growth.

Comment Report Title

20. SCDMH Leadership/Supervisors.

No nursing or employee support! Anything would be an improvement! Leadership staff is not in touch with how units actually function. 1 person should not have to do the job of 3 people! Nursing recommendations should at least be considered by management and physicians.

17. The use of Technology in SCDMH.

There should not be a paper for everything. We should be using the technology just all other hospitals.

18. SCDMH Client, Patient, Resident Services.

We are not helping some of our sick pt. they are not children they need more to do than color.

20. SCDMH Leadership/Supervisors.

Leadership needs to be in the lodges seeing whats going on!! Not just waiting to be told what employee are and are not doing!

17. The use of Technology in SCDMH.

I agree that SCDMH should be up to date when it comes to technology. More technology and less paperwork.

18. SCDMH Client, Patient, Resident Services.

The client, patient should be involved with more activities during the day and evening. They should be doing more then just sitting down watching tv.

19. Employees both full-time, temporary, or contract staff.

I believe that contract staff should have some of the benefits like getting paid more when working a weekend shift and if they work second or third shift. After working under contract for so long should have the option to get hired on with the state if they want to.

19. Employees both full-time, temporary, or contract staff.

Increase of base pay of staff

17. The use of Technology in SCDMH.

Focusing more on technology and its operations, continue to dilute the interpersonal communications among the people. Though technology has its place, it still cannot replace the human element needed to effectively provide direct care.

19. Employees both full-time, temporary, or contract staff.

With taking the focus away from salaries, team building and the feeling of importance outweigh the salary amounts. To feel as a genuine team member increases the quality of care provided, and decreases the stress levels of the "walking on eggshells" mentality that robs employees of their morale.

20. SCDMH Leadership/Supervisors.

Make more efforts to create more leaders, not in the sense of a position driven process, but in the sense of morale increasing tactics and team building strategies.

16. The SCDMH Budget.

We dont have supplies we need because the "supply budget" has already been reached for the allotted period. We have to scrounge, skimp, or borrow things from other lodges on too many occasions.

17. The use of Technology in SCDMH.

The use of technology is needed, however buying the cheapest products or software is an issue due to all the issues with the software. We then dont have the proper training for the new software. We dont have enough IT staff to handle all of the issues that arise.

19. Employees both full-time, temporary, or contract staff.

We need more employees!!!!!!! The ones you have are getting burned out because they dont have adequate staffing on the lodges and they are having to handle too many patients. Also, they are hiring just anybody and not properly training those that are hired.

20. SCDMH Leadership/Supervisors.

Leadership/supervisors need to listen to their staff members on lodge. They also need to spend more than 2-3 minutes on a lodge once a month. They don't seem to care how their actions affect the staff on lodge and how their seemingly thoughtless decision add so much stress to the staff under them. It doesn't seem like much of the upper leadership/supervisors care about the staff members who make the hospital run on a day to day basis.

Comment Report Title

16. The SCDMH Budget.

Allow for increase in pay for cna's

15. The SCDMH Mission, Vision, and Values.

Well stated-good intent

16. The SCDMH Budget.

Need to increase

17. The use of Technology in SCDMH.

allow program to allow

18. SCDMH Client, Patient, Resident Services.

better

20. SCDMH Leadership/Supervisors.

good in both buildings

15. The SCDMH Mission, Vision, and Values.

Not sure what they are specifically-could not find on intranet

16. The SCDMH Budget.

decrease budget on technology and increase budget for shift and consumer programs

17. The use of Technology in SCDMH.

not very dependable at this point

18. SCDMH Client, Patient, Resident Services.

na

19. Employees both full-time, temporary, or contract staff.

salaries not in line for education required, unless you are an md

20. SCDMH Leadership/Supervisors.

do not communicate well enough to staff

17. The use of Technology in SCDMH.

computerized documentation

19. Employees both full-time, temporary, or contract staff.

Contract staff should not make more than other full-time employees in the same role.

15. The SCDMH Mission, Vision, and Values.

To protect patients and staff and build more for staff to help with patient behaviors

16. The SCDMH Budget.

staff need more pay

17. The use of Technology in SCDMH.

To go paperless and for each staff to get on the company to enter there work like vital signs some staff still can not log into the computer.

18. SCDMH Client, Patient, Resident Services.

Some nursing staff need to come out of the nurse station and attended to patients more. They sit an eat. BHAs can not do it all without the nurses.

19. Employees both full-time, temporary, or contract staff.

need more pay and better nursing communication.

20. SCDMH Leadership/Supervisors.

Leadership nurses need to interact with patient and stop staying in nurses station just sitting eating at all times. Nurse know herself. All she do is eating and do nothing for the patient the BHAs needs help.

17. The use of Technology in SCDMH.

Should be a priority

15. The SCDMH Mission, Vision, and Values.

Preserve dignity of patients

Comment Report Title

18. SCDMH Client, Patient, Resident Services.

Provide patients with more activities

19. Employees both full-time, temporary, or contract staff.

competitive pay as compared to similar facilities

20. SCDMH Leadership/Supervisors.

Should have some experiences in each nurses work areas.

15. The SCDMH Mission, Vision, and Values.

The mission, vision, and values of the SCDMH agency is to provide therapeutic patient care is a caring and nurturing environment.

16. The SCDMH Budget.

I am hoping to see improvement in the SCDMH budget, as well as pay increase incentives for all of those employed by the SCDMH agency.

17. The use of Technology in SCDMH.

The use of technology in the SCDMH agency benefits employees by providing more time-efficient documentation.

18. SCDMH Client, Patient, Resident Services.

The scdmh agency provides effective client,patient, and residential services.

19. Employees both full-time, temporary, or contract staff.

The SCDMH agency provides four practices regarding state employees.

20. SCDMH Leadership/Supervisors.

I am pleased with the SCDMH leadership and supervision,

May 26, 2011

Eleanor,

Attached is the 2011 Employee Satisfaction Survey. There are 46 pages of comments as compared to 18 pages of comments in the last one that was done in 2008. However, this time, a survey was sent to all staff and in 2008 that was not the case.

This year we sent out 4,074 surveys and received 1,418 completed surveys back. This is a 34.8% response rate, which is, overall, quite good.

I compared the overall responses of the 2008 survey with the 2011 survey. There was not a significant change in the overall percentages. However, there were many negative comments in the 2011 survey. Staff expressed concern over money, lack of opportunities for advancement, increased work load, etc.

I have gone through the comments of the 2011 survey and have highlighted those things that kept showing up. I hope that this will be helpful to you.

Please let me know if you have any questions.

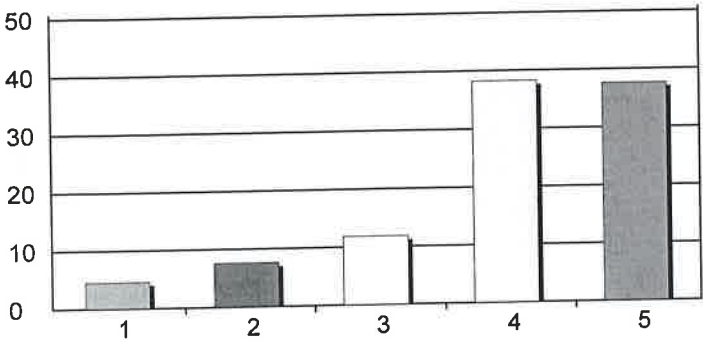
Thank you.

Sandy Hope

SC Department of Mental Helath 2011 Employee Satisfaction Survey

Creation Date: 5/26/2011
Time Interval: 2/28/2011 to 5/20/2011
Total Respondents: 1418

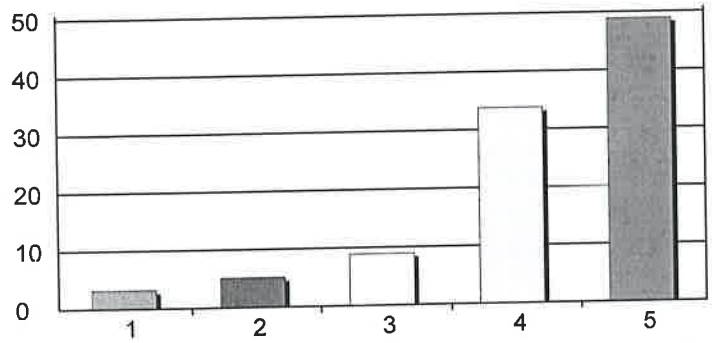
1. My supervisor recognizes contributions that I make to the organization



1. Strongly Disagree	65	5%
2. Disagree	107	8%
3. Neutral	166	12%
4. Agree	535	38%
5. Strongly Agree	527	38%
Total Responses:	1400	

Mean: 3.97 Standard Deviation: 1.10

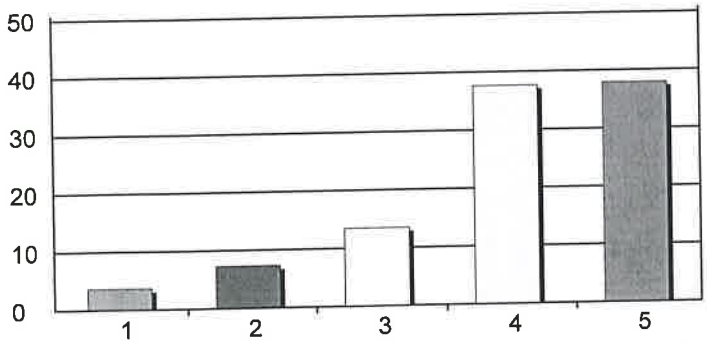
2. My supervisor treats me with dignity and respect



1. Strongly Disagree	45	3%
2. Disagree	72	5%
3. Neutral	125	9%
4. Agree	474	34%
5. Strongly Agree	687	49%
Total Responses:	1403	

Mean: 4.20 Standard Deviation: 1.02

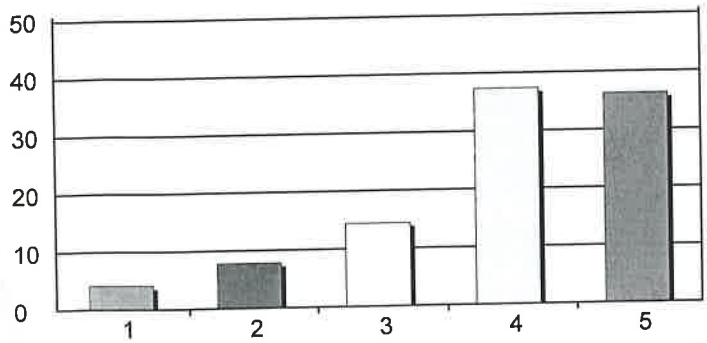
3. My supervisor gives me useful feedback on my performance



1. Strongly Disagree	51	4%
2. Disagree	102	7%
3. Neutral	188	13%
4. Agree	526	38%
5. Strongly Agree	530	38%
Total Responses:	1397	

Mean: 3.99 Standard Deviation: 1.07

4. My supervisor gives me timely feedback on my performance

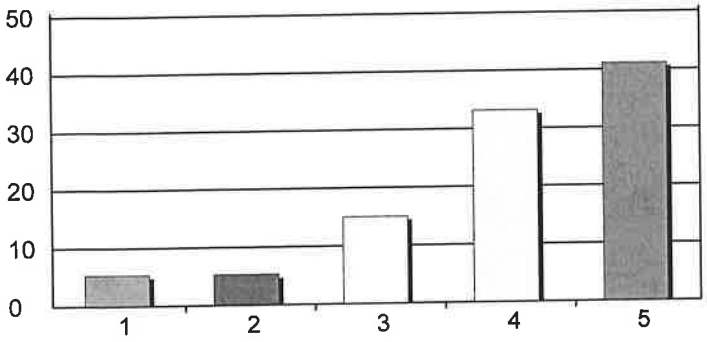


1. Strongly Disagree	58	4%
2. Disagree	109	8%
3. Neutral	201	14%
4. Agree	520	37%
5. Strongly Agree	505	36%
Total Responses:	1393	

Mean: 3.94 Standard Deviation: 1.09

SC Department of Mental Helath 2011 Employee Satisfaction Survey

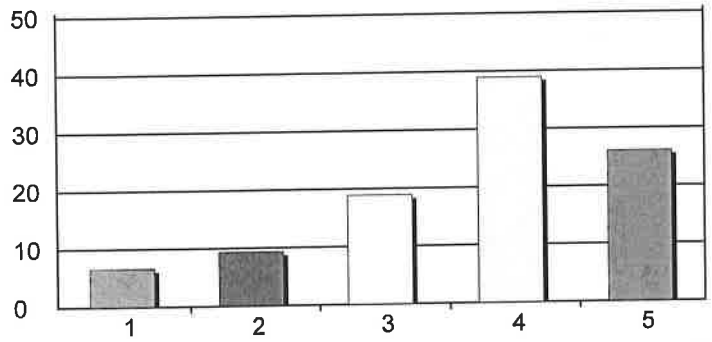
5. My supervisor values my input



1. Strongly Disagree	75	5%
2. Disagree	74	5%
3. Neutral	209	15%
4. Agree	461	33%
5. Strongly Agree	572	41%
Total Responses:	1391	

Mean: 3.99 Standard Deviation: 1.12

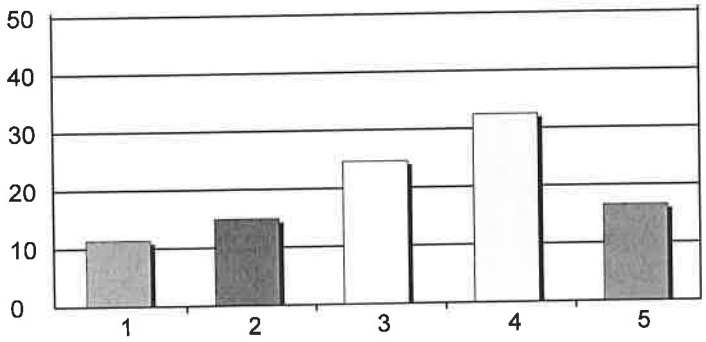
6. The leadership of this organization sets a high standard of performance



1. Strongly Disagree	93	7%
2. Disagree	131	9%
3. Neutral	264	19%
4. Agree	545	39%
5. Strongly Agree	365	26%
Total Responses:	1398	

Mean: 3.69 Standard Deviation: 1.15

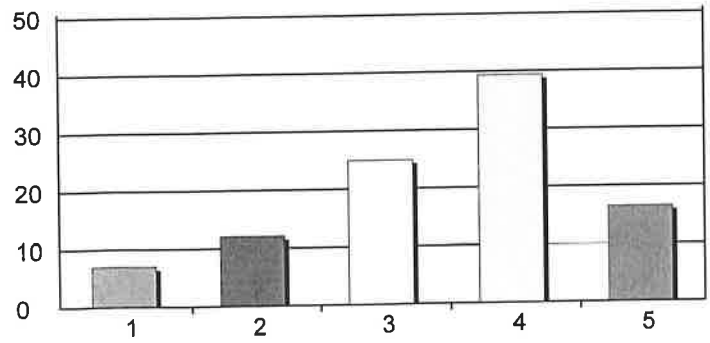
7. The leadership of this organization communicates effectively with its employees



1. Strongly Disagree	159	11%
2. Disagree	208	15%
3. Neutral	343	25%
4. Agree	454	33%
5. Strongly Agree	231	17%
Total Responses:	1395	

Mean: 3.28 Standard Deviation: 1.23

8. The leadership of the Department has developed and effectively communicated its vision for the Department.

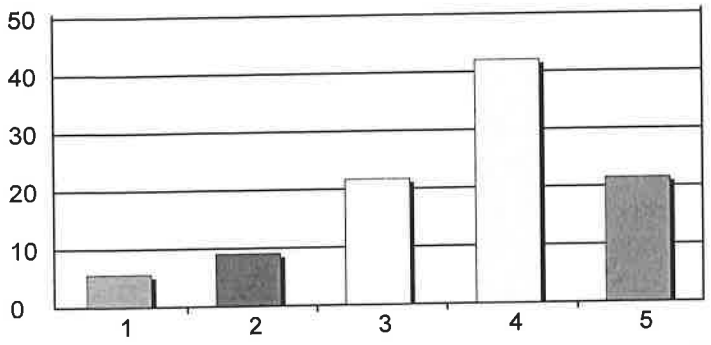


1. Strongly Disagree	98	7%
2. Disagree	169	12%
3. Neutral	348	25%
4. Agree	549	39%
5. Strongly Agree	230	16%
Total Responses:	1394	

Mean: 3.46 Standard Deviation: 1.12

SC Department of Mental Helath 2011 Employee Satisfaction Survey

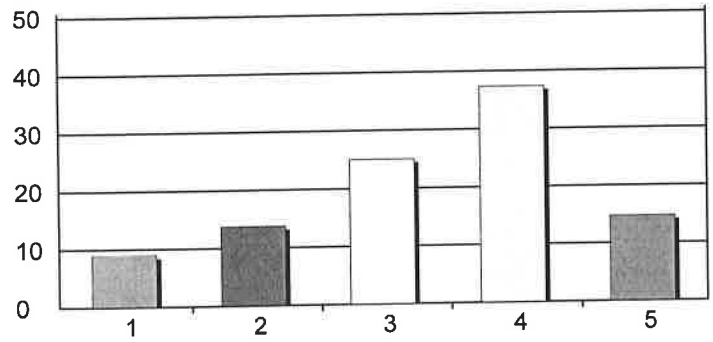
9. The leadership of the Department sets a high standard of performance



1. Strongly Disagree	79	6%
2. Disagree	127	9%
3. Neutral	304	22%
4. Agree	588	42%
5. Strongly Agree	301	22%
Total Responses:	1399	

Mean: 3.65 Standard Deviation: 1.09

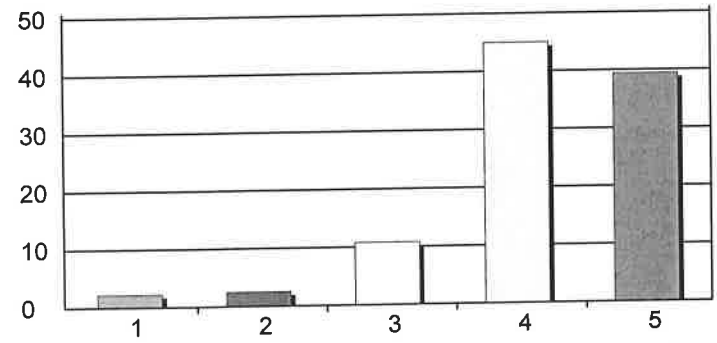
10. The leadership of the Department has created an effective organizational structure



1. Strongly Disagree	126	9%
2. Disagree	192	14%
3. Neutral	349	25%
4. Agree	521	37%
5. Strongly Agree	206	15%
Total Responses:	1394	

Mean: 3.35 Standard Deviation: 1.16

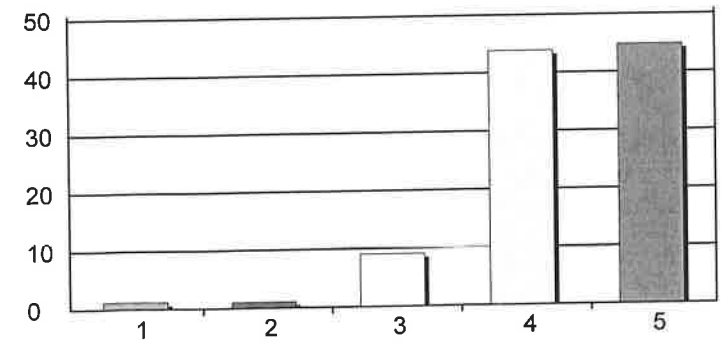
11. I feel that my work efforts contribute to the mission of the Department



1. Strongly Disagree	31	2%
2. Disagree	35	3%
3. Neutral	150	11%
4. Agree	625	45%
5. Strongly Agree	548	39%
Total Responses:	1389	

Mean: 4.17 Standard Deviation: 0.88

12. I value the relationships that I have developed with others in the organization

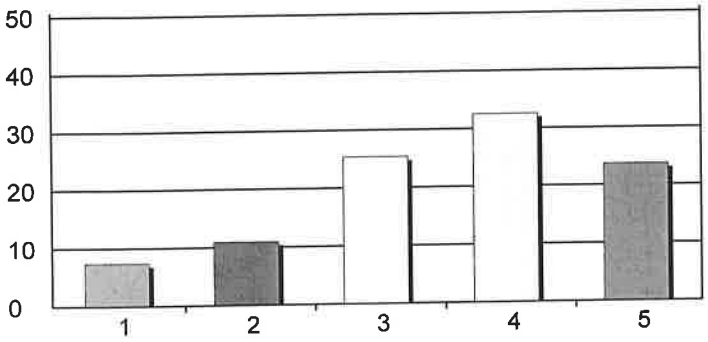


1. Strongly Disagree	17	1%
2. Disagree	15	1%
3. Neutral	127	9%
4. Agree	614	44%
5. Strongly Agree	627	45%
Total Responses:	1400	

Mean: 4.30 Standard Deviation: 0.78

SC Department of Mental Helath 2011 Employee Satisfaction Survey

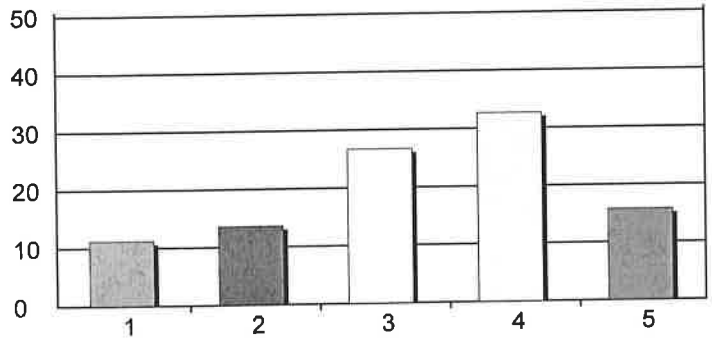
13. Being in this organization is like being part of a family



1. Strongly Disagree	104	7%
2. Disagree	154	11%
3. Neutral	355	25%
4. Agree	456	33%
5. Strongly Agree	332	24%
Total Responses:	1401	

Mean: 3.54 Standard Deviation: 1.18

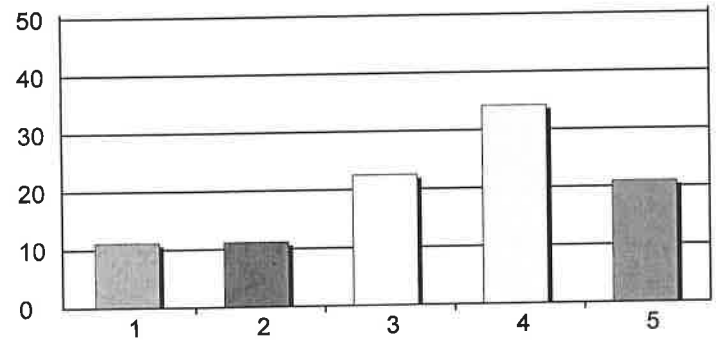
14. People in this organization look out for one another



1. Strongly Disagree	156	11%
2. Disagree	189	14%
3. Neutral	370	27%
4. Agree	453	33%
5. Strongly Agree	219	16%
Total Responses:	1387	

Mean: 3.28 Standard Deviation: 1.21

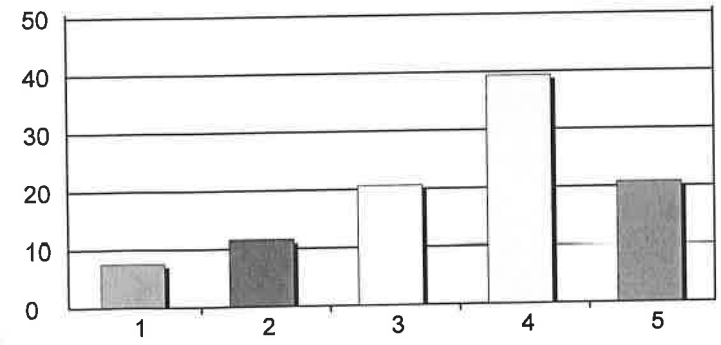
15. The benefits I receive as a state employee are an incentive to remain employed by state government



1. Strongly Disagree	155	11%
2. Disagree	155	11%
3. Neutral	312	22%
4. Agree	475	34%
5. Strongly Agree	291	21%
Total Responses:	1388	

Mean: 3.43 Standard Deviation: 1.25

16. My job provides me with an opportunity to learn and grow professionally

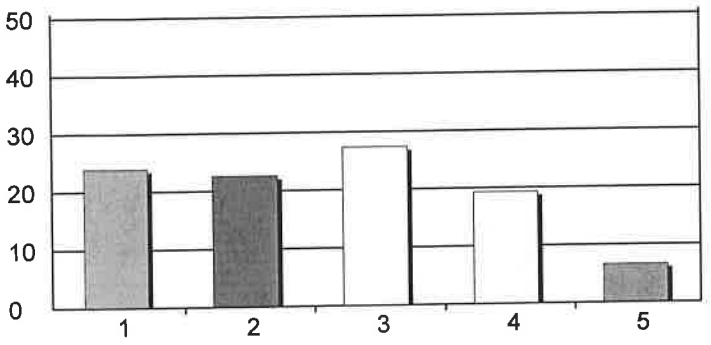


1. Strongly Disagree	106	8%
2. Disagree	162	12%
3. Neutral	288	21%
4. Agree	550	39%
5. Strongly Agree	290	21%
Total Responses:	1396	

Mean: 3.54 Standard Deviation: 1.16

SC Department of Mental Helath 2011 Employee Satisfaction Survey

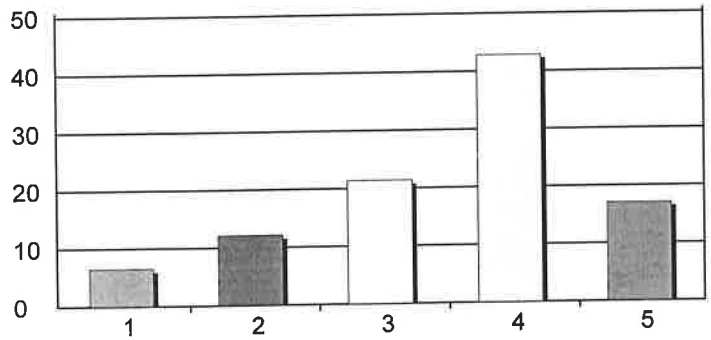
17. The Department provides opportunity for promotions and/or advancement



1. Strongly Disagree	334	24%
2. Disagree	315	23%
3. Neutral	381	27%
4. Agree	269	19%
5. Strongly Agree	93	7%
Total Responses:	1392	

Mean: 2.62 Standard Deviation: 1.23

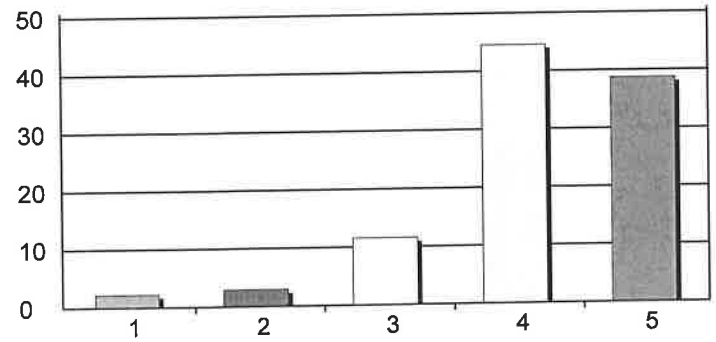
18. I am given adequate training to do my job



1. Strongly Disagree	91	7%
2. Disagree	169	12%
3. Neutral	298	21%
4. Agree	597	43%
5. Strongly Agree	238	17%
Total Responses:	1393	

Mean: 3.52 Standard Deviation: 1.11

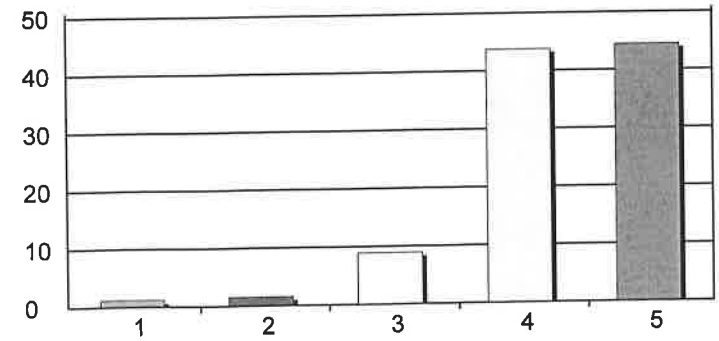
19. My job provides me with challenging work to do



1. Strongly Disagree	31	2%
2. Disagree	41	3%
3. Neutral	162	12%
4. Agree	626	45%
5. Strongly Agree	544	39%
Total Responses:	1404	

Mean: 4.15 Standard Deviation: 0.89

20. I enjoy the type of work that I do here

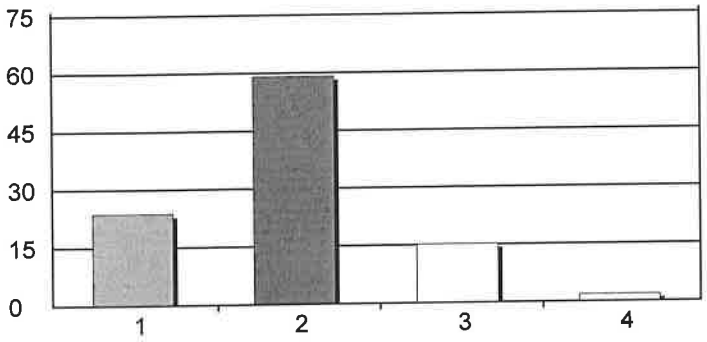


1. Strongly Disagree	17	1%
2. Disagree	22	2%
3. Neutral	125	9%
4. Agree	612	44%
5. Strongly Agree	622	44%
Total Responses:	1398	

Mean: 4.29 Standard Deviation: 0.79

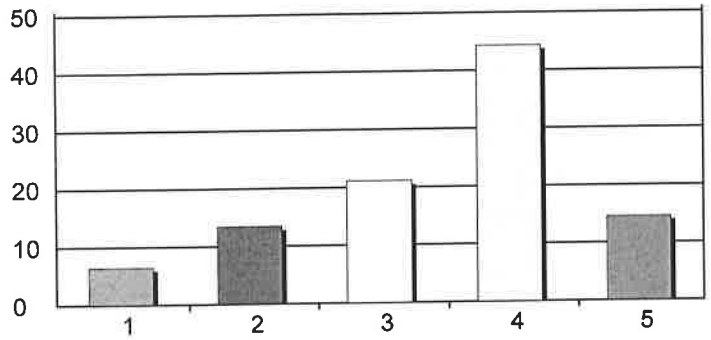
SC Department of Mental Helath 2011 Employee Satisfaction Survey

21. My workload here is (check one):



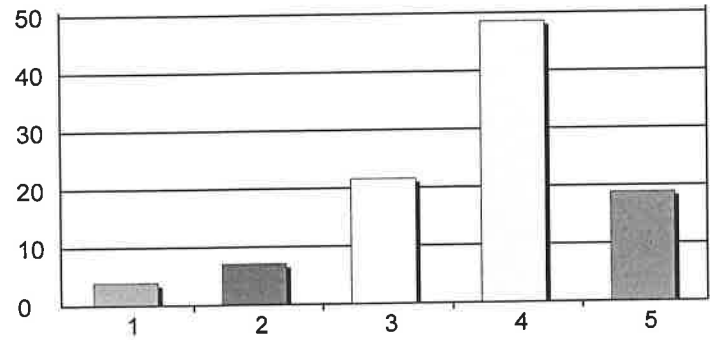
1. Too much for one person	326	24%
2. Occasionally heavy, but about right on most d...	808	59%
3. Just right-not over or under worked	208	15%
4. Not enough-did not fully use my time	26	2%
Total Responses:	1368	

22. The Department sees to it that I have the resources I need to do my job



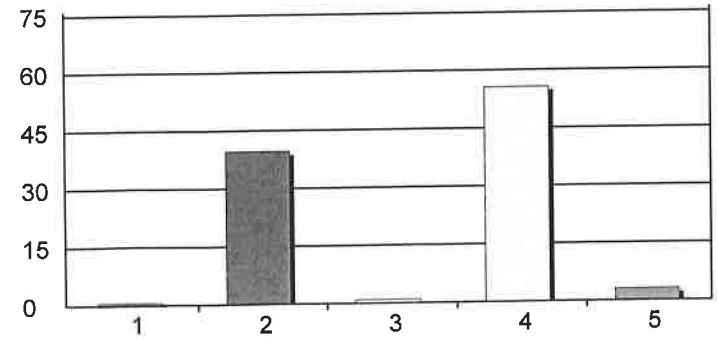
1. Strongly Disagree	91	7%
2. Disagree	188	13%
3. Neutral	295	21%
4. Agree	619	44%
5. Strongly Agree	204	15%
Total Responses:	1397	
Mean: 3.47 Standard Deviation: 1.10		

23. What is your overall level of satisfaction with your job



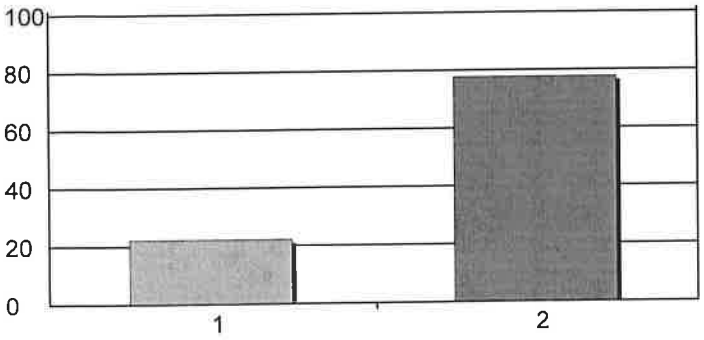
1. Very Dissatisfied	54	4%
2. Dissatisfied	97	7%
3. Neutral	297	22%
4. Satisfied	669	49%
5. Very Satisfied	260	19%
Total Responses:	1377	
Mean: 3.71 Standard Deviation: 0.98		

24. My race (check one) is



1. Asian	8	1%
2. Black	504	40%
3. Hispanic	12	1%
4. White	708	56%
5. Other	39	3%
Total Responses:	1271	

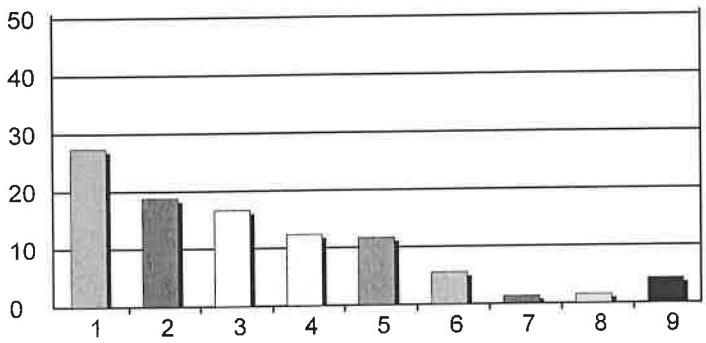
25. My gender is



1. Male	270	22%
2. Female	944	78%
Total Responses:	1214	

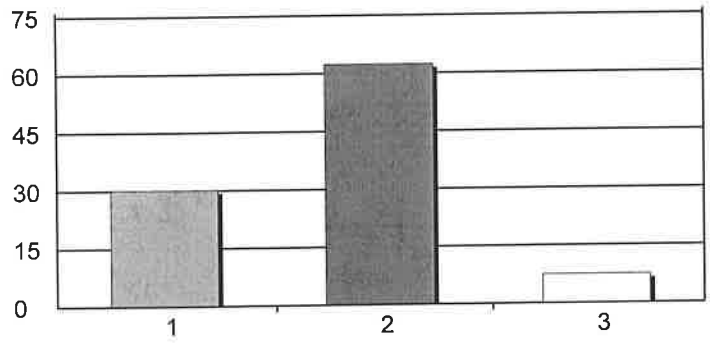
Mean: 1.78 Standard Deviation: 0.42

26. The number of years of state service I have is



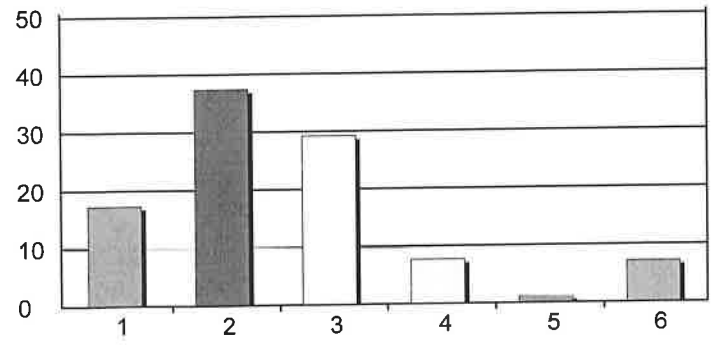
1. 1-5	356	27%
2. 6-10	244	19%
3. 11-15	216	17%
4. 16-20	160	12%
5. 21-25	152	12%
6. 26-30	73	6%
7. 28 TERI	18	1%
8. 30-NON TERI	21	2%
9. 30-TERI	56	4%
Total Responses:	1296	

27. I work in a



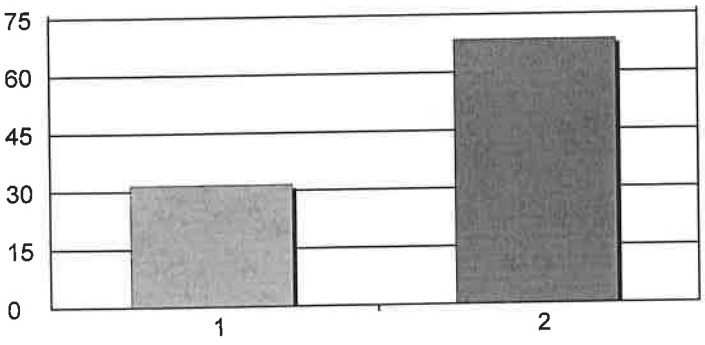
1. Inpatient Facility	387	30%
2. Community Mental Health Center	799	62%
3. Division of the Central Office	95	7%
Total Responses:	1281	

28. My pay band is



1. 01-02	138	17%
2. 03-04	298	37%
3. 05-06	233	29%
4. 07-08	61	8%
5. 09-10	9	1%
6. Unclassified	57	7%
Total Responses:	796	

29. I supervise one or more employees



1. Yes	404	32%
2. No	876	68%
Total Responses:	1280	

Mean: 1.68 Standard Deviation: 0.46

SC Department of Mental Health 2011 Employee Satisfaction Survey

23. What can the Department do to improve your work environment?

- I love my job and work that I do. I am an admin. Spec II. But the supervisor that is in charge of front office is hard to work with. She is very inconsistent. She does not email the front office as a whole. She will tell one person then you hear it second hand instead of having written confirmation. If there are issues one time, she charges procedures right away instead of talking with the front office staff and waiting to see if this problem is consistent. She is a therapist and does not understand the aspects of all job duties in the front office. We are in desperate need of continuity in our office. The morale is terrible and needs to be improved.
- I like my job. This is the best job I have had.
- Supervisor is amazing despite all the stress from leadership – very supportive however-trying to meet productivity when clients have no gas to get here is ridiculous. No increase in pay since I started working here-promoted to supervisor w/add'l responsibilities-no increase approved-am working for less money than when hired. No resources in rural community-not one to follow up. TCM is a joke-can't do TCM unless it: planned but nature of rural mental health is crisis mgmt.-substandard equipment (shredding, chair, computer, etc) asked for ergo computer set up due to neck problem-never followed through in by mgmt. weekly chiro. For clients-no access to MD-Hold Doctors accountable for missing Medicaid deadlines. I believe I do a very good job for this department w/a high level of professionalism that is valued by only a very few people.
- Have a computer system that is reliable! While Dept. gives resources to do the job the reason we are here is lost. The bottom line takes priority over quality of care. There is little in the way of motivating staff, never positive affirmations, strictly bottom line oriented, productivity, productivity, productivity. Try a little encouragement and morale would improve drastically. It is quite sad that a Mental Health Agency is so poor at understanding human behavior. I personally love what I do or I would be earning a living somewhere else. Someone from Columbia who makes these rules should go on undercover boss and see what a job in the trenches is really like! My pay band is ridiculous compared to other states withy master's level clinicians.
- I love working at Coastal, our Director is right on target for running a strong successful business. Technology and compensation should be #1. Central office needs to have business people running the show, not clinical. I think central office needs to replace the head of HR and IT, they are not progressive enough to sustain a growing organization or hire consultants to restructure DMH Processes in procurement, HR, IT these departments are probably 10-15 yrs out of date, especially HR. Am I really writing out my comments on this survey? It should be available online! #8,9,10, (Coastal gets a "SA", Central office gets a "SD".
- Give me a raise. Hire me some help. Even out the inequities within the system-these are what lead to poor morale. We are told for years that raises aren't being approved then read that 1% of DMH employees received an increase of more than 10%. "Only 1%" equates to too many when the rank and file employees receive nothing. Longevity counts for nothing with DMH-you are not respected or rewarded for staying, it's as though our on the job experience is absolutely worthless. School teachers receive increases every year for the first 22 years-our jobs are no less important. In reality, the longer you stay with DMH, the worse off you are financially.
- I have been overloaded with the loss of 2 full time staff members. One being replaced with temp employee. We have same amount of clients less staff. Trying to merge into EMR with equipment that is too slow. EMR is down too much for us to be paperless. I am doing job of 2.5 people. I find it hard to do my job as a supervisor, we are short on doctors. Some clients not seen in over 9

months. Clients are rescheduled to much and with only one doctor they are seen not as often as they should be. 1st dr. appt. is late May!

- Salary increases-merit and cost of living; increase pay bands overall. We are grossly underpaid. Reorganize DMH; eliminate redundancy and combine functions. (eg.ABMHC and Lexington MHC). Training-offer continuing education for LPC & SW staff. Reorganize DMH-administration level (Bull St. office). Decrease paperwork-examine DMH QA functions-reassess and determine how to use most effectively; does Medicaid require all of this paper work or does DMH require?
- Give us a raise.
- Improve motivational tactics (not fear-led mgmt-having "bad list") *note 1am not on the "list"but recognized negative impact on staff. Hard management led moral booster. Ensure quality and qualified individuals get mgmt positions. Workloads are not even or dispersed appropriately in mgmt.
- Everyone needs to follow policy and procedures!
- Most of the problems can be remedied by dealing with improving the state budget. Most days I feel as though I am holding tight to a sinking ship.
- Hire more employees for the volume of work. Support employees in getting further training/credentialing. Reward employees for their efforts/hard work.
- More opportunity for pay raises.
- Provide a psychologist that can do psychological evaluations for kids.
- Have more recognition for staff when things are done well. Incentives for work performance. Increase in pay for licensed staff, which would increase other staff's motivation to become licensed. More training that includes CEU's. Appreciation lunches, etc. for staff, co workers who do not use profanity in the workplace. All staff in the same department treated the same way – no favoritism.
- Need more information ie : insurance pymts to relay to pts.
- There are too many supervisors telling us how to do our jobs – each tells us something different. We are constantly being stabbed in the back, get no raise in pay – only added workload and frustration.
- Be proactive when therapists have issues. I struggle doing my job as I do not have an office, carry things to available areas daily, sometimes moving throughout the day. I do not have a computer, which is a huge barrier to getting things into EMR quickly. This impacts patient care since there is not consistency to "feeling safe" as clients are complaining about being in different rooms often. Morale is down due to micro managing, causing frustrations high with therapists answering to several people on the same issues, which is wasting clients care time! Higher up supervisors do not address issues when brought to their attention.
- Encourage/provide training for senior managers on how to manage their employees/supervisors in a positive, productive way and reduce lateral violence/harassment among staff and in turn providing better patient care.
- Increase annual leave time.
- I know that at this time finances but eventually DMH needs to start being competitive with their pay. Also give pay increase after EPMS reviews.
- Communicate more effectively with employees. Have reasonable caseloads. Caseloads are inconsistent from one MHP to another. Have supervisor conduct monthly meetings with supervisees to communicate news from DMH and supervisors meetings which is relevant to MHP's job.
- Provide compensation commensurate with experience; at least up to average of pay band.
- It would be nice to get a pay increase based on my SE work performance.
- Help with strategies to decrease workload, communicate information effectively.
- Reduce paperwork; train for successful completion of each services especially RPS and TCM.

- Obviously this is beyond the department's reach, but more money would be helpful. Giving at least cost of living raises. Also, dealing with staff in Cola main office can be frustrating. Trying to get problems solved on things done takes forever and has to go through too many hands to be achieved.
- Help encourage and find way to manage large caseloads. The specialty programs are good for PR, but only serve a few clients. How do we get help with large demanding caseloads.
- The dept can commit to helping employees that are not doing a good job be better. If they can't effectively do their job well then they should leave. DMH also could do a better job investing in training for all employees to increase revenue but also provide quality services.
- My department does everything it can to improve my work environment.
- Fix/abolish current EMR and frequency of daytime outages. Training is an issue re continuing education time. Computer training is not the same as attending clinical conferences with real people interaction.
- Offer comp time for when computer is down and work must be done on own time (at home). Price of gasoline and general inflation – no raises in several years.
- Describe a mission statement that features the goal(s) of the administration, hospitals, and CMHC's. Communicate/update all personnel regarding the status of this mission. Describe how administration presents Mental Health not only to the public but also to the legislature.
- More appreciation shown for job done. Consider opinions of employees (all). Of course pay raise for jobs that people exceed in.
- I have a wonderful supervisor and great co workers. I love my job working directly with clients. I do not feel valued by upper management. The information we received is placating only. We are not consulted about decisions and it is implied that we could not possibly understand the "big decisions". There is no possibility for promotion or advancement, and there are not opportunities to learn or grow. There is no time or money to pursue an advanced degree, yet we are told that this is necessary in order to keep our positions in the future. We have no options, and this destroys morale.
- Make everyone follow all policy and procedures not just a few. Policy and procedures are made or put in place to help organize the centers but not all staff is made to follow them.
- Have paid security personnel on sight to ensure more safety in the work place checking people for weapons etc as is the admin.
- Stop cutting the budget 20% reduction in force expected this summer.
- I only feel a lot of stress over one topic. Please do not cut my job due to the budget deficit! I am working with children and they need me. I am just building a caseload but it is growing quickly. Every week, I meet several new young children and I'd like to help each one of them. The people who work here are so wonderful. I hope that we can all continue to do good work for the citizens of this area who come into the MHC.
- Provide better training related to the EMR. Maybe pair a new employee with a mentor within their department that can help with lessening the paperwork.
- Make sure that all staff are cross-trained and aware of the new changes that effect how one performs their job when their supervisor is out.
- More money.
- Continue to improve EMR so it doesn't lose notes or go down when seeing clients.
- The department can discontinue using scare tactics as motivation to work harder. Feeling as though my job is in jeopardy does not inspire me to work harder. Also rewarding staff for the job they do. I have earned an SE on every evaluation/EPMS since being with the state (11 yrs) and have never received a pay increase based on the good job that I do. This is discouraging as I see my pay increase the same as co workers who do not work hard to meet the expectations.
- Believe more in me, give opportunity to hear my side of things without being told I'm defensive.

- Leadership should get out of the business of maintaining its fleet of vehicles. Leadership has retained an unqualified "shade tree" mechanic. To save a buck leadership has put all of us and the clients in danger. As proof check the history of vehicle #1047. Leadership should train the higher ups to treat people with respect and not domination.
- Please give us some more money.
- Difficult to do w/current budget constraints, but at least a cost of living increase on salary annually would improve staff morale.
- Increase communication between mgmt and staff. Better training regarding programs in centers.
- Implement trainings for my department and provide adequate materials for use when performing my job.
- Raises, especially after multiple "Exceeds" or substantially exceeds, EPMS. Am having a very hard time making just living expenses, but have not had a raise in years, even with very positive reviews. This actually means that salary has technically decreased due to no cost of living increases over the years. Very stressful to have to live like this when you put so much into your work.
- My office temperature is usually too hot or too cold. More materials available for groups.
- Provide state car for people in rural areas.
- They can pay their employees more and give raises for good work. I really love my office and my work. The only thing that I would change is my pay. Also some of the people that work here are very negative! I would like to see some incentive for good work and attitude. Otherwise, I am very satisfied with my job and work environment.
- To lift overall morale – they should at least increase our pay for "cost of living". I understand there is not a lot of money – but there are professionals here – that can't even afford living – due to prices going up – just a little might help morale overall.
- Improve the grounds – clients are presented with a dirt yard, unkept and unable to see from the road due to overgrown underbrush. Create a better EMR system that does not require multiple monitors and does not have so may "tabs" to access information. Assist in choice of color schemes that are conducive to calming the environment. Allow staff to pick out furniture that is less institutional looking.
- My work environment can be improved with improved management at Santee-Wateree. Currently we do not have good management/leadership at SW. We continue to experience unfair and unethical treatment and receive no real leadership. Now they have sent us the Administrator (Johnson) from Catawba to assist in the confusion of the center. He has only proven to make morale even worse for SW. He has been allowed to come in and make changes without having to assess the center or our staff. He does a lot of talking but does NO real work. He has yet to do any Administrator work—he has passed it off to everyone else around him. Management at SW is awful and needs some type of intervention from central office.
- My supervisor purposefully discusses data on my productivity and work performance to grade me "meets" in lieu of "exceeds". I am 100% certain I have exceeded productivity requirements consistently since we are so understaffed. Going from 6 to 2 out pt adult clinicians. I was promised a raise once I obtained by license but never happened. I was started on the bottom of the pay scale. I'm the only Tricare, Medicare, etc. provider in the clinic. I am miserable here and will leave as soon as alternate employment is found. Client's lives are in danger due to staffing shortage. PRS still need to help. Clinic needs restructuring.
- Get me a computer.
- Reduce turn over of staff. Administration should listen to concerns of staff, shadow staff to fully understand what the job entails and how time is spent instead of just looking at billable time. Communicate better!

