Effective Components of a Jail-Based Competency Program (JBCR) and Outpatient Competency Program (OCRP)

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Effective Components of a Jail-Based Competency Program (JBCR) and Outpatient Competency Program (OCRP)

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Abstract

The intersection between mental health and the criminal justice system has caused a public health crisis in the United States, leading to increasing competency evaluation and restoration referrals. This has resulted in jails being overcrowded and defendants with significant mental illness decompensating and awaiting competency restoration. Despite the increased demand for competency restoration services and over half of the United States allowing for jail-based (JBCR) and outpatient competency restoration programs (OCRP), only 14 states actively have these programs. Various JBCR and OCRP were examined to provide effective components for states without JBCR and OCRP models. JBCR and OCRP models have successfully placed defendants in the least restrictive environment to address competency restoration. Two evidence-based theoretical frameworks advocate that utilizing a Risk, Need, Responsivity (RNR) and Good Lives Model (GLM) reduces recidivism for justice-involved individuals. If criminal justice agencies, policymakers, current state Department of Health Services, and contracted human service agencies implement the effective components of a JBCR and OCRP, coupled with the RNR and GLM, they will have the ability to streamline competency restoration services along with reducing recidivism rates for justice-involved individuals who live with significant mental illness.

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Section I: Introduction

Statement of the Problem

The number of people waiting to have their competency evaluated and restored in the United States is a significant issue in today's criminal justice system. Competency issues in the court process are vastly increasing, which results in a delay in evaluation and restoration. Since 2023, 82% of states have experienced an increase in competency evaluation referrals, and 78% have experienced an increase in referrals for competency restoration (Substance Abuse and Mental Health Services Administration, 2023). As a result, state hospital beds have reached capacity, leading those awaiting restoration to be left in jail (Fader-Towe & Kelly, 2020).

State hospitals have been the traditional method of placement for criminal defendants found incompetent to stand trial (IST). However, due to the increased number of referrals for competency restoration, alternative methods have been created, such as jail-based competency restoration and outpatient competency restoration (Ash et al., 2020). Jail-based competency restoration programs provide individualized services to defendants awaiting placement to a state psychiatric hospital (Behavioral Consultants Inc., n.d.). Mental health professionals provide individualized services to provide psychiatric care. The goal is to reduce the overall length of the defendants' commitment by reaching competency before the transfer to the psychiatric hospital or reducing the length of hospitalization after transferring to the psychiatric hospital. Outpatient competency restoration programming allows defendants to live in the least restrictive community-based setting. Defendants receive clinical and case management services to restore competency.

Several states offer jail-based competency restoration (JBCR) and outpatient competency restoration programming (OCRP) and have found successful outcomes. JBCR and OCRP allow

defendants to receive restoration services at an earlier rate than being on a waiting list for a state psychiatric hospital. The National Center for State Courts (2021) indicates that some defendants have waited six months to a year to be provided competency restoration services. This is problematic as inmates who have a mental illness are victimized at higher rates than other inmates (Torrey et al., 2014). Furthermore, inmates who do not receive psychiatric care while incarcerated experience more mental health symptoms, which result in decompensation.

The need for utilizing JBCR and OCRP rather than inpatient psychiatric hospitals must be prioritized in the U.S. There is a lack of data when looking at competency restoration program waitlists; however, it is evident that the demand for competency restoration programs besides an inpatient model is warranted given the number of competency evaluation referrals in the U.S. To reduce the number of inpatient hospitalization referrals for competency restoration, states must create and utilize effective JBCR and OCRP to allow defendants to receive the necessary treatment for restoration. Failure to create JBCR and OCRP contributes to jail overcrowding and delays the court system in sentencing defendants.

Purpose of the Study

This research paper will argue the need for increased JBCR and OCRP throughout the U.S. as referrals for competency evaluations rise. Research conducted by Ash et al. (2019) will be one component supporting the effectiveness of JBCR programs in county jails. Research conducted by Gowensmith et al. (2016) will be another component supporting the effectiveness of utilizing OCRP and demonstrating the cost-effectiveness of an outpatient model. Researching the effectiveness of both JBCR and OCRP will provide policymakers with the foundation of effective components to create a foundation for successful JBCR and OCRP.

The Wisconsin Department of Health Services (Behavioral Consultants Inc., n.d.) and the Virginia Department of Behavioral Health and Developmental Services (Virginia DBHDS, 2018) are two additional examples of external programs currently utilizing the JBCR and OCRP model. These programs allow defendants to receive mental health treatment to move them toward competency. Although 32 states allow alternative competency programs such as OCRPs, only 14 states operate OCRPs (Mikolajewski et al., 2017). Thus, states can provide alternative programming; however, they do not. The Wisconsin DHS and Virginia BDHDS will provide a foundation for states to implement these competency programs with statutes allowing alternatives to inpatient psychiatric treatment.

Significance of the Study

The significance of this research paper is to provide recommendations for effective components of JBCR and OCRP to improve the effectiveness of current programs or to create new ones. The need for policymakers, current state Department of Health Services, contracted agencies, and other criminal justice agencies is warranted to reduce the number of defendants who are awaiting competency restoration while state hospitals are overflowing. This paper will analyze and argue the most significant and effective ways to provide competency restoration to individuals who are incarcerated or in the community to ensure treatment is provided in the least restrictive setting, assisting each defendant in learning, to the best of their ability the court system, remove barriers to participants' psychiatric care, and to make rational decisions throughout the court process (Behavioral Consultants, Inc., n.d.).

