

WHITING FORENSIC HOSPITAL OPERATIONAL PROCEDURE MANUAL

SECTION:	Competency and Restoration
CHAPTER: 13	Competency
PROCEDURE: 13.1	Role of Competency Monitors
Governing Body Approval:	January 13, 2020
New:	December 24, 2019

PURPOSE: To define the roles and responsibilities of Competency Monitors in the Whiting and Dutcher Services.

SCOPE: Competency Monitors, Whiting and Dutcher Service treatment teams, Chief of Forensic Services, Forensic Coordinator, Supervising Forensic Psychologist

POLICY:

Primary Responsibilities

The Competency Monitor acts as the liaison between the hospital and the court. He/she is responsible for: educating the patient about the legal system and his/her specific legal situation; conducting the formal evaluation of competency; and authoring and testifying in court about the forensic report opining on a patient's competency.

Within three business days of admission, the Monitor will introduce himself/herself to the patient and explain his/her role as a forensic evaluator who is separate from the treatment team but who collaborates with members of the treatment team. He/she will reiterate the limitations of confidentiality, including between the hospital and the Superior Court and between the hospital and the Probate Court (if necessary). He/she will offer to the patient educational materials in the appropriate native language and reading level to guide the restoration process.

The Monitor will meet or attempt to meet with the patient no less than once every ten days (or more frequently, if clinically indicated) to provide education about the court and the patient's specific legal situation. He/she will cover topics such as: foundations of the court, including terminology, roles, and procedures; case specifics, including charges, allegations, and probable evidence; and working collaboratively with counsel. He/she will document each session in the Progress notes section of the medical record. In addition to the length of the meeting, the Monitor will document: the patient's participation in the session; the patient's ability to remain focused and on topic; the patient's comprehension of information; and the patient's ability to engage in a productive discussion.

Throughout the hospitalization, the Monitor will be involved in Competency Restoration programming on his/her assigned unit, including conducting groups. The “float” Monitor will be responsible for covering a group, to the extent possible, when a unit-assigned Monitor is away and unable to reschedule their own group.

Throughout the hospitalization, the Monitor is expected to review the patient’s medical chart and discuss the case with the treatment team to gather information about the patient’s history, behavior, engagement, and treatment progress. The Monitor will provide weekly updates of the patient’s progress toward competency during the weekly Competency Review meetings. If the Monitor cannot attend the Competency Review meeting, he/she is responsible for providing brief updates about each patient’s progress to the Supervising Forensic Psychologist, the Forensic Coordinator, or the Chief of Forensic Services. Alternately, the Monitor can write updates on the weekly Competency Review notes sheet in advance of the meeting.

Two weeks prior to a patient’s court date, the Monitor will conduct a formal evaluation of the patient’s competency. The Monitor will inform the treatment team regarding the outcome of the formal interview and take into account the treatment team’s feedback in reaching a final opinion about the patient’s competency. In the event that the Monitor and the treatment team do not agree about a patient’s competency, the Monitor will inform the Chief of Forensic Services. The Chief of Forensic Services then will take actions to resolve the conflict that may include:

- Asking a clinician(s) on the treatment team and Monitor to evaluate the patient together;
- Evaluating the patient him/herself or asking another forensically-trained psychologist or psychiatrist in the hospital to do so; or
- Requesting an outside consultation by a DMHAS Consulting Forensic Psychiatrist (CFP)

If a dispute cannot be resolved in this manner, the hospital’s ultimate decision regarding the patient’s competence shall be made by the CEO or his/her designee.

The Monitor then will author and submit for review a report that outlines the hospital’s opinion regarding a patient’s competency. The Monitor will submit the report for review at least ten (10) days prior to the court date. The report will be reviewed first by the attending psychiatrist and then by the Supervising Forensic Psychologist or the Chief of Forensic Services. The Monitor will make the necessary revisions and will finalize the report for court seven (7) days prior to the court date, in accordance with statute. The Monitor will ensure that the report is faxed to the respective parties at the court (i.e., Court Clerk, State’s Attorney, and defense attorney) and will submit the original to Medical Records so that the original can be mailed to the court and copies made for the patient’s chart. When the restoration period has come to an end (i.e., a patient is deemed to be competent or is deemed to be non-restorable), Medical Records will send a copy of all report(s) from the restoration period to the original evaluating Office of Forensic Evaluations (OFE) within five business days of the final court hearing.