- Have the supervisor treat each employee the same. Has pets, shows favoritism to some and makes it hard on others.
- Stop progress summaries. Need a new building with larger offices. Cramped space and computers not in functional arrangement.
- Too much work, too little pay.
- Incentives to keep employees – raises- assistance with licensure you would see much less turnover and people willing to do more.
- Set up CIS to handle co-pays on third party insurance.
- I feel that everyone is overworked. My supervisor is a great counselor but due to her extremely heavy work load is unable to provide the proper supervision that is needed. I also feel that each clinic makes up their own rules which causes an unorganized and unsatisfactory working environment. Supervisors seem to do what they want, change the rules when they want which can be very demoralizing and confusing at times, all though I am sure they mean well. The biggest issue is not getting paid for the amount of work that is required from us, not just getting a raise, but a co0st of living increase. If you give people a reason to stay they will, I work very hard at what I do and made less 20,000 last year alone/net.
- The department should do better in ensuring that those making decisions pertaining to treatment are qualified to do so and are doing so based on clinical research and fact not opinion.
- Step program – raises, low pay and no advancement needs to be addressed.
- Give raises when appropriate to staff who substantially exceed – truly exceed.
- Pay more than McDonalds. Allow experience to substitute for education when hiring for/creating supervisory positions. A master's degree has little determination of a person's leadership abilities, social skills, or ability to effectively problem solve.
- Clean more often and better.
- More frequent in house trainings; incentives; cleaner work environment. Recognition.
- Pay raise.
- Unable to respond for fear of being fired.
- Make sure information needed to accurately and efficiently perform daily duties is passed down from the top to the bottom.
- I believe the department is doing the best it can with our budget cuts.
- Set same standards for all the centers. Put qualified staff in Columbia back in positions that demand direct client time. We are too heavy with Columbia with administrative staff. Centralized accounting in Columbia. Disband auditors from Columbia since each center has its on Q.A. staff. Make a firm decision about who we serve and centralize (same) for all centers. Combine centers and close those in close proximity to others. Increase payment for clients without Medicaid or insurance. Make sure DMH's focus is clients and not allowing for unnecessary jobs that do not serve clients. Everyone should be involved in direct care of our clients.
- Need supervisors who can lead without intimidation. Need supervisors who can lead and communicate without being verbally abusive. Re: paraphrasing, condescending. I need positive motivation not subtle threats.
- Limited opportunity for growth. No opportunity for advancements. No financial assistance for trainings outsidc DMH. Low salary/no raise in years, no incentives/financial compensation for work.
- I know times are bad, but a little more money would help.
- Director interaction makes himself known to the clients that pay our bills.
- Eliminate those that constantly harass other employees.
- To start with a raise would be good since we haven't had one in three years.

- Consistency in supervision. Incentives to continue with the demands of the type of work we do – positive reinforcement. Merit raises.
- Reinstate cost of living increases.
- Improve communication. Provide incentives and rewards such as merit raises and recognition of efforts.
- Decrease required productivity hours! It takes away from therapy effectiveness.
- More money would be great. The cost of living has greatly increased but my pay has not even though I have ES rating on my review. There is a person here who is allowed to talk to the Director and other staff any way she likes, comes and goes, lies, and is the constance problem starter. This causes a poor work environment. Even outside place (doctor offices) have a "special" name for her. All of these problems have been brought up only to be swept under a rug. Cleaning person who cleans our offices and bathroom are gross.
- I would like to see more upper management trained in clinical and support staff jobs so that they can better understand what we do. Some of these supervisors have no clue how hard clinicians and support staff work or the work load dumped on these employees in recent years due to budge shortages, hiring freezes and wage freezes. We haven't had a raise in four years but we keep getting extra job duties added on to our already overwhelming work load. Productivity is pushed at all cost. Scanning has overwhelmed our support staff even causing health issues with several of the support staff. Stress levels are out the roof and no appreciation is shown for a job well done.
- Quit requiring more and more with no increase in pay. Send this form out and ask specific questions about supervisors (use names).
- Reduce the astounding number of on-line courses required-you can't just keep adding more forever. In the on-line courses, put review section in each one.
- To realize we are here for consumers and to strive to do a professional job to serve consumers.
- The level of satisfaction I feel with my job, the actual work with clients that I do, is offset by a 2 hour commute (round trip) each day. I would prefer a work environment in my home town or county. That would improve my work environment 100%. Also, my skills are under utilized in the setting where I am employed.
- Let me work a little longer.
- Provide increase opportunity to network with employees in other locations who are performing similar work; provide office furniture that is in better condition.
- Another van, more outside activities/more raises, cannot recall the last time we received a raise. The state doesn't provide much incentive to continue working at a high productive level, which I feel I do as well as many of my co workers i.e. a yearly bonus. At the very least a 2 to 3% yearly raise would be greatly appreciated.
- I would like to see monetary compensation comparable with other state agencies and salaries that more that move through the pay bands with experience and years of service.
- Ensure that they hire well rounded individuals to lead. Sarcasm and belittling staff is not an effective motivator and is very unprofessional.
- Provides me with a raise, we haven't had a pay increase for several years.
- Make all center/facilities accountable for good and bad decisions. Productivity should be standardized. It's not fair when centers have to hand over their carryover to bail out others. I know we are one under DMH, but we all need to pull our share of the load. Carryovers should be used as incentive bonuses for employees.
- Improve communication at all levels. Be more consistent/fair in how employees are treated.

- Provide more timely, more accurate data to centers. Hold all employees to a standard of excellence. Rate employees on actual duties/criteria on EPMS. Grant appropriate level of autonomy to center leadership w/proven track record.
- Do more things/events to build morale. Everything is about productivity, but events outside our office to relax and be some time to get to know peers.
- Improve on staff moral.
- Offer more incentives.
- It would be great if we could have more vans/automobiles. I have to do home visits almost daily and only get an automobile once weekly. A pay increase would be good too as it is not comprobable to other facilities…hospitals etc. I am saddened by the cuts for mental health by state gov't I know there is not much that can be done about this. Also, we need yearly raises-have worked here 3 years w/average-above average evaluations – no raise yet ☹.
- Need to provide more one on one training new employees or advancement. People are put in positions and are not trained.
- Hire people that are willing to do what is required by the state. People that are willing to be trained and to do what they are trained to do and not just what they want to do. This was a really good place to work but now nobody wants to do what is required and that makes me not be able to get my job finished.
- Pay raises/COL adjustments.
- Have ethical people in positions of power. Not show favoritism. Be respectful of all employees not have favorites. Allow all current employees opportunities to apply and have a chance to get openings at the center-not already decide before the job is advertised who is going to have the position.
- When someone is given extra duties that the assistant director did give them a raise. The center is saving money by not having an assistant director. Give the ones that are working harder the money that the center is saving.
- Smaller caseload, longer appointments. Value clinicians, paid trainings, higher salary, a lot of requirements for small pay.
- Offer reimbursement for those with license to obtain trainings of their choice, instead of standard 30 min appt. move the standard appt. length 1 hour.
- There is a split between admin and clinical. Clinical treats you like family and those sorts of questions (communication-n-feed back questions) admin is very clicky and anti-male as 95% of admin is female. No room for advancement and very rude-n-close with sharing information and assistance. A real divide which starts with admin managers on down. Please do not "quote"my statement for fear of id'ing me and retribution.
- Look at work loads, hire more people, cost of living increase, not spend money on flat screen tv's, mulch for grounds, could have gone for increase in salary, think about employees not building improvements, listen to suggestions, respect others feelings.
- I would enjoy my current position to its fullest if I were doing what I was hired to do. I have no supervision time and when I have asked or suggested ways to receive additional clients for my position, I felt blown off. This is a persons concern for me. My supervisor does not seem to have enough time and it becomes frustrating.
- The split between 2 mental health centers does not work well, in my opinion. Though the Director seems like a knowledgeable person, I do not feel he can give our center the time it needs. Our center has lost its identity. Employees do not have opportunities to interact with and know the director. Therapist's pay is too low for the experience we have, caseloads are too high paperwork is overwhelming and productivity expectations cause great anxiety. The budget worries are on the backs of the therapists.

- Give more incentives for doing a good job, to keep people motivated. I would like clearer standards from our QA staff from Columbia. EMR could be improved a lot.
- Management needs to use higher standards when choosing supervisors-high clinical expertise, effective leadership skills, and ability to provide improved structure. Poor decisions have been made by management over and over again with terrible effects on staff and clients. Staff is moved from week to week. People are put in charge with limited understanding of the job. Misinformation is at every turn. At times there is no supervision at all and staff is told to not worry about it. Management listens to people who do not work in the clinical field (admin) to make important decisions. Certain administrative staff behaves in an unprofessional manner and "tattle" to supervisors. It makes no sense that we have 3 HR workers, 2 QA workers, and only 3 case managers on OP. There is a huge breakdown in communication and professionalism. Certain supervisors bully and use intimidation to control staff, and strangely enough, these people continue to be promoted. This creates a hostile and toxic work environment. Staff feels beaten down, depressed, sick, pressured, and on top of all that are told to "Produce More". "Work harder or you will be working at Target." OP does on a daily basis: phone screenings, walk-ins, purple screenings, Spg assmts., AC appointments, case management, individual therapy, group therapy, POC's and PS's, ER consults, DO's, hospitalizations, jail consults, judicial, crisis/emergencies, assistance with meds, referrals, consultation with the Dr. and nurses, SPD's, staffing transition to other services, and tremendous amounts of paperwork. We need more staff that is well-trained. We need moral to be boosted somehow. We need effective communication from management and we need them to make better decisions. I also feel we should let Dr.'s make more decisions on staff changes and supervisors, as they also feel pressured and beaten down as well and know what is best for the center and our clients and staff.
- I would rate my level of satisfaction with my job very satisfied if only I had a reasonable case load.
- Pay needs to be better.
- Increased funding to provide sufficient employees to complete the work. Also, the dept could benefit from some form of rewarding employees who receive SE's even if it isn't monetary.
- This department has been very sensitive to keeping the environment as stable as possible. We try and have "family lunch" weekly. We celebrate birthdays together. We have special "Beanie Babies" given after a certain amount of time. We have opportunities to get special training that is only available to the AMC team. We have people come in to observe this team, nurses, doctors, police, etc. We are held to a special standard on conduct.
- Fight for wage increase. State employees have not had a cost of living raise in 4 years, this has caused a decrease in the moral of state employees.
- The department could be more organized and offer more training on technology, such as computer software. This will ensure that all staff will have advanced knowledge or how to cover each other's job. Everyone should know essential procedures, such as scanning and importing documents and checking in and out of clients.
- Hire someone to handle medication calls/problems to reduce workload and increase productivity.
- Provide compensation for added duties. Ensure that all employees are treated equally. Put a cap on caseloads. Mine is currently over 200, as are all the case managers at this location.
- Point out to the director that there is indeed money in the centers budget to recognize staff with a salary increase. Large sums of money are left over every year plus billing is held up every year. No employee satisfaction.
- My work environment is great. I really believe the Dept is doing all it can for he people we serve and its employees given the awful financial predicament the state is in. We would all like to have raises, but at this point having a job is a lot to be thankful for! We all need to pull together and do

the best we can for our clients and each other that will make where we work a good place. Cudos to our leadership that has to make these awful decisions they are in my prayers.

- Improve pay structure.
- I feel that commenting really doesn't do any good. Less people working doing even more work, for the same pay. People who give 101% to their jobs get squat for doing a good job. Leaders in the upper echelon continue to get paid more than they are worth, while the ones doing the work get nothing. What can the Dept do to impove my work environment? Pay me for the work that I do. My work load has increased significantly since I started here, and I receive nothing for it. People at other centers get paid at a higher level for the same job and they have less responsibility. Don't get the inequity in that. Obviously the Dept. isn't going to do anything about it, since employees have been complaining about this as long as I have worked here.
- Without an adequate budget there's not a lot anyone can do at this time. Some of my answers reflect the fact that we have not had a raise in 4 years.
- Evaluate population served, resources, when making decisions about budgets for individual MHC.
- The departments should make sure employees get compensated for their jobs. We need a raise.
- Need to give incentive when staff goes beyond the required productivity. Staff member need to feel like there hard work is recognized. You will keep staff if the pay were better.
- I would like more financial recognition for my efforts. If the department would increase my salary I would be even more productive. Eventually, all hardworking employees will leave c/c they are not being fairly compensated.
- I am thankful for a job in this day and time. Yes! We all want more money, but do we do what is ask to even get compensated for that job!! Encourage better leadership with some programs. I like the leadership that Mr. Shields portrays, but too many bosses aren't a good thing. Leadership trainings.
- There have been great improvements here at Pee Dee MHC under the leadership of Stuart Shields. He has made tremendous good changes. If he maintains the pace, he will continue to improve the overall work environment here at Pee Dee MHC.
- I like it when we work in groups or teams. I like to share what I know and I enjoy learning from others.
- More administrative help to write follow up letters would be helpful.
- Give raises, at least cost of living. Everything is going up except our paychecks. I feel very underpaid. It is ridiculous to go years and years without a cost of living raise. These surveys are a waste of time-nothing ever changes and if it does it is usually for the worse. The mandatory dress codes are ridiculous-people do not even have money to buy clothes.
- Improve employee retention.
- We need better equipment, we need more training. We need ways to get bonuses, promotions, raises (no pay increase for 4 years). We also need better morale-all we hear is BAD news.
- Better equipment-updated. Training opportunities for support staff. Incentives for jobs well done. Opportunities for promotions or raises.
- Provide better training. Would like to have a pay increase, I have 22 years of direct service care and have not had a raise or pay increase since 1996 but pay raise for management employee happens every year around here.
- Keep Sue Burns around. Best supervisor I every had.
- Get others to do what is correct, and keep a professional manner about them.
- My job satisfaction is not from the department but with/from my clients. A morale team is much needed to address all the concerns. Start with suggestion boxes in all activities and all suggestions

whether viable or not be reviewed. Simple things like the director speaking "Good Morning, Hi," any sign of acknowledgement. Sad, sad, sad the way management act.

- Get a new executive director, better leadership. Hire person from within who knows the job, and are currently doing the job and stop bringing in persons who don't have a clue. Makes for very poor morale. A leader who is honest and carries the true characteristics of a leader, the centers is messy because the leader is messy. Just as soon as the economy is better and job market better I am out. Too skilled for this mess. I have given my best and still not valued or ever acknowledged. Embarrassed to say I work here.
- I think they are doing the best they can with the budget cuts.
- Provide more activities or events tailored towards children and families.
- Asking employee's opinions before making decisions.
- Since starting EMR at our facility I believe time/quality has decreased. EMR goes down 2-3 times per week which keeps us from doing our job effectively. The system needs to be improved. Nurses need to be given a raise or retention bonus. I have been with the state for 7 ½ years and only one raise has been given. I've been approved for a raise 2 years ago and never received anything. The most recent hired RN for our center is making $4,000 -5,000 more than I am. This is very discouraging and frustrating when I put all my heart into my job and can say I love doing what I do.
- Salary raises for all eligible staff. Advocate with state government to leave state employee benefits alone: retirement fund, insurance premium, etc. Build a positive relationship w/gov. Haley. I interpret Medicaid standards in a manner that benefits SCDMH and those we serve not SCDHHS and the federal government.
- My supervisor has taken mistakes that I've made and harped on them and won't let them go. I've apologized over and over but I feel that she is punishing me for past errors and holding me back from doing my job. She has failed to offer me an opportunity to redeem myself and fails to accept my apologies. She is also evasive making it difficult for me to determine the steps I need to take to "prove" my sincerity. She asserts that she has nothing against me personally but can only provide examples of two minor mistakes, both of which I've apologized for and rectified. Why am I still being prevented from doing my job?
- I love what I do.
- I have never encountered the level of disrespect I have received since accepting employment with SCDMH. At my location, it appears to be frowned upon to want to be a vital part of the company. At other jobs I was respected, my work was appreciated, my input & contributions were appreciated. My current supervisor Bullies, intimidates, harasses support staff. In the past 7 months we have lost approximately 22 staff that can be indirectly attributed to the above statement.
- At the present time my work environment is the bet that it has every been since becoming a state employee.
- On my over-worked days-provide assistance.
- Newer phone system, our clinic needs new furniture in lobby, new printer, otherwise, satisfied.
- Very satisfied.
- Create worker friendly documentation process to have more therapeutic time with clients.
- While I am satisfied it is very difficult to encourage staff who have seen no raises in 4 years. We recognize the economy is bad for everyone, but I believe many of our staff were underpaid prior to recent economic issues. In my community we have BA level people making more money with other agencies, school district, etc than our masters degreed people.
- Clinic administration appears to be disorganized and out of touch w/the needs and challenges of both the employees and the typical client served by the clinic. The messages received from administration are negative and appear to place the balance of financial shortfalls on the employees. Administration would benefit from meeting w/employees to determine what ideas they have to

increase productivity, revenue, and client participation. Also, limited to no communication is received from administration. Information, such as required furlough days, is provided by local media vs. the administration. It would be helpful if administration addressed media stories/reports as well since many times clients call with questions about the clinic that we have kno knowledge of or information on how to calm their fears. The jobs we do on a daily basis are highly demanding and stressful. The community is demanding even further services at this time. Dealing with stressful work environment and then not being able to pay your bills b/c of low pay adds a level of high personal stress. This often leads employees to seek self-preservation by finding other employment. It is a well known fact that many people are experiencing severe financial distress since becoming employees of SCDMH. And in each case that employee was forced to obtain a second job and/or take severe measures to survice, such as filing bankruptcy. This is unacceptable for employees who have advanced degrees, many years of experience helping the community/mentally ill, and provide their employers with quality work.

- I work 6-10 hours a month doing SW supervision. So my current contact and interaction with the system is limited and my benefits are from retirement – not my current position.
- Clearer and more prompt communication from department level. More training on SCEIS. Delegation of SCEIS duties down to the HR specialists at individual centers (excluding payroll) and stop with filling out numerous forms – if I can fill out the form, I can key it in. Automating leave slips – use MYSCEMPLOYEE as it was designed to be used.
- Focus on positive reinforcement. Decrease constant critizism. Recognize that most people are doing the best they can with limited resources, eg: no money for increase in state vehicles while also discouraging mileage request, eg: very high case loads.
- Somehow balance reasonable case loads to better serve clients. Also, decrease "worry" about productivity or somehow take consideration of scheduled appts vs no show appts.
- More training opportunities for LPC, and class for staff to get their LPC, Psychopathology and DSM-IV. Change the EPMS system. More doctors to see clients. More clerical staff to run the front office. Better vehicles, pay raises, pay raises, pay raises. Look for a better dental insurance provider, system to deal better with medications and prescriptions authorizations.
- Cost of living and performance raises would be nice, but I understand the budget "crunch".
- Would like to have provision for time and financial support for continuing education on a regular, on going basis.
- Very dissatisfied with the central office. Admin. With HR department has really went down hill. Will not respond to phone calls, e-mails. We know they are overwhelmed with SCEIS, but so are we! Few staff are still helpful. Lisa Gratton will respond ASAP. Very satisfied with our MH centers good management and supports.
- Pay me a fair salary!!! I am grossly underpaid. The administration at this particular MHC is deaf to the needs of the employees as well as patients and appears to care only about maintaining the bottom line and their own positions. While clinical services are strained, we are top heavy with administrators. It is questionable that many of them do much of anything besides draw a pay check.
- My environment is great – it is a well known fact that we are operating with a very poor budget – however it would be nice to get a raise. I definitely feel that I am contributing to my community – and that is wonderful for me – a privilege.
- Start recognizing quality of work in addition to quantity. All we hear about is "Productivity". Doesn't seem to matter whether we have a license, get specific training, etc.
- The HR for the SCDMH in Columbia is the worst I've had in over 30 years. They micromanage in excess so much as to be a hindrance DMH goals/policies, they are slow beyond any reasonable expectation. They retain far, far too much control over pay while not having a clue of the job and responsibilities outside Columbia. Their internal duties are over fragmented among people who

neither communicate with nor cover for each other. The Columbia HR leadership must be outdated, controlling, and a perfect example of what is wrong in government. My local HR does as well as possible within the above framework.

- Provide training to staff, recognize efforts of staff.
- Employee pay!!!
- It would be nice if Medicaid could be corrected on-line-would save paper (trees). Better phones (more modern) – these phones are so out-dated.
- We do not have the supplies we need. We are constantly reminded we are broke. Our morale is very low, we are also reminded that we may not have our job-due to budget crunch. There is very little incentive to work, no raises, no opportunity for advancement and over worked. Doing jobs we are not trained for. We continue to do our jobs at the best of our ability.
- Central office staff needs to respond to requests in a timely manner. Allow salary increases and or bonuses for high performing staff, especially staff who directly serve clients. Use available technology to do satisfaction surveys, eg, web based-faster, cheaper, not labor intensive, better anonymity.
- Value your long term employees. The department seems to always have money for equipment but not for staff. Communication among centers could be better. Sometimes it is felt that everyone is doing the same thing but know one is on the same page, cannot get a clear answer to questions. All in all I am grateful for the staff I work with. It really helps to have such caring, kind co-workers. I enjoy my job.
- Additional employees to make case loads more manageable.
- It could be more en-user friendly. Too much retyping of notes when saves don't take. I love my job, like everyone else, I could use a raise.
- Do away with computers in psychiatric practice.
- Have more relevant training to DSM diagnoses. More training on documentation of CSN's.
- Get rid of people who don't care about their work and are biding their time to retire. Supervisors that know how to supervise. I just want feel that I am needed rather than being looked at like I am disposable.
- Raise would be nice. Lesson productivity standard or take into account that there are days when these are unbilliable periods.
- Provide more opportunities.
- Show more appreciation for and support of the clinical staff that have the front line responsibility for the day to day care of the clients we serve. In more than 20 years of working at Mental Health the phrase "Management by Threat" best describes how I feel about how the leadership of this agency operates. I would like to see more emphasis on and support for good patient care rather than so much focus on productivity.
- The salary is not competitive at all. The lack of raises and financial incentive (ie licensed vs non licensed) causes tremendous turnover and we lose the good people who work hard. Teachers out of a 4 yr school sometimes make more than us do, and we are considered a specialized service. It's actually laughable-and it's something that can be improved, it just gets chosen not to be. Motivating good employees is not something that is optional.
- More safer environment. More cleaner from animals. Lounge for staff to take breaks. A pay raise.
- Increase salary.
- Give raises.
- The work environment is fine. The Dept of MH should consider adjusting salaries when the economy is better. People here work too many years without raises. We need at least living increase wages. The dept's salary scales are far below other states.

- Have more meetings that involve all staff; not just administration.
- More communication from other departments.
- Continue to keep us informed of what is taking place so we can feel confident in having a job.
- I believe the director of our facility does a wonderful job keeping this facility above average. I feel that he works with the department to secure the things needed to keep our work environment a great one for us and the patients we serve here. I wish the department had the ability to raise our budget for more inpatient beds! …but I know that is out of their hands.
- No planning at center level all shot from hip. No direction, No MD's, No staff, Very Sad. No support at state DMH for CMHC's.
- The "Powers that Be" need to listen to the employees side of a story rather than going by "just" what the supervisor tells them. Many times supervisors have vendettas against an employee and they ruin their careers. This is the case with me.
- Provide clinical forms. Create forms to measure ADHD, childhood depression inventory.
- Would like to make more money. Would like to have financial help to get my 2 year degree (only have five classes to go). I am making the salary I made in 2000 in a textitle Mill. I feel my personal experience and knowledge is worth more.
- Cost of living raises to keep with economic inflation. Incentives not necessarily monetary. Merge the 2 MH centers in Greenville county, i.e. Greenville and Piedmont. We have more problems with catchments areas issues and the centers offering 2 different services that the other won't cooperate with. It is political and is long overdue to be addressed. Provide training that is more in keeping with the age group I work with. To provide cells.
- I believe more training about how/when to provide appropriate services would enhance my job performance.
- The computer system is down more than it is functioning. Whoever developed the programs for the system had poor insight into the needs of the staff/department. As each center does things somewhat differently these things are not included in the system and make it very hard to document correctly. We are told to document and bill, bill, bill but most of the time we cannot do so because the system is down.
- As soon as budget allows, raise pay, hire more clinical staff to meet demands of work load, fight to protect benefits.
- Increased pay for licensed professionals. More training opportunities.
- In order to improve the work environment there needs to be more training on a local level for new employees. There also needs to be better organization on a local level regarding day to day operation of the clinic. Case load sizes needs to be down sized as well as productivity standards. There also needs to be more opportunities for growth.
- Some of the windows where clients check in can be more secure as in all windows should be bullet proof.
- More personal/private office space.
- Give staff incentives or raises to let them know that their work is being appreciated, and also that they are appreciated.
- Need to update our billing system. Need all private third party insurance electronically billed. Need more of an open system and instant response with system errors and problems. Work orders are not being followed up on or responded to. I have had to go through Vania James Smith to get someone to respond to problems I have had.
- Merge MH/SA services more quickly. Continue to improve EMR. Provide increased nurses.
- Have company inservice days to uplift the morale. It would also be nice to receive pay increases.

- I feel like there is a real disconnect between local admin and supervisors with frontline staff. I would like to have reasonable time counted that I spend with clients on the phone connecting them with resources or speaking with family or supporting clients count toward productivity. I take my work home daily to finish, such as CSNs and progress summaries, so that I can meet productivity standards. I don't feel like I have a voice in service provision with supervisors and clinic director here. I would like more flexible time for continuing education and supervision for further licensure. Communications almost non existent here. More organized and comprehensive training.
- I would like the department to be more realistic regarding yearly quota for productivity. Four hrs/day is reasonable, but then it is expected that we can achieve that number for a full 48 wks, which does not make sense. When annual/sick leave , holidays, and seminars/trainings are factored in, the expectation is too high. I normally schedule 5-6 appts/day with no "extra" room to "makeup" productivity. I maintain that I will do my best, but I will not sacrifice my personal/family time or my own well-being to try to meet this unfair expectation.
- I enjoy and value the opportunities provided by my job. I wish that the productivity challenge of 160 would be lowered somewhat. It is very difficult for me at times to keep up with this standard.
- Improve benefits, offer license supervision, offer tuition reimbursement to enhance skills, offer pay raises.
- Be a little more honest with each other. Don't mix friends and jobs together.
- Continue with opened communications.
- I feel the department devalues employees of my pay w/a master's degree is not nearly enough to make ends meet for the amount of work I perform. I feel employees on the male teams (C&A) have never been chastised to work at the high pace and standards of team A and have been allowed to get away with murder. MV has become a poor excuse of a tx facility with very low moral as you can tell. We need a raise or some of your salary. Direct care staff are enormously discounted and underpaid. That's my final answer!
- Establish better communication within department such as mandatory monthly staff meetings. Establish clear goals for department that everyone works toward. Reduce caseloads to reasonable number. Provide time to staff cases with each other and the doctor. Provide raises and promotions. Understand how we work and make REASONABLE demands in terms of productivity and paper work (EMR). We cannot make clients keep appointments.
- Have the ability to structure a work day more suitable to all clients effectively and complete paperwork. Make technology readily available for all staff.
- Provide incentives to go back to school. Write off student loans as related to years worked. Stop the budget cuts. Have more hospital beds available for mentally ill.
- Continued open communications with leadership.
- Dept. may improve if there were incentives and recognition. If there was more of a focus on the effective mess of providing services.
- Provide more safe/secure doors. A pay increase is always welcome. Have all equipment used for job functions operating in the proper perspective-when machines, equipment malfunctions it's impossible to do an effective job.
- Supply more tools to assist consumers to reach their fullest potential towards recovery.
- Pay increase; advancement opportunities.
- Bring back total staff day.
- Make every effort to stabilize staff loss. Recognize the difficulty in being a full time supervisor and clinician. This presents difficulty in my availability to supervise staff and agency partners. Do not pull us from our locations to do "clinic" functions. This decreases morale and diminishes our value to comprehend partners. More training for new employees.

- The CAF coordinator does not value the school based program, and we generate prodigious revenue. This program is highly valued in the community, yet not so in our own clinic. She consistently pulls us back into the clinic to cover it, thereby missing valuable billing time in the schools. We generally cannot recover billing hours in the clinic due to the large number No shows there.
- I'm satisfied with my work environment. (a cost of living raise would be good)
- Becoming a team, encourage each facility to work as a team. Communication should be improved, you never are alerted to changes being made until way after the fact. Most leadership do not even know who the employees are, even after being here for some time.
- As for the department in its self is fine. I think employees should try and work together instead of only looking our for "self". We need something to help with the moral, bring employees spirits up. With all the budget cuts everyone is worried about what the future will bring. Also, a "merit raise" or "cost of living raise" would be nice, since we have not received anything in quite a few years.
- It can be improved by ensuring better communication amongst staff, a better rapport and mutual respect among the various disciplines. Also, there needs to be more of an opportunity for promotion; there is none or some types of incentives to possibly lead to monetary gains in your current position if no advancement is available.
- We need facilities to help people in crisis. Re-opening our crisis unit would save many people from hospitalization and repeated trips to ER. We need more physicians. We are blessed with Dr. Tran, but he can't see everyone! We need more MHPs. We are simply over loaded. If more non clinical work could be done by non clinical staff it would help but we need more communication with in our organization. From top down the gossip is deadly. Summary: we are often asked/expected to give less than adequate care to the very ill and that's unethical and just plain wrong. We need help!!!!
- I feel that my work environment is adequate to do my job and I have the resources I need. The only thing I feel is needed for state employees at this time is a pay raise, but I understand with the present budget cuts that that is not possible. However, it should be a top priority whenever the economy bounces back and the budget issues are resolved. I feel that I am fairly well paid for the job I do, but it is hard to keep up when everything around us (groceries, gas) keeps raising prices and our salaries stay the same. I do love my job and the people I work with and I feel that everyone in our center is working hard and trying to adjust to budget constraints and decreased staff.
- Have a different way of having a drug test-copied and put in a chart. Our procedures is have gloves on-take drug test-come an bring the urine specimen jar lay it on the copier for a copy to be made for chart. This is unsanitary, unhealthy and should be prohibited according to infection control-pahtlore that's required to be taken doesn't seem to match the procedure. The copying machine being used for the drug screen is also used for all other copies.
- Provide resources needed to get the job done. This organization has a chronic problem with unreasonable expectations of its workers and so employees have to be political to get and access to resources and support! No IT support and purchase requests are granted to those who have power. I've worked here for over 8 years and have NEVER been granted a merit based raise. If I were to quit and come back to the dept I have a better change of getting a raise. I have a master's degree and cannot afford to have a child or a foster child. I live very modestly and have always received E or SE on evals. I know I do a good job and provide a very valuable service. My insurance has gone up and up since I've worked here. My insurance doesn't even pay for a woman's GYN exam?!?! Our management team is comprised of some power needing and emotionally unhealthy members who treat less powerful employees w/out respect. It's understood that you will be retaliated against by QI or the business office if you disagree or complain, even in a professional manner. We have power silos (administration).

- Decrease productivity and show more consideration for our work ethic. Salaries should be based on performance not positions.
- The dept. needs to enhance its morale boosting financially. Having a great EPMS does not get rewarded. What's the point of performing well if you're not rewarded? Financial incentives needed. Respecting time on the job w/experience. More organizational activities Christmas parties, etc. Employee of the month? Better rewards.
- I would appreciate getting at least, a cost of living raise. My EPMS has been "SE" for the past ten years with no reward, pat on the back, or incentive to continue doing exceptional work. I work in an area where we cannot bill for our services. I wish our team were recognized by the main center more for our hard work (with few resources) despite our inability to bill.
- Provide incentives for excellent job performance.
- Increase cleaning of work surfaces-disinfect. Increase access to cleaning supplies-such as Clorox wipes. Increase constructive feedback to staff to increase accountability for staff and consistency among staff. Apparently there's no consistency among teams-expectations and skill levels vary and appears to be dependent on their immediate supervisor.
- The company needs to stay abroad change with my job. Provide adequate training for my job.
- Recognize my 22 yrs w/SCDMH as a LPC to translate into leadership role.
- It's good the way it is.
- Keep employing me.
- Improve communication at the State office internally to reduce the number of times the same data is requested or systems are developed without input from the "field". The electronic medical record is a good example of separate entities working on the same project towards one mutual outcome, but it appears they haven't effectively communicated as evidenced in the actual training of "SPA".
- Set a clear mission statement for the entire department to focus on individuals with a chronic and persistent mental illness and children with behavioral disturbances (the current one is too broad). Give incentives to supervisors who hold their employees accountable to their EPMS.
- Considering budget cuts and no cost of living raises for so long – more flexibility with time off would be a plus to make up for no extra pay and increased workload. Would recommend this survey be given via email-to save a tree-every bit of savings helps. So much unnecessary correspondence by paper that could be on-line.
- Doctor, psychiatrist available for children besides 1 day per month. Clear information to schools what to do in specific situations (emergencies). Better training and computers in beginning stages of employees work experience from Beckman center and 1 day is what I received.
- I have been a state employee for several years now and I am constantly surprised at how we work with mental health clients, this is our specialty, but yet we do not take care of our own employees! I have seen countless co-workers be at their breaking points due to emotional stress from their home life and from their work environment and none of them, not one of them have ever gotten any type of assistance from the state to help them gain mental health services! While working for the DMH I lost two loved ones in the matter of 3 weeks. When I returned to work my supervisor came to me and asked me why my productivity was low and then had the audacity to tell me that I would be getting written up for this. ARE YOU KIDDING ME???? This is how we treat our own workers! It flabbergast me that the postal service has free counseling for any employee to access at any time they feel they need to use it, yet we as mental health professionals have no where to turn when we need help! This is ridiculous considering we are in one of the highest emotional stress fields that there are! We already do not get paid nearly what we are worth, constantly get our jobs threaten every year when the budge cuts begin, and get threatened if we do not meet deadlines, but no assistance for state employees to receive counseling for themselves? We have our priorities very mixed up! This is just the tip of the ice burg! Believe me, there is plenty more that I have to say

about SCDMH works and lets down their employees, but I have to make sure my bill time gets done before I get threatened to loose my job for the 2nd time this month! Sincerely, too scared to put my name because I know I would be fired within the week if I did.

- I am not really sure why we are asked to complete surveys and then nothing is done about the problems. Everyone is overworked and underpaid. We stay with state because we do have good benefits but one day the benefits are not going to keep us. Why do we have an annual evaluation that means nothing? I can do my job and exceed at it and another employee meets and does not go outside the box of their job duties and we both remain at the same level of pay. Where is our incentive to exceed at our jobs? Why should we be willing to go out of our way to help others and get nothing for doing more than the person who refusing to do anything but their job duties. The state needs to bring back merit raises!
- Morale is a huge issue at DMH, and not just because of money-but management always zeros in on that aspect because supposedly it is the one thing they are not allowed to do anything about (not that anyone truly believes that, it is just another excuse). Our benefits are very good, but they do not make up for the lack of adequate compensation. In today's economy, I do feel very grateful to have a job at all, but I should not be struggling as I am because the department does not take care of its employees. DMH needs to take long, hard look at the people in management positions, supervisors should have documented training on an on-going basis. It doesn't matter if they have been in their position for four years or fifteen-those skills need to be continually upgraded and reviewed. I think the department also needs to consider hiring business-oriented people for key management positions, not necessarily clinically trained staff. Each one of our area coordinators is a clinical person, and has been during my tenure-and in more cases than not, it does not work real well. This does depend on the personality and work ethic of the employee, of course, but we have two outstanding area coordinators, and a long line of mediocre ones. Let's discuss communication-this is an e-mail all of our staff just received this week: "Hello all- Cola neglected to notify us this year of the Employee of the Year process so we missed it." How can Columbia neglect to inform a center of the Employee of the year process??? Was this supposedly sent to HR reps or the agency as a whole?? Or is this just an excuse because someone on our end failed to act??? (When you don't trust the staff involved, it's kind of hard to decide which answer is correct.) Another big issue – SCEIS and timekeeping. Why we are not to the point staff can enter their own leave slips? Why wasn't the system tested properly before it was rolled out so this could take place from the day we went to SCEIS? Having good, properly tested data is better than meeting a deadline that may not have been properly determined to begin with. Think about it-I can change bank information but I cannot type a leave slip? I feel there are departments in Columbia, such as HR and Procurement, just in job protection mode-there are more rules being made to help someone keep their job in Columbia rather than what makes sense for the process. With the recent Procurement changes, it takes longer to get goods here-because they have to pass through hands in Columbia, it can no longer be done at the local level. "Making work" is never a good idea for a system, it prolongs the process rather than streamline it.
- What can the department do to improve your work environment? Establish more incentives (verbal/monetary) and have some type of raise/bonus for employees that are performing well/displaying high productivity numbers. Inform employees of what is going on in the agency (we do not find matters out until later; often community will know what is broadcasted). More training for administrators/supervisors on managing a team (setting good boundaries, motivating team to perform better other than use of threats of productivity.
- Set priorities for DMH services. Example: SCVRD provides employment services. SCVRD receive federal and state funding to do so. Why does DMH? There is a duplication of services between agencies whether it is SCVRD, DDSN, DSS, etal. We need to define what each agency does,

strengthen those partnerships and utilize accordingly. In the long run this saves money for DMH and other state agencies.

- In re to examining the process of QA, this is related to DMH QA's process not the local mental health centers. The auditors are out of touch with what staff do (clinically and administratively). The audit process should be a helpful process not one of intimidation. I also question if all of the paperwork is necessary. For example, does Medicaid require a 90 day progress summary of treatment for provider(s)? Does our own QA Auditors require more than what Medicaid does? If so this is a problem. We need to eliminate the amount of paperwork done so that staff can see clients. Morale would be increased significantly if wages were adjusted accordingly. Many staff has not seen raises in years. We should be getting cost of living raise yearly and we should also be receiving merit raises. We are already paid 25% less than what mental health workers in NC or GA is paid. Accountability-Hold centers and staff accountable for their work. There needs to be a consistent productivity standard for each center. Center directors should be held accountable for their agency meeting production and deficits. Whey should some centers have to continuously bail our other centers and/or furlough if they are doing well while others are not held accountable.
- Too many relatives on staff. Relatives are being given better positions to work in very short span of time while other employees with years of service are not allowed opportunities for lateral and promotional moves. My supervisor is best friends with admin director, therefore, the staff members under this supervisor displays profound favoritism to certain employees with short term employment. Jobs that become available are no longer posted. Certain employees (relatives) are hand picked for reassignment. My supervisor is rude, tells lies to "save face" for herself, highly judgmental (listens to one side of story); displays great favoritism, completely unfair. Plus, admin director is rarely visible, will not see employees and is quite blind to the operations to support staff. The supervisor is Ginger Queen and the admin director is Jennifer Pearson. The lot of us would like for DMH to offer equal opportunity employment to all. It would be nice to have a supervisor that is more professional and respectful to the support staff. Any conflicts that may arise needs to be heard by both parties involved instead of her spies/brown nosers keeping her daily informed. Jennifer Pearson needs to do her job and allow support staff have meetings with her rather than getting info supplied to her only by Ginger Queen.
- Work towards allowing pay raises in the near future.
- Pay raises, pay incentives, fill jobs that we've had open for years.
- Personnel audit-review job responsibility. Allow employee involvement with decisions when a job is re-classed. Allow employees that apply be considered for position (just don't move staff that you want around). Post the position and interview for the new classified position. I have always received substantially exceeds on my evaluations and have been given more responsibility, but no raise, but have seen other staff in my category get an increase because their responsibility increased.
- I think Pathlore needs to be better regulated. As a therapist why do I have to learn about asbestos, grant writing, control brand diabetic supplies? This is all cutting into my productivity.
- Treat individuals with professionalism no matter what their title or position they hold. Making people understand that things can't be made better just by reporting them to management/supervisors - that effectively telling the person involved, with respect, will benefit the workforce most.
- Staff should interact and treat staff members with mutual respect; dealing with them on a personal basis instead of trying to go above them to supervisors, or person of power. Other than that everything is good, although the staff members deserve to earn raises.
- I am the only person in a 2 person department – I need that second person for back up due to being in billable services. When I am out due to vacation or illness the work backs up until my return. I have no back up. My fear is a prolonged absence and the work not being done, it can take days or

weeks to try and get it back to a normal workload and then I still push to handle a job meant for 2 people. You have to decide what takes priority and what gets placed at the bottom.. This causes a lot of stress.

- Columbia administration different departments nee to work together more. Too many silos. Departments need to think outside their own boxes and share information. Keep up with changing needs of electronic world.
- Increase pay and promotion opportunities. Focus more on what is ethically/morally right instead of meeting a productivity expectation to earn money.
- More training and increase supervision.
- Strengthen the EMR network to prevent work hour downtime. Plan upgrades and maintenance during non-working hours.
- Training and being positive, because everyone works hard.
- Boost morale; better networking; better productivity standards.
- Take in consideration (all) the swapping sacrifices I do to avoid absenteeism, which I could actually take advantage of due to being in FMLA, dependent sick issues, etc.
- I enjoy working with the clients in our community, however, I am concerned that the focus appears to be more on productivity rather than the quality of care our clients receive.
- More opportunities for advancement; increase of pay, recognize clients tends to be no shows for their appts and case managers should not be penalized in regards to productivity.
- It is a job. I am lucky to have a job in this economy so I am thankful. However, SCDMH employees have not had raises for years now. An employee can get a super exceeds on EPMS and no raise. Morale is low because of this fact.
- No raises, soon benefits will not keep your good employees!!! Benefits currently are the only thing keeping employees here. Everyone that I talk to is looking, scouting for other jobs.
- Overall, I enjoy being an employee for the DMH. I have a great supervisor and I have developed some great relationships with others. Once I started working in this field, it was a team effort when I started one year ago at MH. I soon learned that people do not look out for one another. People look out for themselves. I will continue to do my job to the best of my ability to make my work environment healthy.
- Wireless access through out facility.
- Make sure that there are plenty of techs on duty.
- I feel there is no recognition for the certification process in my field of therapeutic recreation. Even my supervisor is not certified on the national level. Since the hospital doesn't require certification my supervisor and others say "why have it" because of this our department is very dictator like in style, not promoting national standards of our field, but the thought and ethics of one person, our supervisor, although our low pay doesn't reflect the amount of education we have, I feel that not working weekends does have some ploy to get therapist to work here. I also think that if my supervisor was nicer, she would do better with me and everybody. I must say though, most of the decisions she has made, I probably would have made as well.
- Promote better communication between all disciplines.
- Cost of living pay increase. Cafeteria for employees/subway. Promotion/more responsibility. Let drug reps give a talk during lunch at least once a month.
- Pay for education and CME's. Provide a guard shack with guard to monitor who comes in and out of facility. Cafeteria or decent food to buy on campus. Provide enough underwear, towels, and bras for patients without giving staff a hard time about it. Don't overwork people who are willing and under work those who are not willing.

- Separate canteen area for patients and one for staff. Make EPMS count for something like small percentage raise. Put a guard shack out front for staff and patient safety. Do soup and salad lunches for staff at a discounted price. Get better phones, eliminate paper work that is redundant.
- Communication is the key. Everyone to be treated fairly. Not friendly environment. To be treated with respect from higher authority.
- The doctors should listen to the nursing staff more and the patients also.
- Make sure that we have the supplies we need.
- Improve pay.
- Have more incentives, increase pay. A lot of people working here are single parents and the pay is not enough to raise a family. Allow for more growth in the job. People that truly are wanting to grow with the state are not given opportunities.
- Improve pay, need resources to get the job done better. Show appreciation for years of experience.
- Our supervisor belittles us. When our workload is extra heavy if someone is out on vacation or sick she never helps us out. Our supervisor continually tears us down and never gives us positive feedback. She has pet employee whom she does extra curricular activities w/outside the job hours who she gives extra favors -even though there are 3 people who have worked here longer than her pet. Many, many employees in this department have quit due to her and they have all filled out explicit exit interviews and nothing has ever been done about the situation. A very good employee in this department is quitting next week due to the above explanation. Most of us have complained to Human Resources and our supervisor's boss w/no outcome.
- Return to prior policy for female patient's briefs – having them readily available due to menses is much preferred. Patients deserve clean underwear. Better and more substantial snacks for patients. Extra large white erase board for Nsg Ed groups. Reinstate monetary incentives for good time management, good work ethics and good production. Everyone in the world is on a budget – when EPMS done – give those who are deserving a small increase in salary.

- The suggested groups that we are asked to do require materials that are not supplied. Visiting hours are difficult to monitor when you cannot separate patients and their visitors from patient without visitors. If visitors were asked to empty the contents of their pockets and leave dangerous or other contraband items in A/D asking visitors to take it to their car does not always insure that the item gets left there. Snacks are pretty puny.
- Change Doctors.
- Make sure needed supplies are available, socks, under ware and bras for the patients, in a variety of sizes – we usually have none or all in small sizes or all in large sizes. Snacks for the patients are inadequate – small pack of 4 crackers, 2 cookies many patients complain of being hungry.
- Change Doctors.
- Up to date equipment. Introduce morale boosters.
- A job performance pay raise would give people here a better attitude and make the work day more enjoyable. 11 years without a performance raise is ridiculous and now we don't receive cost of living raises either. Slowly I become more and more poor working here as the world's cost is getting higher, my paycheck stays the same ☹
- Pay increase would be nice and much appreciated.
- Pay increase
- Get rid of staff that do not do their work and don not care about patients! Precept nurses more on lodge and less in classroom.
- (Salary) yearly raise by state!!!
- Communication between areas of facility is poor.

- Provide a quieter environment and better communication with Columbia.
- Supervisors and administration should not judge staff just by looking at them for a short period of time. Staff gets criticized before they get praise. All staff members are not on the same page where it comes to the rules for the patients therefore patients get mad at the staff that goes by the rules. There should be a lodge meeting for all shifts to be on the same page with the patients.
- Provide more staff.
- Recognize staff contribution through day incentives. Provide staff with official leave time and training onsite. (paid for by center). Value more than high productivity performance percentages. Lower the requirement of productivity percentage's in order to receive an SE substantially exceeds on EPMS from 5.5% above 50% requirement to 3% above 50% YTD requirement (53%SE) and E-exceeds on EPMS from 3% above 50% YTD requirement to no more than 1.5% above 50% YTD requirement.(51%E)
- The work load is too stressful and it is hard to feel satisfaction when I am doing so many tasks that I cannot perform any very well.
- Be fair about placing appropriate people in job vacancies rather than people whom they like or people who receive favoritism. Enforce supervisor's duty of completing EPMS evaluations on time. Supervisors should be held to same expectations as employee meet deadlines. Supervisor should give feedback to staff regarding performance prior to completing EPMS. Administrative staff should be more open about possibility of cutbacks and keep staff informed of performance concerns prior to day of EPMS evaluation.
- Focus on a connected mentality – meaning everyone understands the efforts of all positions and how everyone plays an important part. I feel that the support staff may feel unappreciated by clinical staff. Also, I think that an understanding of the different programs in the department among peers would be helpful. A better transition/working level between CAF and adult services such as when a client turns 18 the CAF case worker sets up an adult yearly assessment appt. Better communication between doctors, nurses and clinical staff. Written department mission statements posted in lobbies. Staff development sessions that focus on improving the family and communication.
- Stop showing favoritism and partiality.
- Better parking, better temperature control of HVC/AC systems in building, more professional presentable office furniture and supplies, cleaner and healthier working areas, more space in some working areas/where other depts.. have excessive spaces and updated office supplies/furniture. Not all offices are created equally! All areas are not clean! So many of these questions are hard to answer w/o discussion or explanation. So many return-teri people didn't work when they were originally hired; why are the lazy unprofessional, complacent people rehired?? Supervisors need to be reminded they are not perfect, they are state employees just like everyone else!!
- Increase staffing to ensure adequate coverage and work productivity. Offer opportunities for cross training.
- We need some type of pay increase. It has been over 4 years and I realize the budget problem but in order for people to continue to be loyal we must have some % of increase. After all everything around us has gone up but our pay.
- More morale boosting activities to replace CEO comments like "just be happy to have a job".
- Train RN's who supervise. Some have no people skills. They have mood swings and talk rough to employees. MHS's need pay raise. I can barely make ends meet financially. We very seldom have a communication meeting of any type. My department does not have the "required" monthly meeting. Rules are not enforced at our facility. Cell phones are used constantly. Cigarette smoking is still happening. (If my handwriting is detected, I'll be in BIG TROUBLE!! Please keep it confidential.
- Increase pay so we can hire and retain staff to get the work done.

- More pay raise for employees. Yearly bonus or 1% salary increase.
- The clerical department at SAMHC is a very stressful environment. Everyone is not treated as equals. The supervisor Ginger Queen has certain ones that she shows extreme favoritism to. Relatives of other employees are given special treatment. When the jobs were changed around due to EMR the employees that were displaced were treated very unfair, they are "floaters" while there is a temp employee with a position that is stable. Nobody will tell employees anything. It is all like a secret around here. When it was announced that Chris Cantrell was retiring, people with seniority asked about the position, this was ignored yet Jennifer Hall (daughter of Lisa Hall) was trained and she hasn't been here as long as others, why??? Because she is a RELATIVE. Scott Filkins has a stable specified position and he is a temporary employee, why? Again he is a relative of someone here. Some employees are nit picked for every little detail while the "favorites" are overlooked for the same things. Mental health can be improved by a thorough investigation into these actions. Going to the "3rd floor" will not help. These people receiving the unfair favoritism are "their" relatives! Hopefully somebody will keep these surveys confidential to avoid more harassment and unfairness!
- There is favoritism displayed. Supervisor got stuck with us and rides us yet gives favorites special privileges or lets them do what others can't. People are put into positions because of who they know or are related to without giving others a chance. Harsh work atmosphere. Everyone afraid to lose job if they speak out openly or be rode even harder! Not a lot of respect seen.
- My direct supervisor is great and always helpful. The work environment has begun to operate on a fear basis. This does not help clients or staff. The department can give us motivators to help lift morale with staff instead of looking at negative. Being appreciated is also great!
- Modernize organization. Move to EMR system only. Find more efficient means of keeping records/filling out forms. Develop system to do automated reminder calls for appointments to increase show rate. Keep building environment clean, effectively cooled or heated.
- On lodge K just keep the teamwork attitude that we have to get the jobs done. Everyone works together to take care of the patients.
- Allow those who actually do the work to have some input, instead of those who don't have a clue or to what's going on make the decisions and that's just the beginning.
- Pay raise, fire the director, get an asst. director and CCO, stop promoting people who don't do their work right, manageable caseloads, promotions and recognition for folks who really do a good job, get rid of spy phones and cameras, follow policies and procedures, don't talk about individuals in management Team – director., don't curse-director., don't play favorites, director., follow your own recommendations/statements-director., don't forget the rules-director, don't publicly fuss at staff/bully –director., obey the law-director., don't put down staff-director., don't go on to n-dir., fire people-director. Director married should not have sexual affairs with married staff and display in public. This has been off and on for years and she received $5,000 raise and was put on management team for it!
- While I believe the majority of department employees that work directly with consumers I don't think there same employees are valued by the department. No pay raises for the employees preventing revenue. Senior management treats employees like they should be happy to have a job-senior management should be grateful for all of the long hours and dedication shown to their consumers. Master degree personnel make a minimum wage based on the hours they work. Too many people work in the central office. All employees need to justify their positions.
- The relationship between clinic C&A and school-based personnel is often strained and if the leadership would find a way to mend those gaps we could all work together peacefully. We all serve a vital need and that needs to be recognized by all. Also, this area needs more school-based

counselors. There are so many benefits to school-based, if the counselors have the time to dedicate to their schools/clients. Most of the school-based counselors have too heavy a case load.

- Paperwork is necessary at times, overwhelming chore. Don't mind doing this, but being asked to complete busy work is stupid! For instance, this batch of Pathlore, I am asked to complete training on writing grants as an investigator!!! I am not an investigator nor do I write grants!! Those 30 minutes is wasted! If the management believes we have nothing to do as the saying goes, walk a mile in my shoes!
- Less time in meetings will allow more time for quality work and productivity.
- Teach me how to use the tools given to me to get my job done.
- During this economy, CMHCs need to restructure-go to PMA's and group therapy only-with limited staff looks like the only alternative. Staff dropping like flies-overwhelmed, system punitive. Good employees with advanced degrees having to take up "slack" which is ok, but when you get punished for documentation not being done onclients you have never seen only transferred to your caseload it really makes you mad. Makes you want out.
- The department can fill positions in the community mental health center so other clinicians are not overwhelmed with more clients from vacant caseloads. We have become paper pushers or should I say chained to computer POC/Summaries/Notes/long ICA's etc rather than true counselors.
- I do not believe the work of employees is truly valued. Work load and expectations are absurd. EMR has made my job truly hectic. It is very clear to me why the turn-over rate is so high. I believe it will continue b/c so many employees are not happy. This should be a huge red flag to admin. I am not sure the dept. can do anything at this point to improve environment. I use to truly love my job, but now I am very dissatisfied and hope to move on as well.
- Keep staff so we can provide the services for the people.
- Give incentive raises anything to meet high cost of living.
- Decrease paperwork/meetings/things that interfere w/seeing clients. Don't stop mileage reimbursements. Stop trying to get water from a stone, we are at max capacity. Be more agile in making changes, if one position funds itself and needs another clinician quickly make a decision to pull someone who is not productive to assume this new position. The hiring process takes too long, clients suffer when we don't respond to demand!
- In general cost of living raises. I have some staff that cannot afford health insurance and work 37.5 hours per week. Specific to my clinic, environment is supportive and encouraging – strong team work and advocacy for clients. Believe in mission – Director sets the moral compass.
- Electronic equipment that works. More copiers and fax machines to limit a lot of running around opposite ends of building.
- DMH could be more understanding when productivity isn't met sometimes it's truly not a case managers fault. Also with all the budget cuts it would benefit us to know definitive answers instead of possibilities.
- Nothing really, have not had a raise in years but I'm thankful to have a job.
- I think more communication of support for employees from the department-state SCDMH-could improve morale for all state clinics/centers. I also think funding based on # of clients served to determine state appropriations, as well as funds from local sources/consideration of local funding or lack thereof would enable our center to provide more effective services to our clients, improve morale, reduce staff turnover.
- More pay.
- Remove the bias from supervisors and treat all employees the same, be just not unfair. The same rules should apply to everyone.

- Provide us with computers, transportation. I also would love to get a raise. I work here for almost 7 years and still at the same level and pay. I like what I do but feel that I'm being underpaid.
- Just be more aware of the type of work and patients we have at times. By that I mean always make sure we are properly staffed. Due to the safety hazards of not being staffed properly.
- Provide a supervisor trained in children and adolescence. Provide additional resource for families that require intensive services.
- More opportunities for professional development (eg. Incentives to earn advanced degrees). At minimum, cost of living salary increases annually.
- Enjoy serving my population-enjoy my work here at DMH and have learned a lot during my time here. Currently there are a lot of questions regarding job security that I'm uncertain can be answered during changing political climate. It becomes a distraction and a concern when clinicians have such uncertainty and high productivity expectations that may be beyond individual control. Makes for tense and stressful environment.
- Focus on client care and let that drive revenue, vs. making revenue the driving force. Provide more employee incentive, or even simply recognition, bonuses, a Christmas party (where we don't have to provide anything), etc.
- Do more cross-training of each others job. Secondary ward clerk or two for admission unit.
- Either replace unfilled clinical vacancies or upgrade level of administrative/clerical staff so clinical staff are not mailing letters, pre cert days and filling out PAP forms. Put energetic, engaged director, assist. Director's administrators with vision for participatory management in place. Communicate vision not just history.
- Create opportunities to improve morale. Create opportunities to raise pay based on performance/additional duties, even a slight raise can increase morale/improve productivity. Provide support at State DMH level to seek grants. Advocate with HHS to make documentation less of a barrier to service provision, example, changes in TCM.
- Interaction 1:1 with supervisor and not so much email or inter-hospital memos, I am just up the hallway.
- More resources, office supplies and therapy materials need to be more easily accessible.
- Speak with the Governor about not making further cuts to our already pitiful benefits. Provide monetary incentives tied to performance. Restructure DMH so it's not so "top heavy" with administrators.
- We need staff there is not many MHS.
- Pay more money.
- Hire enough staff, train staff appropriately, especially in the SVP program. Put someone in charge of the SVP program who knows something about treating and managing sex offenders.
- Work only 4 days per week. There is some kind of plan that "can" make this happen. This would be a benefit to workers and clients. We have a good administrative team here at C&A. I love my job!! Also, a great office manager.
- Basic computer skills and application training.
- Assure all resources benefiting our efforts in support of treatment and recovery of mentally ill persons is/are available for use.
- Praise the department when we do good things instead of always focusing on the negative. Defend the department when you get negative responses from nursing students that only spend a couple of hours on the unit and don't get the full scope of what's happening or what's going on and feel they can judge us on those couple of hours.
- Higher pay or more career advancement opportunities.

- Hire someone that has experience and can multi-task. This is a fast pace office and the temps have no clue what they are doing. I checked in anywhere from fifty to seventy clients a day, answer the phones "which never stops" schedule appts. And all this from one window. We need a check in window and a check out window in the C&A dept. "very stressful" and everyone cannot do it. I have experience to do much more but have not been given the opportunity to grow. CMHC
- Adjusting to EMR has been a challenge for several reasons. There are still incompatibility issues with our system and school-based computers and EMR is not functional during some business hours. As a result I have tried to adapt my schedule which includes traveling between office locations several times per day several days per week. Staff collaborating with school staff and children makes this an enjoyable job.
- Poor, poor communication about changes that affect us with employment turnover should try to return people not turn away with stressors. Questionable org. structure. Little incentives that matter. Need more opportunities for trainings. Low morale not addressed honestly and processed
- Supervisors should be more understanding about family emergency situations! I am receiving leave without pay because I was unable to contact my immediate shift supervisor as I was rushing my husband to the ER for an asthma attack. My supervisor stated that I should have called while I was driving to the ER. I feel this is unreasonable considering I called as soon as my fiancé was in the doctor's care.
- Promotional opportunities.
- Provide laptops, at least 1 per service area to share now that all are EMR. Advocate for salary increases which have not occurred in YEARS. Have more opportunity for flex-schedules since salary increase not happening.
- Communication can be an issue. Constantly trying to do the same amount of work with less and less resources is bad. Trying to keep everyone focused and moral up with less and less resources is sad.
- Bring back wellness walks. They used to give us 3, 30 min. walks (breaks) a week to get our walking in. It really motivated me to walk and kept my back strong. Employees need a break room, especially nurses who only have 30 min. for lunch.
- Afford the supplies I need to get my job done. Give evaluation in period in which it is timely, due in December "2010". Still have not been evaluated. This is April 2011.
- Sometimes supervisors hold information that floor staff was to know to give a better care to residents. Like what kind of preference a resident likes and unit managers knows, however when the weekend comes and staff is not sure and Monday comes and resident is reporting the staff to the unit manager and she said, I knew that and several staff don't know. Nothing to do with meds or treatments or diet more details.
- I enjoy my work, but feel the center and management could be more supportive. Upper management often task clinicians with gathering financial information that should be the job of others in the financial dept. This takes away from my ability to see clients and takes away the rapport I have built with my clients parents. There is also limited ability to be promoted based on work ethic, as the center often hires favorites who are less qualified. High productivity is not rewarded and there are no incentives to continue going above and beyond expected productivity. Management often asks specific departments to work harder and do more in an effort to make up for financial deficits. Overall, I enjoy working with my direct supervisor.
- Lower productivity requirements. Offer financial incentives for high productivity percentages. Overall, I am satisfied with moral and workload and am thankful for opportunities to receive further training.
- I appreciate and am very thankful for my job and the benefits that I have. The workload is always increasing which is very frustrating especially when the expectations keep going up and our pay and

benefits remain the same or actually decrease since the cost of living keeps rising. Salary and workload is not equitable. The staff morale is dismal and the communication is poor.

- More clinicians in the MHC to allow us to have a realistic caseload so we can perform the clinical and QA aspects of our job efficiently and effectively.
- De-centralize – let the centers/facilities operate independently answering only to their bosses.
- Tuition assistance to take classes to gain licensure-LPC. Contract with colleges to offer needed classes at reduced rates and special times like the state arranges for people needing their social work certification. Consider release time for employees who are taking classes for licensure.
- As with any work place we must continue to improve our communication, we've improved over the years, let's not drop the ball.
- The center director's policy which requires that therapists in the acute care dept. schedule clients every ½ hour has greatly reduced my satisfaction with the job I am able to do as I feel 30 minutes is usually too brief a period of time for an effective individual therapy session. Its suggestion that we see the client for 20 minutes so we have 10 minutes to write our notes, seems to me both disrespectful of the role of psychotherapists and dismissive of the clients needs. Also, the fact that the formally assistant director remains in the employment of the center, apparently does very little work and being supervised by an inexperienced on-line educator, young man he mentored and promoted several levels at a time in a brief time frame, is extremely disheartening to hard working staff as well as destructive to the organization.
- Be fair when it comes to promotions or pay increases, promote individuals based on the number of years, education and experience. Stop gender based discrimination!
- More CEU training opportunities. Communicate the strategic plan of the organization.
- New leadership. When jobs are reclassified, they should be advertised and not just given to unqualified family members. Family members should not work in the same department. Family members of employees should not be over leave request. The state is being ripped off in this center (SAMHC). Dr. Powell and Jennifer Pearson need to be forced to retire.
- Opportunity (more frequent) for advancement and for pay compensation.
- Be professionals, stop the lying and back stabbing, and tattling.
- Can't think of anything, no major issues in that area.
- Increase salary.
- Some people are treated differently than others b/c of friendships, but other than that it is good.
- Provide more therapy supplies (books, games, etc). Provide laptops for out stationed clinicians who don't have offices. Minimal support is given to MHPs with high caseloads to help reduce caseloads, I have over 50 clients and keep being assigned clients, though I've asked for help to reduce my caseload. I'm not being heard. School-based clinicians should have no more than two schools. Provide more staff appreciation as a center/organization. Immediate and school supervisor are great. Charge clients for no shows to help budget and client compliance and responsibility. Have at least one LPC who can provide supervision per center or division, since we don't have financial help with supervision costs by CCMHC. Provide more front office staff and provide them more respect from admin.
- Teach a certain supervisor how to speak to an employee. They speak to everyone with the same tone and are very in-polite and makes you feel no matter how hard you try or how good you do your job, it is never good enough. This person is very negative and on several occasions has verbally abused me and has cursed at me twice. I have been to administrator 3 different times and HR once. Nothing gets done about it. Also, when they are given assignments they pass it on down to me with my already overwhelming position. Thank you.
- Not click with other staff members.

- Give us more experienced nursing assistants.
- Make the hiring process less lengthy, cut red tape. Need adequate staff and less long hours.
- Hire more professional nurse manager, staff, and treat all staff with dignity and respect.
- Office supplies have become hard to come by due to cost cutting measures.
- Take a responsible role in improving overall incentive towards care provided to residents by setting a positive and effective attitude by management.
- Forums to allow employees to make input on decisions that affect their work.
- Supervisor need to evenly distribute the workload instead of playing favorites. Treat everyone the same. Reward people with raises when they go over and above their duties, or have additional duties added. Supervisor need to allow flex time for employees from time to time. Supervisor need to support ideas from their employees.
- Have adequate training for your job you are doing.
- Provide ample time to do paper work at work as caseload had increased. Improve cultural diversity by building better relationships with minorities. Educate supervisors/management on how to give and show respect to all employees. Promote fair competition for in house and advertised jobs rather than appointing people. Discourage overcrowding office space with more than 3 people in room size of 15x17 ex. Allow clinicians the opportunity to help make decisions, planning of program and consumer care. Fair salaries in relation to degrees and experience, position. Promote more hiring of other ethnic groups. In need of safety measures/devices (metal detectors, phone/panic buttons, TV monitors eg.)
- Decrease ten checks for one task.
- Staff is left-out on many detail issues, that center around their lives pertaining to changes of the DMH and how it truly affects one's life. Communication is very poor among the non supervisory staff because things that are or should be important to staff; it is hidden from them purposely. I find out that having higher degree should bring more equality to a work setting. No so! Because professionalism does not start with what a person knows, yes it helps! But it starts with fairness to one who has given their all and all to move the business in the direction it should go. The business wants the best job performance there is and the employee pursues it and still is unjustly treated. Very interesting! Need better pay, especially to those who have given more than twenty five years of services to SCDMH!
- Improve/increase team work.
- Investigate the appearance of nepotism.
- Need back up personnel.
- Get rid of SCEIS or provide adequate training!
- More opportunity for pay raises based on merit and more opportunities for advancement. In this economy I am grateful to have a job, but we've had no cost of living raises in yrs. We need help $.
- Computer training. Power Point – Excel – do slides – template.
- Provide pay increase for job performance; increase in job duties.

- Working at ABMHC over recent years under Rick Acton, has become a very intolerable experience. I don't understand how DMH could allow such a man to run one center, let alone two. He has no respect for himself, let alone staff and clients. He puts on a front for whoever he needs to and disrespects everyone else. I even heard he called clients roaches. That was not supposed to get out of the management meeting, but it did. This man talks a good game; looks good on the surface, but inside he is not what he appears to be. That is because he is very arrogant, disrespectful, and shows this behavior openly to those he chooses. I don't know where you found this guy, butt you need to send him back where he came from. He thinks behaving this way is fun. He enjoys it. It's a game to

him. But he doesn't realize, that other's are sitting back watching him, and we are good at analyzing behavior. That's our job. I thank God I don't work for him directly and feel sorry for the people who do. But I am close enough to the man to feel the effects of his behaviors and it doesn't feel good. I could go on and on about the crazy stuff that goes on here, but then you would think I was on a witch hunt. If you really were concerned, you would give us a real leader who could lead with some dignity along with his business sense. Rick Acton may have some business sense, but no dignity and no respect for others and very few people respect him and the sad thing is that he doesn't care. Yes, he has a few flunkies, everyone in authority does, but who respects a flunky? I don't, do you? Concerned staff at ABMHC

- Model the behavior expected from top management down. Support staff instead of only pointing out negatives. Treat all employees with respect, not just a few. Cut out the "good old boy" politics. Increase team building and decrease set ups for (-) competition. Hire mentally stable employees, hold all accountable.
- I absolutely love my job and love the clients that I am blessed to work with. I am very thankful to be able to do the work that I have been able to do. The work environment is good, people treat each other w/respect and help each other out. I only wish I had a little more training when I began working, it would have been much more efficient.
- Improve communication both verbal and written. Respect of employees both verbally and written. Improve work environment ie workspace. Learn to be sensitive and individual needs of employees to provide incentives to employees. Be culturally sensitive. Decrease the presser on one specific program to maintain a facility. Reward based on merit instead of favoritism especially when promoting.
- Communicate with all staff and treat all staff the same!
- Give pay raises when you give people more work to do instead of keeping them at their same title/pay band and not putting the added duties on paper in order to avoid having to give someone a promotion.
- Remove my executive director.
- No support at all aside from immediate supervisors. Staff stays over whelmed, for years and they still do amazing work. Staff fear job loss if not making productivity and never get any positive feedback at all except from each other. They ban together to survive because they love the field and their clients. Director is out of touch. Some have left, some have stayed.
- Executive director should be more involved with each center and within the community, as well as, the other supervisors. There are more problems within the rural communities that should be addressed not only by the clinicians serving the areas, but by the leaders of the agencies it seems the rural areas where centers are located are left out and over looked by others.
- To start back having things for the employee's, bring us all together for a fun day to meet and greet so that the employee morale can be better.
- Keep staff updated more on what is going on. I am tired of wondering if the office is going to be closed!! So I think communication is the key thing.
- More personnel. For the county I work in two therapists for 12 schools is no where near best practice. More people, even just on, would allow us to be more effective and greatly reduce counselor frustration/burnout. Also, more trainings would be good, such as like the it-cst training offered for CEU's The on-line training modules don't provide CEU's nor extended knowledge of counseling strategies. Also, providing training to avoid burnout would be useful.
- No pay raises, talk of cutting benefits, this will send employee's where the money is and it is not DMH.
- DMH would rather hire a friend, outsider with no experience, rather than promote the experienced within. No wonder morale is so bad. My environment can't be helped.

- Pay raises, promote security officers to public safety officer. Security officer can barely make it on their salary.
- Better communication and increased level of "time management" accountability.
- Be more attentive to suggestions made to changes and not turn a deaf ear when asked about what concerns a person has on how to better serve clients. Be willing to make changes.
- To have more inter-discipline classes for job skill improvement, examples, computer skills-word processing, email, clip art-etc, power point, etc. Improve communication among all, no sending out of unnecessary emails. Go by the "KISS" for pat car groups, more simple and basic group. Schedules for the patients. Not – KISS means "Keep it simple Sammy". Activity therapy building needs, adequate or more water fountains for patients and staff.
- Provide gas for the beautician and barber or a car to travel between facilities.
- Nursing staff makes you feel like you are bothering them when asked for help. If people are not busy let other departments use them. Do not make 1 person the one who knows all co workers jobs and have to cover for everyone. Everyone should know co workers job and share coverage equally.
- Stop roasting me in winter or freezing me in spring. Provide better furniture (desk, credenza, etc.) Recognize those of us who work beyond the normal 7.50 hr, 5 days a week for no incentive other than we are dedicated to the department. Increase morale throughout the department which should improve the work environment. Money is tight, but money is not the only incentive for most of us. Recognition in some way goes a long way.
- I have found management to be unprofessional and try to intimidate employees. They say one thing and do another. I have never worked in such a place. I am looking for another place to work on a daily basis.
- Stop bringing staff back that think they know it all, work place violence, bully others and have pick staff to bring coffee to them like a queen.
- Raise cost of living up, no pay raise in years!!
- Need better resources – literature. Out dated computer system – needs upgraded software and hardware.
- Improve technology specific to the hospital setting, but at the very lease provide updated computers in enough quantities to accommodate users. Provide training or funding for training that keeps employees in touch with best practices and current technology as it applies to their specialty. Improve appearance of work environments, keeping side walks and patient areas outside of units free of feces from birds. Grounds upkeep would improve the appearance of the facility, new paint, carpet, curtains in areas that need them.
- Pay raise.
- Improve staffing.
- Promote positive staff relationships by modeling the same. Allow staff to stand up for themselves when wronged, validate.
- Update/replace vehicles and equipment we have and don't have. Budget cuts are always an issue. There are grants out there that will help us obtain vehicles, equipment, training and even more officers.
- Give officers more class in law enforcement.
- Money!!!
- The department could hire more people.
- I think that the department can improve with a better therapeutic strategies to conform the minds of the clients cognitive behavioral mobility therefore it can show improvement of better stability and coping mechanism.
- More communication between staff.

- More training pertaining to traffic and criminal offenses.
- Work environment as a whole is good.
- Leadership interact more with workers; communicate better; more training and equipment.
- Supply necessary resources to achieve department goals. Reward employees and remove punitive environment. Offer flexibility to keep good employees, flex hours, promotions, recognition, etc. This doesn't cost dept. anything to do.
- Supervising staff- nursing must not talk to MHS in degrading way. Practice allowing for creativity.
- Hire within if possible to promote advancement opportunities to retain good employees.
- Communication is poor some of the time.
- I only have great things to say about the people that I work with. They are all very supportive! I could not ask for a better supervisor than the ones that I have here.
- I like my job. Would love the opportunity for advancement and more challenge. Benefits could be a lot cheaper for employee.
- Reduce case loads by hiring enough people to handle/reduce large volumes of chronically and seriously mentally ill people.
- A lounge for employees to eat in and take a break in.
- Work on sidewalk repairs so it is not as easy to trip and fall. Tell us the truth about the budget, money just seems to pop up for some activities. Consider options for clinical staff's schedule (ex 4 day work week) Not everyone would want Friday or Monday off.
- GMH need to first focus on client care by investing more in clinician competence. I have heard clinicians express wanting to improve their craft but there is no true support or incentive for anyone to take time out for developing their clinical skills. This centers focuses in three areas: 1. Productivity 2. Passing audits 3. Productivity. Become more balanced with wanting to run f fiscally responsible center and also look at the type of work clinicians are doing with clients in helping them achieve their personal goals. (Ultimately, this is why we are here!) Cease threatening employees that employees that if you do not get these productivity numbers you will be fired even if they are doing good therapy work with clients.
- Encourage customer service with each other. Allow employees to have feedback in agency planning. Provide a central forum for communication. Provide opportunities for promotion/advancement. Assist with job placement if staff are facing unemployment.
- Consistent approval of flex schedule. Currently each dept. head decides to approve or deny flexing schedule therefore, some staff are allowed to adjust their hours while others are limited to the time they can flex even though all their work is done. This still is a positive work environment.
- Eliminate the amount of paperwork on some things cause it's a waste of paper to write it out and then enter it in the computer and is costly to the state if it's already going in the computer. Why waste paper as well it's the same thing in the computer.
- Cut the red tape, eliminate some of this paperwork, eliminate SCEIS, it does not tell me what days I am paid for when I receive overtime. Is there any way to get our OT schedule to run congruent with regular pay schedule.
- More money.
- Overall I am very pleased in SCDMH. I do have some feedback for consideration: 1) Choose center/facility/division leaders with care. While most are exemplary, there are a handful that don't embody some core principles such as team player commitment, proactive mgt. (vs. reactive). 2) Don't approve TERI for everyone just for the ones that really do have a wealth of institutional knowledge that we can't afford to lose, let the others go and allow fresh blood to move up the ladder.

- Rarely get feedback from supervisor-told if you don't see me your doing okay don't see him so I assume I'm doing okay. We know better than to ask for "resources" –no money. I like the folks I work with but often people bring their personal problems to work. Too many people I see are making long personal cell phone calls. I would like it better if employees could put sign up for Girl Scout cookies etc in central location and if we want them we can go sign up. I get a lot of these request in my mailbox and one can only support so many, it disrupts working relationships when you have to tell them no.
- Provide more detailed training when changes are implemented.
- Reduce top heaviness down town, fill vacant positions, increase salaries.
- Better communication and flexibility regarding specific needs that clinicians have in serving clients. Better emphasis on clean, tidy physical environments.
- Hire a center administrator, hire a cleaning crew, hire a maintenance crew, Monitor E.D's behavior (center).
- Decrease paperwork needed for case management or allow more work time to complete.
- A little paint, clean carpets, a computer that works most of the time.
- Have someone to cover our duties so that we can use our annual leave without having to impose on our colleagues for coverage.
- Salary increase.
- Continue to allow flexibility of schedule as appropriate. Support training opportunities. Promote from within where possible. Recognize Administrative Assistants more.
- I really love working here at MH I find it very interesting and helpful. I've always loved contact with those who need help most. The people I work with couldn't be better, the are great. I can't think of anything to improve right now. All is well.
- All though I understand pay increase is supposedly not in budget – could use one.
- Allow official leave for more continued education activities so that we can stay sharp and be informed of advances in the field.
- Be consistent in it's policies, be less afraid of legal threats and more focused on doing the right thing consistently.
- Salary increase.
- Provide more incentives for productivity.
- Nothing-considering our budget. Can't go to workshops can't get equipment.
- Monetary compensation for overall work performed. Some of us have not had a pay raise in years while others are given salary increases yearly with the assignment of additional duties and excellent performance ratings, increase in salary should be compensated to all.
- Get rid of the lazy people that don't want to work; the one's that you ask for help and they tell you it's not their job, they need to be escorted out the door, too. The way the budget is every one should be willing to "jump" in and help one another, especially for job security. Administration in the center acts as if everything is "top secret" and doesn't let employees know anything that's going on until last minute (information that's not too confidential that is ok for employees to be aware of).
- Help staff know that they deserve fairness and understanding.
- Rate my performance each year and help me build a planning stage. Provide a mentor. Would like my supervisor's guidance, but supervisor is very busy. Circumstances are very scary now and feel I have no support. Would love to make DMH a career, but know I have little chance for advancement and/or pay increases. Feel my supervisor doesn't know what I do or how hard I try or how hard I try to always do my best. Feel the more I do satisfactorily the more work I will be given, but no recognition or chance for advancement. Feel like the ant whose co-workers are grasshoppers…also very scared re: RIFs.

- Assist with advance degree education expenses.
- CAF there needs to be more specific training for clinicians in their strongest areas – for example – working with children 3-17. There is a great need for training in normal child development (very detailed) We need knowledge of normal development to know when kids have maxed out from treatment.
- Stop productivity and allow more quality of work.
- I enjoy working for my supervisor. I have the opportunity to do a variety of jobs that are out of my position title. I have a heavy work load, but enjoy being busy and the chance to learn and be responsible for a large area of management. I feel the dept. needs to reorganize and get streamline. The dept. needs to give the responsibility to the centers for accounting, HR, financial levels. We need to have regions with less administrative employees running more than one center. Need to change with the times. If I did not have training and experience in my field, I sure would not have gotten to work for DMH. It makes my own challenges and enjoy working hard. Unlike a lot of state employees.
- Talk with the people who actually do a job before making changes on how thins are done. Compensate valued employees. Don't tell them what they need to do to get a raise and then deny their request repeatedly.
- Give raises, treat people with respect. Most of us been here 15+ years have not had any raises or advances has been promise raises only to be told there are no raises. By now the one that has been here this long should be at least $25,000. They are getting the work with out given the pay. Let some one hear our cry. If this is going to lie on deaf ear then stop sending out surveys. It is time for the department to take a stand and give your employee some money. Lex Co. MH.
- Reduce case load.
- Some things don't merit a response.
- Better line of communication with director and other administrative staff. Need a raise that is very much over due for the duties that were given or added on.
- We have the same on-going problems year after year with no resolution. Simple computer changes would solve most problems. Need more equipment, i.e. printers, etc. to do our jobs. Need better communication between management and employees.
- Pay MHS better.
- Recognize the ones of us who are licensed CRCF administrators as well as licensed counselors (LMSW, LPC, etc) and who faces the responsibility of adhering to policies and procedures of both DHEC and SCDMH.
- Better training/accountability for staff (outside of my department). Better organization/continuity throughout the department.
- To provide training for potential supervisors. Supervisor need to value input/employee's opinion. Supervisor need to promote/encourage teamwork/not division, "not my way or nothing".
- The nurse managers are not fair within the staff. They show favoritism within the staff. When you have problems or issues on the unit, nothing is done about it. Staff are quitting because of issues that are not handled.
- DMH needs PR!!! No one talks about the good work we do and the extent that therapists lose money to work in public MH. DMH could more readily support my growth as a professional, but funding stalls any unique or exciting opportunities that might bring positive recognition to my center and DMH. For ex, I had opportunity to present at an international conference in my clinical area expertise. Even though I was at a neighboring state and location the, an out of state travel precluded it. No way could I afford the dues, hotel, and travel on my salary!

- All in all we do have supplies but often we need things the company doesn't provide. Don't start new projects without looking ahead to the consequences. Provide safer cars to use. Give more training – most important.
- Reinstate performance raises, eliminate teri, and realistically evaluate hire-backs.
- For thirty years I was with the department and my pay grade is very unsatisfactory to me being a skilled worker I'm to the bottom of my pay grade I would like to see it midway of my grade for all the dedicated work I do and love. I love my job and would like to have a pay increase, to the midpoint of my grade.
- Teri's and rehires should not manage a MHC. Our top officials have 2 or 3 other jobs and perform them on state time. Our MHC is comprised of family, friends, neighbors and church friends. Our MHC lets you go to school on state time and do your homework on state time, then makes a job for you with a promotion. There is no accountability with our leaders. The state should examine the races and sexes of our work force as well as promotions. Our leaders should be investigated. Policies do not apply to them.
- The department has gone from being a professional organization to a bureaucratic mess. Many of the most competent managers are gone due to a bad leadership decision followed by others in succession. The inpatient division is presently a fragmented and segmented mess where blame passes for accountability and micro management is support. People are judged based upon gossip and personality rather than credentials or performance. Prior experience is irrelevant. There is no such thing as a bottom up process and so procedures do not describe practices and so we fly by the seat of our pants. There is disrespect and leaders use intimidation and threats in lieu of collaboration or professional dialogue. Generally SCDMH is 10-15 years behind in both organizational structures, management and standard of care. The high hope I came with in 2000 are gone and a vague memory.
- Stop saying one thing - doing another. Have more flex hours.
- Our manager on A lodge need more training. Also, listen to too much gossip at times encourage it. Miss Felder is a joke and a liar. She doesn't support the mental health specialist.
- To have team work helping out staff when needed. Some staff plays and talks among them self. Want help client out, like if they see a patient need something there response is let her do it. It all about them not the client. If you don't want to work stay home when you come in lets work and stop playing.
- Give me a raise.
- Update all policies and have all policies available out in each unit.
- Unfortunately we are in a budget crisis. Employees work hard and we expect a lot out of them. It would be great if the state offered some type of incentives for job well done. Such as merit raises based on evaluations.
- Pay based on performance. I out work a lot of people who get paid a lot more than me. Performance based pay.
- Acknowledgement. When you are doing an exceptional job in performing your duties.
- A raise!!!
- More computer training resources for excel.
- Get rid of my overbearing, authority abusing, non helpful, unfriendly supervisor.
- I do love my work and my co-workers, but with no pay raises in 5 years, financially and feeling like I am not appreciated for my hard work it is very discouraging.
- I believe that the department is doing everything as well as it possibly can. Though budget cuts are always scary I believe that GMHC has/is handling it well. Honestly I love my job.

- Nepotism needs to stop! Favoritism needs to stop! People who are college graduates need to be compensated and not under paid/over worked. Clerks, (Quality Assurance-High School Diploma) making more than college graduates. The system is corrupt, no room for growth, no room for justice, the system needs to be abolished and we need new director/assistant director and staff based on qualifications and not family connections/or who you go to lunch with. The system needs to be investigated and exposed.
- Give workers incentives.
- Give opportunity to make a raise for job performance.
- I enjoy working with the patients and co workers but my supervisor is very difficulty to work for. They are very overbearing. I have been through the chains of command to work on problems but there were no results from the meetings. All they have done is change my direct supervisor from Susan Williams to Angela Hanks. This change has had no results. I have not once had a supervisor meeting since the change. Susan Williams is still being negative and degrading to her employees. I am still being harassed and demeaned daily.
- More staffing on the floor.
- Increase pay. I have my masters and make under 25,000 bring home in a year. Take away SCOW and ONCALL for people working in intake dept.
- Work toward goal of holding all employees accountable. Work toward goal of a quieter, more pleasant work environment.
- Focus on team work between disciplines to coordinate care for patients.
- Communication, working together, better attitude toward patients, seniors and staff, behavior toward the patients need to be appropriate, working according to the policy and rules, ready to help in time of need.
- I receive my survey but lost it. I still wanted to voice my opinion so I decided to just send a statement. I know it will not count in the survey results, but I do know there was a section for summary, and this part is the most important part to me. The leadership at Aiken Barnwell Mental Health Center is very poor, and by leadership, I mean Richard Acton. I have never worked with person who treated staff with the indignities that he does. People literally have had to debrief with other staff after dealing with him because of the way he treats them. And what makes it worst is he allows one of his doctors, Dr. Watkins to behave the same way, and she treats patients this way. Patients have complained about this woman, refuses to see her, because of the way she treats them, saying that she is cold, and mean in sessions and he refuses to address the situation saying that it is a medication issue, but it is not. This woman has difficulties with everyone, even her co workers. He doesn't lead by example and thinks that people do not see that. Personally, you knew he was a poor leader when you chose him. A leader who can not respect the people he leads is not a leader and a leader who does not respect his people and say he does is a ----. So we have a problem in Aiken.
- Upgrade computers, additional telephone lines in charting room.
- Confront unprofessional behaviors and praise those with a team-up approach.
- Adequate staffing per related equity – eg. More precautions.
- Be fair about raises – during this "budget crunch", some (admins.) receive raises while others on front like me do not. Provide areas for staff to have lunch. Provide results of these surveys and outcomes.
- Have a neutral place for all to eat to have lunch would be great. Quality of life on SCDMH has dropped very low. We need pay raises just like the entire USA. The half of Professional Training/Seminar is an alternative of a day Joke! Be more communicated in all aspects. Stop treating us like we are a lower class. For the past 10 years we have not reached no goals of the real mission of clients. Start some positive action instead of all these meetings. Give us hope. We need to be able to have great pride coming to work for the State Government and not just be grateful that

we have a job. Our supplies are down, our spirit is down and there have been no bread on the table. Not even hope in the future.

- The department can do things that will not have an impact on the budget for employees to let them know that you are appreciative of the work that is being done. The moral is very low. Some employees are just over worked and most definitely underpaid.
- I would request a private meeting to discuss the answer to this question.
- Provide a more extensive job training. Realize that some of us cannot (barely) survive on the salary provided.
- Acknowledge the fact that staffing is the #1 contributor to dissatisfaction in nursing/nurse aids/and ancillary staff (ie PT/OT/ST/RT); and although some area have adequate staffing; from my perspective ie: PT-there are still residents that are getting contractures that are worse now than 3 mos ago plus ie RT: there are many residents that lie in their beds all day, staring at the walls, mentally waneing; and no involvement in any activities, EXCEPT – when DHEC or other authority is here in the bldg. I feel a lot can be done in many areas of care if everyone were willing to take accountability for their part of the care, as it is, many people who genuinely care eventually grow weary of trying so hard that they eventually are broken by the majority rule. Ie: If you can't lik'em, join em!
- More help and better attitudes.
- New employee – no recommendations at this time.
- Everything.
- Head supervisor feels he doesn't have to do any of the jobs we do. He does very little food prep. He does not do serving line, tray up food, carts to lodge, dish room or cleaning up his own mess. He also, will not assemble any utensils when needed. He says that is our job. What he does do real well is recycle cans, for his own profit, on state time. He takes both lids out, labels off, and crushes while we are doing his jobs. He does occasionally clean the fryer, do name labels. He also has the worst attendance record. He was taking off early every Wednesday, so he was given that day off. Now he takes off early every Tuesday. He also comes in late a lot. He has six other jobs besides this one, and an excuse from a doctor, that he can sit down whenever he wants to. He does not feel he has to tell his fellow employees when he is leaving, sometimes he is just gone. He only closes about four days a month, but if he wants to leave early, he will assign that to someone without asking them. He brings it up in meetings that we are not supposed to get personal calls, but he gets more than anyone else. He runs to the director about everything, tattling. If anyone gets employee of the month he gets mad and says they are useless, or a favorite of the boss. He is all about rules and none of them seem to apply to him. He lets other employees off without looking at the schedule, which then leaves us short and does not bother telling us what he has done. It is amazing how everyone can be miserable at what is actually a good job, because of one employee.
- Provide at least 2 MHS per shift so we have adequate staffing!!! Especially in case of an emergency. Working with only one staff each MHS-RN is unsafe regardless of low or high census, especially at night when staffing over all is low. Saving money can cost a life. Also, there are no advancement opportunities. New hires seem to get a better pay than long term employees no matter how good the annual evaluations are. Nutritional needs of patients are not adequately met, even physicians have spoken to nutrition dept. but snacks are not sent as ordered!!! Please provide adequate staffing, meet ordered nutritional needs and give senior employees a better chance at better wages. Experience and loyalty should count.
- Speak don't look down on employees.
- Need more staff.
- Improve funding.

- It will be nice if my supervisor's or administration superior will recognize me for my job duties, and other duties I perform beyond my job description. I'm dissatisfied with the supervisor I have had over the last three years that never ask me what I do on a daily basis, just need to communicate with staff more.
- Enforce the policies that are already in place instead of creating more. Improve communication methods. All do not have computer access yet. Update equipment and get rid of outdated ineffective practices. Hold each dept. accountable for that which they claim to be doing. Too much time is wasted trying to access services via phone calls. Let's update, revise our frequent call lists, not personal, but departmental.
- The job descriptions provided to HRS should be followed by a person in audit to see if there are discrepancies in what is written and the actual duties performed by the assigned employee.
- Far too many personal hires of friends in the same department by management. Far too much advancement for friends in this department. Supervisor is disrespectful and causes division among staff with lies and gossip. Upper management asks an awful lot at times which tends to mandatory overtime. Supervisor never helps participate in multiple projects to ensure the appropriateness of deadlines. As a result moral is at it's lowest. New hires come in with better compensation. New hires are given different titles other than the advertised position to make more money. You cannot report problems to hire management because they are the source. Upper management ensures they are compensated with pay increases; but will not value good employees in the same likeness.
- Improve pay scale.
- I love my job but the pay is very low for the jobs that I do. I go above and beyond on my job as Adm. Spec. I am also a time adm. For 2 depts. I feel that I should have been compensated for all the extra work that has been added since taking this job. The employees in the department come to me for everything, including schedules, dietary issues, and problems in the dept. instead of going to the director or nutritionist. Usually an employee is compensated for doing extra work and I have asked for compensation to no avail. I love my job, as I have said but it's unfair for some to get compensation and others not to. In a lot of ways some administration at Harris Hospital shows prejudice and unfairness, towards some staff. It all boils down to "It's who you are, not what you do!"
- People need to mind they're own business, stop gossiping about one another, and learn to help each other and love. Also, too many chiefs and not enough Indians. People need to come to work with a positive attitude, not negative ones.
- Change department heads or dept. head can be more considerate of the employees working under him. He's more concerned about his self than his employees. When it comes down to money he puts it all in his pocket rather than share with the money with employees that have been working short staffed pulling the load of absent workers and the few are getting the same job done saving the dept money and providing department head with bonuses. He allows one of the supervisors to keep working when the supervisor's health is not allowing him the capacity to do his job.
- Take an interest in its employees. Start making employees that are not doing their best of their ability at their jobs, retire or separate. Too many employees have the attitude that it's not their job. We all work for the same agency. You need to give incentives to boost moral. Employees have low moral. Supervisors need to be held to higher standards when their staff gets into trouble. They need to support their staff more. Maybe Mr. Magill should do the undercover boss thing to know more about what goes on in his clinics.
- Learn to communicate with each other.
- Give me a raise, we could have better classes on how to talk a mentally ill patient into calming down.
- Offer more training for officers and equipment for law enforcement duties.

- Make sure to update equipment, increase pay to be competitive with other agencies.
- Stop saying one thing, then turning around and doing something different than what you say.
- Provide us with the resources and adequate training to make us successful in our jobs. Make the promotion process equal and not biased.
- More training classes, more vehicles, and better body armor that isn't outdated.
- I think the department can do better with raises not certain ones.
- Give out raises, have all the tools we need to complete our jobs.
- Pay increases, cost of living goes up but pay doesn't.
- One you can stop upper management from lying to us. Pay people on merit. Hold meetings that mean something, not lyers. My supervisor is a great person and will do anything to help me or the D.O.M.H. He is probably the only one.
- Less paper work. All the work load is placed on certain people and they are not awarded for it. The people that complain and don't do their jobs get by with it.
- Utilize the resources that have been hired in the department for what they have to offer. Promote-support programs to elevate moral.
- Spread the workload more evenly among all administrative staff. Administrative staff should not supervise administrative staff. Improve moral by those folks that teri, use the program for what it was meant. Train other staff to perform those duties within five years and let the teri folks retire out of the system. This would save money, or if management wants to spend money, they can give pay raises to those that are currently full time employees. Do a mandatory training on workplace "bullying".
- Offer training on commonly used computer software, raises, enable rehiring to go smoother by having HR paperwork training classes.
- Pay raise, promotion, salary adjustment.
- Add divides to provide privacy when talking to a client.
- More staff.
- Our cleaning crew needs more supervision and training. We have building issues, flooding, toilets stopped up, probably mold in the carpet.
- Offer additional help when the unusual – extra heavy load comes.
- Pay increase.
- I work in nutritional services and some days we are short of people, but for the most part it's a good place to work.
- The SCDMH says it doesn't have proper funding. SCDMH waste too much money on unnecessary projects and doesn't maintain what is essential due to poor middle management.
- Personally, I am fortunate to work with good management and staff, but as resources tighten and individuals are asked to do more it can often be stressful, for others. I often see persons willing to strive for quality even in midst of excessive work loads, but I see a need for mandatory training for managers as they can make the difference in work environment and encourage retention and quality with the right skills. I see and talk with many employees who just desire more encouragement.
- I spent 2 days in orientation and learned nothing about HR details, how pay works, holidays, sick/annual leave. Have a routine system for improving moral, work objectives that encourages employees to do well. Give supervisors lessons in encouragement, enthusiasm and a way to show employees appreciation.
- I want to work 7-3 that would improve my work environment very much so ☺.
- More organization, more staff, more accountability, keep supplies ordered.
- Administrative assistance, better training for new software.

- Pay increase, there are no African Americans on the management team or executive committee at HPH. We are a diverse hospital and there is no representation to address issues of this population.
- Less aggression, ventilation in bathroom, mirror in bathroom, cleaner environment.
- Try to look out for employees more especially the good workers. Don't abuse good workers by taking advantage of shortages.
- Change parking for 2nd shift. Safety issue parking in the front and walking back to your lodge. Whether you're walking around or walking through. Especially when the weather is bad (raining, cold, etc.)
- Allow me to cut pay on some employees in order to give increases to those who DESERVE them! We are in danger of losing valuable employees due to no pay raises!
- Rick Acton speaks of principles of leadership all the time. His motto is often "I don't do the work everyone else does the work so I can just pay my rent"; also one of his mottos is "If they don't like it they can just find a new job". In the years that I have been employed at the ABMHC I have never felt so separated from an organization. I'm afraid to speak out because I feel that I will be retaliated against as evidence by those favorites that try to fire people and speak down to people because they feel they can. Maybe, if I kissed his ass and treated people like S___ then he would like me because the very people that support him most have become arrogant and self serving like him. Most of all, he doesn't realize that staff talk behind closed doors about how they feel they have been disrespected by him. Rick Acton is for Rick Acton and he uses people to make himself look good. He should not be allowed to represent this organization because he makes the organization appear to be selfish and arrogant!!!!!!
- More fairness among co workers. There are different rules for different employees within DMH and my division. Need more supervision of these supervising, some seem to be on their own with no leadership. Seems some employees do not have enough to do and others are over loaded with work. Some divisions have more employees with a greater work load. Also, don't agree with re-hiring of all the "Teri" and retired employees.
- For my peers co-workers to do their job or find another one and for them to stop complaining. They didn't complete their work and complain about raises, etc.!
- I enjoy providing therapy to individuals and family. I am satisfied with my job duties. However, I do not agree with the new productivity. I am more motivated by helping those who need versus the number of people I see. This is not private practice where you are directly paid in the number of clients you service. The onuses have been eliminated and there has not been any raises/increase in my salary since the 1st or 2nd year I was employed. I know that I am underpaid as a Licensed Independent Social Worker, but I'm dedicated to providing therapy to those in need.
- Pay a salary commensurate with what I could earn in the private sector.
- Pay me more money for the work I do.
- Different levels to advance, more resources, assist with other training, help with getting licensed and pay increase.
- Increase staff support (emotional) and communication between employees/dept. supervisors, less gossip and leading others by fear, provide or encourage continuing education and training opportunities, consider relevancy of mandatory trainings and do not require triplicate trainings for same thing.
- The department can provide me with a key to the outside building. I believe that when I came to work, I should be able to get in the building and upon leaving. I don't want to be rushed to get out by 5:00. I am used to having a key. A key to one's employment site is very important (or any entrance way of getting inside the building. My job is very important to me and I feel a since of accomplishment at the end of the day. When I know I can come and leave without being rushed. It shouldn't matter.

- The environment at this office is very family like. Every one cares about the other. We go the extra mile to keep each other. My office is a good place to be.
- I enjoy my job, but on most days the workload is very heavy. Since the cut back of staff in the area I work, I had to take on more duties and responsibilities, but I have not received a pay increase. It would be nice to receive a small pay increase for all of my added duties. Whether I receive a pay increase or not, I will continue doing the best job that I can do. I really appreciate having a job.
- A raise would be nice, but considering the current state of the economy I don't believe this is feasible or realistic.
- Honestly, I love my job and the people I work with, my only complaint is I have never had a raise. The cost of living goes up but I have not had a raise since I started.
- No salary increase of any kind in four (4) years. Life is getting tough in the outside world. I resent the fact people starting in same or low band grades are receiving salary the same or more than an employee with 18 years in the same job of new employee. To add insult to injury I have to train the new employee in their position. Supervisor takes employees with long time experience in position and do not need much if any supervision for granted.
- I am sure that everyone has said competitive salary. I have been with the agency since 1997 and started in the file room. My beginning salary was around 18,000, I have been promoted at least 2 or 3 times. I am now an Admin Asst supervising 3. I have always received an SE on my evaluations. The only increases in salary that I have received have been promotional or cost of living increases. In 14 years my salary has increased roughly $8,000. I like my job and all of the people I work with and those we serve. I also know I am supposed to feel lucky that I have a job at all. My job satisfaction very much out-weighs my compensation satisfaction. I also know that money does not solve all problems, but being competitive salary wise would increase morale and job satisfaction. We do have a good benefit package, but why take time off, work is waiting on you when you get back and you don't have funds to do anything. Thank you for letting me vent. The budget will get better and I will do my best regardless!
- Get more input from the field and acknowledge the "small" things. Be available. I never get a person on the phone.
- More training, better pay, more resources for counseling.
- More privacy through the walls, adequate air conditioning in office.
- Better pay. Opportunity for advancement, better communication.
- I honestly don't know.
- My job responsibilities do not match my pay. To maintain a comfortable temp for all employees not just for a few persons with titles. I along with several others get so hot that the work environment is unbearable.
- I feel I am being set up to fail. Request to adjust my productivity benchmark has been submitted by my direct supervisor for several months but still no action. My job has changed so much with EMR implementation that there is no way I can make my benchmark. Seems I am doing more and more non-billable duties since the change.
- I would like to know why jobs are not posted for Spartanburg Administrative Assistants. I too have a son, daughter, sister who needs a job and these jobs are not posted on our web site and we do not know about a position until it is filled by a "favorite" of Ginger Queens. Because of the unrest in the Administrative Department, I know of several of the employees that are very unsure of what they will be doing tomorrow. This is not right. The Administrative staff is too full and we as case managers are not given the full use of the help we need by this staff. As a state employee and a tax payer, I would like to know why.
- Unfortunately, the department is not in a position to do much because of budget. The pay is not equal to my level of experience.

- This dept. needs much, much help and it needs a working supervisor. Our lead supervisor shows no good example of a supervisor. He crushes cans when he should be prepping for a meal. He does not dress appropriately. He does not do his share in the dept. We have employees that right their names on state property and dare you to use it to do your job. Our administrative assistant takes care of this dept. more than the director. Our director does not think that this dept. has any flaws, if he did he would address them. I hope that this does not make it to the trash. I hope that someone actually reads it, and comes to investigate. Our dept. head does not have his priorities together he would rather stay in the restroom, or crush cans to take to the recycle bin, so that he can get paid for it. We should not have to watch the things that we do if we are all working for the good of the patients. Our lead supervisor does not dress in proper uniform, but expects his staff to, wrong example. When you go to the director about someone in the dept. he makes excuses for them. We have employees that are truly dedicated to their job and to the patients. When is the last time that they got a raise or bonus, but our director has gotten one, that's not fare? He does not work the dept. alone. Why did he be the only one to get a raise?
- Not display and engage in overt and covert favoritism in conditions of employment such as salary, space and job assignments.
- Pay more money and hire more staff.
- The entire department is under staffed. CNA's are worked entirely to hard. Wandering units all works with dhec minimum all the time rather than pulling CNA's from units who work w 7, they would rather keep 7 on some units and work w minimum on locked units with wandering patients. CNA's are over worked and under payed. Patients run the department rather than the staff.
- Continue to get hard working people to do the job and enjoy doing it.
- It'll be good if supervisors-leadership had people skills and know the staff job. Need better team work, they will tell you to do something but if you ask them to help you they will say I'm not doing that. If you don't have some letters behind your name or got a degree you're not important. It takes all the staff to make the facility to run. Some need to have a mental exam. They don't know how to talk to people. Do an under cover boss and see what's really going on. Have lots of training and have people that know the job train.
- Respect my experience and knowledge. Reward SCDMH time and experience. Level pay band salaries with experience/responsibility. Some employees are treated better than others.
- Can't explain without telling who I am.
- If I fill out numbers 24-29, I might as well be signing the form.
- Reward with a raise!
- Department directors could assist staff when they are overworked or loaded down with paperwork. Directors could take more active role in their own duties or helping the department instead of assigning more paperwork while they design "cute" calendars or play games on the computers.
- Cut out unneeded services so that a needed raise can be provided. Cut out babysitting with clients running them using money for gas when they have Medicaid and can ride the van. Do not give bus tickets to clients on Medicaid.
- I would like to be able to purchase resources w/o paying for them myself.
- Provide training or pay training needed within area duties. Upgrade computers, servers, speed of IT, upgrade work area, paint, carpet, furniture. When hiring new employees; be able to offer better salaries to get qualified people. Should not be restricted by current salaries within the agency.
- Raise would be great.
- There is very low morale with the employees. It is sad that higher management only looks out for themselves or friends when it comes to increases. Then others are told that there's no money in the budget. I've been here long enough and have seen it happen so many times. Not to mention the new hires that come in making way more than the people they are replacing.

- Provide sufficient resources to meet client needs.
- Please provide security to staff.
- I feel my department's moral would be better if they promoted within and the upper management would STOP hiring their friends and give people that have been here a chance to advance.
- Acknowledge its employees on quarterly basis for the work they do, promotions or advancements. Oversee the operations and performance that supervisors and directors do to hold them accountable for their lack of performance in the work place. Keep building safe and hazardous free. To inform the employees with the truth of whets happening instead of keeping things a secret. Director-does not know what most employees do they don't care about who you are and will not speak to you.
- Treat each employee with respect, distribute the work load evenly. Make everyone fill out leave slips when they are out or come in late. As a supervisor don't have employees do what you the supervisor or the director would not do. As a supervisor or director you have to set standards. Supervisor and directors need to be held accountably for their actions. Also, supervisor and directors should not have a personal relationship with employees discussing other employees that is very unprofessional.
- More up to date equipment.
- I believe there should be consequences for actions here. Instead, it appears that when someone is not performing job accurately that the facility just moves them to a new department, instead of write ups. We are here to take care of our residents and when unsatisfactory work is given, people should be given a consequence so there job performance has incentive to improve.
- I love the meaningful work I do with clients and that the benefits make up for the low pay. However, the demands for other responsibilities (90-day-summarie, discharge summaries, 20 minutes plus for a discharge summary, mandatory on-line training, etc are not billable, don't apply to productivity and require several hours at home!! Do the people in charge know this?? Do they care? Don't know answer to question 26, don't know answer to question 28, and don't have time to find out, sorry!!!!
- Another "catch 22" We are told over and over there's no money in budget (ie., no raise for 3 yrs) and possibly more budget "cuts". So, you know you are not going to do anything about the "work environment".
- Open more beds at MV, BPH, PBH for people that need them.
- Improve leadership.
- Of course it is very challenging to continue to work in an organization/state where there are continuous threats of cuts and potential job loss. I have taken on many new responsibilities voluntarily and I do an outstanding job. It is very difficult to not be able to give any staff and myself increases, sick time should be changed to paid time off so it is not abused. Very difficult to manage employees who call in "State acceptable" Central Admin/community Admin centers are duplication of services, we really need only 1 HR dept, etc. Another layer takes longer, finance, etc. Also, quicker follow through is needed in many areas – contracts, hiring, etc.
- Make sure that EPMS's are done on time. So that staff can feel good about their jobs. Leadership need to communicate more with staff. Give some kind of incentative, rather gift cards, employee of the week, of month, give away cash prizes to the department with the least citations during surveys. Make sure staff have inservices that are fun and more exciting for learning. Give out raises or small bonuses to staff for going over and beyond in their job duties. Exercise classes for staff would be great! More staff socials, pot lucks would be great!
- Ensure employees are supervised by their field of study personnel; having a gammit of various supervisors with different aspects of an employee goals/outcomes can limit growth and creativity…For example if I'm a nurse I would want a nursing supervisor and so on. How can this be implemented? To sustain growth an innovative ideas hire more (BS/BA) graduates.