Other Responsibilities

The Monitor is responsible for coordinating activities with the treatment team and other hospital personnel in the restoration of competency patients. This includes the following expectations:

- The Monitor will coordinate with the team Social Worker to gather collateral records and is responsible for reviewing and compiling the information necessary to author a defensible forensic report to court. In some cases, this may mean that the Monitor collects psychosocial information directly from the patient and/or other sources. However, this is not meant to replace the Social Worker as the individual primarily responsible for gathering psychosocial information about the patient.
- The Social Worker will provide the Monitor with an appropriate discharge plan for the patient in the event that the patient is released by the court. The Monitor will provide updates as soon as possible via secure email to the treatment team regarding a patient's progress toward competency so that a plan can be made. The discharge plan, including decisions about whether a patient needs a hospital level of care and should return to the hospital after resolution of the competency matter, is the treatment team's decision. If a Monitor disagrees with the treatment team's discharge plan, he/she will raise the issue for discussion in the weekly Competency Review meetings. If the conflict is still not resolved, the Chief of Forensic Services will notify the Social Work Supervisor and the Chief Medical Officer, who will confer to make a final decision about the discharge plan.
- The Monitor will inform the treatment team and Medical Records of any changes in a patient's court date. The Monitor is responsible for obtaining the updated Continuance Mittimus or Orders of Placement from the Superior Court and will ensure that the original is provided to Medical Records.
- The Monitor will consult with multidisciplinary staff on the unit in order to conduct a thorough evaluation of the patient from multiple perspectives, and then he/she will formulate an opinion about the patient's competency. He/she will seek input from the staff/team about their observations, impressions, and opinions regarding a patient's competency, and he/she will provide to the staff/team progress updates at least weekly, and more frequently if needed.
- The Monitor will coordinate with Medical Records regarding the faxing and mailing of court reports, and will inform the treatment team, Supervising Forensic Psychologist or the Chief of Forensic Services and Medical Records when a patient has been discharged or returned from court.
- Prior to the patient's court date, the Monitor will coordinate with the treatment team about how and when to inform the patient about the hospital's opinion regarding the patient's competency.
- For planned absences, the Monitor will inform the treatment team and supervisors at the earliest possible time so that appropriate plans for the patient's court date and/or

discharge plan can be made. Every effort will be made not to delay a patient's discharge from WFH due to planned Monitor absences.

The Monitor also is responsible for communicating with parties outside of the hospital regarding the competency evaluation and related matters. The Monitor represents the hospital to these entities; therefore, it is essential that the Monitor comport himself/herself as professional, knowledgeable, and unbiased. The Monitor will communicate with court(s) regarding the following matters:

- When patients have cases in other jurisdictions (but no competency order in that jurisdiction), the Monitor is responsible for informing the other courts regarding their placement in the hospital (contact: Court Clerk)
- When additional time for restoration within the statutory guidelines is needed, or if we have reached our opinion early and wish to accelerate the court date, the Monitor is responsible for conveying such to the court. The former may be done via a brief letter, the latter via a full report. (contact: Court Clerk, State's Attorney, and defense attorney);
- Once the report has been submitted to the court, the Monitor will ensure the report was received by all parties and will inquire whether testimony is necessary (contact: Court Clerk, State's Attorney, and defense attorney);
- The Monitor is responsible for contacting the marshals to ensure that the patient will be transported to/from court (contact: Judicial Marshals);
- When the likelihood that the defendant will be released is crucial to resolve discharge planning issues, the Monitor may contact the attorneys to inquire about such after the matter has been discussed and agreed upon in Competency Review meetings (contact: State's Attorney and defense attorney);
- For patients returned under CGS 54-56d(m), the Monitor will communicate the outcome of the Probate Court hearing or a transfer to a less restrictive setting, and will request that the court remove the patient's bond in order to facilitate discharge planning. *Note:* The Monitor is only responsible for this at the conclusion of the Probate Court hearing. Once a patient has been transferred to a different unit in the hospital, the Chief of Forensic Services will assume responsibility for coordinating with treatment teams and the court regarding these issues.

In general, Monitors *do not* communicate with attorneys individually (i.e., without then calling the other). In other words, no *ex parte* communication should occur. There are few exceptions to this rule, including:

- The Monitor may contact the defense attorney to obtain information regarding his/her experience with the defendant prior to the WFH hospitalization, any specific difficulties they perceive in working with him/her, etc.; and

- When necessary (i.e., if the information is not provided to us and is essential for our evaluation), the Monitor may contact the Court Clerk or either attorney in order to obtain police reports, protective orders, and similar case-related information.

Any other instance should be discussed with the Supervising Forensic Psychologist and/or Chief of Forensic Services prior to communicating with an attorney. In all cases, information should be sought, not provided. Attorneys and other court personnel (e.g., court clerks, DMHAS jail diversion personnel, Public Defender social workers) should not be informed of the hospital's opinion prior to submitting the final report to the court, nor should the attorneys' wishes for the outcome of the case be sought.