- Hire people who act in a professional manner. Let's not hire lazy people as this adds to the burden of other staff. Also, transferring staff internally to fill the gap then re-transferring that staff is disruptive in this work environment.
- Develop opportunities for advancement. Enhance communication among employees/department managers.
- Offer raises for good performance ratings. Provide reimbursement for work related training as cost of training falls to the employees. As many state employees have to work a second job just to make ends meet, it would be nice to be adequately paid for my expertise and experience!
- Strongly minimize tons of paperwork!
- Their needs to be a pamphlet developed to explain all the programs to aid staff in determining what program a client can be referred to if additional services are needed.
- Work more to retain and train good case managers/therapists, also, do more to reach out to the chronically mentally ill in the community by expanding the workforce that leaves the office when they decrease the staff of ACT teams/outreach employees. With decrease hospital beds, need better outpatient services to prevent decompositions and the consequences of the decomposition.
- No proper training. Have to buy own supplies. Constantly pulled to do projects for other departments. Billing system not compatible with job. Depts. Work against each other. Work not evenly divided. Transparent favoritism. Budget cuts only apply to some employees (not all). Too many meetings (useless). Employees in positions that is not qualified. Hiring methods not on the up and up. (also transparent) etc, etc, etc. Way too much to mention – wish there had been more time given.
- I would rather like the department to grandfather MHP staff for LPC status for improved insurance eligibility.
- Not enough clinical and nursing staff to meet needs of clients.
- Hire people who are competent to supervise and manage. Monitor any new supervisor - make sure they have training for supervision and not allow them to over-run others who have the years of experience and training but not the title and salary. The culture of this organization is oppressive and unfair to the staff.
- As an officer with DMH I often feel that I am not given all of the tools to successfully complete my job. As an officer there is no ability to continue the law enforcement education needed to better perform our job tasks. When the issue is addressed it is laughed off and dismissed. It is my opinion that DMH would retain more officers if the officers were trained to do the jobs they are asked to do.
- Offer computer classes. Since EMR, more work related injuries – nerve/carpel tunnel, etc. – need more/better conditions for computer work.
- Provide better resources to offer/provide to clients due to limited income. Not able to take clients to many community resources ie. (museum of art, state museum, train museum) due to purchase of tickets and state budget out of balance.
- Come up with better billing statements that are mailed to clients. No client should receive three or four statements for serves each month. They are not consumer friendly and cost the dept. more money. Too many calls are received from clients complaining about this.
- As a RN I thoroughly enjoy my function with the department. At this time I do not see anything that is necessary to improve the work environment.
- Certain people continually act inappropriately or do not do their jobs, leaving others with extra work and a stressful environment, but supervisors are afraid to fire people, because they can not hire new employees!
- Decreased caseload. Increase pay. Offer incentives.

- Utilize dictation service or voice activated typing program. Make the EMR more nurse friendly. There needs to be (just like the med form) a forum for office nursing-vitals, education, etc such as first aid. And one for Telephone nursing to include name of caller, relation to client, concern, recommendation and whether nurse handle alone or had to consult M.D. 95% of EMR documentation is done after hours although a plan is in the works to get me some help. Nurses should not have to function as secretaries.
- I am an administrative assistant. The center has entirely too many people not producing or just pure lazy. Since we are in a budget crunch, why not get rid of the people not working or doing a poor job and pass those funds on to those of us that are. This is frustrating. No one wants to lose their job, but it motivates me to work harder but it only allows the non-workers to become lazier. I know I would like to have their salary.
- Treat me with respect. Give better communication directly to me not to me through other co-workers. Treat me the same as other workers. Help me to empower my clients, especially in group settings, and stop trying to drive my work productively down. Have meetings to share information that will increase productivity and stop all the drama that pulls co-workers apart, and allow all workers to be on the same playing field. Be or have more confidentiality among co-workers (ex) Stop having supervisors tell co-workers about other co-workers productivity, etc. Over all "Better" communication.
- Too many problem employees just keep getting transferred around and no one confronts or discusses the problem head on, the employee hasn't been given the real chance to improve his/her problems or deficiencies if he/she just gets transferred to another department with the same problems. On the other hand, when an employee is not performing satisfactory and strong evidence is clear, example, "Unsatisfactory time and attendance". Why do supervisors hesitate to fire someone? They just want to get rid of the problem to someone else, instead of confronting the problem. Maybe this is why so many employees are unsatisfactory/lazy because they don't have to worry about getting fired; they just get transferred to another department so that another department can choose to deal or not to deal with the problem. In the meantime, this COST DMH MONEY! Keeping unsatisfactory employees hurts the budget and causes good employees to get discouraged! Morale is down enough do to the rising cost of living and cost of living raises are "a vague memory".
- Increase my pay and pay of my co-workers. Scheduling is the worst here I have ever seen. When you're hired to work 1st relieving 2nd, you expect to work 1st and occasionally work second as needed. Here it is a pure swing shift between 1st and 2nd. We were hired as 12 hour employees but frequently are required to work 8 hour days if only one person is out. This is a very dangerous job. PSO should be physically strong to handle dangerous pts. Two little female PSO is not safe. State workers need more pay!
- Better finances, merit raises on the rating of our "EPMS" like before, not open to others ideas.
- The department has very few incentives to offer currently, yet in this era of no raises and eliminations of jobs (requiring us to do the same or more with fewer resources), the department has increased aversive accountability, approvals have to pass through too many hands so inexpensive, creative or time sensitive opportunities are routinely lost. Way too much emphasis on bureaucratic processes which are aversive, morale busting and create a culture that is all about what can't be done vs what can. Since the incentives have all dried up, such Byzantine bureaucracy should be reduced to at least get out of the workers way. I spend way too much time documenting for permissions when I could be creating solutions, providing services, etc.
- Unit is very crowded and patients become more easily agitated due to lack of space. Improve supervision so that supervisors actually work on the unit so they even better understand what their staff experience from patients.

- The salary structure needs to be revamped. Many well-educated and well trained employees are not fairly compensated.
- Cost of living increases, opportunity for raises when progress and good work and productivity shown on EPMS, payment for trainings and supplies for Tx +/or reimbursement.
- The cuts to community service, Inpt. Beds, resources and services for those I assist have been my greatest distress. I spend far too much time begging, fighting and looking for help for our clients (medications, including fight with Ins. Co's, Tx services, etc.). The escalating difficulties with the EMR, consumes valuable time I could give to those I see and my peers. At one time this was the greatest and most fulfilling work I had ever done, felt like family and work was appreciated, we were doing good for our clients and their family and there progress was evident. I can no longer say any of these things, it is disheartening. I had planned to be here 30 years or more, but that has changed. Jan. I had 26 years and I plan to leave at 28. If I thought things were going to change I would return to positive outcome and real help for those I serve I would stay, but this is not going to happen.
- I have not received supervision outside of EPMS in years. Middle management at this MHC spends more time targeting employees to fire for no reason than they every think about spending in pt. care as help to employee. I have never once been commended on my performance by MHC management team, although I am preferred provides to most front line staff. Middle management at this MHC is not truthful and it is hard to work for people you cannot trust. People are written up with her most of the time and management says they are forbidden by Columbia to give excellent EPMS evals.
- When placed in position, one should be compensated for extra duties.
- More man power!
- If we all work together as a team and not put to much on one person.
- On some days more help is needed: I really would like to see more team work. I would like to see more incentives for housekeepers: I myself would like to move up to something better, but now I'm using my time to learn about C.M.Tucker. Really deciding if this is where I'm needed: I like what I'm doing and enjoy working with all people.
- Have equipment that you need posted at all the buildings. Females should not have to pull machinery all over the grounds.
- Communicating more with employees.
- Get more staff, give more raise, do more for the staff, let them know how much they appreciate the hard work they are doing not only when we get survey.
- Can do a better job if hands weren't tied.
- Leadership needs to no who there employees are it is more chief, then Indian. No morale here.
- Make sure everybody does equal share of work not just one person doing all the work. Make sure we get a raise! raise! raise! Make sure when supervisors in any field when approaching employees make sure it is done proper and respectfully.
- This department needs better equipment, more cleaning supplies and people that will help instead of just leaving areas trashed.
- More money.
- We are not making the money for the work we do.
- More money, more staff have stress-free work environment.
- Need to listen at their employee more, giving them the benefit of the truth. Moral can be better if they had someone who would listen at them and understand what's going on in their lives.
- Make frequent visit on units. Ask these questions face to face. Increase salaries.
- Provide enough staff to effectively do/care for residents.

- Employees are always given the response "The Budget" when any request for additional pay increases of which state employees have not received in 4 years. We are constantly given additional duties without compensation and are suppose to receive them with open arms and just be thankful we have a job! This type of philosophy has destroyed morale completely. Yes we do need our jobs, but we also need the chance for promotional opportunities. Send the Teri folks packing, to give others a chance for advancement!!!!
- Since this is a residential care facility that provides counseling to the mentally ill, I personally think that the pay needs to increase since we as staff are performing different job duties (counseling, Medicare and Medicaid funding), independent skills, cooking, med monitor, appts and etc.
- I would first like to state, I enjoy my job. I like my co-workers and I enjoy helping and communicating with the clients I serve, but the leadership of my facility needs improvement. There is no growth in my current program. I am unable to learn and advance because my current supervisor does not have the knowledge and skills of a leader. My supervisor does not treat me and other staff with the same impartiality. The department can improve my work environment by providing me with a supervisor with adequate training and knowledge. Also, if material and information regarding the program and department was distributed in a timely manner this could improve my work experience i.e. this survey was to be completed and returned by April 15, an I just received it 4/21/11.
- Better computer hardware.
- The organizational leadership has poor communication with staff. They also do not respond to stated needs from the staff. The state will not provide physical materials needed to do my job, requiring me to purchase my own (such as printers).
- Promote and provide resources for professional development. Allow greater autonomy and trust for staff to make meaningful contributions for short and long range planning. Continue to promote a safe environment to "agree, to disagree" without fear of reprimand.
- Regulate the air and heat! It's too cold in the winter and too hot in the summer.
- Pay raise and better insurance!!
- More pay, better benefits with insurance.
- Need pay raise.
- Do you really care! NO
- Make timely repairs. Make hiring process more expedient. Hire more qualified personnel. Consider appropriateness of admissions to this facility, elderly patients housed with younger more volatile patients. Consider raises for good employees and lower paid staff. Administration top heavy need frontline staff.
- Let me do what I have been doing for 20 years escorting campus wide, patients off of all lodges.
- Provide promotional opportunities. Offer performance raises based on level of performance. Show some form of recognition for the employees who are doing a good job. Offer more work shops to deal with stress in the work place and relaxation skills. Get rid of unnecessary, unused clutter on the lodges. Treat all staff with respect; you must give it in order to get it.
- More money better insurance.
- Catawba Mental Health (York Adult) needs structure, organization, psychiatrist and employees that fall together as a unit. Everyone does their own thing making it very time consuming to get simple jobs completed. MHP's staff medications an office clerk putting in Dr. orders, a psychiatrist that doesn't pay close attention to medications and many errors are made due to this. Our director has no knowledge of medications which leaves employees wondering where to go for answers and creates confusion. MHP's managing nurses and have no clue of what nurses need/require or can't even answer simple questions. I am very disappointed in the lack of structure at York Adult and problems will continue to get worse until corrected. York Adult also needs medical trained employees at front

desk. Front desk is very unprofessional and this is a horrible example to our clients. Sorry I am late; I really hate to submit such a bad survey.

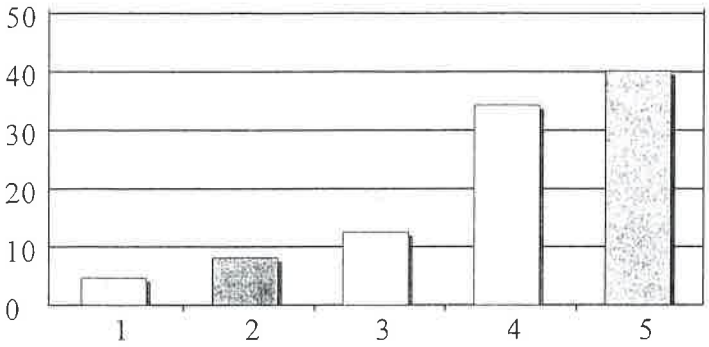
- Staff or MHS activities on weekends.
- Allow me to use gifts I have to utilize the best for my clients. (Art of recovery). Compensate for excellent work production. No raise in 18 years – only small increments everyone received. Use fair, honest, practice instead of staff discrimination for those receiving compensation.
- Major issue – cost of living increase needed! Pay structure too high for certain people and not for others who do same type of work!!!

2008 Employee Satisfaction Survey

SC Departement of Mental Health
2008 Employee Satisfaction Survey

Creation Date: 8/12/2008
Time Interval: 7/31/2008 to 8/12/2008
Total Respondents: 996

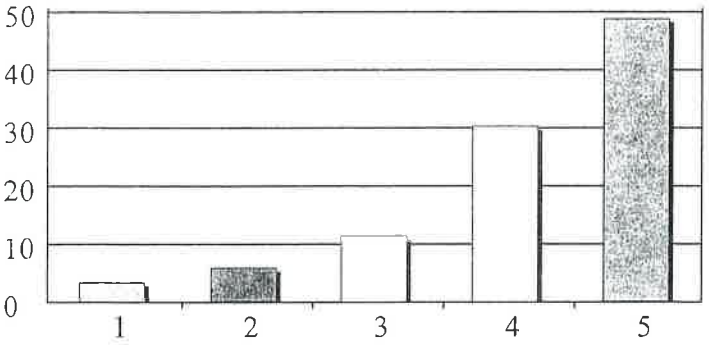
1. My supervisor recognizes contributions that I make to the organization



1. Strongly Disagree	47	5%
2. Disagree	81	8%
3. Neutral	124	13%
4. Agree	339	34%
5. Strongly Agree	397	40%
Total Responses:	988	

Mean: 3.97 Standard Deviation: 1.13

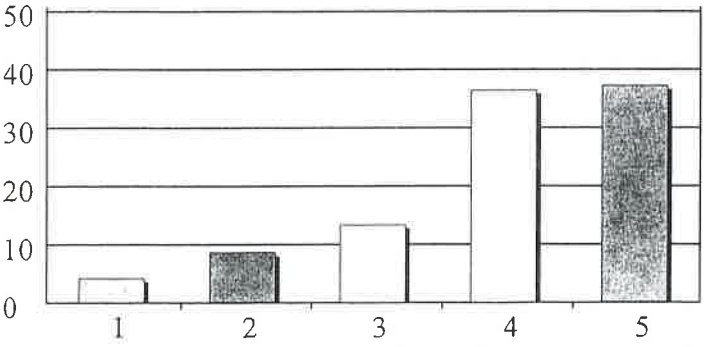
2. My supervisor treats me with dignity and respect



1. Strongly Disagree	34	3%
2. Disagree	59	6%
3. Neutral	113	11%
4. Agree	300	30%
5. Strongly Agree	484	49%
Total Responses:	990	

Mean: 4.15 Standard Deviation: 1.06

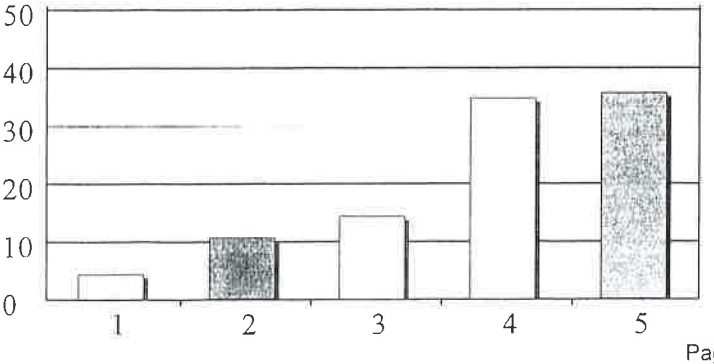
3. My supervisor gives me useful feedback on my performance



1. Strongly Disagree	42	4%
2. Disagree	86	9%
3. Neutral	132	13%
4. Agree	361	36%
5. Strongly Agree	369	37%
Total Responses:	990	

Mean: 3.94 Standard Deviation: 1.11

4. My supervisor gives me timely feedback on my performance

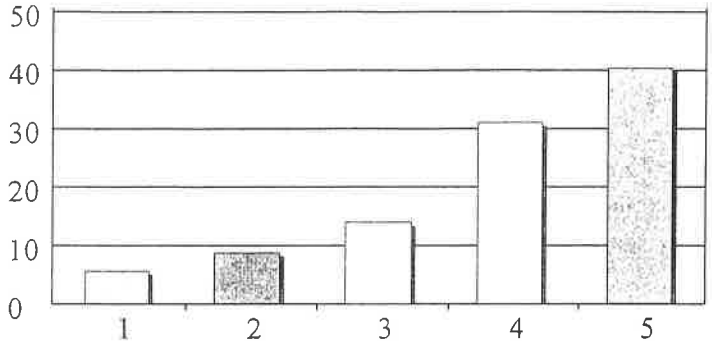


1. Strongly Disagree	44	4%
2. Disagree	106	11%
3. Neutral	142	14%
4. Agree	343	35%
5. Strongly Agree	352	36%
Total Responses:	987	

Mean: 3.86 Standard Deviation: 1.15

SC Departement of Mental Health
2008 Employee Satisfaction Survey

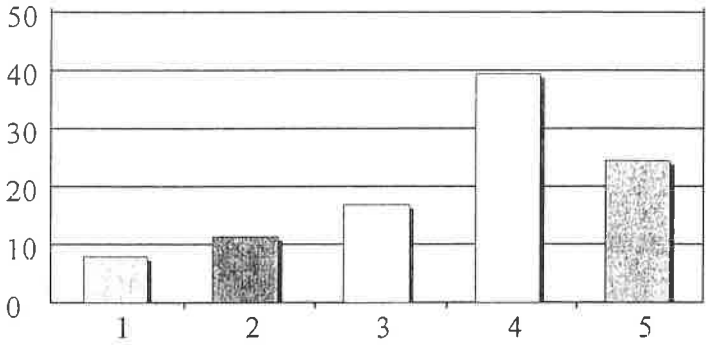
5. My supervisor values my input



1. Strongly Disagree	56	6%
2. Disagree	87	9%
3. Neutral	138	14%
4. Agree	306	31%
5. Strongly Agree	398	40%
Total Responses:	985	

Mean: 3.92 Standard Deviation: 1.18

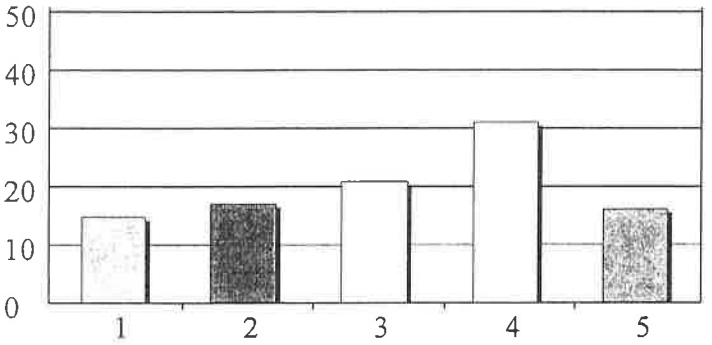
6. The leadership of this organization sets a high standard of performance



1. Strongly Disagree	78	8%
2. Disagree	112	11%
3. Neutral	166	17%
4. Agree	388	39%
5. Strongly Agree	241	24%
Total Responses:	985	

Mean: 3.61 Standard Deviation: 1.20

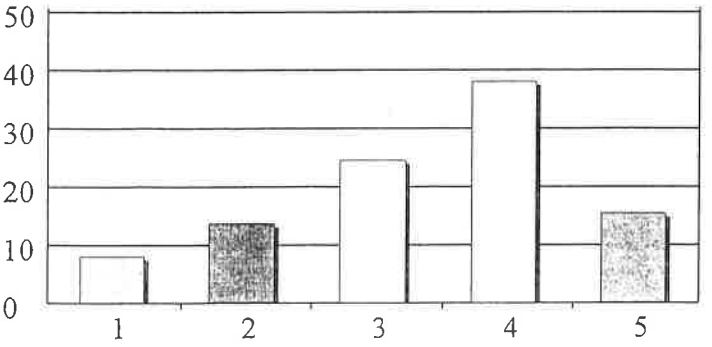
7. The leadership of this organization communicates effectively with its employees



1. Strongly Disagree	146	15%
2. Disagree	168	17%
3. Neutral	206	21%
4. Agree	306	31%
5. Strongly Agree	159	16%
Total Responses:	985	

Mean: 3.17 Standard Deviation: 1.30

8. The leadership of the Department has developed and effectively communicated its vision for the Department.

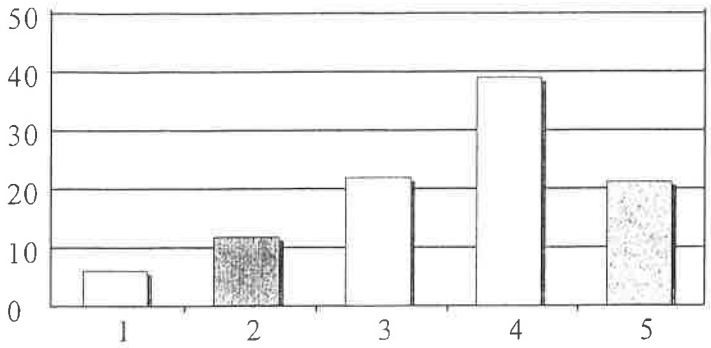


1. Strongly Disagree	80	8%
2. Disagree	136	14%
3. Neutral	243	25%
4. Agree	376	38%
5. Strongly Agree	153	15%
Total Responses:	988	

Mean: 3.39 Standard Deviation: 1.14

SC Departement of Mental Health
2008 Employee Satisfaction Survey

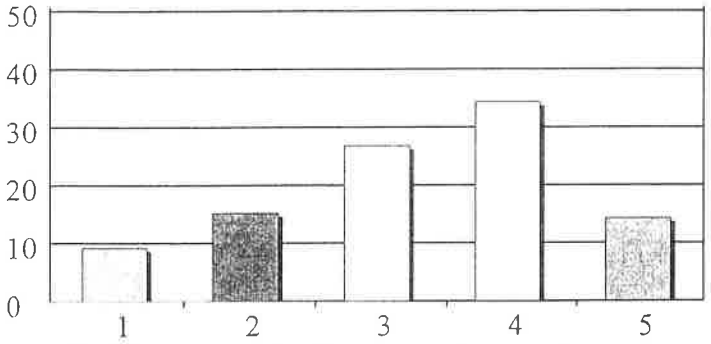
9. The leadership of the Department sets a high standard of performance



1. Strongly Disagree	60	6%
2. Disagree	117	12%
3. Neutral	216	22%
4. Agree	384	39%
5. Strongly Agree	209	21%
Total Responses:	986	

Mean: 3.57 Standard Deviation: 1.13

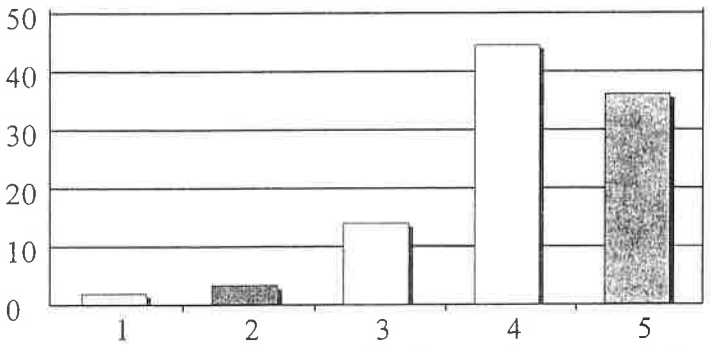
10. The leadership of the Department has created an effective organizational structure



1. Strongly Disagree	91	9%
2. Disagree	150	15%
3. Neutral	264	27%
4. Agree	338	34%
5. Strongly Agree	141	14%
Total Responses:	984	

Mean: 3.29 Standard Deviation: 1.16

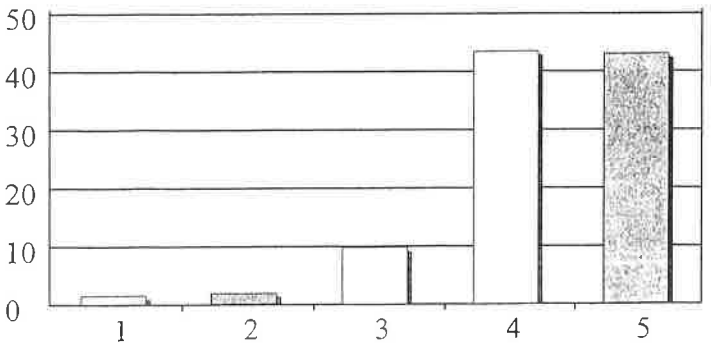
11. I feel that my work efforts contribute to the mission of the Department



1. Strongly Disagree	19	2%
2. Disagree	33	3%
3. Neutral	137	14%
4. Agree	436	45%
5. Strongly Agree	354	36%
Total Responses:	979	

Mean: 4.10 Standard Deviation: 0.90

12. I value the relationships that I have developed with others in the organization

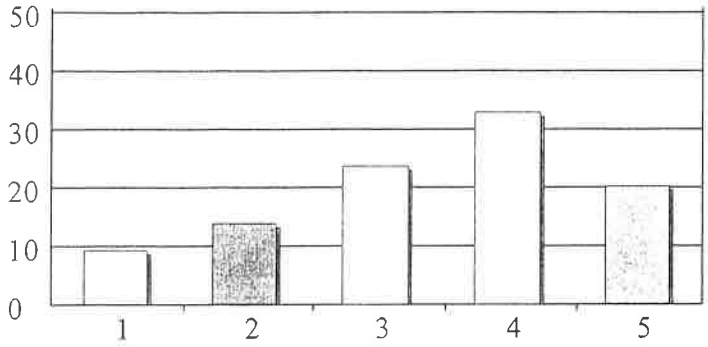


1. Strongly Disagree	16	2%
2. Disagree	20	2%
3. Neutral	97	10%
4. Agree	431	43%
5. Strongly Agree	427	43%
Total Responses:	991	

Mean: 4.24 Standard Deviation: 0.83

SC Departement of Mental Health
2008 Employee Satisfaction Survey

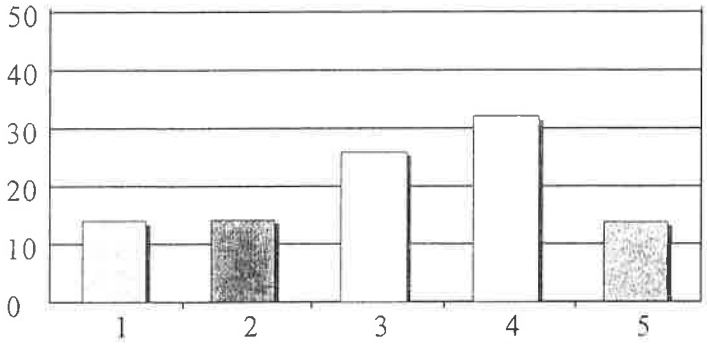
13. Being in this organization is like being part of a family



1. Strongly Disagree	92	9%
2. Disagree	137	14%
3. Neutral	233	24%
4. Agree	324	33%
5. Strongly Agree	200	20%
Total Responses:	986	

Mean: 3.41 Standard Deviation: 1.22

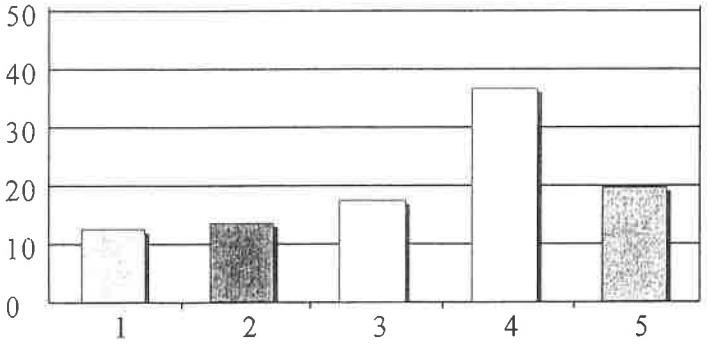
14. People in this organization look out for one another



1. Strongly Disagree	137	14%
2. Disagree	139	14%
3. Neutral	253	26%
4. Agree	314	32%
5. Strongly Agree	135	14%
Total Responses:	978	

Mean: 3.17 Standard Deviation: 1.24

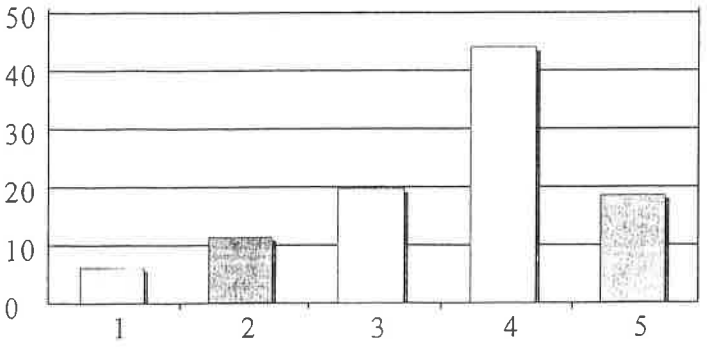
15. The benefits I receive as a state employee are an incentive to remain employed by state government



1. Strongly Disagree	124	13%
2. Disagree	134	14%
3. Neutral	172	17%
4. Agree	361	37%
5. Strongly Agree	194	20%
Total Responses:	985	

Mean: 3.37 Standard Deviation: 1.29

16. My job provides me with an opportunity to learn and grow professionally

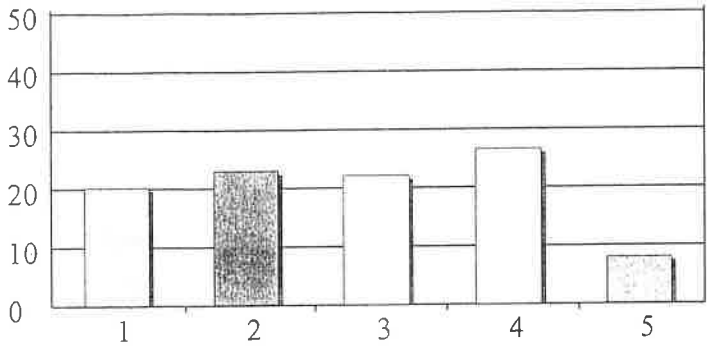


1. Strongly Disagree	61	6%
2. Disagree	113	11%
3. Neutral	195	20%
4. Agree	436	44%
5. Strongly Agree	184	19%
Total Responses:	989	

Mean: 3.58 Standard Deviation: 1.10

SC Departement of Mental Health
2008 Employee Satisfaction Survey

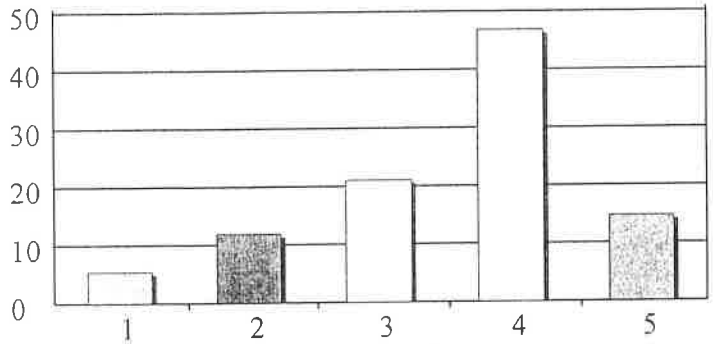
17. The Department provides opportunity for promotions and/or advancement



1. Strongly Disagree	200	20%
2. Disagree	227	23%
3. Neutral	218	22%
4. Agree	262	27%
5. Strongly Agree	79	8%
Total Responses:	986	

Mean: 2.79 Standard Deviation: 1.26

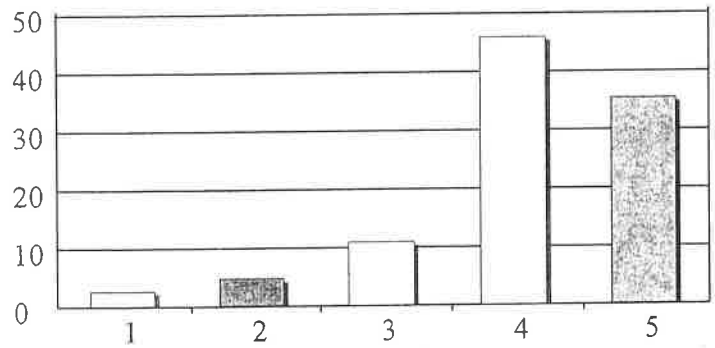
18. I am given adequate training to do my job



1. Strongly Disagree	54	5%
2. Disagree	117	12%
3. Neutral	207	21%
4. Agree	460	47%
5. Strongly Agree	145	15%
Total Responses:	983	

Mean: 3.53 Standard Deviation: 1.05

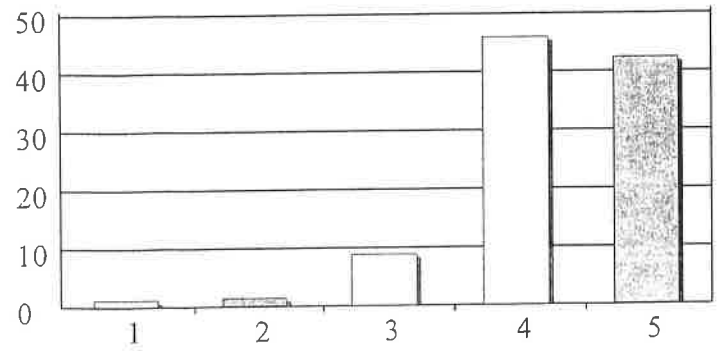
19. My job provides me with challenging work to do



1. Strongly Disagree	27	3%
2. Disagree	48	5%
3. Neutral	109	11%
4. Agree	457	46%
5. Strongly Agree	353	36%
Total Responses:	994	

Mean: 4.07 Standard Deviation: 0.95

20. I enjoy the type of work that I do here

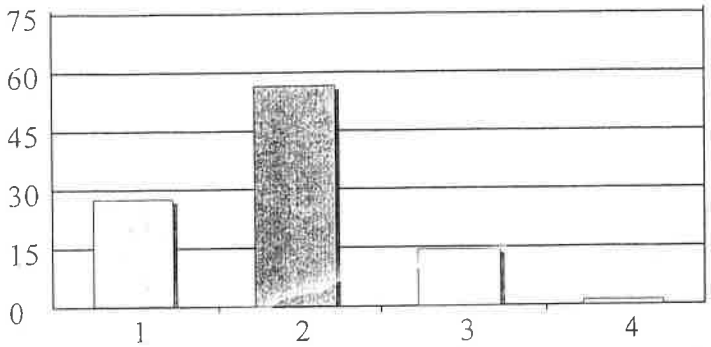


1. Strongly Disagree	12	1%
2. Disagree	15	2%
3. Neutral	87	9%
4. Agree	452	46%
5. Strongly Agree	417	42%
Total Responses:	983	

Mean: 4.27 Standard Deviation: 0.78

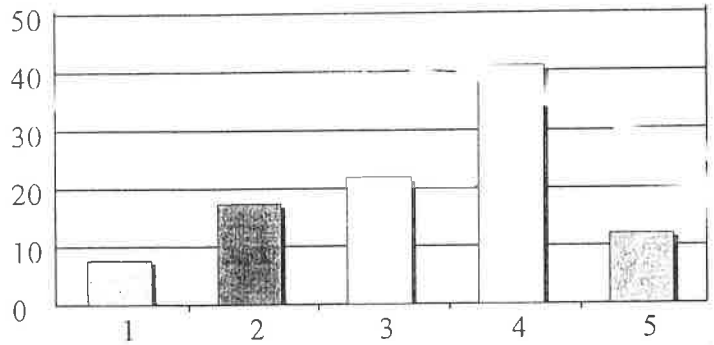
SC Departement of Mental Health
2008 Employee Satisfaction Survey

21. My workload here is (check one):



1. Too much for one person	271	28%
2. Occasionally heavy, but about right on most d...	554	57%
3. Just right-not over or under worked	141	14%
4. Not enough-did not fully use my time	13	1%
Total Responses:	979	

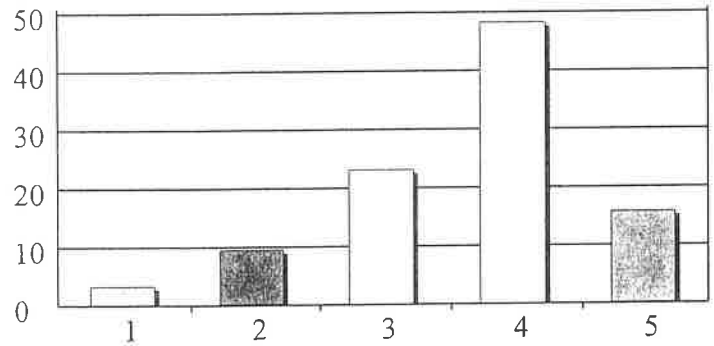
22. The Department sees to it that I have the resources I need to do my job



1. Strongly Disagree	76	8%
2. Disagree	171	17%
3. Neutral	215	22%
4. Agree	402	41%
5. Strongly Agree	119	12%
Total Responses	983	

Mean: 3.32 Standard Deviation: 1.13

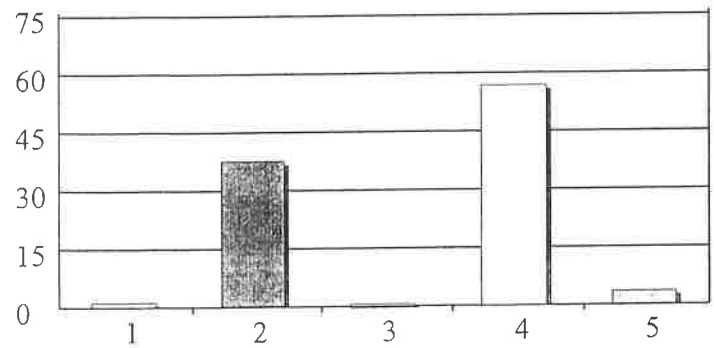
23. What is your overall level of satisfaction with your job



1. Very Dissatisfied	32	3%
2. Dissatisfied	92	10%
3. Neutral	223	23%
4. Satisfied	466	48%
5. Very Satisfied	153	16%
Total Responses:	966	

Mean: 3.64 Standard Deviation: 0.97

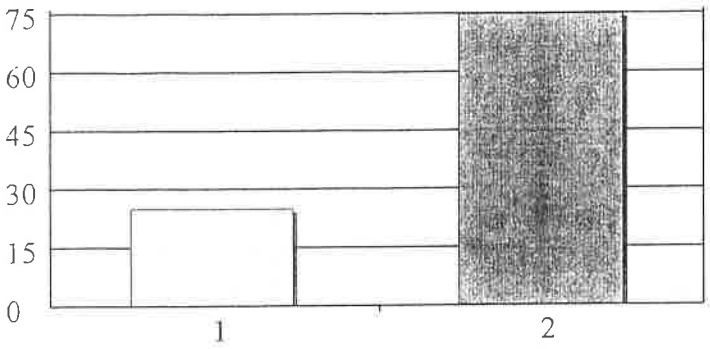
24. My race (check one)



1. Asian	12	1%
2. Black	329	38%
3. Hispanic	5	1%
4. White	496	57%
5. Other	31	4%
Total Responses:	873	

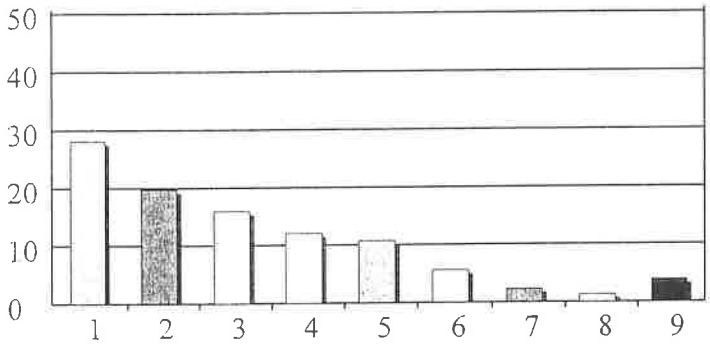
SC Departement of Mental Health
2008 Employee Satisfaction Survey

25. My gender is



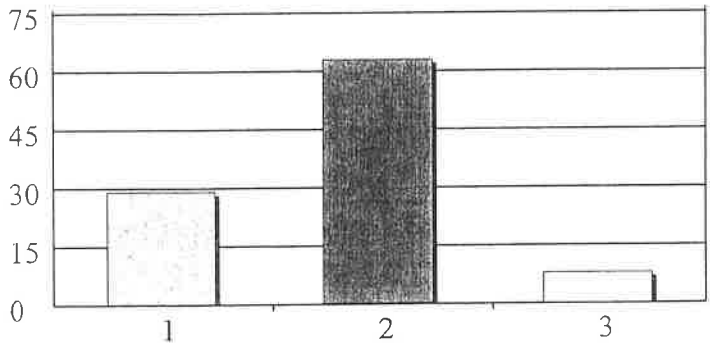
1. Male	208	25%
2. Female	623	75%
Total Responses:	831	
Mean: 1.75 Standard Deviation: 0.43		

26. The number of years of state service I have



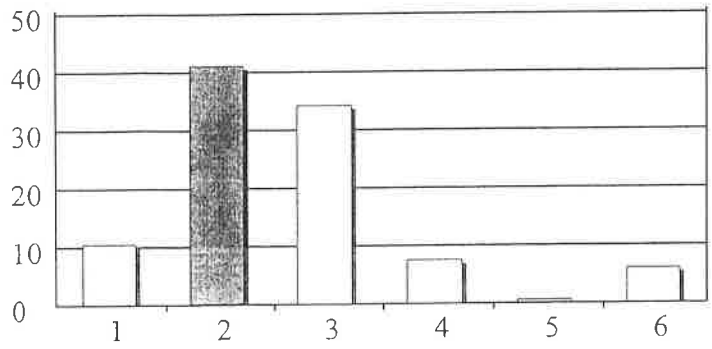
1. 1-5	253	28%
2. 6-10	178	20%
3. 11-15	144	16%
4. 16-20	109	12%
5. 21-25	97	11%
6. 26-30	51	6%
7. 28 TERI	21	2%
8. 30-NON TERI	12	1%
9. 30-TERI	35	4%
Total Responses:	900	

27. I work in a



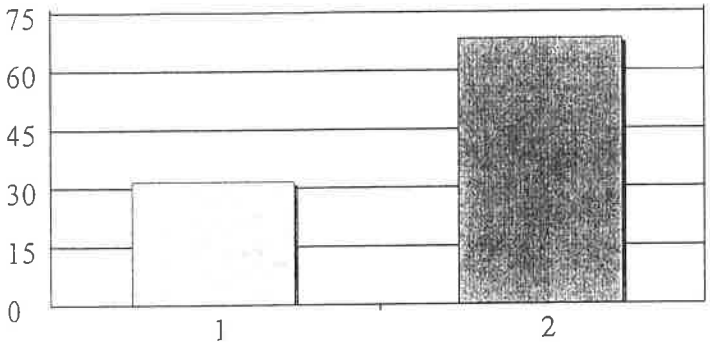
1. Inpatient Facility	259	29%
2. Community Mental Health Center	561	63%
3. Division of the Central Office	70	8%
Total Responses:	890	

28. My pay band is



1. 01-02	70	11%
2. 03-04	274	41%
3. 05-06	228	34%
4. 07-08	50	8%
5. 09-10	4	1%
6. Unclassified	40	6%
Total Responses:	666	

29. I supervise one or more employees



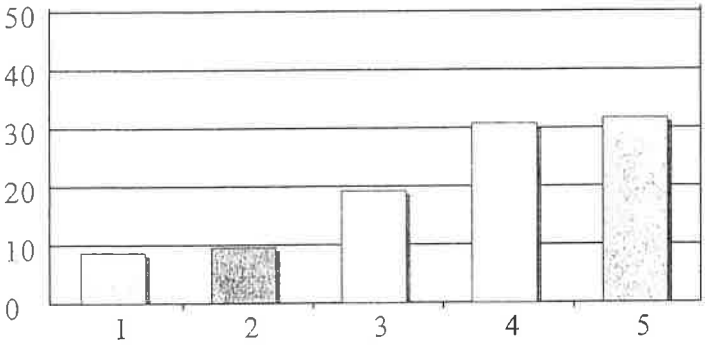
1. Yes	282	32%
2 No	607	68%
Total Responses:	889	

Mean: 1.68 Standard Deviation: 0.47

SC Department of Mental Health
2008 Employee Satisfaction Survey
Unmarked Work Area

Creation Date: 8/21/2008
Time Interval: 8/21/2008 to 8/21/2008
Total Respondents: 105

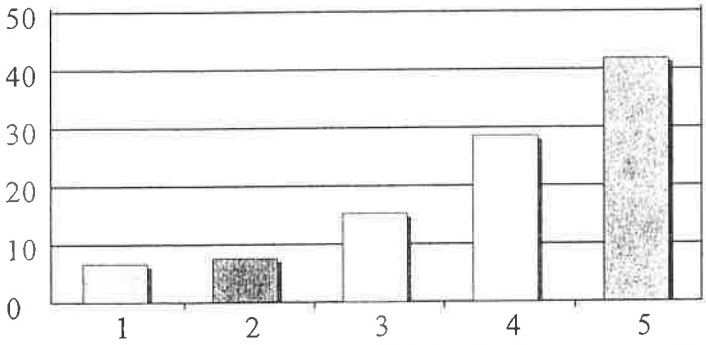
1. My supervisor recognizes contributions that I make to the organization



1. Strongly Disagree	9	9%
2. Disagree	10	10%
3. Neutral	20	19%
4. Agree	32	31%
5. Strongly Agree	33	32%
Total Responses:	104	

Mean: 3.67 Standard Deviation: 1.26

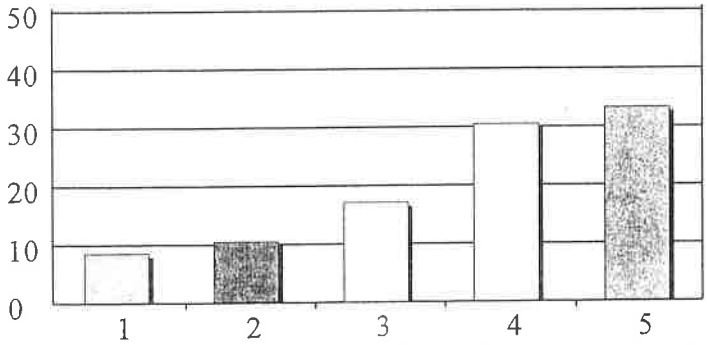
2. My supervisor treats me with dignity and respect



1. Strongly Disagree	7	7%
2. Disagree	8	8%
3. Neutral	16	15%
4. Agree	30	29%
5. Strongly Agree	44	42%
Total Responses:	105	

Mean: 3.91 Standard Deviation: 1.22

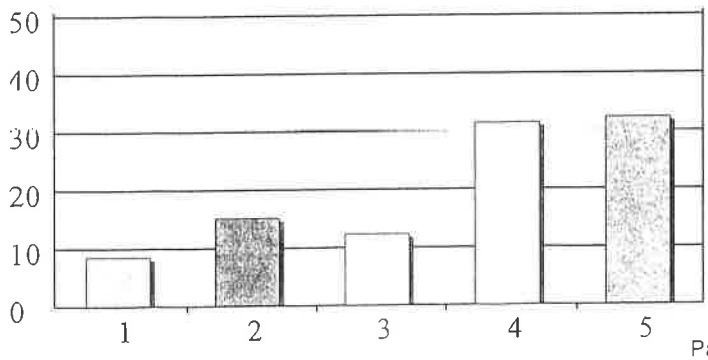
3. My supervisor gives me useful feedback on my performance



1. Strongly Disagree	9	9%
2. Disagree	11	10%
3. Neutral	18	17%
4. Agree	32	30%
5. Strongly Agree	35	33%
Total Responses:	105	

Mean: 3.70 Standard Deviation: 1.27

4. My supervisor gives me timely feedback on my performance

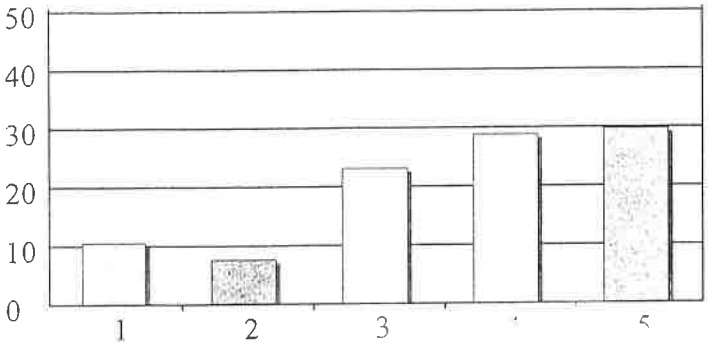


1. Strongly Disagree	9	9%
2. Disagree	16	15%
3. Neutral	13	12%
4. Agree	33	31%
5. Strongly Agree	34	32%
Total Responses:	105	

Mean: 3.64 Standard Deviation: 1.31

SC Department of Mental Health
2008 Employee Satisfaction Survey
Unmarked Work Area

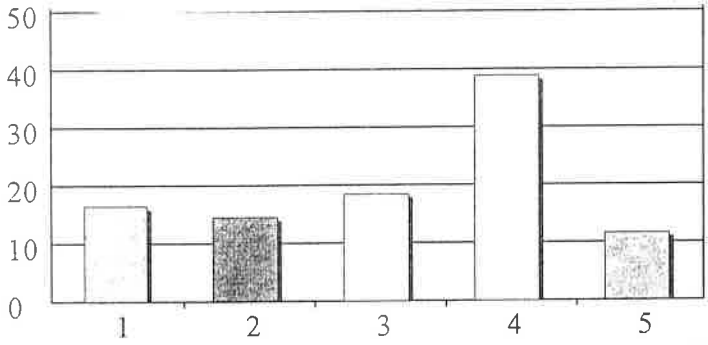
5. My supervisor values my input



1. Strongly Disagree	11	11%
2. Disagree	8	8%
3. Neutral	24	23%
4. Agree	30	29%
5. Strongly Agree	31	30%
Total Responses:	104	

Mean: 3.60 Standard Deviation: 1.28

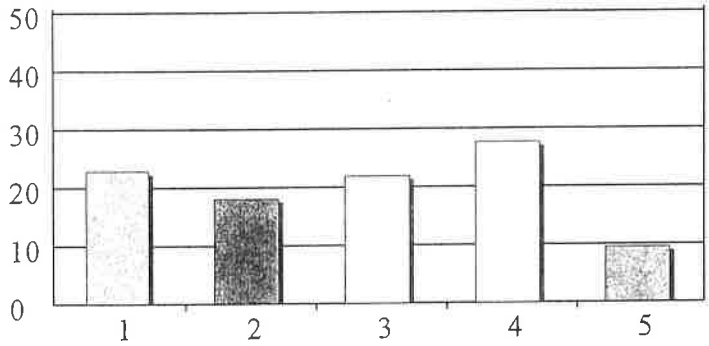
6. The leadership of this organization sets a high standard of performance



1. Strongly Disagree	17	17%
2. Disagree	15	15%
3. Neutral	19	18%
4. Agree	40	39%
5. Strongly Agree	12	12%
Total Responses:	103	

Mean: 3.15 Standard Deviation: 1.29

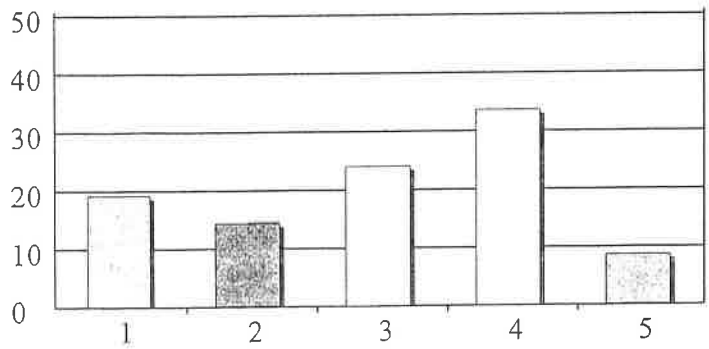
7. The leadership of this organization communicates effectively with its employees



1. Strongly Disagree	24	23%
2. Disagree	19	18%
3. Neutral	23	22%
4. Agree	29	28%
5. Strongly Agree	10	10%
Total Responses:	105	

Mean: 2.83 Standard Deviation: 1.32

8. The leadership of the Department has developed and effectively communicated its vision for the Department.

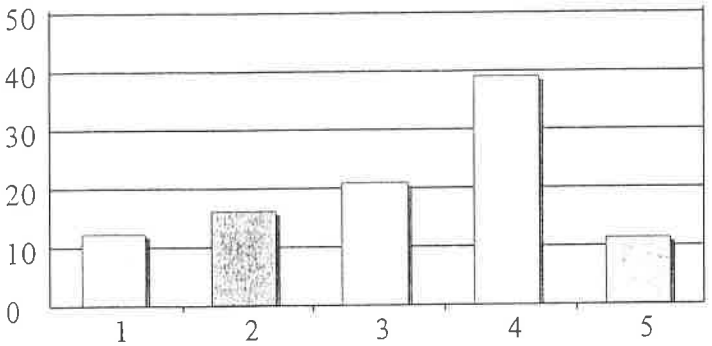


1. Strongly Disagree	20	19%
2. Disagree	15	14%
3. Neutral	25	24%
4. Agree	35	34%
5. Strongly Agree	9	9%
Total Responses:	104	

Mean: 2.98 Standard Deviation: 1.27

SC Department of Mental Health
2008 Employee Satisfaction Survey
Unmarked Work Area

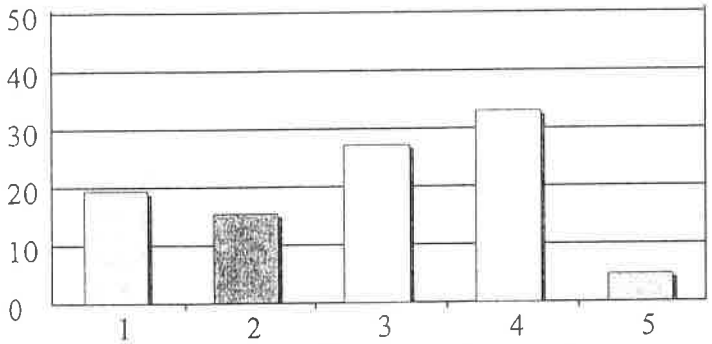
9. The leadership of the Department sets a high standard of performance



1. Strongly Disagree	13	12%
2. Disagree	17	16%
3. Neutral	22	21%
4. Agree	41	39%
5. Strongly Agree	12	11%
Total Responses:	105	

Mean: 3.21 Standard Deviation: 1.21

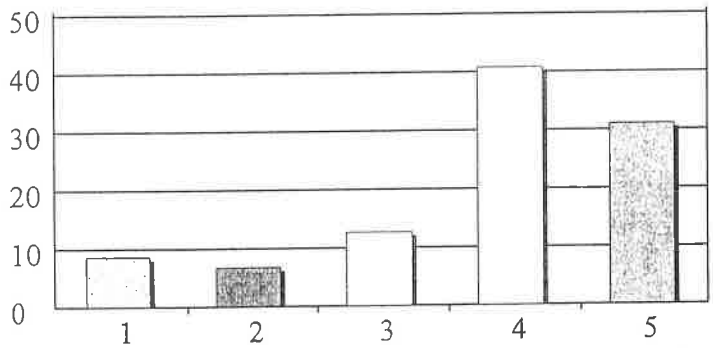
10. The leadership of the Department has created an effective organizational structure



1. Strongly Disagree	20	19%
2. Disagree	16	16%
3. Neutral	28	27%
4. Agree	34	33%
5. Strongly Agree	5	5%
Total Responses:	103	

Mean: 2.88 Standard Deviation: 1.21

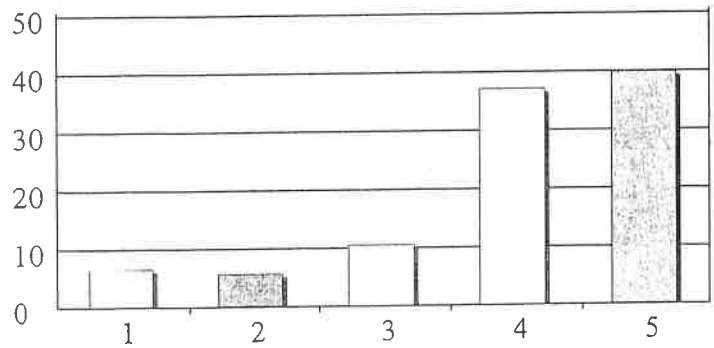
11. I feel that my work efforts contribute to the mission of the Department



1. Strongly Disagree	9	9%
2. Disagree	7	7%
3. Neutral	13	13%
4. Agree	42	41%
5. Strongly Agree	32	31%
Total Responses:	103	

Mean: 3.79 Standard Deviation: 1.21

12. I value the relationships that I have developed with others in the organization



1. Strongly Disagree	7	7%
2. Disagree	6	6%
3. Neutral	11	10%
4. Agree	39	37%
5. Strongly Agree	42	40%
Total Responses:	105	

Mean: 3.98 Standard Deviation: 1.16

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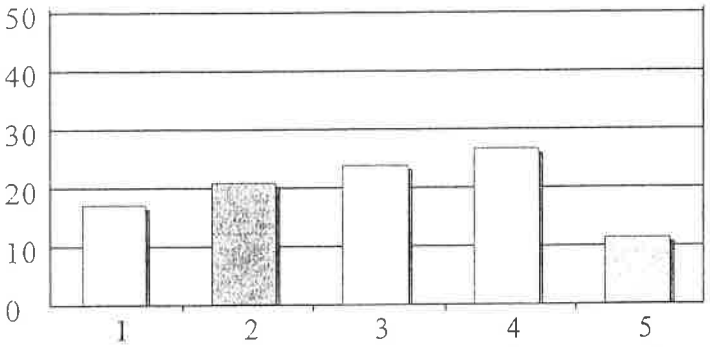
Unmarked Work Area

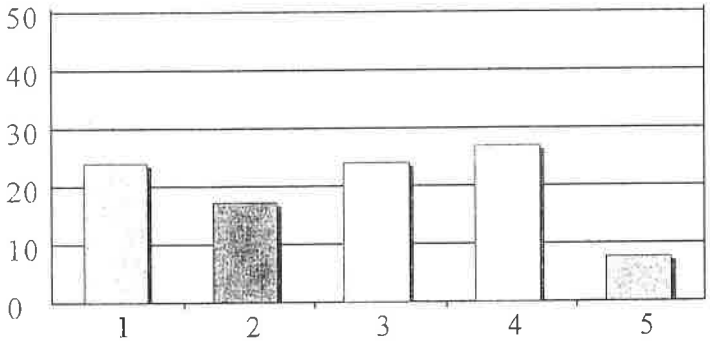
13. Being in this organization is like being part of a family



1. Strongly Disagree	18	17%
2. Disagree	22	21%
3. Neutral	25	24%
4. Agree	28	27%
5. Strongly Agree	12	11%
Total Responses:	105	

Mean: 2.94 Standard Deviation: 1.28

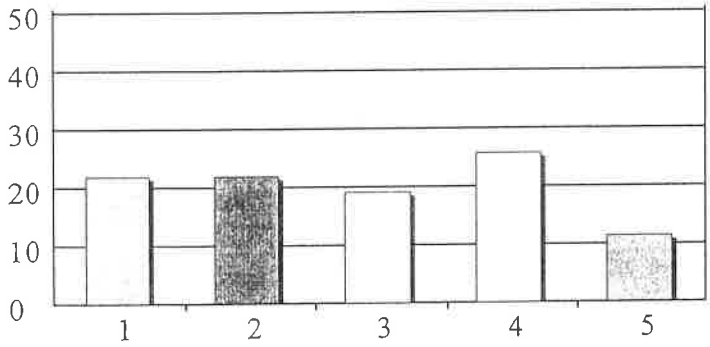
14. People in this organization look out for one another



1. Strongly Disagree	25	24%
2. Disagree	18	17%
3. Neutral	25	24%
4. Agree	28	27%
5. Strongly Agree	8	8%
Total Responses:	104	

Mean: 2.77 Standard Deviation: 1.29

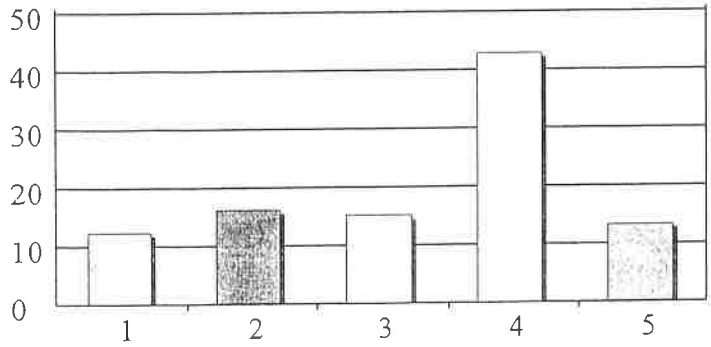
15. The benefits I receive as a state employee are an incentive to remain employed by state government



1. Strongly Disagree	23	22%
2. Disagree	23	22%
3. Neutral	20	19%
4. Agree	27	26%
5. Strongly Agree	12	11%
Total Responses:	105	

Mean: 2.83 Standard Deviation: 1.34

16. My job provides me with an opportunity to learn and grow professionally

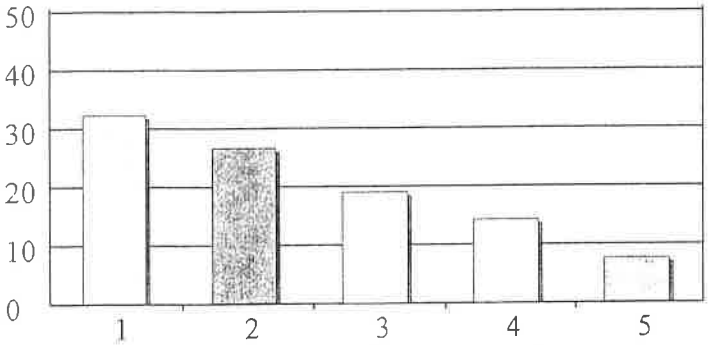


1. Strongly Disagree	13	12%
2. Disagree	17	16%
3. Neutral	16	15%
4. Agree	45	43%
5. Strongly Agree	14	13%
Total Responses:	105	

Mean: 3.29 Standard Deviation: 1.25

SC Department of Mental Health
2008 Employee Satisfaction Survey
Unmarked Work Area

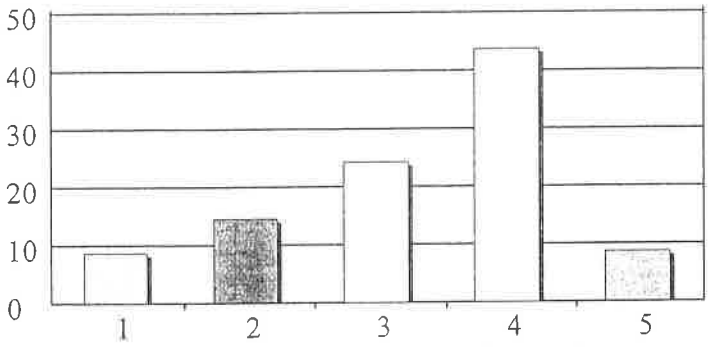
17. The Department provides opportunity for promotions and/or advancement



1. Strongly Disagree	34	32%
2. Disagree	28	27%
3. Neutral	20	19%
4. Agree	15	14%
5. Strongly Agree	8	8%
Total Responses:	105	

Mean: 2.38 Standard Deviation: 1.28

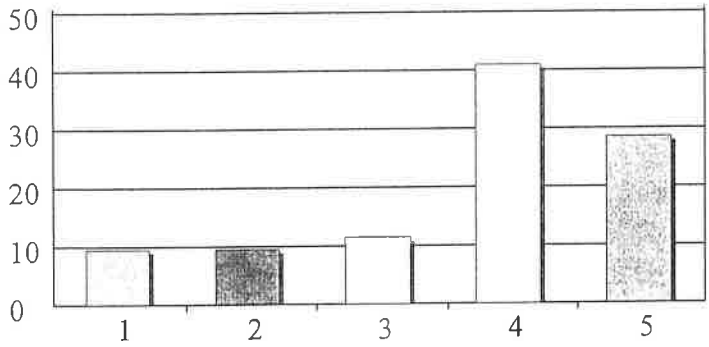
18. I am given adequate training to do my job



1. Strongly Disagree	9	9%
2. Disagree	15	15%
3. Neutral	25	24%
4. Agree	45	44%
5. Strongly Agree	9	9%
Total Responses:	103	

Mean: 3.29 Standard Deviation: 1.10

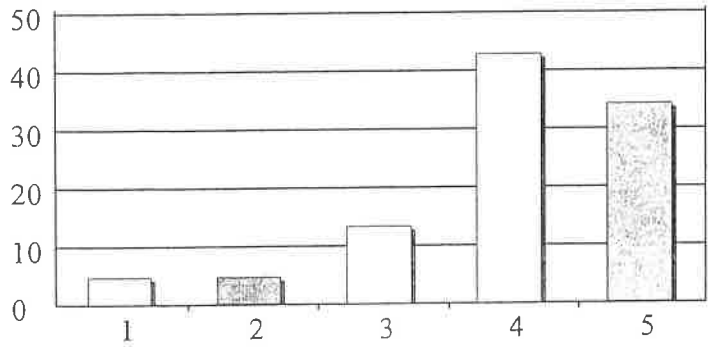
19. My job provides me with challenging work to do



1. Strongly Disagree	10	10%
2. Disagree	10	10%
3. Neutral	12	11%
4. Agree	43	41%
5. Strongly Agree	30	29%
Total Responses:	105	

Mean: 3.70 Standard Deviation: 1.25

20. I enjoy the type of work that I do here

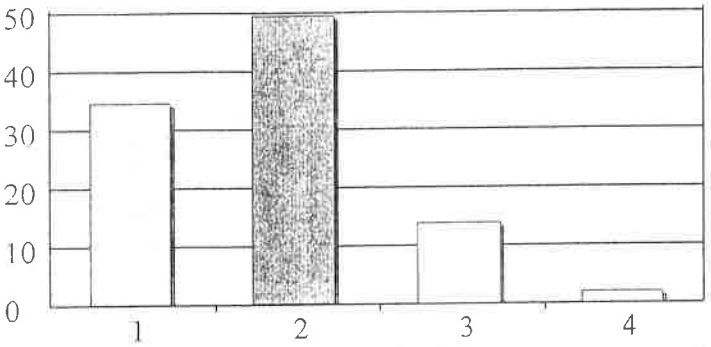


1. Strongly Disagree	5	5%
2. Disagree	5	5%
3. Neutral	14	13%
4. Agree	45	43%
5. Strongly Agree	36	34%
Total Responses:	105	

Mean: 3.97 Standard Deviation: 1.05

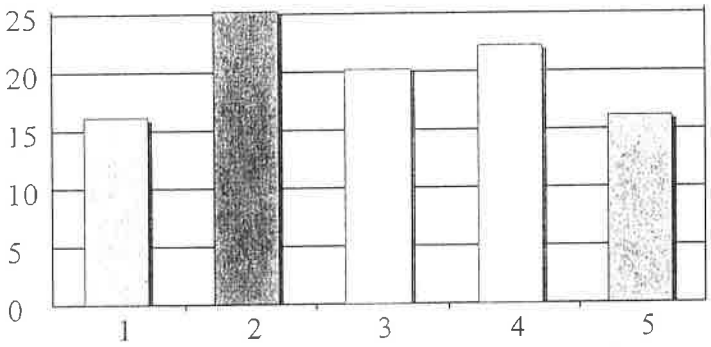
SC Department of Mental Health
2008 Employee Satisfaction Survey
Unmarked Work Area

21. My workload here is (check one):



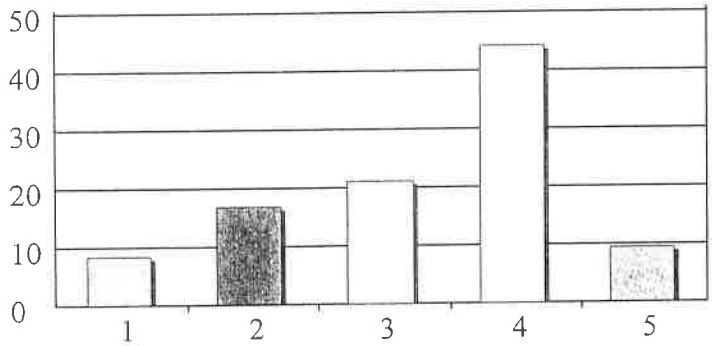
1. Too much for one person	35	35%
2. Occasionally heavy, but about right on most d...	50	50%
3. Just right-not over or under worked	14	14%
4. Not enough-did not fully use my time	2	2%
Total Responses:	101	

22. The Department sees to it that I have the resources I need to do my job



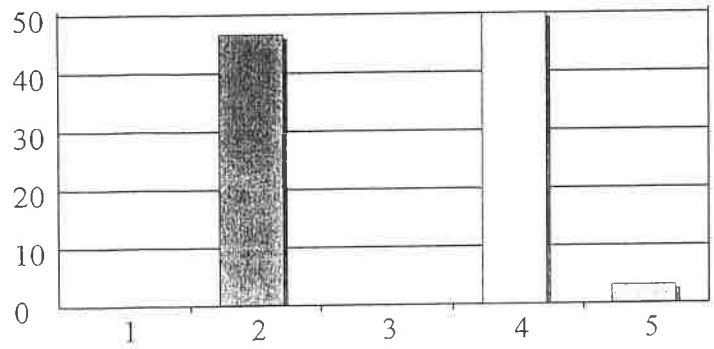
1. Strongly Disagree	16	16%
2. Disagree	25	25%
3. Neutral	20	20%
4. Agree	22	22%
5. Strongly Agree	16	16%
Total Responses:	99	
Mean: 2.97 Standard Deviation: 1.34		

23. What is your overall level of satisfaction with your job



1. Very Dissatisfied	8	8%
2. Dissatisfied	16	17%
3. Neutral	20	21%
4. Satisfied	42	44%
5. Very Satisfied	9	9%
Total Responses:	95	
Mean: 3.29 Standard Deviation: 1.12		

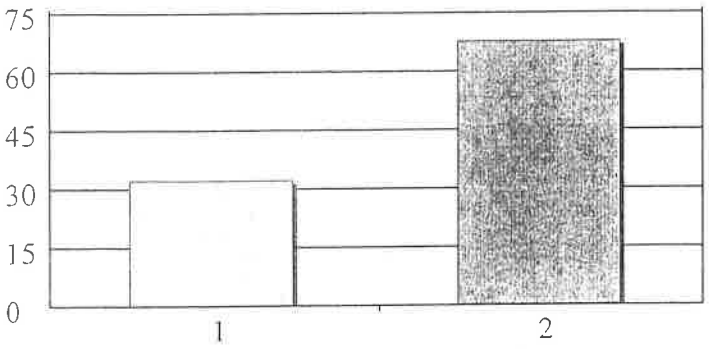
24. My race (check one)



1. Asian	0	0%
2. Black	14	47%
3. Hispanic	0	0%
4. White	15	50%
5. Other	1	3%
Total Responses:	30	

SC Department of Mental Health
2008 Employee Satisfaction Survey
Unmarked Work Area

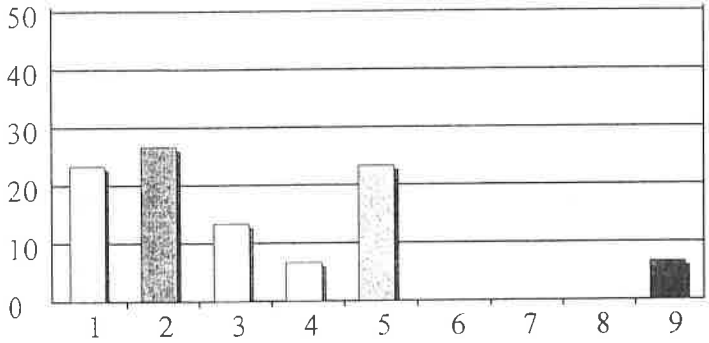
25. My gender is



1. Male	10	32%
2. Female	21	68%
Total Responses:	31	

Mean: 1.68 Standard Deviation: 0.48

26. The number of years of state service I have

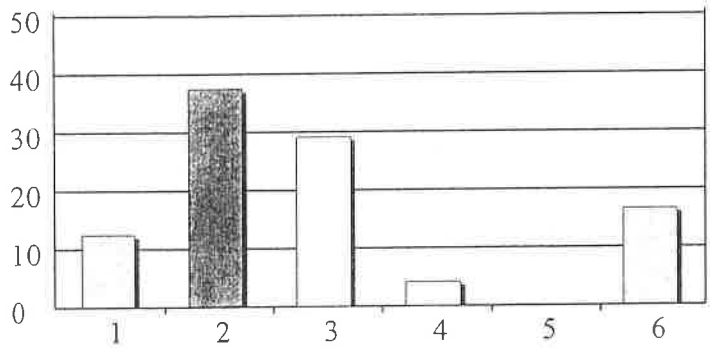


1. 1-5	7	23%
2. 6-10	8	27%
3. 11-15	4	13%
4. 16-20	2	7%
5. 21-25	7	23%
6. 26-30	0	0%
7. 28 TERI	0	0%
8. 30-NON TERI	0	0%
9. 30-TERI	2	7%
Total Responses:	30	

27. I work in a

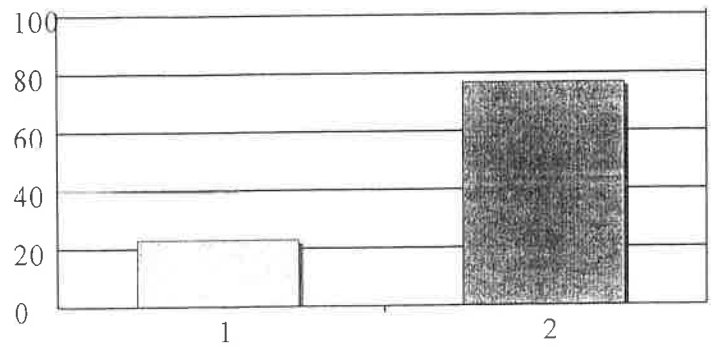
There are no responses to this question.

28. My pay band is



1. 01-02	3	12%
2. 03-04	9	38%
3. 05-06	7	29%
4. 07-08	1	4%
5. 09-10	0	0%
6. Unclassified	4	17%
Total Responses:	24	

29. I supervise one or more employees



1. Yes	9	23%
2. No	30	77%
Total Responses:	39	

Mean: 1.77 Standard Deviation: 0.43

SC Department of Mental Health
2008 Employee Satisfaction Survey
Comment Report

23. What can the Department do to improve your work environment?

- Provide supportive leadership. Provide adequate resources to reach the level of service to which the department aspires.
- I feel that the department could start by providing voice mail to each and every employee. Provide compressed work weeks due to gas prices with the option of having Friday or Monday off. Provide a pay performance policy. Provide keys to every employee to enter the building. Implement a career path program. Better communication with Directors of Departments.
- Complete renovations. Increase in salary for additional education (Masters Degree)
- It has become just a job since October 07. Have some person to go to with problems, supervisor none or no support at all with any problem. Fix yourself or lose job. Please send memo to all employees on who we may go to, not only my problems.
- Increase work environment (furniture, desks, chairs) (ours & clients). Improve ventilation, improve parking (Ha! Ha!). Our computer access is negative more than accessible, so can't access CIS or email or in-services, etc. Keeping up with audits/medical records/paperwork is mind boggling at times. Activities are steadily increasing and nsg shortage is increasing. Our equipment (hole punchers, tape dispensers, pens, camera to take client or ID to avoid med errors) we order supplies (medicine & toiletries and at times, its several weeks before we receive them. Our work space is limited. We don't have adequate way to have client enter here on admission and not over stimulated and/or? Not overwhelmed and/or? Not depersonalized due to our cramped area. The entrance way, one assessment area being major staff are/kitchen/workroom/med room, etc.
- Not let people take advantage of others in their department by using unfair leave time and unfinished work.
- Hire more officers
- Promote raises for employees at the same time and also give raises to employees with other skills contributing to his position.
- Give more teeth to EPMS. Give supervisors support needed to enforce department directives.
- Do drug test on all employees. Up education requirements for CNAS to high school diploma.
- Better scheduling so MD's are able to attend staffing meetings at all places they are working in order to keep building relationships and improve how they operate.
- Give the ones that do their job and others job more money. The cost of living has gone up and up but our pay checks have not. This is not fair or right.
- Computer upgrades – pay upgrades.
- Improve lines of communications. Clarify organizational structure, responsibility, decision making path, need greatly improved professional courtesy and common courtesy.
- I would like to know why everyone can't have access to the computers. Everyone must use them for training.
- The department needs to increase pay or pay the employees every two weeks. This will help improve the work environment.
  Provide better training.
- Create more opportunity for advancement/salary increases; get holidays as those at the center, have charts.
- Provide more security for safety.
- My work environment is satisfactory.
- Need more harmony in the work place.

- Employee building (team building) exercises – i.e. retreats, conferences, etc. Productivity, Medicaid standards and billing procedure alignment reasonable expectations for each department by caseload or population demand. State trainings for new department leaders on goals and expectations, leadership training.
- Hire a new IT person or assistant who can get the job done in a timely manner, LMHC.
- Need more money and less stress.
- The department can evaluate my performance work load and progress (work habits, attendance, etc) and promote accordingly. Salary too low for job duties. More retreats for staff.
- Train supervisors to do their job.
- By being fair when there is a change in the staff's credentials. This organization seems to not recognize these things. They could do so by monetary or promotional rewards.
- A well lighted parking lot during the night and PSO during the 3-11 and 11-7 shift at the parking lot, scary.
- More computers, more salary better working relationships.
- Provide recognition (productivity time?) for non-billable services, e.g. work with families that's not billable as targeted case management on out reach (phone calls, home visits) to get clients to come in.
- Since 2/08, refers to the more recent transition from Charleston Clinic to Dorchester Clinic at which I have learned and become aware of a lot more and received much better, more effective supervision, then in my 1st two years at the C/CMH. The department needs to go entirely too electronic medical records (training those who need training). The department should also pay more adequately according to experience and job expectations. Having said this the department should pay closer attention to what CM actually do and are actually expected to do, rather than the very simplex, vague job descriptions we are given, and have our pay scales better match the actual jobs we perform on a daily basis within of one job title. This I feel will decrease burnout and turnovers within our dept. Also, as a school-based counselor, I feel the dept. should recognize that legally we are to work on the school schedule. This will decrease the "call outs" and increase effectiveness among the counselors during the school year, not to mention increase productivity (we all feel this way).
- Long term employees need to know they are valued. There should be mandatory training for supervisors, including high level ones on how to treat and interact with employees. Especially those at the department much longer than them. New is not automatically better. New supervisors should be required to have at least a minimal understanding of the jobs their employees perform. The department should consider getting input from subordinates regarding supervisor's performances.
- My center is too "top heavy", there are too many staff in administration. Administration seems poor guided. Instead of seeking creative solutions to common rural problems (transportation), they focus on blaming clinicians. I am honestly trying to present this objectively, as opposed to venting.
- Spend less time nitpicking about issues that are not part of the clinical process like how many people are in the ER waiting for a bed. Work harder to create more beds rather than expecting (centers to get people out of the ER's around the state.
- Nurses and CNA's need better more adequate pay.
- Decrease workload, get new supervisor. Support clinical staff, recognize that MENTAL ILLNESS = MEDICAL!!! I'm sick and tired of Non Medical people running a Medical Department !!! My supervisor, who is an ex therapist x several years said we ARE NOT MEDICAL!
- I know that I do more than what is expected and that satisfies me.
- Please provide results of survey to staff.
- This survey was answered as though I were still in Home share. I have recently changed positions and am significantly more satisfied.
- To appreciate the ones working hard and getting money in here to pay for expenses by giving ones who actually do the work a raise at least 1 @ 2yrs., and not only higher up getting more money. (you don't know the half of it).
- Bring back (at least) merit increases. Improve opportunity for promotions, advancement. Make pay bands more equal across the board.

- A dress code is needed. Better housekeeping and grounds maintenance. Automated telephone system, pay increases for "substantial EPMS". Stop rating EPMS "Substantial" when employee does not deserve it. Stop denying increases when increase is requested for those who do deserve it.
- Concrete ways to show appreciation for good work/more open and clear communication/concerns have been met with loss of temper or no plan to change identified problems. Leadership becomes irrational or angry before knowing true facts. Smoking policy is not being followed. Staff and patients smoke just outside doors and windows, allowing smoke to enter the building causing health issues for those who are allergic to smoke or have respiratory problems. Non smokers are being routinely/daily exposed against their will to smoke. Leadership has been consulted, but has not corrected the problem. Citing it is a central office issue, which is outrageous. DHEC guidelines should be followed by DMH or go to smoke free campuses.
- I am satisfied with my dept at Adult Outpatient. As an overall center I am grossly disappointed. Several vocal employees here at ABMHC were not given a survey to complete. I do not think this was fair unless random selection was done. Our executive director is selfish, untrustworthy and a bully to some employees. We need help here. Please we need trainings on sexual harassment, ethics, consumer rights, and stress management. We need immediate help on ways to improve communication skills and resolve conflict within our center. I use to love my job and my place at employment. Now it's extremely stressful to come to work here even though I still love the consumers.
- With the increase in fuel prices, I feel more community mental health centers would support employee's working a 4 day week. If Mr. Magill would endorse this to agency head. Also, it will be beneficial for the results of this survey to be shared with centers. Additional comments: I feel the short turn around time may impact the results of this survey. Surveys were received by our center on Friday, June 27th, with a return deadline of June 30th, which makes it impossible for many of our out based staff to receive, complete, and return, by the deadline.
- Follow policies/procedures in place. Treat employees with parity/equity. Evaluations at my center were a joke. One supervisor giving out excellent and promotions to those whose charts and work consistently need clean up by others. Another supervisor basing evaluations on personal bias, not knowing the work of their people, judging by personality not performance. When will therapists who work with children/adolescents actually not have to buy all therapy supplies themselves? Regarding question #13, working relationships are in error if modeled after family ones, unhealthy to do so and sets climate for serious errors, poor judgment, incorrect decision making. Maybe this is one problem example: "favorite work relative" promoted rather than a worker who is capable, effective, and good for DMH. #17, Supervisory positions have been filled without advertisement or opportunity. Not allowed to work in this century! I am also not allowed to use my forms, etc on DMH website, told to hand write even though I am fast accurate typist.
- Fair and equal treatment. Honor policies, procedures, documents, etc. Realistic work expectations.
- More respect. Need more bathrooms for staff only. Supervisor who is an advocate not just an administrator. Higher salary, designated parking.
- Improve pay "cost of living" increases do not come close to actual cost of living increase!
- Provide adequate staffing more consistently.
- One of our busy days that we could get some help need for everyone to get along.
- Drug test all employees and hold all employees accountable to the same standards of conduct and performance.
- Provide working communication equipment.
- Have resident's clean rooms weekly as a requirement.
- Purchase vehicles that are safe and reliable. Hire and promote based on effective skill level and performance. Clearly define job duties between divisions and organizational components.
- More pay to officers. Also, be consistent in designated work assignments.
- Increase communication within the department. Get employee feedback on ways that we can use our data and put data out there.

- Get rid of the unstable CMHC exec. Directors.
- Increase access to advanced training and wide range of training opportunities in and outside DMH – e.g. advanced graduate courses. Prepare and train in advance and face to face for important organizational changes. Putting all medical records online. My division had 2-3 weeks notice of having to have to do all med records on line. I had no computer skills, causing great stress. With notice of 3-6 months, I could have taken a computer course. Provide employees with communicate well with employees about current benefits and benefits for retirement. Virtually no written information is readily available about retiree health insurance benefits or TERI program. We no longer have annual meetings to update us on health insurance, etc. Provide psychological evaluations to children in mental health centers by licensed clinical psychologists and licensed school psychologists.
- Hire a secretary.
- More money.
- I'm satisfied with my job, but neither with my pay band nor my salary.
- More staff.
- Incentive raises/raises in general to keep up with economic changes. Rewards for good work. Adequate staffing, less micromanagement.
- The SCDMH Administration (top level) appears to be out of touch with what significant facilities are doing, and certainly the top level needs to communicate on a more on-going level so that everyone feels they know what DMH is doing overall.
- The department can reduce so much unnecessary paper work. Training i.e. Best this can be limited to improve a move/focused area on client/relationships.
- Provide adequate equipment (computers, IT support, desks/chairs that are conducive to less strain on body); provide adequate support for provision of services (including It, front office, admin); truly evaluate the poor pay for clinicians and provide incentives for staying @ DMH once trained and gathered experience!!!
- Look at our center director, totally unsupportive of what we do. Just wants to make money and look good for him.
- Coordinate IT support more effectively.
- Improve communication across the board between clinical and administrative staff. There needs to be more pay raises based on merit. More opportunity for advancing up the pay scale, etc. An IT person at the center who knows the software we use and who can help with software problems.
- Better equipment, computers, and printers.
- Need to be more serious about there job as a supervisor.
- Incentives for exceptional work performance (pay, bonuses, merit increases, recognition)!
- Increase pay, reward hard work with incentives. There's always an excuse not to get a raise. Even though you're receiving constant praise for your performance. Slackers receive same across board (cost of living) raises as hard workers. FRUSTRATING!
- Training (much improvement needed) to perform at my level; given my area of responsibility.
- Provide better pay for the ones who deserve it.
- Less focus on productivity and more focus on quality of cure! More acknowledgements of the many things we do as a part of our jobs that aren't billable!
- Regular pay increases. Promotional opportunities. Value professional skills. Avoid power struggles. Be receptive to suggestions. Better communication and individualized training.
- Give C.N.A.'s more money and bigger raises.
- Help us to work in and around a very healthy and safe environment and always be kind to one another and pull and work together as a team and always let us have more SAP training and any other training pertaining to technology.
- Pay upgrade.
- More help.
- Provide training, provide resources, and provide clinical supervision.

- Hire sufficient staff to do the necessary work.
- Whenever and employee needs resources to work with and don't ever get them is wrong. Whenever an employee get ignored on a job because the equipment that they have is broken and they report it and nothing happens that's wrong and can't get their performance evaluations on time that's wrong.
- Make sure there is adequate staff for ward coverage.
- As a PSO trainee, I feel the department is spending money for my training which is why I feel the department should put more attention on trainee development programs, prep classes for the CJA and some performance oriented training to insure a successfully completion and financial loss.
- Offer us a raise due to the current gas and overall living standards I believe we are entitled to more than 1% and better choices for health insurance.
- Reclass positions, for more money/get more help and better communications.
- Treat employees as humans, not their dogs. Send all 10 or 12 retirees home so we might get an up grade. (Buddy, Buddy) Get us work trucks with AIC. Management won't drive the junk we have. Stop painting in PPS building. OHSP and DHEC would have a field day with fines. & smoking. 4 day work week. I like my job but the management is the worst I have ever worked for. Because I am not in their Buddy Buddy system they have nothing to do with those who are not.
- Give individuals a raise periodically on their performance, not just the once a year cost of living raise. It is a shame that new employees can come in making just as much as someone who has been here for 20 years in the same position. A survey needs to be taken on who it getting raises and who is not. Because raises and bonuses are being given to certain people! Do a survey on when someone last received and internal raise or bonus. You will see that some people are getting them, when others are not. Some directors and supervisors are only concerned with what they can get and nothing for their employees. Some are too lazy to even submit the paperwork for an increase for their employees.
- Adequately train staff to do their job. Hire and adequate # of employees to get the job done. Quit making empty promises re: hiring, filling positions, raises.
- Employees who are had workers and execute a strong work ethic should be the ones who are promoted to leadership with better pay.
- Improve clinical work space including patient rooms and treatment team space. Electronic medical records.
- Improve the level of pay to qualified social workers to acquire and retain them. This would decrease a lot of turnover which would make the job more consistent and satisfying.
- Develop a fair promotion and advancement system in forensics.
- Cooler office.
- Realistic expectation of productivity, decrease volume of documentation, leaders who have real understanding of clinical setting, increase pay and or promotion opportunities to enable me to keep up with the cost of living based on years of service/experience.
- Increasing training opportunities (for counseling), Have increased Cost of Living Raises or merit raises.
- My entire supervisory structure is dominated by females except for the state director. Every position is held by a women and a man does not stand a chance for advancement. SCDMH is looking at a lawsuit and still keeps men in low positions.
- Have meetings. Our supervisor does not talk to us.
- Hire more employees.
- Offer activity therapy training and supply to do a better job.
- Update technology, some of us have to travel out of the office a lot, should have blackberry's or I phone to check email.
- Some people need to be changed to a different work area CMT gives people bad reference so they can't be transferred.
- Hire another person, get updated equipment.
- Offer more detailed indebt hands on clinical training for children/family service counselors.\
- More educational and financial incentives.

- From a departmental perspective my dept needs a skilled clerical person to handle day to day responsibilities. As a physical structure make sure the staff center is totally clean from the glass doors to each persons office.
- Morris Village/bldg. A has too many cubicles in one area which impact the work environment regarding patient and staff confidentiality and concentration for work efficiency is difficult with so many different conversations and noise level is very high.***My supervisor has never met with me as a Dept. in the HIS area since CHP has merged with BPH and Morris Village. My supervisor has no idea of my work load, which is very extreme, I am only a person of one serving all of MV, and she has three employees in her area at BPH. My supervisor rates my EPMS and has never sat with me one day to see what type of work habits I have, yet has been grading me since BPH & MV merged. I should have a supervisor who is a leader at MV not BPH. I do not receive any back-up in my area as I did before MV and BPH merged. I only receive help if I am on vacation. My supervisor does not understand that I am torn between pleasing management at MV and my supervisor at BPH because she says I do not follow the chain of command, my MV Mgmt. needs to be kept abreast of problems at MV too., she believes I am going behind her back, when I inform upper Mgmt. of problems. I cannot serve two masters, MV and BPH. BPH does not have the admissions to their facility like MV does, yet the have 3x the employees in one dept that MV has one employee. I am expected to enter information in a database that has not been completed to do reports, my supervisor does not understand the differences between MV and BPH, I think a very grave error was made by placing employees under supervisors who are not even in the same facility. I am unable to order supplies and more because they have to go through BPH and they do not want MV taking away their supply limit. I have been with SCDMH and will probably find another job in a private company due to mgmt does not care or listen to the "working" admin. Staff.
- Outside my door I see too much trash and no one is picking it up. Need to upkeep grounds better. Fix pot holes in roads. Hire more staff to secure grounds, too much vandalism.
- Teach employees to work as a team – not in clicks – or ban together by race. I'm tired of all back stabbing and racial dividing by employees themselves; I miss the closeness of employees that I experienced years ago when staff actually cared about each other regardless of race, gender or status in facility.
- Listen to employee feedback on the development of the department.
- Better leadership, better role-models who get an example and make an effort to improve moral.
- Like job, lacks challenges and growth opportunities.
- Provide a bigger facility for our group space.
- Need more responsible supervisory positions to effectively utilize my business degree and experience.
- Be fair to each employee.
- Approve RTFP's for adequate Admin support staff needs so that certain Admin support staff would not have to be responsible for duties of 2 ½ staff on a long term basis.
- Upper management can increase communication and aide clinicians in helping clients.
- Reward good performance with recognition, money or more paid days off. Give enough raise to at least cover cost of living.
- Lower case load, more money for training, more supplies-we run out of screening tools.
- Lower case loads – 200 + is too many! Too much paperwork, much of it is repetitive. Increase pay. Provide incentives for obtaining licensure, additional credentials.
- Keep frequently communicating budget updates, time-sensitive goals, and remind upper mgmt & supervisors the importance of giving approvals, signatures in a timely manner.
- Decide what the mission is - too much conflicted information. Be more precise and clear on job duties and expectations. Hire part-time professionals. Increase clerical staff and job duties.
- To boost salary. Have better vehicles.
- Employ more clinical staff to increase ration of staff to patient load and contact.
- Too many clients for case load.

- Pay is not commensurate with to case loads, paper work or community standards.
- Adequate housing/space/supplies.
- Safety factors for staff, better lights through out the facility open areas so that staff can be aware of there surroundings and feel safe.
- Need more training by management not other employees.
- Better leadership from our director. Less favoritism. Clinicians are scape goated for all the problems at our MHC.
- I have to pay out of my pocket for resources. Stop letting one person think they do all-work and every one else is here for looks. I feel if they allowed comp time would be a big incentive.
- I cannot think of anything that needs to be done to improve my work environment.
- To be treated as adults. We do a good job. Don't feel that we are appreciated by our supervisor. Stop people from back-stabbing. Teach people to work as supportive members of a team.
- It would be nice if we didn't have to get up every few minutes to let someone in the door.
- Provide administrative and leadership training for Forensic leadership and MD's. Provide policy information to Program Directors who lack or disregard this information.
- Take people out of supervisor position who don't know what that means and how to do it.
- Give pay increases to people whom are promoted.
- More support example: Audit mistakes are meticulously noted, but good charts often are not praised. Lately, some effort noted through email (supplies are not provided for art, etc).
- Screen office management positions before hire.
- Give anniversary pay raises after 20 years of service, also better pay for employees based on their performance review.
- I have difficulty reading the pink CAFAS due to color blindness. There is not an alternative.
- Employ more clinical staff to decrease case loads. Nurses should be given "Meds only" clients.
- Provide more and updated computers and tech. equipment to all centers.
- Hire 3rd in office C&A person. Provide safe reliable transportation for all summer programs.
- Communicate Effectively. Advocate for workers. Be consisted and fair.
- Allow supervisors to implement suspense dates for tasks to be completed and a disciplinary system that will reflect in performance evaluations and eventually termination. If suspense dates and extension dates are not met in a timely manner.
- Money for educational reasons and transportation to different sites should not come from community mental health budget but should be provided by DMH budget.
- Work incentives and better cost of living raises to keep up with the rising cost.
- A significant pay increase would make my work environment look much better.
- Treat each employee the same.
- Provide additional staff so that I can keep up with work load.
- Do a salary comparison of Columbia nurse managers and HPH nurse managers
- Decrease paperwork for clinicians. Decrease duplicate documentation and make clinical forms more relevant.
- We have inadequate clerical support. Due to high gas prices many of us would like to change to a 4 day work week.
- Step up a forum for employees to discuss strengths and challenges of agency, here about the needs.
- Improve communication and team work in deaf service statewide.
- Make the pay commensurate with the level of education I'm REQUIRED to have.
- Offer to pay for the materials used in counseling sessions, books, games, etc.
- More space to see families.
- Transfer me to a more challenging position where I can be better productive.
- I think the program manager who has employees at satellite office needs to make more contact with their employees. Also, make sure the supervisors are doing what they are suppose to do at the satellite office and not have the employer do all the work and they take credit as well as bill time.
- More staff meeting one on one, communication, respect for everyone, not only certain ones.

- Materials to interact with the children. Resources to implement treatment plans (books, games). More training, pay increases.
- Much bigger office space. Up to date technological equipment that properly functions.
- Increase pay.
- There seems to be an overall sense of distrust. Being in a maintenance dept. my job would be easier and jobs could be completed sooner if the supervisor had access to a credit card to buy needed supplies, especially emergency items.
- Provide us with a computer system capable of handling programs used. Servers don't appear to be able to handle program load.
- Appreciation of the input and special skills I have.
- I would like to see more feedback given by supervisors and more materials available to be used with clients.
- Please give me more money so that I can pay more bills and buy gas.
- Give a real pay raise so I can pay bills and buy gas.
- Instead of a break room – need employee lounge's decorated in a pleasing, relaxing décor.
- Increase pay I'm earning $5.00 hour less than previous employment. Increase medical benefits.
- Clean the building daily. Provide van daily for case manager. Provide disabled label for van and car.
- Reduce work load-currently work @ 45+ hrs/wk just to get the paperwork completed.
- Update surroundings-looks like the 60's & 70's and institutional in an allegedly professional environment.
- Offer more training. Provide more space for 10 employees in one office.
- More pay, 4 day work week.
- Better and reliable IT supports. Better communication with key staff at DMH. Notification of policy changes and an opportunity to provide input. An avenue to address promotion for administrative and support staff.
- Doing it now within the last year. Having a contact person to assist with A/R matters. Thank you.
- More computers, internet connection and printers to complete my work in a timely manner and be effectively.
- My salary is in the poverty level for a family of 5!
- Better communication.
- As state employees, I feel we should receive better raises. We are expected to perform above requirements on our job but we get no rewards for the good job. We need merit raises between 3% - 6% depending on EPMS evaluations.
- Get a new clinical director.
- Hire more workers and fewer chiefs.
- Allow employees to work the shift that is best for them and their families; give them a transfer when they ask for it!
- Overall my immediate supervisor is great! I am not happy with leadership above. There is no follow through with requests not even simple email or phone calls are returned. I don't feel recognized above my boss and there are no incentives from above to keep going.
- Allow a four day work week with staggered days off to help with gas prices. Encourage staff to network.
- Set reasonable paperwork/QA requirements. Eliminate duplication in charting. People spend more time treating the charts than treating the patients. Get MV admissions to answer the phone and return calls 803 935-7101.
- Improve pay. Stop changing policies everyday! Stop making therapists look like idiots by moving us around and making so many superfluous changes.
- Hire people that have dignity and enjoy doing what they do. People without prejudices.
- Allow for a 4 day work week due to gas prices. (Especially for those employees who drive more than 45 minutes – 1 way)

- Transition out clients who have achieved their goals and are functioning at their maximum level of independence in the community. Allow clients who are more in need of services and direct interventions to move in (TLC apts) and help them progress toward their goals. Require better communication – look at ways levels employees can be promoted in specialized fields like computer.
- More communication with other departments.
- We need to earn enough to keep pace with the ever rising costs of living. There should be opportunities for advancement within each center. Since I go separated and divorced I cannot afford my life working her!!!
- Understanding, reduce workloads,
- Insure that every employee is properly and professionally trained in all aspects of policy and procedures.
- Get rid of "Power" minded people, those who abuse it!
- I love my job! I do feel my job is important and I feel I do matter here. The only thing that would make a difference would be to reward all employees that do work hard and put 150% into what they do!
- Staff development training by a professional not within our department
- Help us with recruitment and retentions. Allow upper level staff to go to national conferences.
- Communication skills/importance training for top managers. Encourage conservation of resources: work at home, 4 day work weeks, and schedule flexibility.
- Improve leadership in Quality Assurance Dept.
- Due to the budget deficit for our country, it is almost impossible for the Dept to help to improve the work environment. We have down sized in support staff twice in 1 year – working conditions are very stressful.
- Purchase more tools therapeutic games. Pay for training.
- Better communication and consistency.
- Give information regarding changes in program before they are instituted.
- Provide a "paperwork" day 1x month to catch up. Berkeley County MHC use to or perhaps still does this and employees appreciate it.
- Reduce the focus on productivity.
- Provide more advancement opportunities, pay raises, more cars, more administrative support, financial support/scholarship for CC's to become Case Mangers – to keep experienced people working for this agency (investment in people will benefit this organization).
- Have electronic medical records. Have case management to put in their own paper work in the charts.
- Fair
- Be less punitive and more supportive. Too much red tape, administration out of touch with community work.
- I feel the department could choose supervisors that enjoy their jobs and not stay out so much.
- Cut down on paperwork!
- Provide more training, more room for advancement and raises.
- Set realistic goals.
- More training opportunities. Better benefits and pay.
- Increase wages.
- More educational training should be offered.
- Provide opportunity for advancement based upon experience rather than masters degrees which aren't worth the paper they are printed on. You employee people with master's degrees whose clinical notes are written in Ebonics. A B.S. with 6 years in the field should be credentialed as MHP.
- Concentrate more on the positive things front line staff contribute. We rarely get complemented on what we do but always seem to be reminded about the negative.
- Competitive pay, licensed practitioners poorly compensated. Yet expected to perform no less professionally than private practitioners.

- Reduce my work load.
- Fully stocked equipment needed bodily fluid spill skits for blood bourne pathogens.
- Hire older mature people.
- Like for my supervisor to work with staff, listen and do her part as a supervisor. Not tell me one thing and do another. Supervisor needs more leadership experience.
- Bring supplies that are needed to work with on time.
- I cannot appropriately treat patients without being able to order appropriate supplies, which I am often unable to do (not allowed to spend$). Allow us flex scheduling or job sharing to combat the inability to increase our pay for the present economy (i.e. increase gas prices).
- Communicate, Innovate, Train supervisors to really supervise and lead. 4 day work week. Take less than 8 months to respond to request for pilot project.
- We need more money to survive the economic situation. We were already well below the private sector income.
- Get rid of huge roach, bugs and ants, residual ceiling mildew is a problem. HPH
- Probably nothing. We need a new facility, a clean facility. I as a nurse need a convenient place to wash hands and a closer place to store medication.
- More incentives for employees.
- The pay could be better. Lowest administrative staff in the dept.
- New equipment – computers, monitors, another medical records scanner.
- Get better organized, provide more employee rewards.
- Provide counselors who are out-based with lap tops and/or access to computer accessible records while away from the office.
- RAISES!
- I have gotten an SE on my EPM the last 4-5 years and I have been given significantly increased responsibilities over and above what I was hired to do. Yet I have never been given a raise. If I am not going to be rewarded for superior performance or increased amount of work then I should be able to refuse to accept any additional work being given to me.
- I enjoy my job but there was a RIF and now I am a receptionist coming from being an office manager. I just signed a PD for Adm. Specialist and I was Adm. Cord. I. Before the RIF I am thankful that I have a job, but you know this is difficult.
- Make scheduling, reports, messaging, faxing, more technologically advanced or at least working properly. If I need to look up a client's appointment it takes ½ hour to look through the book instead of scheduling it directly into "the scheduler". That is the only disagreement I have with the organization of the facility, however why it has to be done that way.
- New Computers, more training on site.
- Be fair to everyone don't just pick 41 people to give a raise to. Split the money fair among all of the employees.
- Supply the office with equipment that works so we can do our job in a timely manner.
- Dedicate laptop computers. More $ and official leave for those w/licensure since the department bills 3rd party payers based on my license. Less videoconferencing and more live, regional CE training for counselors to board recognized CEU's
- Freshen up paint covering marks on walls, shampoo carpet, clean out air/heat ducts/vents.
- The department should pay each employee $0-2,000 bonus based on work performance3. The employees would feel valued and want to stay with the department.
- Eliminate Nurse Mangers and Institute Head Nurses on each unit or team. Department is not racially balanced and it seems discriminatory towards whites.
- Find a way for staff to have more time to spend with clients and not have to be tied down with paperwork.
- Treat everyone fairly and with respect!!!
- Housekeeping needs to improve dramatically.