In court, the Monitor will make an effort to present himself/herself to both attorneys upon arrival and will (to the best of his/her ability) sit somewhere neutral in the courtroom awaiting the hearing. This is done to ensure that we present an unbiased presentation to the court.

Court Report

The Monitor will write an original (self-authored) report to court that articulates clearly:

- the nature and referral source for our evaluation;
- the data upon which we relied in formulating our opinion; and
- an opinion(s) in accordance with statutory guidelines.

In situations where the report is not our first report to court (e.g., a patient has returned for more treatment, is hospitalized anew for restoration, etc.), the Monitor will write the report based on the following guidelines:

- A patient was returned to the hospital from court as not competent but restorable (NC-R): The psychosocial history can stay exactly the same, if no new information has been obtained in the interim.
- A patient was returned to the hospital from court pending an appeal of our opinion or outside evaluation: If there is no change in our opinion, the Monitor will write a brief letter to the court reflecting what has transpired in the case to date; updated Course of Hospitalization, including any further interventions/efforts aimed at restoration; and the fact that our opinion remains the same. If there is a significant change in our opinion, or new information has come to light, the Monitor will conduct a new evaluation and write a new report on that basis. In cases where more than 90 days have elapsed while waiting for an independent evaluator to complete his/her work, the Monitor will seek guidance from the Supervising Forensic Psychologist and/or the Chief of Forensic Services regarding whether or not to conduct a new evaluation and write a new report to the court.
- A patient who was hospitalized previously for competency restoration is admitted under a new order for competence restoration, assigned to the same monitor: The psychosocial history can be essentially the same, but with additions made as relevant, particularly regarding: a) what happened during the previous hospitalization for competency restoration; b) what happened since they left the hospital; and c) any additional new data

not reported in the previous evaluations. When reporting on previous competency restorations, the Monitor will summarize: any noteworthy symptoms; the patient's compliance/engagement in treatment (including whether a Special Limited Conservator was necessary); final diagnosis; medication regimen at discharge; and time to restoration. If there were multiple prior restoration efforts, the Monitor may summarize this information across hospitalizations.

- A patient who was hospitalized previously for competency restoration is admitted under a new order for competence restoration, assigned to a different monitor: The Monitor will write the psychosocial history anew, in his/her own words.

For cases in which a patient has separate competency restoration orders out of two or more jurisdictions, the Monitor may prepare the same report for all jurisdictions, changing the relevant case details in the Introduction section of the report and patient's understanding/appreciation of the charges/allegations in the Results of Evaluation section. Obviously, if they are competent for one and not another, that should be reflected differently in the opinion.

Caseloads and Transfer of Cases

With the exception of the "float" position, Monitor positions are unit-specific and, therefore, caseloads will be determined by admissions to the unit. For patients who are transferred from one unit to another, the assigned Monitor will follow the case at least through the next court appearance, and then the receiving Monitor will pick up the case. If the patient is transferred within 10 business days of admission, the case may be re-assigned to the receiving Monitor immediately. Other transfers of cases will be considered by the Supervising Forensic Psychologist and/or the Chief of Forensic Services on a case-by-case basis, based on conflicts of interest, impasses in establishing a working relationship, prolonged disparities in caseloads, safety concerns, or other unresolvable issues.

Independent Evaluations

Generally, all communication and coordination with outside, independent evaluators should be done through Medical Records (for requests of records) and administrative assistants (for scheduling of appointments). Independent evaluators are expected to provide their own informed consents for conducting the evaluation and their own Release of Information for any records they request.

From time to time, Monitors may be asked to help coordinate or facilitate these evaluations. Given the nuances of such cases, and the potential ethical problems that can arise, the Monitor will discuss all such cases with the Supervising Forensic Psychologist and/or the Chief of Forensic Services prior to interacting with the independent evaluator.

90-Day Restoration Cases

For competency cases involving a maximum exposure of 90 days (i.e., C misdemeanor), or other situations in which the patient has been incarcerated for a period of time approaching their

maximum exposure, the Monitor will seek clarification from the judge (via the Court Clerk) regarding their interpretation of CGS § 54-56d (h)(2)(A). This may be done via a brief letter (see Document Templates). The period of time for restoration will follow in accordance with the court's interpretation.