- Provide training on software programs. Reinstate alternate work schedules. Allow frozen position to be filled.
- Effective communication in respecting your fellow employee.
- My supervisor tends to change her mind about a project or has contradicted me in front of colleagues. I feel this makes an uncomfortable environment.
- More pay.
- Workload is too high ref number of clients and bill time. Poor supervision, affects turnover and morale.
- Administration stop showing favoritism. Director of hospital having affairs with some staff. Nursing supervisors moody and don't speak. HPH rules different and less pay. New nursing supervisor was involved in sex scandal cover up and was allowed to remain supervisor – no morals.
- Team building exercises and a review of cost of living to increase salary might improve morale.
- My department is great. My director is wonderful. The organization is not structured well in my opinion. I feel like my department is like my family not the organization.
- At times, crack the whip – more team work needed.
- Provide appropriate work space and equipment – printers.
- Promoting from within our facility instead of outside.
- Pay and benefits.
- More increases in salary. Merit raises.
- Hire more help!
- Assure that staff does not supervise people who have a position "higher" than supervisors position.
- Help employees with opportunities for growth and development without this being so difficult. More time for studies – administrative leave to help advance self for purpose of helping the organization grow.
- Less emphasis on making bill time – this agency is more concerned about quantity instead of quality.
- At Byran Lodge F, director needs to develop people skills, control less and create a team more. Does not communicate with staff but dictates. Also no access to supplies to do jobs sometimes NO Gloves.
- Make sure everyone is treated fairly and receive same considerations based on experience and performance-not personal reasons. Pre-selection of employees is rampant.
- Have a supervisor who stands behind you.
- To get more working.
- Staffs break room or lounge.
- More time for Quality Assurance.
- Computer access and passwords that work.
- Get more in to work so that the other staff want get burned out with the star * and the pound #.
- Better staffing – better screening of new employees. More respect from CNAs. Less "attitudes" more consideration for "night shifts" employees (more classes and opportunities to get new ID's etc).
- Changes in program structural PRS constant change: Need some stability at this stage in PRS program.
- Hire additional staff.
- Better pay w/regular salary increase, training for my supervisors, better equipment.
- Provide more equipment (vital machine, scale etc)
- Safety for the patients and staff good help.
- Continue to provide adequate funding for my program (ARC). Provide better pay for therapists. Reduce paperwork load to increase productivity.
- DMH management assists w/facility management, oversee, assist w/issues, and insure proper facility management by Exec. Directors. Ensure employees (all) are treated fairly. Ensure Ex. Dir. Has management/supervisory experience to manage facility.
- Remove the racist director, all promotions, pay increases are done on a racist basis. There have been no blacks given any real increases or promotions while some white pay increase on paper increased responsibility.

- Micro management is not needed by center. The Director has lost touch with the employees. Without the employees there would be no clients or center. Money management in the center sucks.
- Be proactive and communicate changes before it happens. F/U on new systems. Communicate, share visions, get input from sources that work it!
- Salaries more in line with national standards and more reflected of education and job duties and work performance.
- Better team work.
- I feel supported by my direct supervisor, but no one above that. Also, feel like most supervisors aren't honestly representing the needs of their staff.
- Hire more staff.
- Decrease number of superfluous staff at DMH. Ineffective staff are source of frustration especially when they are significantly overpaid.
- More money.
- Before putting unrealistic work loads on employees take at least one day and try to do the work I do you will understand a lot better, make necessary changes instead of telling me "you better be glad you have a job"!!!!
- Spartanburg Mental Health needs to enforce policies such as productivity and tardiness. It is difficult to be a proficient supervisor in such a "lax" organization. It seems to be an environment of "do what we say-not what we do".
- Hire more help. Work on discrimination and jealousy among staff. Address issues instead of sweeping under rug or act passive. Not treat minority staff different than the majority.
- Supply employees with up-to-date equipment to work with. Provide a more pleasing work atmosphere.
- Go back to giving raises due to job performances and quality of each individuals work.
- Get rid of negative supervisors who treat people according to their own personal need.
- Cleanse out corruption beginning at the leadership level.
- Stock all office supplies that we need on the grounds we work at instead of ordering outside facility.
- We need easier computer access to do notes and search the internet for Ct's needs. Also, more readily available supplies to use with young ct's would help, craft items, etc.
- What can be done when people do not have respect for one another and are not willing to cooperate?
- Raises don't look like something that will happen in the near future but being thriftier and not wasteful is something we can all do to help.
- Provide uniform and consistent upper management leadership.
- Improve communication from the central office; clarify the chain of command, better notification when people assume/leave positions.
- Improve communication within the department. For instance different divisions being knowledgeable about functions/happenings.
- At this time possibly go to a 4 day work week. Provide more incentives raises to staff – (bonus cks).
- Hold staff to work ethics.
- I don't know at this time.
- There is little connection between the Dis leadership and WSHPI. Generally we operate with poorly designed systems for operations. There is a large gab between what we say and what we do.
- Funding to pay for trainings to help improve skills and maintain CE's – limited due to budget cuts.
- Merit raises.
- Stop being prejudice, stop changing rules every minute, or client by client, therapist by therapist. Be fair across the board, not by color or therapist by therapist.
- Hire more help.
- High standards are placed on therapist. We are held accountable for our productivity while others (i.e.-transportation, human resources, computer techs, LCCMHC ceo, etc.) are not held accountable and have little to show for being productive.
- Decrease unnecessary paperwork-duplicate paperwork!

- Purchase another van for TLC.
- Increase tx resources, play therapy, books… Increase time for research/training. Increase clinical supervision vs staffing. Flexible work schedule, my own office, more timely decision making, decrease rigidity.
- Allow me to practice my vocation. Support me and my colleagues in the basic of needs. Attitude and practices of non medical supervisors which have continued to endanger pts.
- I think all employees should be accountable for work hours. That work hours are 8:30-5pm. Yes there needs to be some flexibility, but still remain accountable for the hours and work we are suppose to do.
- Include benefits for domestic partners (health benefits).
- Do away with monthly productivity for nursing staff.
- Give me cost of living raises!!! The state is robbing its employees. The congressman makes the money and we do the work. God is not pleased!!!
- Have the sale rules for all employees. Have people that will volunteer to help each other.
- Too much "red tape" – over control.
- Lock for offices at C&A building or at least locking file cabinets. A scan card entrance to C&A for safety reasons.
- Increase my salary because I feel like the time and effort that I put into my clients is not recognized in my pay check.
- Worry about the client's best interest more. Raises!
- Decrease productivity standards for supervisors. Supply cell phones, reimbursements for material to therapists. Provide substantial clinical training to staff. Supply money to hire appropriate clinicians for appropriate staff (TFS).
- The only reason I can do this job is because my husband gets a good pay check. This is an act of love for me to help. SCDMH ought to be ashamed how our pay varies from center to center and is so low. Staff is your most important investment. Are the folks taking care of white men who have heart attacks paid really low? If so, I apologize. If not, think.
- Increase salary to = increase in cost of living. Improve training and promotions/advancement. Reduce case loads to a more appropriate number, the paperwork is enormous. Many staff stays over 2-3 hours every day to finish paperwork.
- Lack of promotional opportunity due to TERI and post-TERI employment.
- Overall I feel that if less favoritism not only among staff, but clients also would alleviate the morale problem around here.
- Promote good communication skills among employees and supervisors.
- Listen to their employees more; stop telling employees how easily they can be replaced. Lower productivity.
- Waccamaw doesn't recognize good work or successful cases only if your productivity is met. This is a problem. Most of your best therapist are overworked and underpaid, but have the most successful outcome with clients.
- More money, less stress!
- Higher pay, Educational and training incentives, tuition reimbursement, and incentive pay raises. There should be an open door policy when addressing issues and concerns arising pertaining to the treatment of others and certain existing conditions that make work environments uncomfortable and stressful.
- Be sure that all staff is treated equally. There are two sets of rules at my center. One for the front hall and one for the back! Just me! Poll my center and see!
- Hire additional psychiatrists.
- Provide adequate support – resources, staff, and education - for employee to do their jobs.
- No suggestions at present time.
- Competitive salaries. Decrease paperwork; provide more recovery materials not just words.
- Expand (physical plant)

- I would love to attend some training focused on forensics and how DMH can most effectively serve the mental health population in jail. Recognize the hard work those of us do who are not in billing positions.
- Being in this organization is like being part of a dysfunctional family. Treat and communicate with me respectfully, live its values, pay me equitably, give performance increases, give a reasonable workload, we seem to have a culture that condones disrespectful communication while that behavior is publicly condemned incongruent.
- Everyone pull together to focus on the consumers with excellent care, respect.
- More communication between management and staff on the line. Better pay.
- Local leadership committed to recovery for our consumers. Assure equal opportunity for promotion and advancement for all employees. Effective and honest communication form leadership that also listens and responds appropriately. The work environment could be improved by providing leadership that is in touch with all staff members. Since we are experiencing extremely low morale, leadership needs to be able to build trust and close the distance between leadership and employees. This would revive creativity, decrease cynicism, increase morale, and rejuvenate loyalty. Effective leadership is needed in order to get beyond current demands with less stress, to maximize ingenuity by turning obstacles into opportunities, and to value all employees in order to get everyone working as a team player.
- Have a better trustworthy system. Increase front office pay.
- Have a better system where you can go to upper management with support. Don't have a buddy. Don't have a work environment where you can't voice your concerns with fear of retaliation.
- More support staff (pull charts in timely manner, etc.), communicate changes in policies/procedures, more state vans (to accommodate home visits), another psychiatrist/nurse to accommodate case load.
- Electronic billing, or "check off" tickets instead of ill in, hire more nurses; coordinate nurses/PAP reps; train staff to interact more across Depts., not to take everything to supervisory level; allow clinicians in Medical Records again; allow attendance at conferences, workshops in other areas; in NC, GA, etc. Train Clinic Directors in appropriate, fair treatment of each employee, clear communication;. Department should assess and evaluate the "Mental Health" of each clinic. Consolidate regions to decrease cost of managers, make statewide Directors more visible, more accessible and more relevant to front line providers.
- Increase pay incentives and training experiences.
- Too much at times.
- Recognize you for your knowledge and commitment, expertise in your job working knowledge of relationships (professional working relationships) with other staff and DMH as a whole. Example: Knowledge and commitment qualifying you for a job, not necessarily a college degree.
- Computer scoring programs for psych testing and method of printing.
- After more opportunities to a diverse group of people and promotions.
- Love my bosses and colleagues but am weary of the criminal population. We have extremely capable leaders in Dr. Wadman and in Dr. Musick. The Department should make every effort to provide them with the support and the resources that these leaders deem necessary to continue the success now evident in forensics.
- Hire qualified people, not just warm bodies.
- The department can honor the promise advancement/adjustment on salary as they spoke of when they were asking me to do additional duties to support my reasons for adjusted salary pay.
- I'm not sure the Department can get around or wants to get around the red tape to improve the work environment.
- Ensure all employees are provided the same opportunities and advantages (i.e. all computers equal, access to all training or specific training developed). Promote from within.
- Clean up the nasty carpet, bathrooms stink and get some up to date furnishings. We are in the basement and that's bad enough!
- Newer vehicle.

- Allow me to hire an assistant. Pay my staff what they deserve.
- Give me a nicer car to drive.
- It would be great if there was more emphasis on wellness – physical and mental. I would recommend increasing the visibility of the EAP and perhaps contracting with a more appropriate organization to provide EAP services. Also, a "greener" workplace – easy recycling, place to bark bikes. Discounts at area gyms, Increase healthy food in canteen.
- I erased what I wrote. I would write stuff here but I don't know how anonymous it is or if the survey will be shown to people. Please provide an anonymous way to answer these questions other than a suggestion box. Everyone sees you put things in and the admin director reads them all. I don't want anyone to know what I think or it would be bad.
- Acknowledge employees. Commissioners and management seldom speak. Interact with staff as if they are "underlings".
- Work environment is fine, we need merit raises, and there is no such thing here.
- Allow staff to cross train.
- New vehicles, give raises on performance.
- More money.
- Work as a team.
- Technical support/IT at my center is extremely poor. This center needs more than one IT staff member, and those personnel should be approachable, helpful, and respectful of co-workers/staff. Our one IT person here has none of those attributes.
- Provide more pay incentive. Raises are few and far between. Work load increases regularly but pay does not match work or years of service. Equipment items are not always available to be able to do our job.
- Give us an increase in salary and let us go on flex-time because of the gas prices.
- More money.
- Need to recognize staff for promotion and pay.
- Raise the security spec III salary because the other organizations USC, city pay more and security spec III should get raise when certified officers get their 10%. We are doing the same job.
- Get me an assistant or provide over-time and not comp time.
- Paint the offices and steam clean the office rugs.
- Having corrections clean is definitely not ideal. It's ineffective and disruptive. The only good thing about it is its cheap and provides work to inmates. The cleaning itself is not adequately done due to poor equipment and daytime scheduling.
- Provide more "Grooming for promotion" to younger (10yrs and less) state employees.
- Give us an office with windows and more air circulation.
- Don't throw you into the position so fast. Still learning.
- Give all employees' proper raises for the work that they put out for the department. The safety of others on campus and the highways.
- More money, better benefits.
- Better vehicles.
- I am discouraged with the emphases on "Productivity" and it not being focused on client care. It is discouraging to see the center turn into a "business" with lessening concern for the clients.
- Update electronic equipment (computers etc.)
- I have greatly enjoyed the increase of quality and quantity of clinical education opportunities from ETR/Staff Development over the past 2 years. Please continue – this helps!
- Provide the opportunity for upward mobility, pay raises, increase employee incentives.
- Higher quality IT equipment and support.
- I would love to have a quiet office with a door. I'd probably be happier if I were paid what I am worth.

- #5. My supervisor values my input: Since David Fitzgerald has no more power and gone Stephen Hattrick and positive supervisor not Mr. Fitzgerald. It is great to get up and come to work! 5 straight days of Saturdays.
- It would be wonderful if the state could offer employees an exercise program. 30 minutes lunch breaks are not long enough, 1 hour breaks will give employees enough time to eat and digest adequately.
- Provide highly functional technology. Better pay. Increase in qualified counselors. Less paperwork and more client centered.
- Need pay raise.
- Increase work between departments within the agency. Increase qualified staffing for programs so the workload is evenly distributed; provide annual evaluations for staff along with incentives.
- Improve working conditions, salaries, etc.
- Add vending machines to our floor.
- The case load is too great for the few therapists at our center. Additional therapists are needed. The salary is just....wrong. I am absolutely not trying to be greedy or funny. We need a raise to meet STANDARD living conditions. The cost of living has increase greatly and our salary has not.
- Salary per experience.
- Fewer schools for school – based clinicians. More reliable computer records system.
- Hire supervisors who promotes good office moral with their attitude and care. Lower the productivity number because we are case managers and counselors, paper work alone could be a full time job. Supervisors/office managers to be considered as part of office problem just as much as individual employees/especially if a lot of people quit under their leadership. I have office managers/supervisors who don't just have the education but "real" people skills not afraid to be wrong or corrected. The work load isn't too much for one person, but it definely gets hectic with case managing, crisis, more special needs clients that can get someone behind. Yet they are still expected to perform at agency high standard level with focus on productivity and jobs being threaten by upper management who hasn't had to deal with half of what clinicians do today in 10, 15, 20 yrs or more. Leave room for "slack" due to those other time altering variables that everyone knows come with the job. Also, consider more economic or unknown variables why clients just don't show, instead of immediately blaming clinician especially if contact has continued to be made. Keep sending things like this that employees can be honest without fear of reprimand or denial. Because if most say something something has to be true. However I absolutely love my job and the other counselors I work with, but I know if management were better I'd automatically be a lot better. Also a supervisor going in offices for no reason either before or after is not right. Seems like no trust.
- Provide adequate compensation that recognizes the level of education expected and the level of service provided to our clients.
- Develop programs to create stronger leaders within the organization.
- Salary increase/promotion.
- Give me more than a 1% raise.
- More money for supplies and more training.
- Solve computer issues with the portal.
- Stress teamwork between support staff and therapists instead of a "that's not my job" mentality.
- Focus more on quality and manageable workloads (that don't guarantee stress disorders) and less on quantity, productivity with out regard to means of achieving it.
- Resolve work place antipathy with designation of distinct chain of command. Recognition and merit for longevity of professionalism with superior employee performance for entire time served.
- Look closer at caseloads as well as work loads. Dept needs access to more inpt. Psych beds. Look at the benefits package. SC is way below average for pay in this area.
- Demand pay increase with cost of living; make effort to provide LPC licensure with an incentive for pay or grandfather MHP in with LPC (use technology to your advantage – paperless)

- Provide opportunities for training outside DMH, Improve opportunity to collaborate and network with peers, have more input in change and more open communication with leadership. Respect honor and value successful Tx's, have adequate staffing and skills to provide quality services that are valued by the client and staff. Not just #'s served and bare tx provided.
- Educate our management on what constitutes inappropriate or offensive comments. Many employees at my center have been offended by derogatory comments made by our Center Director. *Comments have been made in meetings that devalue employees based on gender, age and place of birth.* Many employees are offended but do not speak out due to fear of reprisal or think they will not be taken seriously. It is offensive and it needs to stop. Actually listen to employees and take our concerns seriously. We understand that DMH and local components have to make the best of our budget. However, *and when we have legitimate issues concerning the operation of programs the care of those we serve*, our local leadership tells us that we are being negative or that we are "whiney". We cannot do our jobs properly if we are not taken seriously and supported by our local leadership. We are given increasing work loads, fewer employees and have out dated or broken equipment. In regards to workload, many of us put in extra hours to get the job done, but are never recognized or compensated for it. Many of our employees who want to do good work and whocare for the clients we serve, there needs to be better compensation and working conditions. Otherwise, employees will continue to leave for the private sector. I hesitated to make the comments that I did, but I feel they needed to be made. Not being taken seriously or being reprimanded for doing so was a concern. However, I feel that for the health of SCDMH and the care of those we serve, I needed to speak up. Could SCDMH provide a way for those of us on the front lines to be heard? We often feel devalued and unimportant. So many people feel that way but feel they can't speak up. I truly hope that we can improve. I truly want SCDMH to be a great place to work, a leader on the national level and a place of care and hope for those with mental illness. Thank you for your time.
- Allow for more autonomy in the work environment. More cohesive relationship within the department. Have never met the Director of ETR.
- Less talk about budget, provide the organization with up to date resources for example: all employees have access to email so they can complete the required on line training. Pay employees based on performance. Let performance be utilized for pay increases.
- We need more cars or an increase in mileage money. Stop having to turn in yellow Mc Bee's with completed McBees – it's degrading to be treated like a child. Improve turn around time on Medicaid audits, new hires, care updates. Give 1 day per month w/out billing requirements to let us focus on details of our charts (paperwork). Change PMA policy so that family's can reschedule their missed appts, especially for those of us who are not clinic paid. Total overload for clinicians!
- Increase pay and benefits as incentive for employees to remain on site.
- Replace acting C on 124 – Henrietta Ashe

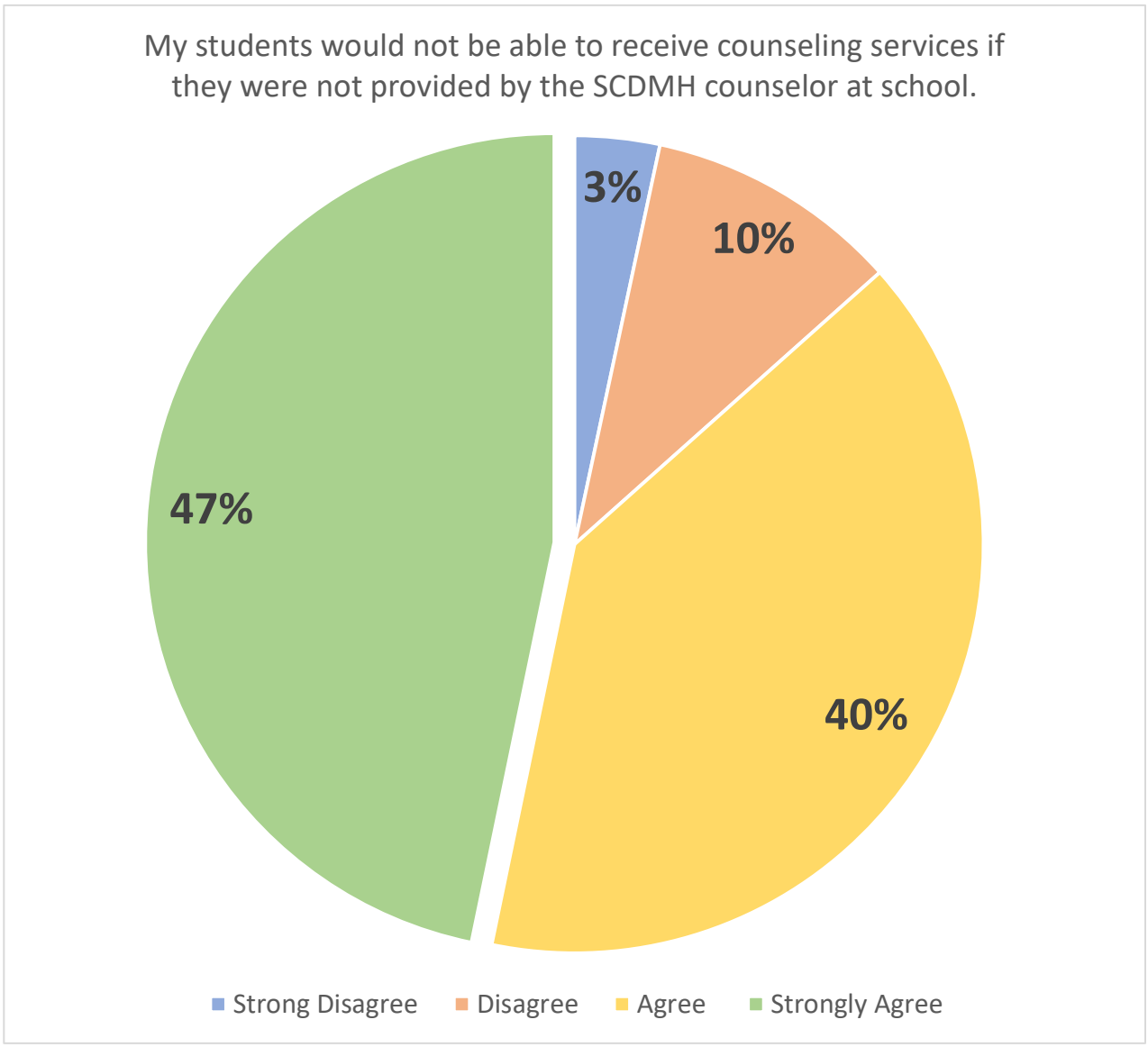
11 WAYS TO IMPROVE MANAGEMENT , 1) Focus on mission, not on procedure: Case in point – Case manager had a potential client to be interviewed for a special program offered by Center (a professional in community called CM on short notice to say that the client was in her office), case manager also had a cancellation in her schedule, so she left office to go meet the potential candidate, signing out in front office, and taking a cell phone. Case manager was written up for not telling the boss ahead of time. Who's advocating for the mentally ill and building community relationships and who's advocating for a procedure book? 2) Don't be penny wise, pound foolish: Case in point – Agency had a good, professional clinician on staff, but she was treated insensitively at a time in which her father was potentially dying. If the clinician had received genuine support during a difficult family time, versus being picked on for lowering productivity, she probably would not have left. It costs a lot of money to get staff trained for agency, and it's disheartening to see them leave because management is thinking short-term instead of long-term. 3) Admit that you have shortcomings. There's nothing worse than a boss that doesn't admit to having her own faults. Losing paperwork is understandable in this business - there's a lot of it – but when a manager is adamant that the case manager is at fault for not turning in a on-call sheet, for instance, it doesn't seem very open minded. How hard would it be to say "I hope I didn't misplace it" as a possibility? 4) Look at your numbers. In 4 years, we've seen 23 co-workers leave and 11 psychiatrists come and go. That's a problem. I don't think it can all be blamed on "well, were in a rural community so we're just going to get workers who need a couple of year's experience, and then they'll move on." 5) Don't scapegoat certain employees. Management will never admit this one, but the clinical staff is well aware that certain employees seem to be targeted by management and given a very tough time on a variety of things, and we all know that other clinicians have done the same without reprimand. Be fair if you want our respect. 6) Fire people that deserve it. Sadly, we see some folks hired that almost immediately not suited for the job (calling in for negligible reasons and/or showing a poor attitude toward clients). Management is doing the employee a disservice by keeping them for any length of time and is definitely affecting the morale of the "good guys" that are not abusing the system.

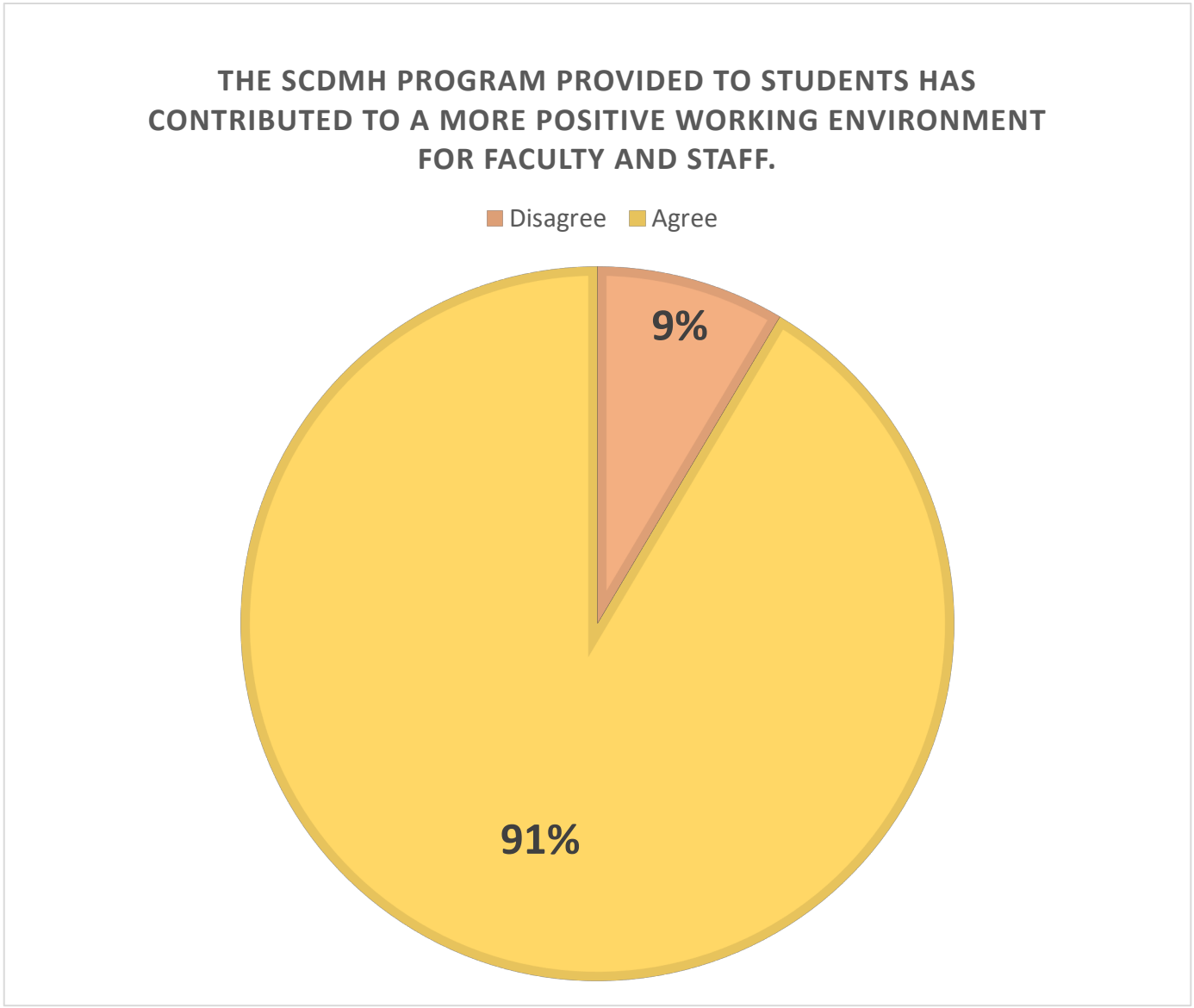
7) Don't bait and switch job descriptions. This is a biggie. Don't hire people for one job, and then once on-board, switch them to a different niche. I've know co-workers who've made significant life upheavals to come work for the agency. After they arrive, they are casually told, "oh, by the way, you'll be working with adults not instead of children" (or some other major change). If you need employees to be ready for any assignment, say so in the interview. 8) Don't manage via memos. It may be easier to pass out memos telling how to do things such as "how to present your chart in treatment team" when it seems pretty obvious that just a couple of employees need to sharpen their skills at this process. How about talking to them individually? It seems impersonal, and cowardly, to manage people through generic memos. 9) Encourage us versus finding fault. We're in a tough job. Counseling is not easy, and there are few cookie-cutter approaches that we can employ. So IF you see a chart that we could use a different approach that's known to be clinically effective, talk to us versus reprimanding us for doing it wrong. It's very easy to think of better ways after the fact, but it can be challenging within sessions to get it right. 10) Be reasonable with vacation concerns. This one may be personal to me and not important to others (but I'm still mentioning it). Only allowing us to ask for time off 8 weeks prior to the days off isn't reasonable for the majority of my trip planning. If the concern is staffing levels, the argument seems illogical, since most employees only give 2 weeks notice anyway. 11) Have upper management stop by on occasion and ask us if we have any concerns. We want to be listened to sometimes, even if we know you can't fix it.

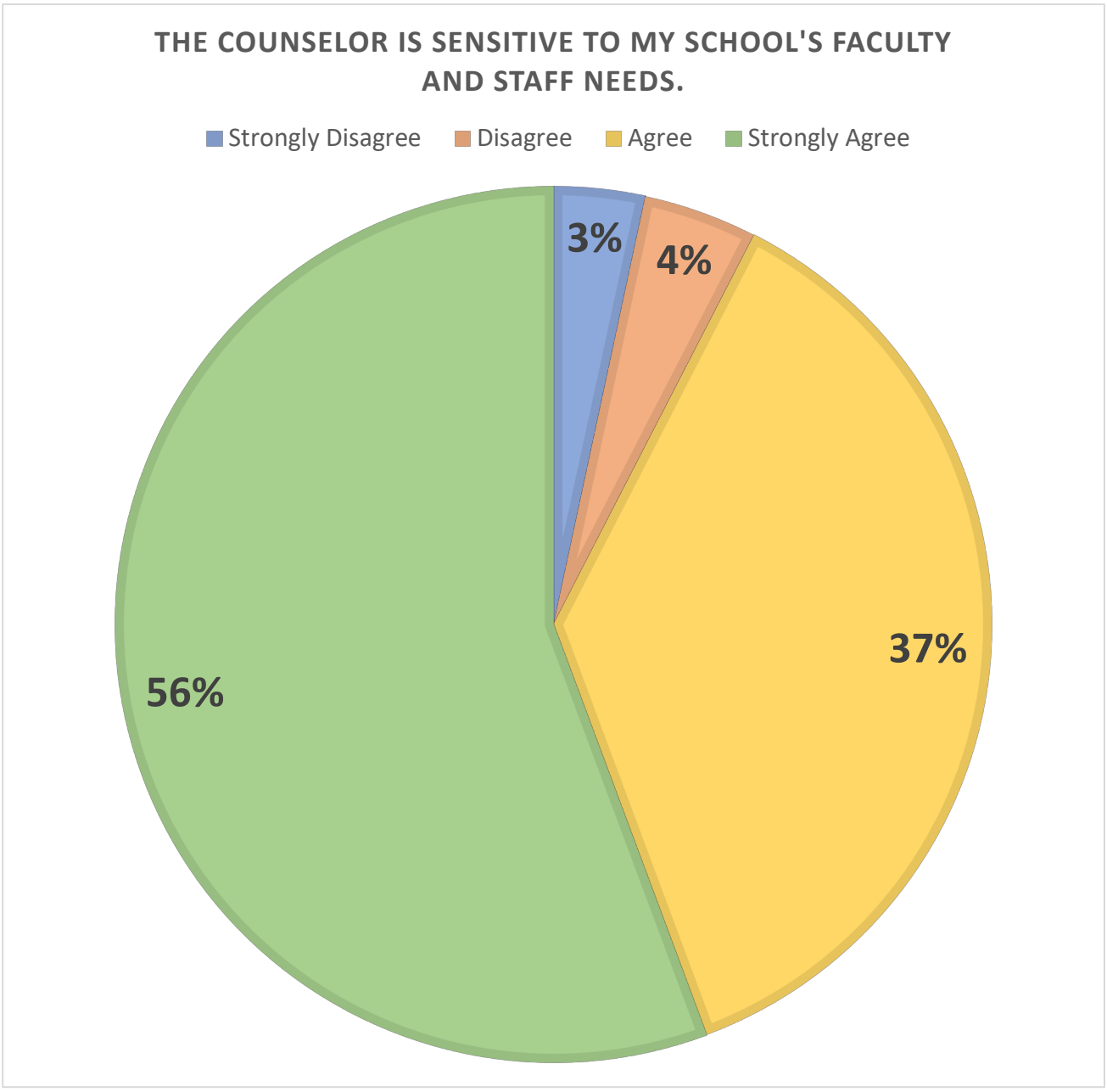
Mental Health Centers
County Appropriations

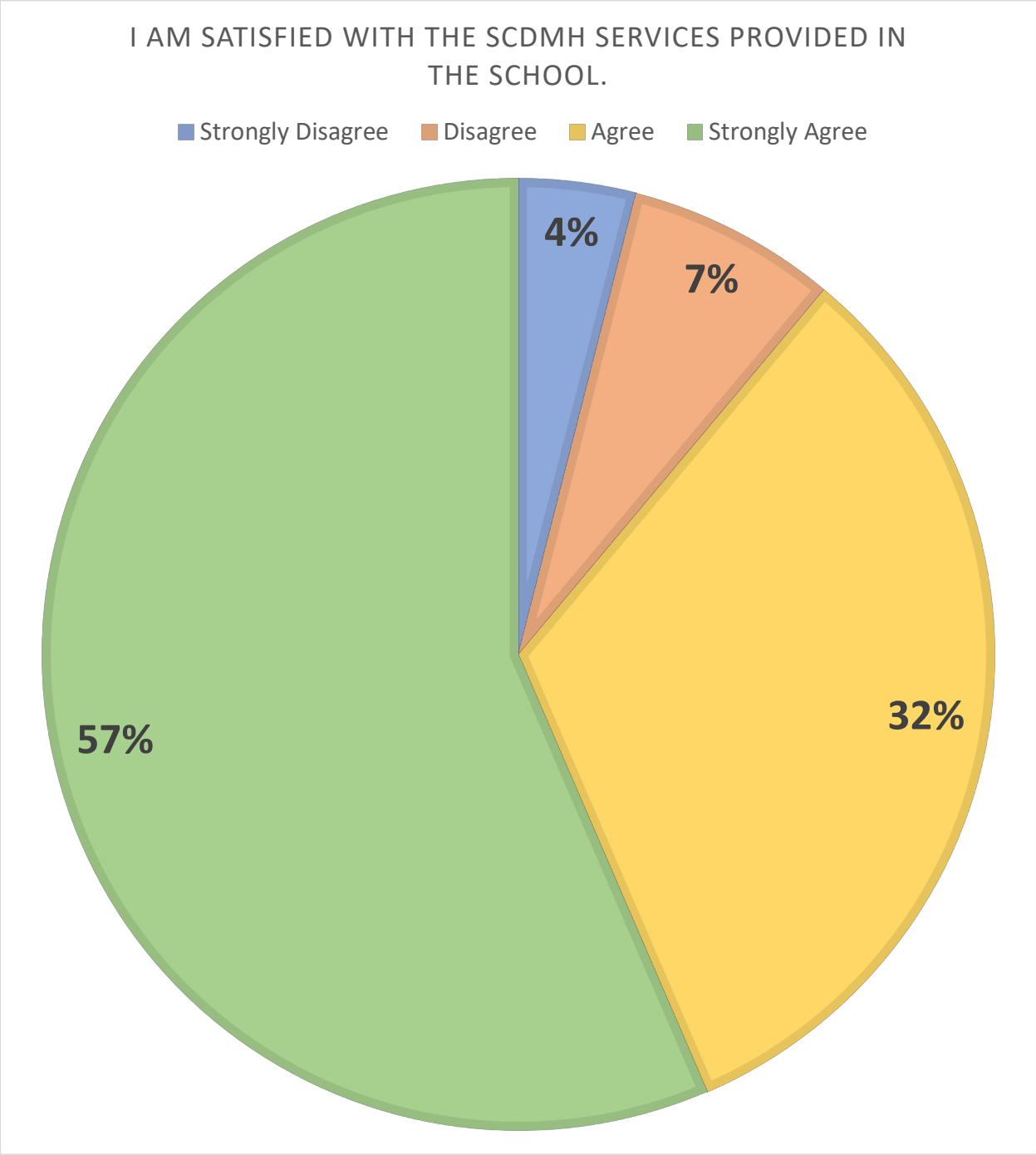
County	FY17	FY18	FY19
Aiken	**1,000.00**	**1,500.00**	**1,500.00**
Aiken	-	500.00	1,500.00
Barnwell	1,000.00	1,000.00	-
Anderson	**112,780.00**	**111,725.00**	**98,793.75**
Anderson	52,780.00	51,725.00	38,793.75
Oconee	60,000.00	60,000.00	60,000.00
Beckman	**35,475.00**	**20,475.00**	**16,447.50**
Greenwood	15,000.00	-	-
McCormick	6,885.00	6,885.00	6,885.00
Newberry	13,590.00	13,170.00	9,562.50
Saluda	-	420.00	-
Berkeley	**40,000.00**	**40,000.00**	**40,000.00**
Berkeley	40,000.00	40,000.00	40,000.00
Catawba	**3,000.00**	**2,250.00**	**3,750.00**
Chester	3,000.00	2,250.00	3,750.00
Charleston	**62,247.00**	**62,247.00**	**62,247.00**
Charleston	47,247.00	47,247.00	47,247.00
Dorchester	15,000.00	15,000.00	15,000.00
Coastal	**96,534.00**	**96,534.00**	**44,987.50**
Allendale	3,000.00	3,000.00	3,000.00
Beaufort	45,884.00	45,884.00	-
Colleton	30,000.00	30,000.00	30,000.00
Hampton	2,650.00	2,650.00	1,987.50
Jasper	15,000.00	15,000.00	10,000.00
Columbia	**2,112,998.00**	**2,189,211.06**	**2,201,374.96**
Fairfield	70,000.00	70,000.00	70,000.00
Richland	2,042,998.00	2,119,211.06	2,131,374.96
Greenville	**95,013.00**	**95,013.00**	**95,013.00**
Greenville	95,013.00	95,013.00	95,013.00
Lexington	-	-	-
Orangeburg	**29,000.00**	**21,300.00**	**19,770.00**
Calhoun	6,000.00	6,000.00	6,000.00
Orangeburg	23,000.00	15,300.00	13,770.00
Pee Dee	**6,315.00**	**6,315.00**	**6,315.00**
Florence	4,515.00	4,515.00	4,515.00
Marion	1,800.00	1,800.00	1,800.00
Piedmont	**58,245.00**	**58,245.00**	**58,245.00**
Greenville	58,245.00	58,245.00	58,245.00
Santee-Wateree	**34,160.00**	**34,160.00**	**34,160.00**
Kershaw	5,000.00	5,000.00	5,000.00
Sumter	29,160.00	29,160.00	29,160.00
Spartanburg	**312,640.00**	**312,640.00**	**312,640.00**
Cherokee	35,000.00	35,000.00	35,000.00
Spartanburg	277,640.00	277,640.00	277,640.00
Tri-County	-	-	-
Waccamaw	**82,513.62**	**82,234.75**	**77,225.00**
Georgetown	68,600.00	68,600.00	68,600.00
Williamsburg	13,913.62	13,634.75	8,625.00
Total	**3,081,920.62**	**3,133,849.81**	**3,072,468.71**

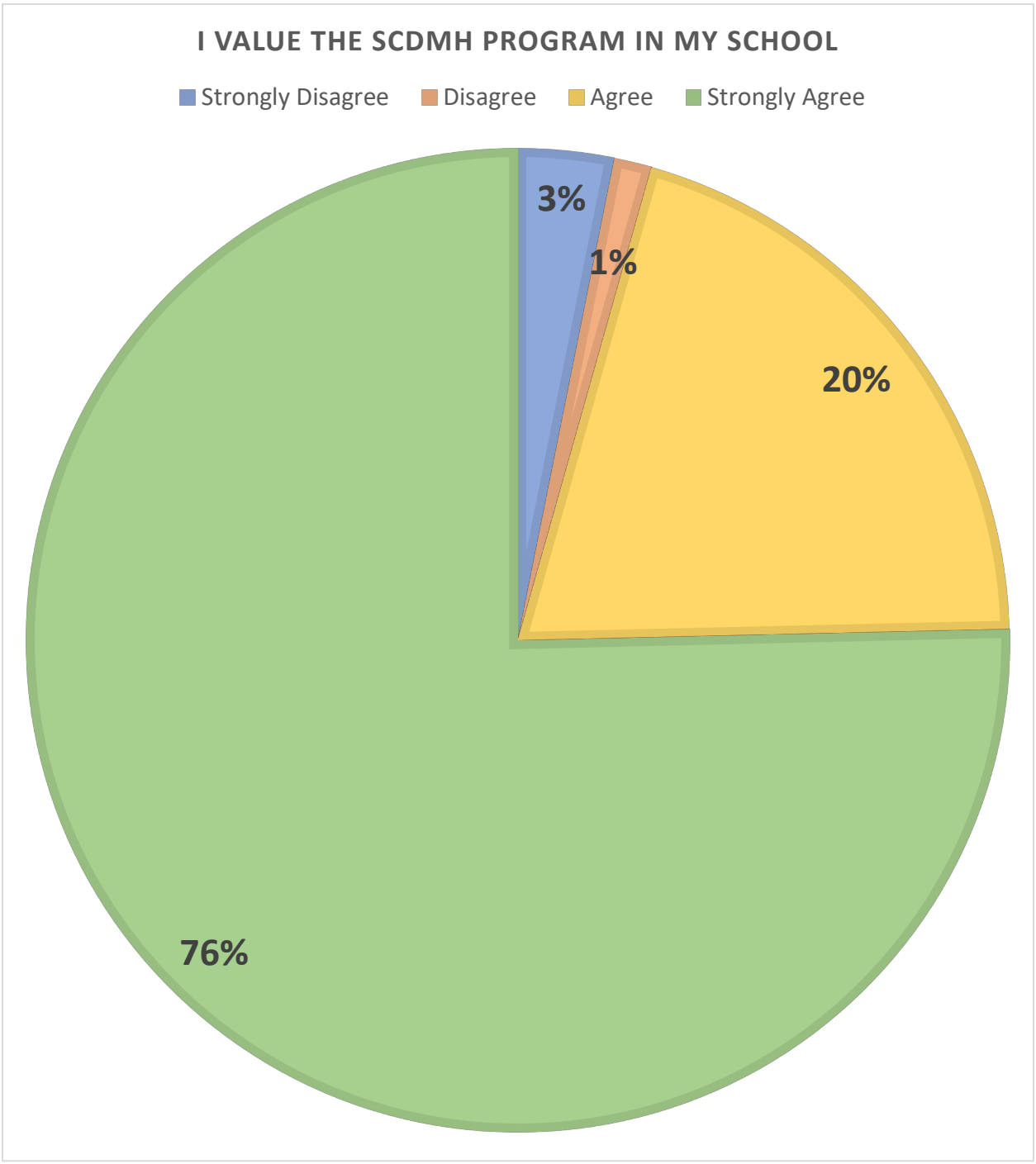
The following outcomes are from the SC Department of Mental Health School Administrator Survey 2019. Over 480 school administrators from across the state responded to this survey! The details of the outcomes are represented in both graphs and frequency tables below to help visualize the responses from the South Carolina school administrators.

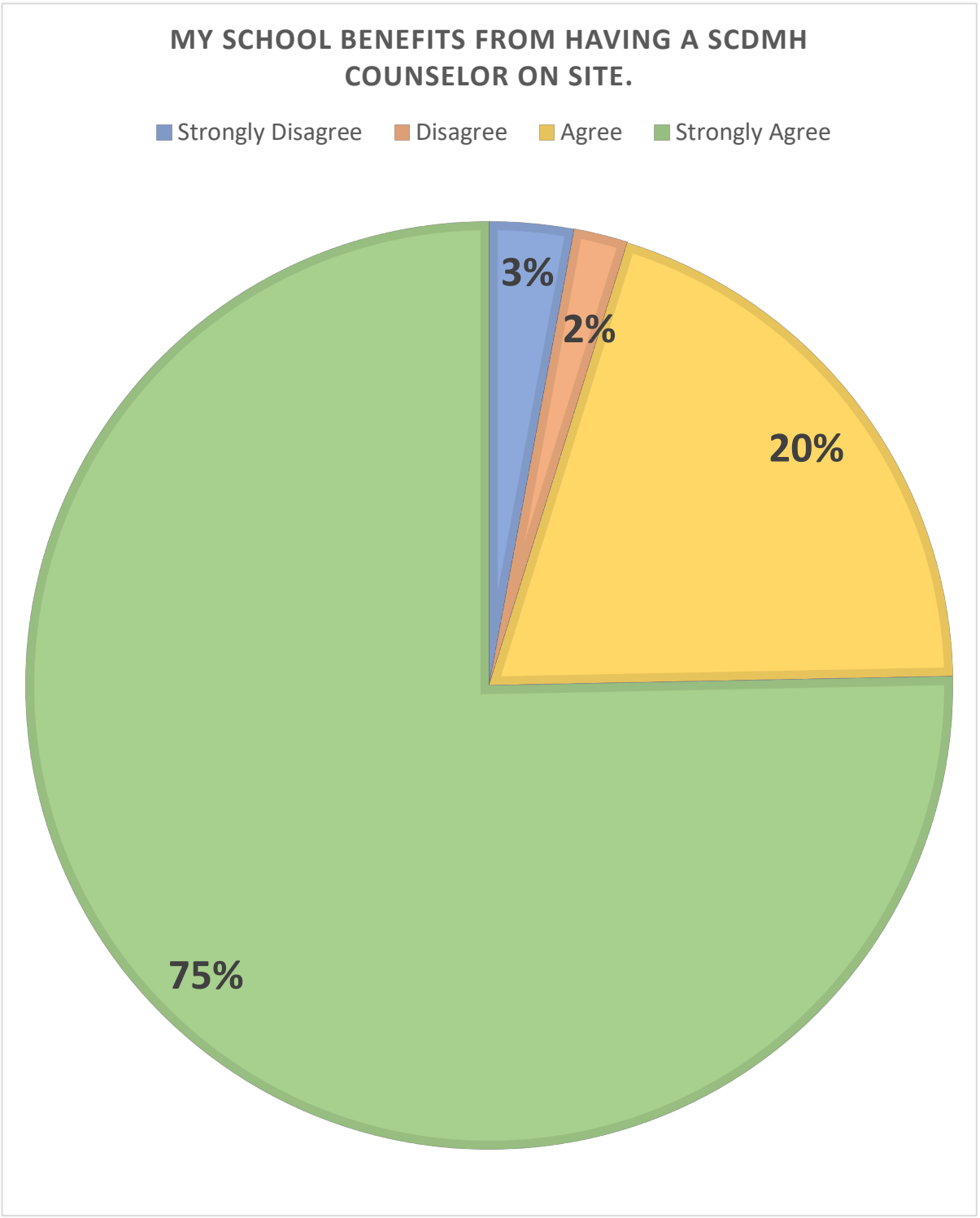



THE SCDMH PROGRAM PROVIDED TO STUDENTS HAS CONTRIBUTED TO A MORE POSITIVE WORKING ENVIRONMENT FOR FACULTY AND STAFF.
Disagree
Agree
9%
91%


THE COUNSELOR IS SENSITIVE TO MY SCHOOL'S FACULTY AND STAFF NEEDS.
Strongly Disagree
Disagree
Agree
Strongly Agree
3%
4%
37%
56%


I AM SATISFIED WITH THE SCDMH SERVICES PROVIDED IN THE SCHOOL.
Strongly Disagree
Disagree
Agree
Strongly Agree
4%
7%
32%
57%


I VALUE THE SCDMH PROGRAM IN MY SCHOOL
Strongly Disagree
Disagree
Agree
Strongly Agree
3%
1%
20%
76%


MY SCHOOL BENEFITS FROM HAVING A SCDMH COUNSELOR ON SITE.
Strongly Disagree
Disagree
Agree
Strongly Agree
3%
2%
20%
75%

School Administrators responded to the following prompt: *"What is working well with the SCDMH school mental health program?"* Below are the identified themes that emerged as well as examples of responses that were provided.

Top Positive Themes	Frequency (of 488 responders)
Mental health services are easily accessible	108
Clinician is available for crisis intervention	32
Clinician collaborates with school staff and has become part of the school culture	66
Clinician provides quality services to support students/families	116

Highlighted Responses:

"Having a resource for our kids that have challenges outside the school setting. They have a great relationship with students and teachers, making it easier to serve the students that need help."

"Having trained mental health counselors to meet with students is very beneficial and needed here at our high school, as we see an increase in student mental health concerns."

"As one of the school psychologists in the building my relationship with the mental health counselor is so valuable. We collaborate and work together to better mental health outcomes and educational success for our students."

"Working together with our MTSS team we have been able to identify students with need and get the supports quickly."

"Availability is critical to our students at Lee Central Middle School. Assessing and providing services for students while at school ensures that students receive needed help."

"The ability for students to be seen on campus without being dependent on parents taking them to appointments off campus."

School Administrators responded to the following prompt: *"What could be improved about the SCDMH school mental health program?"* Below are the identified themes that emerged as well as examples of responses that were provided.

Top Themes for Areas of Improvement	Frequency (of 488 responders)
Need full-time/consistent/additional SMH Clinicians	231
Need better integration and communication from clinicians with other school personnel	34
Need clinicians to provide more training/professional development for school staff	6
Schools need access to more mental health services (e.g., groups; summer services)	10

Highlighted Responses:

"I would like to be able to have a full-time mental health counselor at each school."