Patients Transferred to DOC under CGS §54-56d(p)

Competency restoration patients are sometimes transferred to the Department of Correction (DOC) because they are too dangerous to treat safely at WFH. In these cases, treatment teams must inform the Monitor, Supervising Forensic Psychologist, and/or Chief of Forensic Services before such a transfer occurs in order to determine the status of the competency restoration efforts. The treatment team and Monitor will then agree to one of the following options:

- A determination about the patient's competency has not yet been made, and the Monitor will continue to evaluate and educate the patient in DOC until the patient has been restored or is transferred back to WFH. The frequency of such visits will be determined through consultation with the Supervising Forensic Psychologist and/or the Chief of Forensic Services.
- The Monitor has concluded that the patient will be recommended as competent. If this determination is made more than 14 days in advance of a patient's court date, the Monitor will request that the patient's court date be accelerated. If the court does not agree to accelerate the patient's court date, the Monitor is responsible for contacting DOC as necessary to obtain sufficient clinical information about the patient's progress since leaving WFH to write a defensible report to the court. In some cases, such as when a Monitor learns that the patient has decompensated since leaving the hospital, re-evaluating the patient in DOC for a "formal" competency evaluation may be necessary. This, too, will be determined through consultation with the Supervising Forensic Psychologist and/or the Chief of Forensic Services.

Rapid Restoration Cases

Occasionally, patients are admitted to the hospital for Rapid Restoration (via CGS Section 17a-513, Voluntary admission of inmates of correctional institutions in hospital for psychiatric disabilities), prior to the OFE evaluation and a finding of incompetence. In these cases, a Monitor will be assigned to the case only to provide the patient with a competency education packet, invite him/her to competency education groups, and communicate with the court and/or attorneys if necessary. The unit Social Worker will be responsible for coordinating with the OFE to arrange the patient's evaluation. No report is submitted by the hospital to the court in Rapid Restoration cases.

Outpatient Restoration

As part of the formal evaluation of a patient's competency, a determination must be made about the least restrictive environment in which restoration (if such is still necessary) should occur. The Monitor will consider, and will discuss with the treatment team the feasibility of, this option

when it is deemed to be appropriate. Some factors to consider in making a determination about whether a patient is suitable for outpatient restoration include (in no order of importance):

- Engagement in treatment;
- Past experience (success) with restoration;
- Unanswered diagnostic or other competency-related questions, or testing in progress;
- Need for involuntary interventions;
- Compliance issues (e.g., h/o non-compliance with treatment, or probation/court orders);
- Bond in other jurisdiction(s);
- Availability of discharge plan (i.e., stable housing, outpatient services, reinstatement of entitlements, etc.);
- Substance use issues;
- Transportation issues;
- Immigration issues

**WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL**

CHAPTER: 13	Competency and Restoration/PSRB
PROCEDURE: 13.2	Acquittee Call-In While on Temporary Leave
Revised:	December 24, 2019, September 10, 2024
Governing Body Approval:	January 13, 2020, September 16, 2024
Effective Date:	October 7, 2024

PURPOSE: To define the protocol and expectations of patients while on Temporarily Leave (TL) in order to monitor patient’s status while in the community and to ensure safety.

SCOPE: Dutcher treatment teams, Nursing Staff, Forensic Coordinator, Supervising Forensic Psychologist

POLICY:

In order to monitor and assess how an acquittee is doing while in the community on a PSRB-approved Temporary Leave (TL), he or she must call his treatment unit at least once per day during the Leave. When the acquittee is staying overnight with family or is beginning to live in his/her future community residence, he/she still must call the treatment unit at least once each day. The treatment team shall schedule with the acquittee a one-hour block of time for the acquittee to call the treatment unit (taking into consideration the nature of the Leave and the acquittee’s whereabouts, schedule of activities, and relevant risk management considerations).

The treatment team shall ensure that the Temporary Leave Supervisor(s) is informed of the scheduled time for the call-in so that he/she can be aware and monitor whether the call-in was made.

When the acquittee calls, nursing staff should ask what he/she is doing, how the activities are going, how he is feeling and if any incidents of note. The content of the call, including the date/time of the call, with whom he/she spoke, and a summary of the content shall be documented in the patient’s medical record in a progress note. Any concerns or problems mentioned by the acquittee, or any concerns staff have about the acquittee’s status should immediately be referred directly to appropriate treatment unit staff. After hours and weekends/holidays, the DN and on-call psychiatrist must be notified, and administration contacted as deemed necessary.

In the event that the scheduled call-in from the acquittee has not been received within the specified one-hour block of time, treatment unit staff shall immediately try to contact the Temporary Leave Supervisor or, if at a community agency/program, other responsible agency staff to locate the acquittee. If the TL Supervisor or other responsible parties cannot be contacted and/or the acquittee cannot be located within ten (10) minutes, the CEO and Chief of

Forensic Services are to be notified immediately in order to determine if the hospital escape/AWOL procedure should be initiated.

To communicate patients' expected call ins, each unit shall maintain a call-in logbook that will include the days/times that the patient is expected to call (based on the MOD). This information will also be noted on the shift report daily as a prompt to staff. Staff are expected to know when their patients are required to call and immediately report any deviation.