"Many of our students need more support. Having a counselor available on a daily basis would be more beneficial."

"It would be helpful to have a counselor here more than just 2 days a week."

"Keep communication open; ensuring the school is informed as is appropriate."

"Providing workshops for faculty members so that we can gain a better understanding of students and family's needs and how to handle them in a school setting."

"An overview of the program, goals and best ways to measure effectiveness."

"Improved communication between SCDMH and school administration. Daily, weekly and monthly schedules as well as identified students is a must in keeping lines of communication open."

"…more frequent individual and family group sessions."

Vulnerable Adult Fatalities Review Committee Meetings

Meeting Date	Attendee	Discussion
March 13, 2019	Gary Ewing	Discussed the importance of documenting and following safety precautions for consumers in Department of Mental Health facilities. The committee discussed how appropriate precautions should be maintained in accordance with each individual's unique plans for both their behavior and medical needs.
January 9, 2019	Gary Ewing	
May 9, 2018	Gary Ewing	Discussed concerns regarding medicine administration over the weekends in facilities.
March 14, 2018	Gary Ewing	The concern was voiced that consumer records for investigated cases are not always provided in a timely manner by facilities. There was a recommendation by the committee to the Department of Mental Health to disseminate a reminder to their facilities reminding them of the seriousness of this matter, and that it is by law that they provide requested records to SLED.
January 10, 2018	Gary Ewing	Discussed the documentation that is kept in Department of Mental Health homeshare facilities – Also discussed concerns with the services provided to consumers that have dual diagnoses associated with both the DDSN and DMH. There are inadequate mental health and intellectual disability service opportunities for consumers that need care. Diagnoses for the two agencies occasionally overlap, making it difficult to determine which type of facility the consumer should be placed. The committee sees this as an issue of growing concern, and believes that it should be addressed in the future in order to provide better quality of care.
October 12, 2017	Julius Freeman (DMH Proxy)	
May 9, 2017	Gary Ewing	
March 8, 2017	Gary Ewing	
January 11, 2017	Gary Ewing	
November 2, 2016	Gary Ewing	

July 13, 2016	Gary Ewing	A patient was transferred between facilities (DDSN/DMH/jail) several times, but he was transferred without paperwork. The receiving

		facilities did not have record of his medications. This is a systems failure; no case manager was involved.
March 9, 2016	Gary Ewing	
January 13, 2016	Gary Ewing	Documentation of medication given – The issue has come up on several cases in the past of improper documentation on Medication Administration Records (MAR). The Committee again stressed the importance of proper documentation at the correct time. Recommendation made that DMH representatives on The Committee discuss these systemic issues with their respective boards to explore solutions at specific facilities.

File Number	Agency Ref.	Plan Year	of	Overall	of		
FY1 2019-2020							
101	DMH01	1	7	1	49	700,000	VVH Chiller Replacement
102	9759	2	7	2	49	1,600,000	J12-9759-ML, Coastal Empire Community Mental Health Center HVAC, Sprinkler System, Fire alarm and Roof Replacements
103	9736	3	7	3	49	16,167,812	J12-9736-FW; Harris Hospital HVAC/Fire Sprinkler Renovations
104	9751	4	7	4	49	3,600,000	J12-9751-JM; Crafts Farrow Campus Electrical Distribution System Renovations
105	9763	5	7	5	49	470,000	SCDMH Campbell Kitchen Drain Repair
106	DMH02	6	7	6	49	3,500,000	Community Buildings Deferred Maintenance
107	DMH03	7	7	7	49	1,000,000	Inpatient Buildings Deferred Maintenance
FY2 2020-2021							
208	9766	1	10	8	49	4,619,727	Harris Hospital Renovations Lodges A, G, H, J, and K
209	DMH04	2	10	9	49	3,300,000	Crafts Farrow State Hospital and Tucker Center Laundries
210	DMH05	3	10	10	49	1,600,000	Waccamaw Center for Mental Health HVAC, Sprinkler, Fire Alarm and Roof Replacement
211	DMH06	4	10	11	49	12,430,000	Anderson-Oconee-Pickens Mental Health Center Construction
212	DMH07	5	10	12	49	12,430,000	Catawba Mental Health Center Construction
213	DMH08	6	10	13	49	8,050,000	Columbia Area Mental Health Center Construction Phase III
214	DMH09	7	10	14	49	3,940,000	Campbell State Veterans Nursing Home Renovations
215	DMH10	8	10	15	49	1,000,000	Roddey Nursing Home Floor Replacement
216	DMH11	9	10	16	49	2,000,000	Demolish four vacant buildings on the Crafts Farrow campus
217	DMH12	10	10	17	49	450,000	Morris Village Nursing Station Renovations
FY3 2021-2022							
318	9737	1	9	18	49	54,100,000	J12-9737-LC; State Veterans Nursing Home Central
319	DMH13	2	9	19	49	2,420,000	Bryan Psychiatric Hospital Roof & HVAC Replacements
320	DMH14	3	9	20	49	1,700,000	Bryan Lodges (Water Isolation, Tile Replacement and Storefront Replacement)
321	DMH15	4	9	21	49	350,000	Bryan & MV Sidewalk Construction, Repairs and Covers
322	DMH16	5	9	22	49	2,200,000	Central Administrative Building Renovation
323	DMH17	6	9	23	49	350,000	Physical Medicine Building A/C and Roof Replacement
324	DMH18	7	9	24	49	500,000	Morris Village Administrative Modulars and West Classroom Replacement
325	DMH19	8	9	25	49	1,485,000	DIS Central Pharmacy Construction
326	DMH20	9	9	26	49	1,700,000	Building 29 Roof Replacement
FY4 2022-2023							
427	DMH21	1	12	27	49	1,800,000	Construction of a new Abbeville Mental Health Clinic
428	DMH22	2	12	28	49	3,245,000	Construction of a second floor addition to the Charleston MHC Children's Clinic Wing
429	DMH23	3	12	29	49	300,000	Harris Hospital Activity Shelters Construction
430	DMH24	4	12	30	49	14,000,000	Lexington County Community Mental Health Center
431	DMH25	5	12	31	49	1,200,000	Tucker Center Storage Building Construction
432	DMH26	6	12	32	49	550,000	Storm Drainage Improvements at Bryan
433	DMH27	7	12	33	49	1,400,000	Crafts Farrow Campus Road/Parking Lot Repairs and Repavement
434	DMH28	8	12	34	49	1,800,000	Kershaw Mental Health Clinic Addition and Roof Replacement
435	DMH29	9	12	35	49	3,600,000	Cherokee Mental Health Clinic Construction
436	DMH30	10	12	36	49	1,680,000	Crafts Farrow Building 17, Public Safety Renovation
437	DMH31	11	12	37	49	2,560,000	Crafts Farrow Building 6 Renovation
438	DMH32	12	12	38	49	1,400,000	North Augusta Satellite Mental Health Center - New Construction
FY5 2023-2024							
539	DMH33	1	11	39	49	3,000,000	Construction of a new Pickens Mental Health Center
540	DMH34	2	11	40	49	2,400,000	Construct a new Aiken Barnwell Mental Health Clinic to replace the Hartzog Clinic
541	DMH35	3	11	41	49	2,000,000	Edgefield Mental Health Clinic Construction
542	DMH36	4	11	42	49	600,000	Harris Hospital Pavement and Exterior Lighting Renovations
543	DMH37	5	11	43	49	920,000	Interior renovations of patient areas at Harris Psychiatric Hospital

Crafts Farrow State Hospital and Tucker Center Laundries	
2,550,000	construction
2,626,500	Y1 Inflation
2,705,295	Y2 Inflation
270,530	10% Contingency
216,424	A&E
15,000	3rd Party
20,000	Abatement
3,227,248	Total

544	DMH38	6	11	44	49	500,000	Harris Psychiatric Hospital Renovation and Expansion of A&D and Public Safety
545	DMH39	7	11	45	49	3,600,000	Construction of a new Brook Pine CRCF and Gaston Clinic
546	DMH40	8	11	46	49	2,000,000	Construction of an addition to the Clarendon Mental Health Clinic
547	DMH41	9	11	47	49	2,400,000	Construction of a new Bishopville Mental Health Clinic
548	DMH42	10	11	48	49	2,400,000	Construction of a new Union Mental Health Clinic
549	DMH43	11	11	49	49	1,397,000	Construction of a new McCormick Mental Health Clinic

South Carolina Department of Mental Health
Forensic Waiting Lists Elimination Plan

December 6, 2002

The following steps represent the Department of Mental Health's plan to bring about the elimination of the waiting lists of criminal defendants awaiting admission to the Department's forensic inpatient programs at the Columbia Care Center.

STEPS TO ELIMINATE FORENSIC WAITING LISTS

1) Increase Bed Capacity in the Pre-trial program. Increase size of Pre-trial program initially from the current 18 bed unit to a 22 bed unit by converting some unused space to patient rooms. The Pre-trial unit has generally only been able to safely treat 14 patients due to staffing limitations. Assign an additional physician, psychologist and social worker to the Pre-trial unit, and thereby increase capacity on Pre-trial unit to all 22 beds. The increased staffing and increased beds will enable the program to increase admissions and discharges to the 20 - 25 per month range needed to meet the average demand and reduce the current waiting list by an average of 5 - 10 per month.

2) Additional staff for the PRP program. Increase staff of PRP program to improve efficiency and effectiveness of the intermediate care treatment program.

- **a.** Additional social work staff are needed to work on aftercare planning–locating and making application to structured, supported community placements and completing the multiple steps generally needed to finalize a discharge for this population, including report preparation for Forensic Review Board and the reviewing Court.
- **b.** Assign or hire additional Mental Health Specialists in PRP for escort duty to accompany patients on trips, further freeing up social workers that have been performing that function.

3) Open step-down programs to facilitate discharges from PRP. Use a closed ward or building on CFSH campus to locate step-down programs for those PRP patients who are clinically stable and no longer need the level of care or security of the Columbia Care Center, but whose history or legal status makes discharge to a private community setting difficult. The availability of such programs will increase discharge options for the PRP patients and, freeing up capacity within the PRP program.

4) Develop means to regularly review status of PRP patients. Increase clinical review of PRP patients' treatment plans to ensure treatment teams are timely and appropriately addressing clinical issues of individual patients, and to identify when the treatment team may require assistance. This is another means to improve the efficiency and effectiveness of the current programs.

5) Pilot the feasibility of an outpatient restoration service program. The vast majority of individuals awaiting admission to the agency's inpatient forensic program have been found incapable of standing trial, but likely to become competent with further treatment. Several states currently provide competency restoration services on an outpatient baisis, generally sending clinical staff to provide such services to defendants in detention

centers. As with almost every other clinical service, outpatient services are less expensive. It may be possible to serve one category of defendants who currently require inpatient forensic services on an outpatient basis, reducing the demand for inpatient services.

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Status Report #3: Forensic Waiting Lists Elimination Plan

January 27, 2003

The following is a report of the current status of several of the steps that are being implemented to bring about the elimination of the waiting lists of criminal defendants awaiting admission to the Department's forensic inpatient programs at the Columbia Care Center. This is the third such report.

The Department delivered its "Forensic Waiting Lists Elimination Plan" to the Honorable Henry Floyd on December 6, 2002. Judge Floyd has been appointed by Supreme Court Chief Justice Jean Toal as a special circuit court judge with jurisdiction to "review and approve a statewide plan for the orderly and timely disposition of commitment orders and to monitor the status of all inmates currently in custody and awaiting admission pursuant to commitment orders."

Judge Floyd has scheduled a hearing to review the Department's Plan at 2:00pm on January 29, 2003 in the Richland County Courthouse.

STEPS TO ELIMINATE FORENSIC WAITING LISTS

1) Increase Bed Capacity in the Pre-trial program. Increase size of Pre-trial program initially from the current 18 bed unit to a 22 bed unit by converting some unused space to patient rooms. The Pre-trial unit has generally only been able to safely treat 14 patients due to staffing limitations. Assign an additional physician, psychologist and social worker to the Pre-trial unit, and thereby increase capacity on Pre-trial unit to all 22 beds. The increased staffing and increased beds will enable the program to increase admissions and discharges to the 20 - 25 per month range needed to meet the average demand and reduce the current waiting list by an average of 5 - 10 per month.
The Pre-trial unit was modified and the number of available beds increased to 22 effective October 29, 2002. As soon as the PRP waiting list is eliminated and the PRP patient census declines [see 2), below], further additions to the size of the Pre-trial unit will be pursued.

A new psychologist was hired effective January 2, 2003. Although she is physically located in the Cooper building, she is now providing psychological evaluations for Pre-trial patients and the turn-around time on such evaluations will be improving.

An additional physician was assigned to the Pre-trial unit from State Hospital. However, shortly after the reassignment the existing physician transferred to a vacant position at a Mental Health Center. Another physician was then hired, and was expected to begin working in the Pre-trial unit January, 2003. However, she had to be assigned to another program with a critical need for psychiatric coverage. Another psychiatrist has applied and will be interviewed this week.

One additional Masters trained social worker transferred to the Pre-trial unit in

November. Given the continued high demand and need, the addition of another Masters trained social worker is currently being considered.

The rate of admissions and discharges has significantly improved since August, 2002, but is not yet consistently above the 20 per month currently believed necessary to both meet current demand while reducing the Pre-trial waiting list at a pace which will meet the Department's goal of eliminating the list by the summer of 2003.

2) Additional staff for the PRP program.

a. Additional social work staff are needed to work on aftercare planning–locating and making application to structured, supported community placements and completing the multiple steps generally needed to finalize a discharge for this population, including report preparation for Forensic Review Board and the reviewing Court.

The addition of mental health specialists (below) did free up some social workers time. In addition, some existing social work staff was reassigned for greater efficiency. The rate of discharges from the PRP program has increased, and the PRP waiting list is projected to be essentially gone by the end of February.

b. Assign or hire additional Mental Health Specialists in PRP for escort duty to accompany patients on trips, further freeing up social workers that have been performing that function.

Seven (7) Mental Health Specialists (MHSs) were authorized and all seven were hired as of January 17, 2003.

3) Determine possibility of opening a step-down program to facilitate discharges from PRP. Determine feasibility of using closed ward or building on SCSH or CFSH campus as step-down program for those PRP patients who are clinically stable and no longer need the level of care or security of the Columbia Care Center, but whose behaviors or legal status make discharge to a private community setting difficult, thereby increasing discharge options for the PRP patients and increasing the pace at which NGRI defendants and defendants found incompetent but likely to become are able to be admitted.

Building 1 on the old Crafts-Farrow State Hospital campus was successfully re-modeled into two 16 bed Community Residential Care Facilities (CRCF). The first, known as "Sunrise," and operated by the Piedmont Center for Mental Health Services, was licensed by DHEC January 3, 2003, and accepted its first three (3) residents from the PRP the week of January 6, 2003. It now has a census of six (6). Ten (10) additional PRP patients have been approved internally for discharge to the CRCFs, but are still awaiting court approval of their discharges. Following some delays in scheduling hearings around the holidays, three (3) hearings per week are scheduled in each of the next three weeks, and it is anticipated Sunrise will be near capacity in mid February. The second CRCF will likely open in late February.

4) Develop means to regularly review status of PRP patients. Increase external review of PRP patients' treatment plans to ensure treatment teams are timely and appropriately

addressing clinical issues of individual patients, and to identify when the treatment team may require assistance.

Chart reviews in the PRP units are done at the 60, 90, and 120 day point by a utilization review nurse. Management still hopes to initiate focus audits at a future point to further ensure that treatment teams are timely and appropriately addressing patients' clinical issues.

5) Pilot the feasibility of an outpatient restoration service program. The vast majority of individuals awaiting admission to the agency's inpatient forensic program have been found incapable of standing trial, but likely to become competent. Several states currently provide competency restoration training on an outpatient basis, generally sending clinical staff to defendants in detention centers. As with almost every other clinical service, outpatient services are less expensive. It may be possible to serve one category of defendants who currently require inpatient forensic services on an outpatient basis, reducing the demand for inpatient services.

A pilot project in such Midlands counties whose detention centers are willing to participate has been approved. A team consisting of a forensic psychiatrist and a social worker has been identified. Efforts are continuing to finalize a protocol with a detention center in the Columbia area to test the feasibility of an in-jail competency restoration service.

SC Department of Mental Health
Grant Portfolio
as of 8/28/2019

Grant Name	Grantor	Description	Award Date	Amount Awarded	Source of Funding
Behavioral Health Services Information System (BHSIS)	SAMHSA/Eagle Technologies	SAMHSA awarded Eagle Technologies the responsibility to distribute funds for the support of the Behavioral Health Services Information System (BHSIS) developed by SAMHSA to support portions of the data needed for Block Grant application requirements.	9/23/2013	$745,879.12	Federal
SC Youth Suicide Prevention Initiative (SCYSPI)	Substance Abuse and Mental Health Services Administration (SAMHSA)	The ultimate goal is to reduce suicide deaths and non-fatal attempts across the entire 10 - 24 age range, $736,000 per year for 5 years.	9/8/2015	$3,680,000.00	Federal
Catawba CMHC/Community Medicine Foundation Primary Care Initiative (SCPBH)	Substance Abuse and Mental Health Services Administration (SAMHSA)	Provide integrated primary and behavioral health to clients of Catawba CMHC by contracting with local FQHC for primary medical personnel. Primary medical care will be provided in the Catawba CMHC Clinic sites. 4 year grant	9/2/2016	$1,548,308.00	Federal
Mother Emanuel Victims Assistance	U.S. Department of Justice/Crime Victims Assistance, Sub-Recipient through The Medical University of South Carolina	The purpose of the request made to the Office for Victims of Crime is to obtain resources needed to provide comprehensive, holistic, and coordinated long-term services to direct and indirect victims of the Emanuel AME Church racially motivated domestic terrorism murders.	10/21/2016	$600,365.47	Federal
Projects for Assistance in Transition from Homelessness (PATH)	Substance Abuse and Mental Health Services Administration (SAMHSA)	Provides services to people with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness.	9/5/2017	$680,202.00	Federal
2018 Community Mental Health Services Block Grant	Substance Abuse and Mental Health Services Administration (SAMHSA)	To provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system.	12/8/2017	$10,391,425.00	Federal
SC Zero Suicide	Substance Abuse and Mental Health Services Administration (SAMHSA)	The purpose is to implement suicide prevention for individuals who are 25 years of age or older. $700,000 per year for 5 years.	7/23/2018	$3,525,000.00	Federal
Homelessness in South Carolina	Services Administration (SAMHSA)	coordinated, evidence-based treatment services to individuals who experience chronic	8/17/2018	$5,000,000.00	Federal
Victims of Crime Act (VOCA)	U.S. Department of Justice Sub-recipient agreement through The SC Office of the Attorney General	The proposed project will expand CDMHC's very successful Family Violence Unit located at Charleston Police Department.	8/22/2018	$406,898.00	Federal
SC Healthy Transitions (Roads of Independence)	Substance Abuse and Mental Health Services Administration (SAMHSA)	The purpose of the grant is to improve access to treatment and support services for youth and young adults, ages 16-25, who have serious emotional disturbance (SED) or a serious mental illness (SMI). $1,000,000 per year for up to 5 years.	8/23/2018	$5,000,000.00	Federal
Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P)	Substance Abuse and Mental Health Services Administration (SAMHSA)	The purpose of the SAMHSA Funded CHR-P program is to identify youth and young adults, not more than 25 years old, at clinical high risk for psychosis and provide evidence-based interventions to prevent the onset of psychosis or lessen the severity of psychotic disorder.	9/12/2018	$1,581,720.00	Federal
Advancing Wellness and Resiliency in Education (Project AWARE)	Substance Abuse and Mental Health Services Administration (SAMHSA) Sub-recipient agreement through The SC Department of Education	The purpose of this program is to build or expand the capacity of State Educational Agencies, in partnership with State Mental Health Agencies (SMHAs) overseeing school-aged youth and local education agencies. We are a sub-recipient through SC Department of Education.	9/18/2018	$2,050,453.00	Federal
2019 Community Mental Health Services Block Grant	Substance Abuse and Mental Health Services Administration (SAMHSA)	To provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system.	12/26/2018	$10,306,043.00	Federal
CDMHC Transportation Services Program	Federal Transit Administration (FTA) Sub-recipient agreement through The Berkeley, Charleston, Dorchester Council of Government	Proposal to the FTA for enhanced mobility for seniors and individuals with disabilities	2/14/2019	$26,284.00	Federal
Continuum of Care	U.S. Housing and Urban Development	The Continuum of Care (COC) Program is designed to promote communitywide commitment to the goal of ending homelessness	4/15/2019	$297,393.00	Federal

SC Department of Mental Health
Grant Portfolio
as of 8/28/2019

Grant Name	Grantor	Description	Award Date	Amount Awarded	Source of Funding
Continuum of Care	U.S. Housing and Urban Development	The Continuum of Care (COC) Program is designed to promote communitywide commitment to the goal of ending homelessness	4/15/2019	$566,373.00	Federal
Continuum of Care	U.S. Housing and Urban Development	The Continuum of Care (COC) Program is designed to promote communitywide commitment to the goal of ending homelessness	4/15/2019	$276,904.00	Federal
		Total Federal Grants		**$46,683,247.59**	
Community Telepsychiatry	Department of Health and Human Services	SC Telehealth Alliance is an unprecedented collaboration of SC hospitals, providers, government leaders, and other entities working together to improve access to quality, cost-effective care through the use of telehealth services.	7/1/2012	$300,000.00	SC State Agency
SC Telehealth Alliance	Medical University of South Carolina	SC Telehealth Alliance is an unprecedented collaboration of SC hospitals, providers, government leaders, and other entities working together to improve access to quality, cost-effective care through the use of telehealth services. 1st Contract 06/01/2016-12/31/2017 $350,000.00 2nd Contract 01/01/2018-12/31/2019 $3,000,000.00	6/1/2016	$3,350,000.00	SC State Agency
		Total State Agency Grants		**$3,650,000.00**	
Mental Health Awareness	Linda M. Summer Family Services	Linda M. summer bequeathed to Pee Dee Mental Health Center fund to be utilized for the purpose of direct support to children and families enrolled in Pee Dee's CAF programs.	6/23/2006	$400,000.00	Foundation
Pee Dee Resiliency Project (PDRP)	BlueCross BlueShield	PDRP aims to build resiliency and improve well-being for students, families, and communities.	12/1/2015	$1,580,660.00	Foundation
Mental Health Courts	The Duke Endowment	South Carolina mental health courts can improve non-violent mentally ill offenders' quality of life and facilitate mental health recovery by reducing their jail time and by involving individuals in much needed healthcare treatment and community resources. 3 year grant.	5/5/2017	$1,220,000.00	Foundation
Mental Health Service Infrastructure	The Duke Endowment	Utilization of APRNs and Licensed Mental Health Counselors in Community Telepsychiatry	5/8/2018	$600,000.00	Foundation
School E-Health Virtual Information Supports for Treatment Access (VISTA)	The Duke Endowment	The project is designed to comprehensively support the mental & physical health needs of all 10,298 students enrolled in Darlington County School District via a staged approach. 3 year grant	5/8/2018	$1,200,000.00	Foundation
Engaging and Training with Compassion Project	BlueCross BlueShield of SC	SMH and Family Engagement Initiative to improve parallel service delivery across schools in three Community Mental Health Centers: Santee-Wateree, Columbia Area, and Lexington	12/6/2018	$996,748.00	Foundation
CDMHC Spanish-English Intake/Therapist Position	Sisters of Charity Foundation of SC	Funding is requested of the Sisters of Charity of SC Immigrant Families Initiative to be used towards a percentage of the salary and benefits of a Bi-Lingual (Spanish-English) master's level position to provide intake for the mobile unit and as well as providing therapy.	5/8/2019	$7,500.00	Foundation
Mental Health Law Enforcement Alliance Project	BlueCross BlueShield Foundation of SC	Intended to strengthen mental health / law enforcement collaborations, expand the reach and impact of the Adverse Childhood Experiences (ACE) Initiative, create a Community Support Unit (CSU), and establish 10 alliance teams available to respond to the needs of communities, families, and children faced with trauma	5/15/2019	$874,971.00	Foundation
		Total Foundation Grants		**$6,879,879.00**	
		Subtotal Awarded Grants		**$57,213,126.59**	

SC Department of Mental Health
Grant Portfolio
as of 8/28/2019

Grant Name	Grantor	Description	Award Date	Amount Awarded	Source of Funding
Grants in Conditional Approval Status					
South Carolina Veterans Nursing Home	Veterans Affairs	This is the State of South Carolina's project to construct a veteran nursing home facility in Florence.		$28,539,163.90	Veterans Affairs
South Carolina Veterans Nursing Home	Veterans Affairs	This is the State of South Carolina's project to construct a veteran nursing home facility in Gaffney.		$29,412,178.90	Veterans Affairs
		Subtotal Conditional Approval Grants		**$57,951,342.80**	
		Total Grants		**$115,164,469.39**	

SCDMH - DIVISION OF INPATIENT SERVICES

SC House Legislative Oversight Committee Responses
August 19, 2019 Memo Responses &
Follow up Responses to Previous Correspondence

Submitted by: Versie J. Bellamy, DNP, MN, RN,
Deputy Director,
Division of Inpatient Services and Division of Long Term Care

HLOC Memo Question #4

Question	Response
Quantify the increase in the Agency's evaluation capacity with the addition of each new evaluator.	With each new full time evaluator position, DMH can complete approximately 100 Competent to Stand Trial (CST)/Criminal Responsibility/Capacity to Conform (CR) evaluations.

HLOC Memo Question #6

Question	Response
Provide Detailed Organizational Chart	Attachment: DIS ORG CHART EDITED 8/27/19

Division of Inpatient Services (DIS)

South Carolina Department of Mental Health

(Division of Inpatient Services (DIS) Leadership

Update: 8-28-2019

Interim DMH State Director

DIS Executive Oversight/Direct Reports

Deputy Director for the Division of Inpatient Services and the Division of Long Term Care

- **Director, DIS Org. Planning/Project Development & Position Controller**
  - **Coordinator, Staffing Standards**
- **DIS Administrator and Emergency Management Director**
  - **DIS Director Health Information**
  - **Director Materials Management** (Columbia Facilities)
  - **Director Nutritional Services** Operations (Columbia Facilities)
  - Supervisor **Central Entitlements** (Columbia Hospitals)
  - **Director Central Therapy Services** (Services Administration) (Columbia Facilities)
  - **Community Development/ Volunteer Services** (Columbia Hospitals)
- **DIS Financial Controller** (CPA)
  - Dual Reporting to SCDMH and DIS
  - **DIS Director Financial Services** (BPH, MV, SVPTP & Specialty Clinics)
    - **Finance Services (Payables)**
    - **Cashier/Post Office Services**
    - **Contract Services**
  - **HPH Financial Svcs**
  - **Nutritional Services** Financial Services
  - **Long Term Care** Financial Services
- **DIS Director Quality, Risk Management and Regulatory Compliance**
  - **Performance Improvement** Manager
  - Environmental Safety Officer
  - **Infection Control Manager**
  - **Risk Manager**
- **DIS Compliance Officer**
- **Director Forensic Contract Monitoring & Forensic Outpatient Services**
  - **Forensic Inpatient Contract Monitoring** (Operated by Wellpath)
  - **Sexually Violent Predators Treatment Program(SVPTP) Contract Monitoring** (Operated by Wellpath)
  - **Sexually Violent Predators Treatment Program(SVPTP) Contract Monitoring** (Operated by Wellpath)
  - **Forensic Evaluation Services (FES)**
  - **Forensic (NGRI) Outreach Services**
- **Hospital Director Bryan Psychiatric Hospital** (3 Hospital Components)
  - **Bryan Psychiatric Adult Civil** Hospital Component
  - **BPH – William S. Hall Psychiatric Institute** (Child & Adolescent) Hospital Component
  - **BPH – Forensic Adult** Hospital Component
  - **Hospital Director Harris Psychiatric Hospital** (Adult Civil Hospital)
  - **Hospital Director Morris Village** (Alcohol & Substance Abuse Treatment Program)
- **Chief Nursing Officer for the Division of Inpatient Services and the Division of Long Term Care**
  - **Asst Chief Nursing Officer for the Division of Long Term Care**
  - **Director of Nursing Bryan Psychiatric Hospital** (Adult, Forensic & WSHPI - Child & Adolescent Services)
  - **Director of Nursing Harris Psychiatric Hospital** (Adult Psychiatric Services)
  - **Director of Nursing Morris Village Alcohol & Drug Addiction Treatment Program** (Adult Services)
  - **Director of Nursing** CM Tucker, Roddey (Adult Services)
  - **Director of Nursing** CM Tucker, Stone **CM Tucker, Stone VA Nursing Home**
  - **Director Practice & Development**
  - **Central Staffing Coordinator**
    - KRONOS Administration,
    - Advanced Scheduling
    - Agency Staffing & Billing Coordination)
  - **Director, Informatics**
    - Systems Data Administration
    - Clinical Staff Core Competency Validation Repository
- **Assistant Deputy Director for the Division of Long Term Care Services & Chief Medical Officer (CMO) for Medical Practice and Standards for the Division of Inpatient Services**
  - **DIS Hospital and Nursing Home Medical Directors** (Report to CMO for Practice and Standards)
    (Hospital Medical Directors Administratively Report to the Respective Facility Director)
  - **Long Term Care Medical Staff** (Roddey Pavilion & Stone Pavilion)
  - **LTC Primary Care Medical Director/Advisor**
  - **Director DIS Clinical Initiatives**
  - **DIS Pharmacy Services** (2) Pharmacy Directors (Columbia Facilities)
  - **DIS Specialty Clinics**
  - **Director for Veterans Services & Nursing Home Administrator for Tucker – Stone Pavilion**
  - **Veterans Victory House (VA Nursing Home)** Contract (Operated by HMR)
  - **Campbell Veterans Home (VA Nursing Home)** Contract (Operated by HMR)
  - **Nursing Home Adminsitrator Tucker – Roddey Pavilion** (General Nursing Home)

HLOC Memo Question #7

Question	Response
Provide Position Descriptions for NP, Physicians and Psychiatrist (Scope of practice, skill set requirements and reporting chain)	Attachments: Sample Position Descriptions (NP, Primary Care Physician & Psychiatrist) Nurse Practice Act

STATE OF SOUTH CAROLINA POSITION DESCRIPTION

GENERAL INFORMATION

Position Number: | | | | | | | | |

Agency Code: U 1 2

Agency Name: South Carolina Department of Mental Health

Division / Section / Unit: DIS/Medical Staff

City / County: Columbia/Richland

Employee Name:

County Code: 4 0

Is Position in Central Office: N Y/N

Current State Title: Nurse Practitioner II

Alphanumeric Code: E A 6 5

Slot:

Band: 0 8

Full / Part Time Indicator: F 5 2

Supervisor State Title: Medical Director

Alphanumeric Code: U B 2 6

Slot:

Hours Per Week: 3 7 . 5 0

Base Hours: 1 9 5 0

SOURCE OF FUNDING

State %: 1 0 0

Federal %:

Other %:

☐ OHR COPY ☐ AGENCY COPY

OFFICE OF HUMAN RESOURCES

Agency Code:

Alphanumeric Code:

Slot:

Authorized Date:

☐ Delegated ☐ New Position ☐ Prototype

☐ State Title Changes ☐ Update

Approved State Title:

Approval Signature:

Date Approved:

REQUESTED ACTION INFORMATION

Requested Action:

Requested State Title: Nurse Practitioner II

Alphanumeric Code: E A 6 5

☐ FLSA Designation

Supervisor's Signature:

Date:

Other Required Signature:

Date:

THE FOLLOWING SECTION OF THE POSITION DESCRIPTION IS TO BE COMPLETED BY THE SUPERVISOR

1. What are the minimum requirements for the position (Minimum requirements must at least meet the state minimum requirements for classified classes but may include additional requirements.)?

Graduate from an accredited school of nursing with clinical experience. Graduate from an accredited school of nursing a master's degree in nursing. Requires a nursing license and official recognition by the Board as a Nurse Practitioner practicing in the extended role and authorized for prescriptive authority in South Carolina.

2. What knowledge, skills, and abilities are needed by an employee upon entry to this job including any special certification or license?

Nursing license and official recognition by the Board as a Nurse Practitioner practicing in the extended role and authorized for prescriptive authority in South Carolina.

3. Describe the guidelines and supervision an employee receives to do this job, including the employee's independence and discretion.

Clinical guidance is provided by supervisor, as assigned. Able to work independently, exercising judgement and seeking guidance on an "as needed" basis.

4. Indicate additional comments regarding this position (e.g., work environment, physical requirements, overnight travel).

The employee must be flexible in regard to work environment and travel. Must be able to work with repetitive unusual patient behaviors. Including but not limited to combative, threatening, acting out and unpredictable violence. Must be able to lift minimum of 50 lbs.; may be required to lift more during times of emergencies.

MISCELLANEOUS DATA

Employee Number:

Position Dept. Number:

STATE OF SOUTH CAROLINA POSITION DESCRIPTION

1. Job Purpose:
Plans, directs and executes delegated medical care activities for Bryan Psychiatric Hospital patients including the prescription of medication, pursuant to approved written protocols developed in collaboration with a physician preceptor.

2. Job Functions:	Essential/ Marginal (E or M)	Percentage of Time
A. Provides primary medical care to assigned patients admitted to Bryan Psychiatric Hospital with mandated physician supervision and as directed by approved protocols. This includes, but is not limited to, the admission history and physical examination, evaluation of new complaints, and coordination of indicated consultations and ancillary evaluations. Those activities are accomplished with required supervisory contact.	E	55
B. Evaluates patients on sick call and directs patient care within guidelines of formulary. Seeks consultation of supervising physician to assist in rendering care when indicated.	E	15
C. Maintain medical records as required by Bryan Psychiatric Hospital and DMH policies. Maintains proper documentation on assigned patients, including the history/physical, progress notes, acknowledgement of consultation and test results, documentation of supervisory contact and timely completion of discharge summaries.	E	15
D. Attends treatment team meetings, interventions and medical staff meetings routinely. Also serves on committees as appointed by the Facility Director or Medical Director. Participates in a collaborative manner as a resource for medical care issues on the multi-disciplinary team caring for assigned patients.	E	5
E. Provides education to staff and patients regarding health care issues of the population served through concerned groups and in-service presentations.	E	5
F. Performs other related duties as required.	E	5

3. Position's Supervisory Responsibilities:
If this position includes supervisory responsibilities, please indicate the state title and number of positions of the three highest subordinates.

	STATE TITLE	**NUMBER**
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____

Number of employees directly supervised: _____

Total number supervised: _____

4. Comments:

5. The above description is an accurate and complete description of this job. _____ _____
Employee's Signature Date

STATE OF SOUTH CAROLINA POSITION DESCRIPTION

GENERAL INFORMATION

6 0 0 3 0 3 9 0 — Position Number

U 1 2 — Agency Code

S.C. Department of Mental Health — Agency Name

DIS/Medical Service — Division / Section / Unit

Columbia/Richland — City / County

Employee Name

4 0 — County Code

N — Y/N Is Position in Central Office

Physician — Current State Title

U B 2 7 — Alphanumeric Code

Slot

1 0 — Band

F 5 2 — Full / Part Time Indicator

0 3 7 5 0 — Hours Per Week

1 9 5 0 — Base Hours

Medical Director — Supervisor State Title

U B 2 6 — Alphanumeric Code

Slot

SOURCE OF FUNDING

1 0 0 . 0 0 — State %

Federal %

Other %

☐ OHR COPY ☐ AGENCY COPY

OFFICE OF HUMAN RESOURCES

Agency Code | Alphanumeric Code | Slot

Authorized Date

☐ Delegated ☐ New Position ☐ Prototype

☐ State Title Changes ☐ Update

Approved State Title

Approval Signature | Date Approved

REQUESTED ACTION INFORMATION

Requested Action

Physician — Requested State Title

U B 2 7 — Alphanumeric Code

☐ FLSA Designation

Supervisor's Signature | Date | Other Required Signature | Date

THE FOLLOWING SECTION OF THE POSITION DESCRIPTION IS TO BE COMPLETED BY THE SUPERVISOR

1. What are the minimum requirements for the position (Minimum requirements must at least meet the state minimum requirements for classified classes but may include additional requirements.)?

Graduation from an approved school of medicine, completion of internship or one (1) year residency training, and two (2) years experience in medical services programs.

2. What knowledge, skills, and abilities are needed by an employee upon entry to this job including any special certification or license?

Thorough knowledge of the techniques and skills used in examination, diagnosis and treatment of the mentally ill and chemically dependent. Thorough knowledge of principles and practices of medicine. Ability to conduct mental and neurological examinations. Ability to prepare necessary paperwork. Ability to establish and maintain a satisfactory working relationship with patients, other professional employees and the general public.

3. Describe the guidelines and supervision an employee receives to do this job, including the employee's independence and discretion.

Licensed to practice medicine in the State of South Carolina.

4. Indicate additional comments regarding this position (e.g., work environment, physical requirements, overnight travel).

May be exposed to blood. Must be able to lift a minimum of 50 pounds, may berequired ot lift more in an emergency.

MISCELLANEOUS DATA

Employee Number

Position Dept. Number

STATE OF SOUTH CAROLINA POSITION DESCRIPTION

1. Job Purpose:
Thorough consultative supervision by the Medical Director, provides medical assessment, diagnosis and treatment of patients with mental illness and/or addiction. Maintains appropriate documentaiton in the medical record.

2. Job Functions:	Essential/ Marginal (E or M)	Percentage of Time
1. Provides medical consultation to medical director and other clinicians.	E	22
2. Completes History, Physical Examination, Admission Note and Initial Treatment Plan on assigned patients. Medical treatment: Responsible for diagnosis and prescription of treatment including sick call and emergencies and assigned patients..	E	25
3. Administrative Duties: Prepares progress notes, dictates final summaries and completes necessary documents.	E	15
4. Performs designated examinations and attends probate court hearings, as necessary.	E	15
5. Attends treatment team meetings and other meetings as necessary.	E	10
6. Acquires Continuing Education credits in general medicine topics.	E	5
7. Provides consultation to other physicians.	M	4
8. Performs other related duties as assigned.	M	3

3. Position's Supervisory Responsibilities:
If this position includes supervisory responsibilities, please indicate the state title and number of positions of the three highest subordinates.

	STATE TITLE	**NUMBER**
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____

Number of employees directly supervised: _____

Total number supervised: _____

4. Comments:

5. The above description is an accurate and complete description of this job. _____ _____
Employee's Signature Date

STATE OF SOUTH CAROLINA POSITION DESCRIPTION

GENERAL INFORMATION

☐ OHR COPY ☐ AGENCY COPY

14087 — Position Number
J12 — Agency Code
South Carolina Department of Mental Health — Agency Name
DIS/Medical Staff — Division / Section / Unit
Columbia, Richland — City / County
Employee Name
40 — County Code
N — Y/N Is Position in Central Office
Psychiatrist — Current State Title
UB26 — Alphanumeric Code
Slot
00 — Band
F52 — Full / Part Time Indicator
37.50 — Hours Per Week
1950 — Base Hours
Medical Director — Supervisor State Title
UB26 — Alphanumeric Code
0204 — Slot

SOURCE OF FUNDING

100 — State %
00 — Federal %
Other %

OFFICE OF HUMAN RESOURCES

Agency Code
Alphanumeric Code
Slot
Authorized Date
☐ Delegated ☐ New Position ☐ Prototype
☐ State Title Changes ☐ Update
Approved State Title
Approval Signature
Date Approved

REQUESTED ACTION INFORMATION

Requested Action
Psychiatrist — Requested State Title
9309 — Alphanumeric Code
E — FLSA Designation
Supervisor's Signature
Date
Other Required Signature
Date

THE FOLLOWING SECTION OF THE POSITION DESCRIPTION IS TO BE COMPLETED BY THE SUPERVISOR

1. What are the minimum requirements for the position (Minimum requirements must at least meet the state minimum requirements for classified classes but may include additional requirements.)?

Licensed to practice medicine in South Carolina. Must maintain South Carolina Medical Licensure, federal DEA, and South Carolina DEA. Completion of a four-year residency in psychiatry and a minimum 3 years in a psychiatric program. Board certified/eligible in general/adult psychiatry.

2. What knowledge, skills, and abilities are needed by an employee upon entry to this job including any special certification or license?

Must be licensed to practice medicine in South Carolina. Board certified/eligible in General Psychiatry. Excellent communication skills. Will be required to testify in court. Must be able to work in an atmosphere atmosphere with persons who have a high potential for violence.

3. Describe the guidelines and supervision an employee receives to do this job, including the employee's independence and discretion.

As a trained psychiatrist, employee will have considerable independence and discretion, but supervision and consultation will be provided by the GWBPH Medical Director.

4. Indicate additional comments regarding this position (e.g., work environment, physical requirements, overnight travel).

Court appearances may exceed regular work hours. Travel within stale for court appearances required. Must be able to work with repetitive unusual patient behaviors including but not limited to combative, threatening, acting out and unpredictable violence. May be exposed to blood. Must be able to lift a minimum of 50 lbs.

MISCELLANEOUS DATA

Employee Number
Position Dept. Number

STATE OF SOUTH CAROLINA POSITION DESCRIPTION

1. Job Purpose:
Under limited supervision, performs services to psychiatric patients in an inpatient hospital setting. Exercises medical responsibility for a hospital psychiatric unit; interviews, examines, diagnoses, and treats mental disorders of patients. Performs professional duties requiring analysis of broad and complex issues.

2. Job Functions:

	Essential/ Marginal (E or M)	Percentage of Time
A. Supervises individual treatment team and monitors lodge treatment teams in the care and treatment of mentally ill patients. Systematically evaluates the treatment planning process. Collaborates with other disciplines in the identification of patient needs and interventions. Assures documentation, delineates patient care responsibilities, interventions and desired patient response. Ensures that patient care services are timely and consistent with the overall patient care needs. Monitors length of stay on the lodge and ensures treatment/service/care planning processes are effectively implemented.	E	35
B. Executes care and treatment for mentally ill patients, conducts daily rounds, and completes psychiatric history and mental status examination. Completes all necessary paperwork/reports concerning patients' evaluation, progress, staffing, court examinations, discharge and disposition.	E	30
C. Takes night, weekend, holiday and back-up calls when required. Will provide coverage for physicians on leave. Attends staff conferences and serves on committees as required by the Hospital and/or Medical Director. Will actively participate and provide cases for case conference.	E	20
D. Maintains knowledge of age-specific needs of adult and geriatric populations and utilizes this knowledge in assessing and treating patients. Adheres to all corporate compliance, outcome evaluation, research and/or continuity of care policies and procedures. Adheres to HIPPA, harassment-free workplace, policies, time/attendance policies and facility's requirements for cultural awareness training. Maintains documentation of clinical services with State/Facility Quality Assurance Standards.	E	10
E. Other related duties as required.	E	5

3. Position's Supervisory Responsibilities:
If this position includes supervisory responsibilities, please indicate the state title and number of positions of the three highest subordinates.

	STATE TITLE	NUMBER
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____

Number of employees directly supervised: _____

Total number supervised: _____

4. Comments:

5. The above description is an accurate and complete description of this job. _____ _____
Employee's Signature Date

Title 40 - Professions and Occupations

CHAPTER 33

Nurses

ARTICLE 1
Nurse Practice Act

SECTION 40-33-34. Performance of medical acts; qualifications; practice agreements; prescriptive authorization; anesthesia care; definitions.

(A) An advanced practice registered nurse applicant shall furnish evidence satisfactory to the board that the applicant:

(1) has met all qualifications for licensure as a registered nurse; and

(2) holds current specialty certification by a board-approved credentialing organization. New graduates shall provide evidence of certification within one year of program completion; however, psychiatric clinical nurse specialists shall provide evidence of certification within two years of program completion; and

(3) has earned a minimum of a master's degree from an accredited college or university, except for those applicants who:

(a) provide documentation as requested by the board that the applicant was graduated from an advanced, organized formal education program appropriate to the practice and acceptable to the board before December 31, 1994; or

(b) graduated before December 31, 2003, from an advanced, organized formal education program for nurse anesthetists accredited by the national accrediting organization of that specialty. CRNAs who graduate after December 31, 2003, must graduate with a master's degree from a formal CRNA education program for nurse anesthetists accredited by the national accreditation organization of the CRNA specialty. An advanced practice registered nurse must achieve and maintain national certification, as recognized by the board, in an advanced practice registered nursing specialty;

(4) has paid the board all applicable fees; and

(5) has declared specialty area of nursing practice and the specialty title to be used must be the title which is granted by the board-approved credentialing organization or the title of the specialty area of nursing practice in which the nurse has received advanced educational preparation.

(B) An APRN is subject, at all times, to the scope and standards of practice established by the board-approved credentialing organization representing the specialty area of practice and shall function within the scope of practice of this chapter and must not be in violation of Chapter 47.

(C) A licensed nurse practitioner, certified nurse-midwife, or clinical nurse specialist must provide evidence of a practice agreement, as provided in this section. A licensed NP, CNM, or CNS must spend a portion of his time practicing in an underserved or rural area or serving an underserved population as defined in Section 40-33-20. A licensed NP, CNM, or CNS performing medical acts must do so pursuant to a practice agreement with a physician who must be readily available for consultation.

(D)(1) Medical acts performed by a nurse practitioner or clinical nurse specialist must be performed pursuant to a practice agreement between the nurse and the physician or medical staff. The practice agreement must include, but is not limited to:

(a) the following general information:

(i) name, address, and South Carolina license number of the nurse;

(ii) name, address, and South Carolina license number of the physician;

(iii) nature of practice and practice locations of the nurse and physician;

(iv) date the practice agreement was entered into and dates the practice agreement was reviewed and amended; and

(v) description of how consultation with the physician is provided and provision for backup consultation if the physician is unavailable; and

(b) the following information for medical acts:

(i) medical conditions for which therapies may be initiated, continued, or modified;

(ii) treatments that may be initiated, continued, or modified;

(iii) drug therapies that may be prescribed; and

(iv) situations that require direct evaluation by or referral to the physician.

(2) Notwithstanding any provisions of state law other than this chapter and Chapter 47, and to the extent permitted by federal law, an APRN may perform the following medical acts unless otherwise provided in the practice agreement:

(a) provide noncontrolled prescription drugs at an entity that provides free medical care for indigent patients;

(b) certify that a student is unable to attend school but may benefit from receiving instruction given in his home or hospital;

(c) refer a patient to physical therapy for treatment;

(d) pronounce death and sign death certificates;

(e) issue an order for a patient to receive appropriate services from a licensed hospice as defined in Chapter 71, Title 44; and

(f) certify that an individual is handicapped and declare that the handicap is temporary or permanent for purposes of the individual's application for a placard.

(3) The original practice agreement and any amendments to it must be reviewed at least annually, dated and signed by the nurse and physician, and made available to the board for review within seventy-two hours of request. Failure to produce a practice agreement upon request of the board is considered misconduct and subjects the licensee to disciplinary action. A random audit of a practice agreement must be conducted by the board at least biennially.

(4) Licensees who change practice settings or physicians shall notify the board of the change within fifteen business days and provide verification of a practice agreement. NPs, CNMs, and CNSs who discontinue their practice shall notify the board within fifteen business days.

(E)(1) An NP, CNM, or CNS who applies for prescriptive authority:

(a) must be licensed by the board as a nurse practitioner, certified nurse-midwife, or clinical nurse specialist;

(b) shall submit a completed application on a form provided by the board;

(c) shall submit the required fee;

(d) shall provide evidence of completion of forty-five contact hours of education in pharmacotherapeutics acceptable to the board, within two years before application or during the time of the organized educational program shall provide evidence of

prescriptive authority in another state meeting twenty hours in pharmacotherapeutics acceptable to the board, within two years before application;

(e) shall provide at least fifteen hours of education in controlled substances acceptable to the board as part of the twenty hours required for prescriptive authority if the NP, CNM, or CNS has equivalent controlled substance prescribing authority in another state;

(f) shall provide at least fifteen hours of education in controlled substances acceptable to the board as part of the forty-five contact hours required for prescriptive authority if the NP, CNM, or CNS initially is applying to prescribe in Schedules II through V controlled substances.

(2) The board shall issue an identification number to the NP, CNM, or CNS authorized to prescribe medications. Authorization for prescriptive authority is valid for two years unless terminated by the board for cause. Initial authorization expires concurrent with the expiration of the Advanced Practice Registered Nurse license.

(3) Authorization for prescriptive authority must be renewed after the applicant meets requirements for renewal and provides documentation of twenty hours acceptable to the board of continuing education contact hours every two years in pharmacotherapeutics. For a NP, CNM, or CNS with controlled substance prescriptive authority, two of the twenty hours must be related to prescribing controlled substances.

(F)(1) Authorized prescriptions by a nurse practitioner, certified nurse-midwife, or clinical nurse specialist with prescriptive authority:

(a) must comply with all applicable state and federal laws and executive orders;

(b) is limited to drugs and devices utilized to treat medical problems within the specialty field of the nurse practitioner or clinical nurse specialist as prescribed in the practice agreement;

(c) may include Schedules III through V controlled substances if listed in the practice agreement and as authorized by Section 44-53-300;

(d) may include Schedule II nonnarcotic substances if listed in the practice agreement and as authorized by Section 44-53-300, provided, however, that each such prescription must not exceed a thirty-day supply;

(e) may include Schedule II narcotic substances if listed in the practice agreement and as authorized by Section 44-53-300, provided, however, that the prescription must not exceed a five-day supply and another prescription must not be written without the written agreement of the physician with whom the nurse practitioner, certified nurse-midwife, or clinical nurse specialist has entered into a practice agreement, unless the prescription is written for patients in hospice or palliative care;

(f) may include Schedule II narcotic substances for patients in hospice or palliative care if listed in the practice agreement as authorized by Section 44-53-300, provided, however, that each such prescription must not exceed a thirty-day supply;

(g) must be signed or electronically submitted by the NP, CNM, or CNS with the prescriber's identification number assigned by the board and all prescribing numbers required by law. Written prescription forms must include the name, address, and phone number of the NP, CNM, or CNS and physician. Electronic prescription forms must include the name, address, and phone number of the NP, CNM, or CNS and, if possible, the physician through the electronic system. All prescriptions must comply with the provisions of Section 39-24-40. A prescription must designate a specific number of refills and may not include a nonspecific refill indication;

(h) must be documented in the patient record of the practice and must be available for review and audit purposes.

(2) An NP, CNM, or CNS who holds prescriptive authority may request, receive, and sign for professional samples and may distribute professional samples to patients as listed in the practice agreement, subject to federal and state regulations.

(G) Prescriptive authorization may be terminated by the board if an NP, CNM, or CNS with prescriptive authority has:

(1) not maintained certification in the specialty field;

(2) failed to meet the education requirements for pharmacotherapeutics;

(3) prescribed outside the scope of the practice agreement;

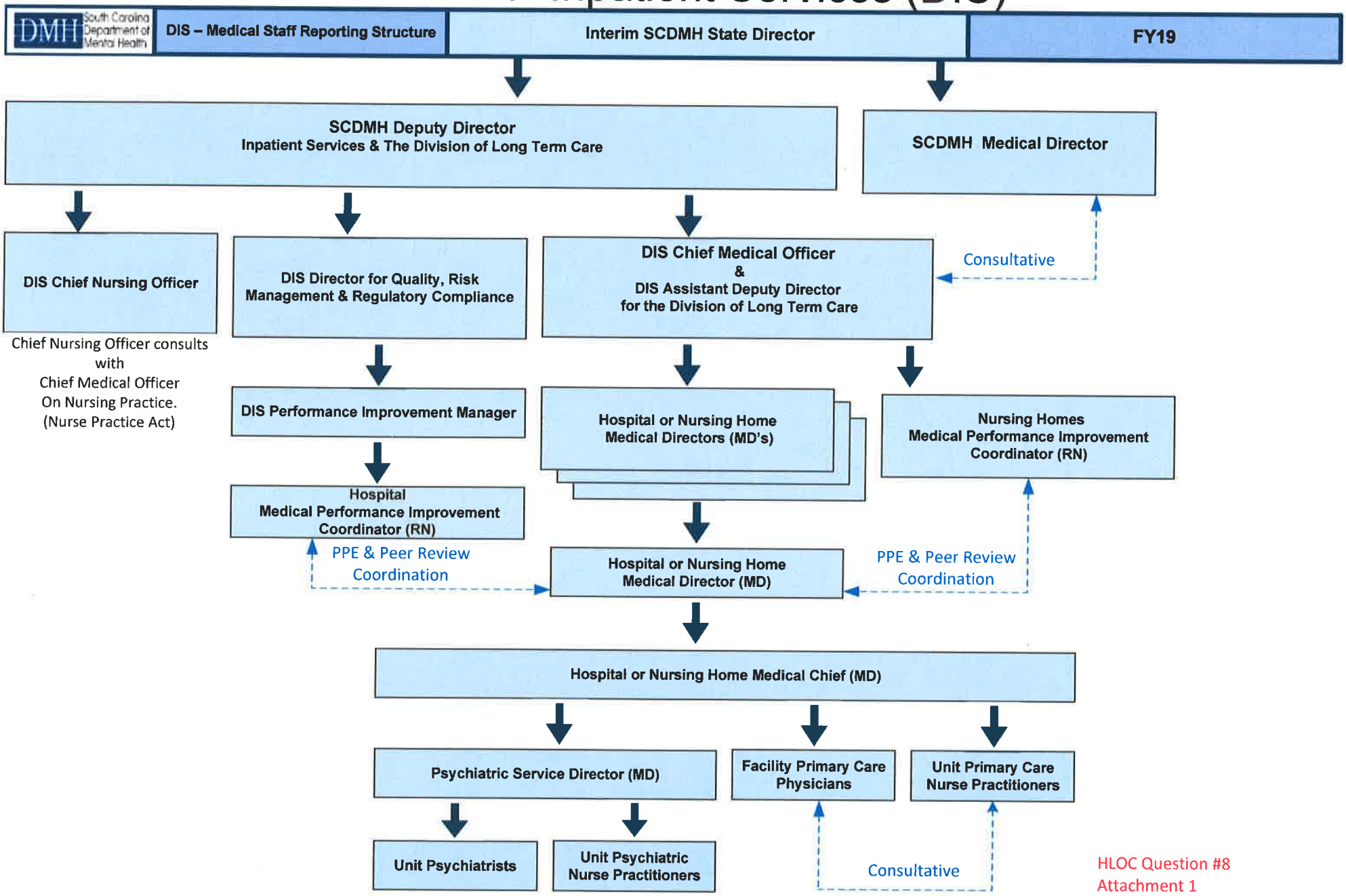
(4) violated a provision of Section 40-33-110; or

(5) violated any state or federal law or regulations applicable to prescriptions.

HLOC Memo Question #8

Question	Response
What positions perform the practitioner evaluations described by Representative Ridgeway, beginning at time stamp 1:45 of the August 12, 2019 meeting? What position in DIS Organizational chart includes the responsibilities typically performed by a hospital peer-review coordinator?	Attachment: DIS Medical Staff Reporting, EDITED 8/29/19 Attachment: DIS Policy and Procedure Directive MS3 State Comparison

Division of Inpatient Services (DIS)



HLOC Question #8
Attachment 1

Prepared by: Division of Inpatient Services, Office of Organizational Planning
Update: 8/29/2019

Division of Inpatient Services DMH South Carolina Department of Mental Health	POLICY AND PROCEDURE DIRECTIVE **Applies To:** G. Werber Psychiatric Hospital: ☒ Adult Services ☒ Forensic Services ☒ Child & Adolescent Services (WSHPI) ☒ Patrick B. Harris Psychiatric Hospital ☒ Morris Village ☐ C.M. Tucker Nursing Care Center

SUBJECT: MEDICAL STAFF PROFESSIONAL PRACTICE EVALUATION/ PERFORMANCE IMPROVEMENT AND PEER REVIEW PROCESSES	NUMBER: MS 3 EFFECTIVE OR REVISED DATE: JULY 2019 Note: Individual pages may be revised and revised date shown on them.

PREPARED BY: MEDICAL EXECUTIVE COMMITTEE DATES REVIEWED:	APPROVED: Versie J. Bellamy Versie J. Bellamy, DNP, MN, RN, Deputy Director

I. PURPOSE:

This directive describes the process by which the Medical Staff monitors, evaluates, and reports on the quality of patient care provided by its members and how opportunities for improvement in performance and outcomes of care on an individual and organization wide basis are identified.

II. POLICY:

It is the policy of the Division of Inpatient Services (DIS) to confirm the competency of the members of the Medical Staff at the time of initial privileges, when new privileges are granted, when there is a question regarding current practice, and periodically on an ongoing basis. The Medical Staff endorses the monitoring and evaluation of a practitioner's practice as an essential component of medical care which allows the organization to identify practice trends that impact quality of care and patient safety.

III. STATUTES:

All categories of evaluation, monitoring and review will fall under the peer review privilege. Data acquisition and review activities are protected from "discovery, subpoena, or introduction into evidence in any civil action" by South Carolina statutes 40-71-10 and 40-71-20.

IV. DEFINITION:

Medical staff peers are defined as those licensed (physicians and nurse practitioners) or certified (physician assistants) practitioners with similar training and experience who manage similar clinical problems as the practitioner under peer review.

V. MEDICAL EXECUTIVE COMMITTEE:

The Medical Executive Committee (MEC) has the authority and the responsibility to monitor and evaluate the quality of patient care through the medical staff performance improvement process. The MEC provides oversight to the process and receives reports and determines appropriate action. The Performance Improvement Department/Liaison proposes to the MEC general standards for review, monitors the review process, and when appropriate, recommends to the MEC the initiation of a specific peer review.

VI. GENERAL STANDARDS:

All types of practice review conform to the following standards:

A. The process insures patient confidentially.
B. The process is objective, and uses outside experts in the field when appropriate.
C. The review process is well documented and yields clear recommendations.
D. Practitioner performance concerns, as evidenced through the quality improvement process, are relevant to an individual's practice and used in the process of granting privileges.
E. The review process is consistent and fair, employing criteria developed from professional standards and approved by the Medical Staff.
F. The process is performed in a timely manner.
G. Medical Staff members participate willingly in the review process. The practitioner is provided all information used in the reviews and an opportunity to address any committee or body that deliberates on the findings of the review as described in the Medical Staff Bylaws.

VII. REVIEW PROCESSES:

A. Medical Staff Peer Review:

The Medical Staff participates in ongoing peer review. Twice a year the Medical Staff at each hospital/program selects a topic for review. The topic selected and indicators developed relate to established clinical processes associated with the assessment and treatment of patients (i.e., clinical practice guidelines). The Medical Staff approves review criteria. The sample size will consist of 5 cases per practitioner, or 100%, whichever is less. Aggregate data is reported in Medical Staff Committees and practitioner specific information is reviewed by the Medical Director forwarded to the Credentials Coordinator for inclusion in the PI file for credentialing purposes.

B. Ongoing Professional Practice Evaluation (OPPE):

The Medical Staff conducts periodic performance review of all current practitioners using performance indicators approved by the medical staff. OPPE is conducted every eight (8) months on each practitioner and helps the organization identify individual professional practice trends. Information is factored into the decision to maintain existing privileges, revise existing privileges or revoke an existing privilege prior to or at the time of renewal. The information may be acquired through one of the following methodologies:

1. Periodic chart review (5 cases/chart reviews)
2. Direct observation
3. Monitoring of diagnostic and treatment techniques
4. Discussion with other individuals involved in the care of the patient including consulting physicians, nursing and/or administrative personnel.

Copies of the information are submitted to the Credentials Coordinator for inclusion in the PI file for credentialing purposes.

C. Initial Professional Practice Evaluation (IPPE): For clarity purposes, the focused professional practice evaluation of initial privileges will be referred to as IPPE. IPPE is the process whereby the Medical Staff evaluates the privilege specific competence of the practitioner for all initially requested privileges. This review occurs at the following times:

1. When a new practitioner coming to the organization does not have documented evidence of competently performing the requested privileges at the organization.

2. When an existing practitioner has been granted NEW privileges. Using methodologies listed in section VII A above, the proctoring practitioner evaluates the competency (ies). At the end of the thirty-day timeframe, the Medical Director determines if the applicant has completed the process satisfactorily and is competent to perform the requested privilege(s). Copies of the information are submitted to the Credentials Coordinator for inclusion in the PI file for credentialing purposes.

D. Focused Professional Practice Evaluation (FPPE) for Performance Issues as directed by the Medical Staff:

The Medical Staff develops criteria to be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. The criteria and monitoring plan must be approved by the MEC and the practitioner undergoing review is notified. FPPE can be "triggered" by any of the following circumstances:

1. An important sentinel event or near miss
2. Absolute trends or patterns that significantly and undesirably vary from established patterns of clinical practice.
3. When results of an organizational improvement or Medical Staff monitoring function identify a significant deviation from accepted standards of practice.
4. Significant patient or staff complaint
5. Repeated failure to follow Medical Staff Rules and Regulations, hospital policy and/or accrediting/regulatory standards.

The decision to conduct the FPPE is based on the practitioner's current clinical competence and ability to perform the requested privilege. The review is conducted by an ad hoc team comprised of Medical Staff members with knowledge, training, experience, and skills in managing the clinical topics under review. Review findings are included in the practitioner's PI folder and MEC recommendations may include but are not limited to considerations of Medical Staff reappointment, suspension, or a change in privileges.

E. Other Medical Staff Review Activities

1. Medication Management Monitoring Plan (See DIS Directive MM 23, Medication Management Monitoring Plan):
   Criteria based monitoring, evaluation, and analysis of medication usage patterns and practice. The focus of the plan is to reduce practice variation, errors, and misuse with subsequent implementation of corrective measures which insure quality, safe, and cost effective drug therapy. Medication management is assessed in a multidisciplinary, collaborative effort by the medical staff, pharmacy, nursing management and administrative staff and others as required. Key areas of monitoring are:
   - Medication Utilization Evaluation
   - Medication Error Monitoring
   - Adverse Drug Reactions

   Medical staff performance as a whole is reported to the MEC and practitioner specific information is maintained in the individual practitioner's PI file for credentialing purposes.
2. Utilization Management (See DIS Directive PI 4, Utilization Management Plan):
   Utilization Management (UM) monitors and assesses the quality of patient care and the utilization of hospital resources to assure patient care is medically necessary, appropriate, timely, efficient, cost-effective, and meets internal and external quality standards.

The components of UM include:

a. Utilization review and assessment of medical necessity of professional services furnished, including drugs and biologicals, and appropriateness (justification for admission or continued stay)
b. Evaluation of specific cases, patterns, and trends indicating over utilization, underutilization and misutilization
c. Intervention to prevent or resolve utilization problems
d. Planning for discharge/transition.

Monitoring results are reported in the DIS Performance Improvement Committee and individual practitioner issues are forwarded to the Medical Director. As appropriate, practitioner specific information is maintained in the individual practitioner's PI file for credentialing purposes.

3. Medical Record Delinquency Reports
Physician specific medical records delinquency reports are forwarded to the Medical Director and a copy is maintained in the individual PI profile for credentialing purposes.

4. Hospital Wide Performance Improvement
The Medical Staff participates in performance improvement activities at all levels of the organization to improve the quality of patient care and safety. Activities include Medical Staff participation in the following:

a. Multidisciplinary record review
b. Hospital Quality Goals
c. Oryx indicators
d. Quality Care Review Boards
e. Performance Improvement Teams
f. Proactive Risk Assessments

Medical Staff relevant information obtained during participation in hospital wide performance improvement is incorporated in the Medical Staff Performance Improvement process.

VIII. REPORTS AND ACTION PLANS:

A. Reports and conclusions of medical staff professional practice evaluation, performance improvement and peer review activities presented to the Medical Executive Committee who will develop a written plan of action if indicated.

B. Reports and conclusions of individual practitioner performance improvement activities are sent to the Hospital/Program Medical Director and a copy placed in the individual practitioner's quality profile within the Credentialing Department.

For moderate or serious concerns, a plan of action is developed by the Hospital/Program Medical Director. The reviewed member of the medical staff will be asked to respond in writing to the Hospital/Program Medical Director. The individual summary, action plan and the response is filed in the reviewed physician's quality profile.

A report of findings, actions and response is submitted to the Medical Executive Committee with names of individual medical staff members undergoing review redacted from the minutes.

IX. QUALITY RECORD AND CREDENTIALS COMMITTEE ACTIONS:

A. A quality profile is maintained in the Credentialing Department for each member of the medical staff. The record will contain all written products of performance improvement/peer review activities that pertain to the practitioner's clinical performance.

B. In preparation for recredentialing of a practitioner, the Program Medical Director/relevant physician supervisor will review the quality profile to assist in formulating the recommendation for reappointment and assignment of clinical privileges. The quality record will be made available to the Credentials Committee in its efforts to evaluate an application for reappointment.

C. The reviewed practitioner, Program Medical Director/relevant supervising physician, Medical Executive Committee and Credentials Committee may review a practitioner's quality profile held in the Credentials Department.

X. DISTRIBUTION:

Each Psychiatric Service Chief, Administrative Department Head, and Discipline Chief will read and brief subordinates.

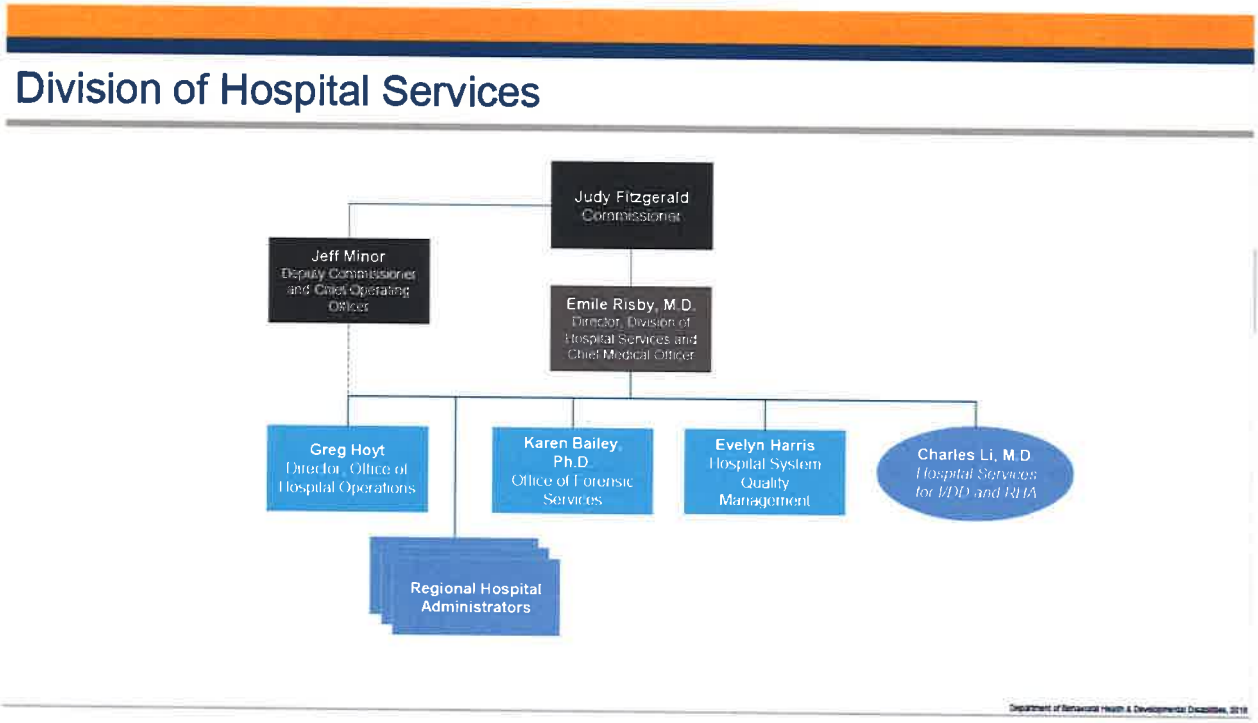
XI. RESCISSIONS:

This directive rescinds Directive MS 3 dated January 2015.

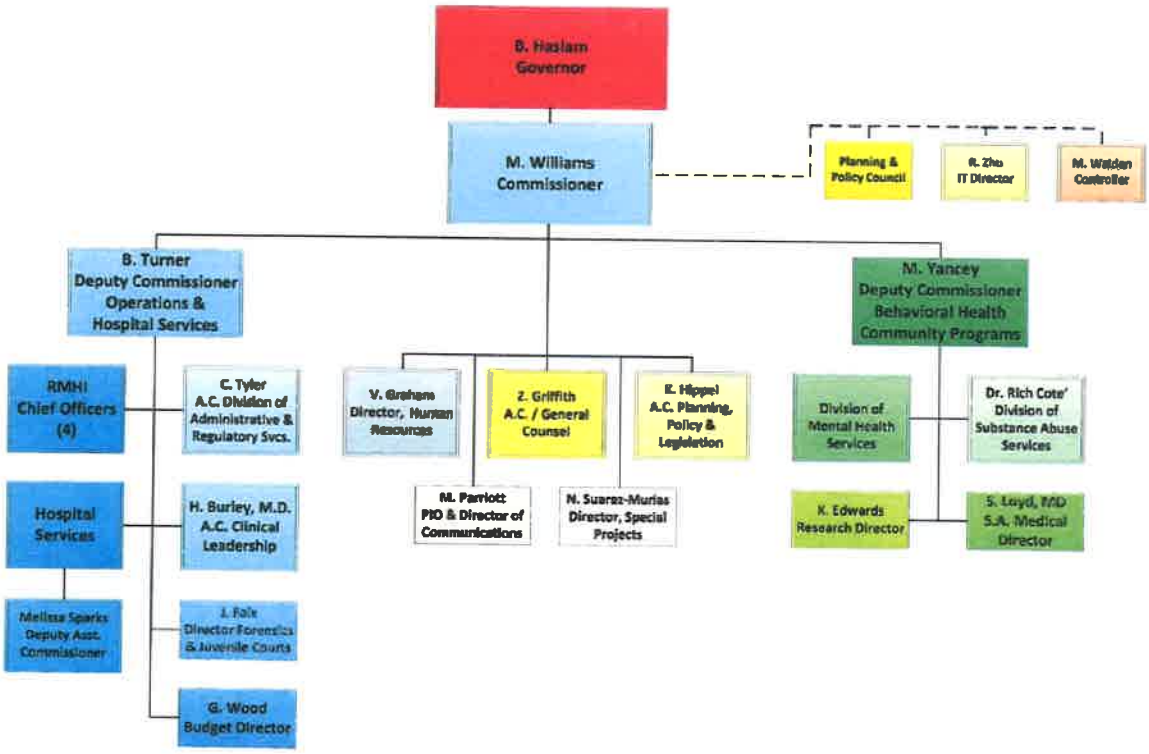
Three states, Georgia, Tennessee, and Wyoming have shared organizational structure related to inpatient psychiatric facilities. All three public hospital systems have the psychiatrist as the Chief Medical Officer (CMO) with providers reporting to the CMO.

Georgia:

Georgia Chief Medical Officer is Dr. Emile Risby, MD. He is a psychiatry specialist in Atlanta, GA and board certified in Forensic Psychiatry and Psychiatry.



Tennessee Department of Mental Health and Substance Abuse Services
January 5, 2018



Dr. Howard Burley Jr., MD is a board certified psychiatrist in Nashville, Tennessee. He is board certified by the American Board of Psychiatry and Neurology in Psychiatry and in Addiction Psychiatry. He is the Clinical Leader for the Hospital System.

Wyoming:

From Email:

Currently have two Family Nurse Practitioners that provide medical services to patients. They both report to the Medical Director (psychiatrist). We are requesting an MD position. If we are able to get the position (and fill it) the FNP's would report to the MD who would then report to the Medical Director. Let me know if you still want the org chart.

Callie Perkins, RN

Risk & Performance Improvement Manager

Wyoming State Hospital

307-789-3464 x 650

HLOC Memo Question #9

Question	Response
For last 3 years, what are the annual morbidity and mortality rate for each inpatient facility?	Attachment: DIS Hospitals & Nursing Homes Mortality Rates, FY17 - FY19

SCDMH DIVISION OF INPATIENT SERVICES - HOSPITALS/PROGRAMS

Fiscal Year 2017	Total Deaths	Numbers Served	Mortality Rate Per 1000 per year
BPH ACUTE PSYCH - ADULT SRVCS	3	367	0.022395581
BRYAN HOSPITAL FORENSICS	1	487	0.005625721
WSHPI	0	539	0
MV	0	1544	0
HPH ACUTE PSYCH	2	594	0.009224667
SEXUALLY VIOLENT PREDATORS	1	204	0.01343003
FY 17 MORTALITY RATE	7	3735	0.005134694

Fiscal Year 2018	Total Deaths	Numbers Served	Mortality Rate
BPH ACUTE PSYCH - ADULT SRVCS	2	359	0.015263098
BRYAN HOSPITAL FORENSICS	4	491	0.02231956
WSHPI	0	402	0
MV	0	1500	0
HPH ACUTE PSYCH	0	451	0
SEXUALLY VIOLENT PREDATORS	1	203	0.013496187
FY 18 MORTALITY RATE	7	3406	0.005630676

Fiscal Year 2019	Total Deaths	Numbers Served	Mortality Rate
BPH ACUTE PSYCH - ADULT SRVCS	4	338	0.032422793
BRYAN HOSPITAL FORENSICS	0	428	0
WSHPI	0	508	0
MV	0	1520	0
HPH ACUTE PSYCH	1	443	0.006184483
SEXUALLY VIOLENT PREDATORS	0	214	0
FY 19 MORTALITY RATE	5	3451	0.003969467

SCDMH DIVISION OF INPATIENT SERVICES - NURSING HOMES - Mortality Rate

Fiscal Year 2017	Total Deaths	Numbers Served	Mortality Rate Per 1000 per year
TUCKER/RODDEY	17	182	0.255908475
TUCKER STONE	21	117	0.491745697
VETERANS VICTORY HOUSE	104	334	0.853088344
CAMPBELL NURSING CARE CENTER	123	369	0.913242009
FY 17 MORTALITY RATE	265	1002	0.724578241

Fiscal Year 2018	Total Deaths	Numbers Served	Mortality Rate
TUCKER/RODDEY	15	185	0.222139948
TUCKER/STONE	24	122	0.538962497
VETERANS VICTORY HOUSE	107	337	0.869883338
CAMPBELL NURSING CARE CENTER	120	364	0.903206383
FY 18 MORTALITY RATE	266	1008	0.722983257

Fiscal Year 2019	Total Deaths	Numbers Served	Mortality Rate
TUCKER/RODDEY	18	196	0.251607492
TUCKER/STONE	24	118	0.557232412
VETERANS VICTORY HOUSE	91	325	0.767123288
CAMPBELL NURSING CARE CENTER	88	333	0.724011683
FY 19 MORTALITY RATE	221	972	0.622921247

Original Question	Follow-Up Question	Response
Does internal audit or the risk management office review employee training compliance?	Are employees ever asked what was successful or unsuccessful about training, as far as preparation for work? When was the Clinical Competency Oversight Committee established, and what are its guiding principles and procedures?	Yes. Attachment: 30/60/90 Questionnaire Appointment Letter and Charge of Competency Oversight Committee.

30-60-90 – Day New Employee Retention Meetings

30-day meeting date _____ 90-day meeting date _____

Name: _____ **Department:** _____

Job Title: _____ **Hire Date:** _____

Supervisor: _____ **Trainer/Preceptor:** _____

1. How do we compare with what we said in your interviewing process?	
2. What's working well?	
3. Which individuals have been helpful to you?	
4. Based on your past experience, what ideas do you have for improving our processes or operations?	
5. Is there anything that would cause you to think about leaving?	
6. (90 Days) Do you know of any candidates that you can recommend as possible employees for our organization?	

Additional Comments: Questions?

_____

_____

_____

Thank you for your time and feedback!

_____ _____

DATE INTERVIEWER

StuderGroup

Division of Inpatient Services
A Division of Behavioral Health
DMH South Carolina Department of Mental Health

Internal Memorandum

Date:	August 5, 2019		
To:	Irene Thornley, DIS, Facilitator Algie Bryant, DIS, Co-Chair Patricia Handley, DIS, Co-Chair Kelli Bray, PBH Elizabeth Brown, DIS Natasha Davis, DIS Sandy Hyre, DMH/ETR Michaela Kelly, BPH Robert Morgan, CMT-Stone Eleanor Odom, DMH/HR Kimberly Rudd, DIS Galen Sanders, CMT Stuart Shields, BPH Allyson Sipes, DIS	**From:**	Versie J. Bellamy DIS Deputy Director
Program:	Division of Inpatient Services (DIS)	**Program:**	Division of Inpatient Services (DIS)
Subject:	Appointment to Clinical Competency Oversight Committee		

You are hereby appointed to serve on the Clinical Competency Oversight Committee. The purpose of this committee is to review processes and oversee systems within DIS to ensure that staff involved in patient care are qualified, appropriately trained as specified in policy, and competent to provide services. The committee will provide regular status reports to the DIS Leadership and Governing Body Committee for Inpatient Facilities.

Ms. Bryant and Dr. Handley are appointed Co-Chairs, Ms. Thornley is appointed Facilitator.

The first meeting is scheduled for Thursday, August 8, 2019 at 9:00 a.m., in the WSH/DIS Administration Building, Conference Room C.

Thank you for your active participation on this important committee.

cc: Debbie Calcote, DMH, Deputy Director of Administrative Services
Robert Bank, DMH, Medical Director

Follow-Up Questions from Previous Correspondence

Original Question	Follow-Up Question	Response
Does the agency have a schedule by which policies related to inpatient services are reviewed and updated?	Is there a notation of the review, such that it is easy for agency management and auditor to determine if the review has actually occurred?	Policy and procedure directives should be reviewed every two years. The date of review is entered on the first page of the policy.

Original Question	Follow-Up Question	Response
What are the onboarding and continuous training strategies for front line employees in inpatient services?	Does the agency know if higher scores on the training assessments correlate with higher rate of service provision with fidelity to agency policies? If so, how does the agency know this?	The agency currently doesn't have a method which correlates higher scores on training assessments and rate of service provision; however the agency will begin development of a method within the charge of the Division of Inpatient Services' Competency Oversight Committee.

Original Question	Follow-Up Question	Response
Who is the agency's current designee for the Vulnerable Adult Fatalities Review Committee? How does that person provide feedback to the administration on the committee's discussion of statistical, cross-agency training and technical assistance needs, and services gaps? Please provide attendance record of the agency's designee for the last three years?	How does that person provide feedback to the *agency's* administration on the committee's discussions of statistical studies, cross-agency training and technical assistance needs, and service gaps?	Attachment: Memo from State Director

Division of Inpatient Services

DMH South Carolina Department of Mental Health

Internal Memorandum

Date:	August 30, 2019		
To:	Gary Ewing, M.D. Physician, CM Tucker Nursing Care Center	**From:**	Mark W. Binkley, J.D. Interim State Director
Program:	Division of Inpatient Services	**Program:**	Office of the State Director
Department:	Medical Services	**Department:**	Administration
Subject:	Vulnerable Adult Fatalities Review Committee Feedback		

I would like to thank you for serving as the agency's designee for the Vulnerable Adult Fatalities Review Committee (VAFRC).

As the appointed representative for the agency, I am requesting that you submit a report to the SCDMH State Director's Office within one week of each quarterly meeting. If there are relevant recommendations (statistical studies, cross-agency training and technical assistance needs, and/or service gaps), please provide a written summary of those recommendations in your report.

Your continued service as the DMH representative to the Vulnerable Adult Fatalities Review Committee and the South Carolina Department of Mental Health is invaluable and greatly appreciated.

cc.: Versie J. Bellamy, DNP, MN, RN, Deputy Director, DIS and Division of Long Term Care
Kimberly B. Rudd, MD, Chief Medical Officer, DIS and Asst. Deputy Director, Division of Long Term Care
File

SCDMH FORENSICS ACTION PLAN

Revised July 2, 2019

ACTION PLAN MEASURES TO ADDRESS FORENSIC WAITING LISTS:

1. **INCREASE STAFFING RESOURCES FOR THE FORENSIC EVALUATION SERVICE**
2. **DIVERT CIVILLY COMMITTED FORENSIC PATIENTS AWAITING TRANSFER/DISCHARGE TO AVAILABLE DMH CIVIL HOSPITAL BEDS**
3. **DIVERT CIVILLY COMMITTED DEFENDANTS AWAITING ADMISSION TO AVAILABLE DMH CIVIL HOSPITAL BEDS OR TO OUTPATIENT TREATMENT WHEN APPROPRIATE**
4. **INCREASE COMMUNICATION AND COLLABORATION BETWEEN INPATIENT AND OUTPATIENT, INCLUDING THE FORENSIC OUTREACH CLINIC, TO IMPROVE PATIENT CARE**
5. **INCREASE STAFFING IN FORENSIC INPATIENT SERVICES**
6. **INCREASE AVAILABILITY OF SUPERVISED STEP DOWN PLACEMENTS FOR FORENSIC PATIENTS NO LONGER IN NEED OF HOSPITALIZATION**
7. **WORK WITH THE SOCIAL SECURITY ADMINISTRATION AND SC DHHS TO EXPEDITE RESTORATION OF PATIENT BENEFITS TO IMPROVE TIMELINESS OF DISCHARGES**
8. **EXPLORE USE OF JAIL-BASED AND OUTPATIENT RESTORATION**

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1. INCREASE STAFFING RESOURCES IN FORENSIC EVALUATION SERVICE

Discussion: In September 2015, Judge Frank Addy, in monitoring DMH weekly reports gave DMH a very specific short time for DMH to substantially reduce or eliminate the waiting list for these adult criminal defendants awaiting a Court of General Sessions ordered evaluation of their Competency to Stand Trial and/or their Criminal Responsibility/Capacity to Conform. DMH State Director, John H. Magill responded by issuing a memo directing agency management to make reducing the Forensic Evaluation waiting list a top priority. This memo from Director Magill was copied to Judge Addy. DMH had significant evaluator vacancies in its Forensic Evaluation Service.

From September 2015 through 2016, DMH was able to increase the number of qualified evaluator staff to complete Forensic Evaluations as Ordered. DMH primarily accomplished the increase in staffing by means of short and long-term contracting with qualified Psychologists

and Psychiatrists, including expanding its use of a contract with the Medical University of South Carolina (MUSC).

From 2017 to present, the evaluation service has continued to work to recruit and retain full time permanent evaluators to support the longevity, stability, and internal quality control of the Forensic Evaluation Service. As a means of supporting recruitment, retention, and ongoing professional training and development, the Forensic Evaluation Service developed the new DIS Forensic Psychology Postdoctoral Fellowship, with the first fellows starting in September 2018. The psychology fellowship program trains new psychologists in the highly specialized areas of forensic and SVP evaluation so that they may become licensed in South Carolina at the end of the training year and can immediately start as independent forensic evaluators. The fellowship didactic training occurs in collaboration with the University of South Carolina and with support of the DMH Office of General Counsel. Prior to the first day of the first fellowship year in 2018, the American Board of Forensic Psychology granted the DMH forensic psychology fellowship their coveted waiver status. This approval allows for graduates of the DMH fellowship to immediately begin the strenuous process of board certification in forensic psychology, in lieu of 5 years of forensic psychology postdoctoral practice. Fewer than 20 programs across the country (and no other program in South Carolina) have been approved for this status, and this serves as a powerful advertisement and recruitment tool. The first two psychology fellows will graduate in August 2019 and both have applied for full time permanent positions in the Forensic Evaluation Service. Inquiries into the fellowship have also led to increased numbers of qualified candidates applying for full time permanent evaluator positions.

Since 2017, the full time evaluation staff has doubled and cross training efforts have allowed for greater efficiency in performing forensic and SVP evaluations. Since July 2018, 2 new full time evaluators have been hired, in addition to two psychology postdoctoral fellows. As of June 2019, two offers for additional full time evaluators are pending. Contracted evaluation hours have been reduced as the full time staffing level has increased. Contracts have continued to receive an increased level of oversight to ensure the quality and consistency of forensic evaluations and compliance with statutory requirements. Major contracts have been revised in 2019 or are under current revision in order to support maintenance of these standards.

Status: Despite continued increase in numbers of evaluation orders every year, Forensic Evaluations continue to be, on average, completed and reports submitted, within the statutory and Court Ordered time frames.

Responsible Person:
Holly Scaturo/Dr. Kelly Gothard

Other supporting staff:
Dr. Versie Bellamy

Monthly Deliverable: Currently FES is preparing a monthly report to Judge Addy including most of the following elements:

• County
• Patient/Defendant Name
• DMH Patient ID #, if known
• Date Order Signed
• Type of Order (CST v. CR/CTC)
• Judge's Name
• Date Order Received by MUSC
• Date Evaluation was Cleared for Scheduling (Date by which all required records have been received)
• Date Report is Due [or Delinquent] (30 or 60 days following the Cleared for Scheduling Date, based on type of evaluation)
• Date(s) of exam
• Date Report sent
• Examiner's Name
• Exam results
• Any circumstances which are causing a delay in completing the evaluation.

The monthly report also shows the average number of days for FES to complete evaluations of defendants' Competency to Stand Trial (CST) for all initial CST evaluations completed in the preceding month.

2. DIVERT CIVILLY COMMITTED FORENSIC PATIENTS AWAITING TRANSFER/DISCHARGE TO AVAILABLE DMH CIVIL BEDS

Discussion: Forensic patients often remain in the hospital for weeks or months beyond when they clinically no longer require Secure Forensic Hospital level of care. There are several reasons for this:

- Many must first be approved for discharge by a Court;
- Many who no longer need hospitalization still require the staff-assisted level of care provided by a Community Residential Care Facility (CRCF), or even a Nursing Home, and so must await the efforts of social work staff to locate placement in an available CRCF or Nursing Home willing to accept a patient with a past criminal history;
- Most are psychiatrically disabled, and will need public benefits established, or re-established, including Social Security, Medicaid, Optional State Supplement (OSS), before they will have the financial means to transition to the community and pay for their clinical care.

  The end result, however, is that because there are a finite number of beds in the agency's secure Forensic Hospital units in Bryan Psychiatric Hospital – 218 -- delays in discharging a Forensic patient who no longer requires hospital level care causes delays in the admission of a defendant who has been Ordered committed by a Court of General Sessions.

In addition to the secure Forensic Hospital units in Bryan Psychiatric Hospital, DMH currently operates 189 civil hospital beds at Bryan Psychiatric Hospital (BPH Civil) and 131 civil hospital beds at its Harris Psychiatric Hospital (HPH) in Anderson. Although both civil hospitals maintain significant waiting lists for admission (often for patients who are in a community hospital Emergency Department), DMH has nevertheless begun looking for appropriate opportunities to transfer/discharge civilly committed Forensic patients awaiting discharge to its less secure civil hospitals in order to free up Forensic beds for additional Forensic admissions. DMH also operates a community nursing home at C. M. Tucker Center, also with a significant waiting list. Again, in appropriate circumstances, DMH will consider discharge of a civilly committed Forensic patient in need of nursing care to free up a Forensic bed.

Status: Ongoing review continues to identify patients appropriate for transfer or discharge to non-Forensic Inpatient beds. DMH will continue to consider the transfer of civilly committed forensic patients who are awaiting discharge to less secure DMH civil hospitals or its Nursing Home, when appropriate.

Responsible Person:
Dr. Kimberly Rudd

Other supporting staff:
Versie Bellamy
Stuart Shields
Dr. Allyson Sipes
Allison Findley
Dr. Dale Adair
Lesley Jacobs
Allen McEniry
Dr. Teresa Bishop
Ted Jones
Robert Morgan

Monthly Deliverable: Specify the number of BPH Forensics patients transferred to BPH Civil, and/or discharged to Harris Psychiatric Hospital and/or C.M. Tucker Nursing Care Center during the past month.

3. DIVERT CIVILLY COMMITTED DEFENDANTS AWAITING ADMISSION TO AVAILABLE DMH CIVIL HOSPITAL BEDS OR OUPATIENT TREATMENT WHEN APPROPRIATE

Discussion: Not all criminal defendants found to lack the capacity to stand trial, and also found unlikely to be restorable to capacity (non-restorable) and thereafter civilly committed to DMH require hospitalization in in the agency's secure Forensic Hospital units in Bryan Psychiatric

Hospital. Some of those on the current waiting list for admission can be appropriately treated and managed in one of the Department's civil hospital units at BPH or HPH.

Additionally, not all criminal defendants found to lack the capacity to stand trial, and also found unlikely to be restorable to capacity (non-restorable) and who thereafter are civilly committed to DMH require treatment for their mental illness in a hospital. Many have been receiving psychiatric treatment while in detention, or in the community through a Community Mental Health Center while on bond, and some are psychiatrically stable. Although such defendants will require ongoing mental health care, including medication, such care can be provided on an outpatient basis.

Status: Beginning in July, 2015, the DMH Office of General Counsel began arranging visits to some detention centers which were holding defendants on the Forensics waiting list. A Forensic Social Worker also participated in the visit. The criminal history and clinical condition of the defendants were reviewed with Detention Center management and medical personnel, as well as with clinical staff from the local DMH Community Mental Health Center. The DMH Division of Community Mental Health Services in July 2015 began to provide all DMH Community Mental Health Centers (CMHCs) on a periodic basis with a list of defendants on the waiting list for BPH Forensic who are housed in the detention center in the County or counties which are served by that CMHC. DMH CMHCs have been instructed to contact Detention Center management in an effort to determine the clinical status of each defendant on the waiting list, including which, if any psychiatric medications they may be receiving. Centers will provide that information back to the Division and to BPH Forensics staff to help determine what types of future efforts DMH can undertake to help ensure all defendants on the waiting list are receiving ongoing treatment for their psychiatric disorders. The Detention Center visits and reviews of the defendants on the waiting list have continued on an ongoing basis.

Since March, 2016 BPH Forensics and the Office of General Counsel have met regularly to identify those persons on the waiting list who have not had their probate hearing and have formed a Forensic Designated Examiner team ("DE team") with an inpatient psychiatrist and social worker to assist local probate judges in conducting those hearings. The Forensic Hospital DE Team focusing on general psychiatric and gero-psychiatric populations evaluate defendants for appropriate level of care and diversion from Forensic level or hospital level of care.

As of June 2019, the focus will shift from review of all defendants on the waitlist to those identified by BPH Forensic Hospital Admission Coordinator as possible diversions. CMHC Clinicians will complete an in-person assessment to obtain clinical status information as addressed above and forward to the BPH Forensic Hospital Admissions Coordinator for review and determination if the inpatient Designated Examiner (DE) Team will further evaluate for diversion.

Responsible Person:
Stuart Shields

Other supporting staff:
Versie Bellamy
Deborah Blalock
Dr. Kimberly Rudd
Monique Lee/Logan Royals
Lesley Jacobs
Allison Findley
Dr. Allyson Sipes
Dr. Bank
Tracy Richardson
Allison Farrell

Monthly Deliverable: Specify monthly the number of defendants on the waiting list who were identified and evaluated for diversion and the status of diversion if admitted to BPH Civil or HPH, or outpatient treatment. Using information from CMHC Clinicians' in-person Assessments and Forensic inpatient DE Team evaluation, as well as consultation with Office of General Counsel, the Wait List Management Committee will identify those defendants who may be appropriate for admission to BPH Civil or HPH, or diversion to outpatient treatment.

4. INCREASE COMMUNICATION AND COLLABORATION BETWEEN INPATIENT AND OUTPATIENT TO IMPROVE PATIENT CARE

Discussion: The history of movement from hospital liaisons to transition specialists: There was an identified weakness in using hospital liaison staff from each community mental health center to assist in arranging needed aftercare services for hospitalized patients from a particular Center's service area. For hospitalized patients with multiple aftercare needs, especially those at high risk for re-hospitalization, not every Center had all the needed aftercare services available. In order to ensure that high need patients were assisted in a consistent manner, regardless of which geographic area of the State from which they were admitted, the Department decided to take a different approach by developing transition specialists. Transition Specialists' sole job would be to focus on working with high need hospitalized patients, often forensic patients with long lengths of stay, and would assist the patient access the needed aftercare resources, regardless of where in the State those resources were available, in order to transition to a community treatment setting in a timely fashion.

Status:

- Transitions Program Supervisor hired to start 7/2/19
- BPH Transitions Specialists hired to start 7/2/19
- Transition Specialists to be stationed a Columbia Area MHC hired to start 7/2/19
- Transitions Specialists and BPH Discharge Coordinator will work to prioritize patients for discharge appropriateness; Transition Specialist and Social Worker will work together with the treatment team to identify housing needs; Transition Specialist to look for the housing in the community

- Transition Specialist to coordinate videoconferencing between inpatient treatment team and outpatient clinician/treatment team prior to discharge
- Transition Specialist to complete assessment (ICA and DLA-20) prior to discharge allowing the first outpatient appointment to be a treatment appointment

Responsible Person:
Tracy Richardson

Other supporting staff:
Stuart Shields
Dr. Allyson Sipes

Monthly Deliverable:

- Monthly meetings with the Transitions Program Director and BPH Clinical Leadership began 5/20/19; will move to include Transition Specialist→ review the Transition Specialist's caseload and patient movement success and identify barriers
- Every two weeks Community Collaborative Meeting → BPH inpatient provides bed forecast, number of beds needed for the next 30, 60 and 90 days
- At present, community liaisons provides updates on patients identified for transition to the community and/or an update on which patients have been screened for placement.
- July 2019: Transition Specialist for BPH to begin 7/2/19 and will be on campus the week of 7/8/19. Ms. Findley to complete a BPH specific orientation with her by the week of 7/15/19.

Deliverables for Transitions Specialists:

- Daily communication with DIS staff/patients
- Communication with MHCs to coordinate tele psychiatry staffing of patients
- Communication with appropriate contact person for housing options for the patients in the community (CRCF, Boarding homes, independent living)
- Participation in Treatment Teams DIS and CMHC
- Linkage to Care coordination for psychosocial needs of the patients
- Complete ICA, DLA20 on all referred patients prior to discharge
- Mutual Collaborative Education Initiatives with DIS
- Collaboration with MHCs on coordination of services for patients
- Partnership with CMHCs with education/training of staff
- Maintaining up-to-date resources for housing options for the patients

Data Tracking for Transition Specialists:

- Number patients referred for transition
- Number of patients transition to community
- Time frame on patients transitioned to the community
- Completed ICAs
- DLA20 score at time of assessment

- Patient discharged to what type of service for first appointment
- Number of patients linked to care coordination
- Days Variance (1st Service, post Discharge)
- Maintained community tenure 30, 60 days post discharge
- Type of housing patients discharged to (CRCF, Community Housing, Supervised Apts.)
- Geographical Area patient discharged to

5. INCREASE STAFFING RESOURCES IN FORENSICS INPATIENT

Discussion: In September, 2015, the organization and staffing of BPH Forensic Services was reviewed by the DMH Division of Inpatient Services to ensure that patients were receiving active treatment and that the program was appropriately staffed so that patients received maximum benefit from their hospital treatment. Additionally, the review focused on ensuring there was an appropriate process, with oversight, to identify those patients whose psychiatric condition had improved to the degree that they could be safely treated on an outpatient basis, and that whatever community supports, including supervised housing, and community treatment resources that were needed for a safe and successful discharge were identified and pursued.

In November, 2015, BPH Forensics hired a Discharge Coordinator. The DMH Division of Inpatient Services subsequently assigned a dedicated Benefits Coordinator to support the Forensics Benefits Specialist to expedite internal processing of public benefits applications for patients who no longer were in need of hospitalization.

Maintaining a sufficient workforce is challenging for all healthcare organizations, given that the supply of trained healthcare professionals does not keep up with the demand. However, it is particularly difficult for mental health care organizations due to the national shortage of psychiatrists, psychologists and other mental health professionals. The difficulties are even greater for a public provider like DMH, which offers salaries that are generally below market rate. Recruitment and retention of BPH Forensic Services staff will be an ongoing process.

Status: Ongoing recruitment efforts continue for Psychiatrists/Psychiatric Nurse Practitioners, Primary Care Physician/Medical Nurse Practitioners, and Social Workers.

Responsible Person:
Stuart Shields

Other supporting staff:
Versie Bellamy
Dr. Allyson Sipes
Dr. Dale Adair

Monthly Deliverable: Specify the number and type of Forensic staff who were added or lost in the past month, as well as any notable recruitment or retention activities in the previous month.

6. INCREASE AVAILABILITY OF SUPERVISED STEP DOWN PLACEMENTS FOR FORENSIC PATIENTS NO LONGER IN NEED OF HOSPITALIZATION

Discussion: Forensic patients often remain in the hospital for weeks or months beyond when they clinically no longer require hospital level of care. As previously mentioned, one of the reasons for this is that many Forensic patients who no longer need hospitalization still require the staff-assisted level of care provided by a Community Residential Care Facility (CRCF), and so must await the efforts of social work staff to locate placement in an available CRCF willing to accept a patient with a past criminal history

The result, however, is that because there are a finite number of beds in the agency's secure Forensic Hospital units in Bryan Psychiatric Hospital – 218 -- delays in discharging a Forensic patient who no longer requires hospital level care causes delays in the admission of a defendant who has been Ordered committed by a Court of General Sessions.

Status:
The efforts of the DMH Division of Community Mental Health Services and the 16 DMH Community Mental Health Centers to increase the availability of CRCF placements for Forensic patients no longer in need of hospitalization, and to assist BPH Forensics with placement of particular Forensic patients, will be an ongoing priority. In July of 2018, CMHS took over the management of 12 CRCFs previously run by the Piedmont MHC, the Lexington MHC, and the Santee Wateree MHC. Marjorie Wilson Guess is the program Manager of the CRCF program. Ms. Wilson-Guess will endeavor to also develop more CRCF capacity for Forensic patients.

Responsible Person:
Deborah Blalock

Other supporting staff:
Christian Barnes-Young
Mallory Miller
Marjorie Wilson-Guess
Michele Murff

Monthly Deliverable: Describe any updates, progress or accomplishments in the past month towards securing additional Community Residential Care Facility (CRCF) beds available and willing to accept BPH Forensic patients who are no longer in need of hospitalization.

7. WORK WITH THE SOCIAL SECURITY ADMINISTRATION AND SC DHHS TO EXPEDITE RESTORATION OF PATIENT BENEFITS TO IMPROVE TIMELINESS OF DISCHARGES:

Discussion: Forensic patients often remain in the hospital for weeks or months beyond when they clinically no longer require hospital level of care. As previously mentioned, one of the reasons for this is that many Forensic patients who no longer need hospitalization are psychiatrically disabled, and will need public benefits established, or re-established -- including Social Security, Medicaid, Optional State Supplement (OSS) -- before they will have the financial means to transition to the community and pay for their residence and their clinical care.

The result, however, is that because there are a finite number of beds in the agency's secure Forensic Hospital units in Bryan Psychiatric Hospital – 218 -- delays in discharging a Forensic patient who no longer requires hospital level care causes delays in the admission of a defendant who has been Ordered committed by a Court of General Sessions.

Status: Since January, 2016, the DMH Division of Inpatient Services and DMH senior staff have worked with the Social Security Administration and the State's Medicaid agency, the South Carolina Department of Health and Human Services (DHHS) to help eliminate the backlog of benefits applications (SS, Medicaid, OSS) which is often a barrier to the discharge of many Forensic patients.

In April, 2016 DMH approved using DMH State funds pay for one month's CRCF charges as "bridge funds", pending approval of public benefits, to assist in more timely discharging Forensic patients who have been accepted at a CRCF.

The role of the Transition Specialists and Care Coordinators prior to and post discharge will facilitate the establishment of the patient's public entitlements. Education of CRCF administrators regarding the process of initiating benefits following discharge will be essential.

A discussion needs to be facilitated with DIS Leadership and DHHS about a method for accelerated processing of the benefit applications of BPH Forensic patients, possibly exploring a dedicated DHHS staff member assigned to BPH. These efforts will be ongoing until the timeliness of processing Forensic patient's benefit applications improves.

Responsible Person:
Stuart Shields

Other supporting staff:
Dr. Allyson Sipes
Allison Findley
Grace Scott
Dr. Bank
Tracy Richardson
Marti Landrum

Monthly Deliverable: Describe any updates, progress or accomplishments in the past month towards improving the timeliness of determinations of Forensic patients' benefits applications for OSS and Social Security.

8. EXPLORE USE OF JAIL-BASED AND OUTPATIENT RESTORATION

Discussion: A significant portion of the current waiting list for admission to BPH Forensics consists of defendants who have been found incapable of currently standing trial, but "likely" to be restored to such capacity if provided a period of hospital treatment aimed at "restoring" their capacity to stand trial. A short-hand term for defendants in this legal category is "restorables."

The test for capacity to stand trial is whether the defendant understands and appreciates the nature of the charges against him/her, and whether s/he is capable of assisting in their own defense.

The course of treatment at BPH Forensics for a patient admitted for restoration is essentially in two parts:

1. To ensure that their psychiatric disorder is being adequately treated by means of psychiatric medication to reduce the symptoms of their illness which interfere with cognition and function; and

2. To work with the patient to help them understand what they are being accused of, the potential consequences should they be convicted of those charges, as well as the role of the Judge, the Solicitor and their defense counsel.

The first part –treatment to stabilize their psychiatric disorder –is a medical process. But the second part –assessing their level of understanding of the criminal judicial process, and providing information/instruction about that process in an effort to educate them –is an educational process, although tailored to the patient's personal circumstances. The instruction is generally provided by an assigned social worker.

Unless the defendant is acutely psychotic or has an unstable mood disorder, it is not generally necessary for either their psychiatric treatment or the educational instruction to occur in a hospital setting. Forensic hospital resources are both expensive and limited, so a number of States now provide by law for the option of jail-based or outpatient restoration, in addition to a hospital. These options generally not only save money by reducing the need for admitting the defendant to a hospital, but may enable the restoration effort to start sooner than if the defendant had to await admission to a Forensic psychiatric hospital.

Status: DMH is exploring creating the option in South Carolina law for restorable defendants to receive restoration treatment in a detention center, or, in appropriate cases for defendants on bond, in a community setting, in addition to a hospital.

Responsible Person:
Mark Binkley
Elizabeth Hutto

Other supporting staff:
Deborah Blalock
Stuart Shields
Dr. Allyson Sipes

Monthly Deliverable: Describe any updates, progress or accomplishments in the past month towards amending the laws.