Methods of Approach

This research paper will use a secondary analysis as the method of approach. Information will be obtained from peer-reviewed scientific articles, journals, government websites, and

documents. An extensive literature review will determine the effective components of jail-based and outpatient competency programs. Moreover, the benefits of jail-based and outpatient competency restoration programs rather than inpatient state hospitals will be included. Excerpts and relevant data from cited governmental agencies and psychiatry and clinical psychology experts will be included to focus on ideal competency programs in the United States.

Contribution to the Field

The first contribution to the research will be recommendations for policymakers to create ideal jail-based competency restoration and outpatient competency restoration programs to reduce inpatient hospitalizations. The specific focus will be evaluating the least restrictive placement option that will allow the individual to be successful while protecting the public from victimization. The second contribution to the research will be recommendations to the current state Department of Health Services, contracted agencies, and other criminal justice agencies providing jail-based competency and outpatient competency restoration programs. Evidence-based practices will be explicitly highlighted so these agencies can improve their competency restoration programs. Benefits and limitations to both inpatient, jail-based, and outpatient competency restoration programs will be discussed.

Section II: Literature Review

The following literature review is divided into five sections. The first section will review the history of psychiatric hospitals in the United States. The second section describes the lack of alternative competency restoration programs in the United States and how misdemeanor crimes impact the court system. Research definitions are given in the third section of the literature review to facilitate understanding of the common language and terms used in the research. The fourth section of the literature review will cover current statutes surrounding the defendant's

ability to be incompetent to stand trial (IST) and will have two subsections. The first subsection will describe the characteristics of defendants who are IST. The second subsection will explain the lack of jail-based competency restoration (JBCR) and outpatient competency restoration programs (OCRP) in states allowing alternative programming rather than placement at a psychiatric hospital. The fifth section will describe the stigmas associated with significant mental illness (SMI) and place these individuals in the least restrictive setting to allow for competency restoration. The sixth section of this literature review will demonstrate the critical need that is warranted in the United States to implement JBCR and OCRP throughout the United States to decrease defendants' length of stay in county jails and place them in a competency program that suits their needs while also protecting the community.

History of Psychiatric Hospitals in the United States

People in the United States are ten times more likely to be incarcerated than hospitalized, according to West (2023). Individuals with significant mental illness (SMI) experience limitations in accessing proper mental health care throughout the U.S., which increases their likelihood of entering the criminal justice system. West (2023) indicates that due to the lack of access to mental health care, the American Psychiatric Association has declared this a "crisis." As a result, individuals with SMI tend to re-enter the criminal justice system, which leads to multiple incarcerations, serving longer sentences, probation, and parole revocations due to technical violations, and return to jail in the first year after release (Hailemariam et al., 2024). This is a result of the deinstitutionalization of individuals with SMI and a lack of funding for community-based mental health services. Lain (2024) notes that numerous studies have shown that since state psychiatric hospitals decreased, the population of SMI individuals in jails and prisons has grown. According to Alang et al. (2021), the amount of people who have an unmet

need for mental health services has steadily increased. In 2018, one in four adults reported that their mental health needs were unmet at higher rates between 2008 and 2017. Individuals who live with SMI lack insight into their mental health, which typically only results in an inpatient psychiatric stay if they are a danger to themselves or others (Rossi, 2023). Therefore, these individuals usually stop taking their medications as prescribed and do not seek community-based treatment. This is likely due to the lack of insurance or their unmet basic living needs. Now that psychiatric hospitals are mainly seeing individuals with SMI for involuntary needs, community-based mental health clinics have poor insurance reimbursement rates, which results in poor patient outcomes. As a result, these individuals with SMI are becoming introduced to the criminal justice system like a revolving door.

Competency Restoration Challenges in the United States

Individuals who enter the criminal justice system include the basic requirement that individuals who face criminal charges must be able to assist in their own defense (Fader-Towe & Kelly, 2020). This is problematic as individuals with SMI are entering the criminal justice system at high rates and may not be able to assist in their defense. If an individual does not have the ability to understand and participate in criminal court proceedings, either a judge, prosecutor, or defense can raise concerns. This process is called competency to stand trial (CST). Once an individual’s competency is questioned, the individual will undergo a competency evaluation. If needed, restoration services may be provided in the community or at an inpatient facility, which is typically a state psychiatric hospital or jail. It should be noted that the court proceedings are paused once an individual's competency is raised. Competency restoration services provide individuals with the ability to prepare them to participate in the court process, which generally includes symptom management or legal education (Fader-Towe & Kelly, 2020).

The number of CST evaluations has skyrocketed in the United States, and the current estimate of CST evaluations per year is 160,000 (Wall, 2020). This is a reflection of the mental health crisis in the United States. As a result, state psychiatric hospitals are at capacity, which results in individuals with SMI being left to wait in jail, and their mental health symptoms increase (Fader-Towe & Kelly, 2020). Fader-Towe and Kelly (2020) note that individuals in jail are isolated, separated from community-based support and treatment providers, and exposed to trauma. Jail mental health providers often change their medication regimen due to availability and cost. Moreover, once an individual regains competency at a psychiatric hospital, the individual typically moves back to a jail-based setting, which increases their chances of decompensation again. The Substance Abuse and Mental Health Services Administration (SAMHSA) (2023) notes that most CST evaluations are conducted in jail despite an increase in states that do allow for community-based evaluations.

Due to the proliferating number of CST evaluations ordered by the Court, states do not have enough service providers to complete them promptly. Murrie et al. (2020) note that in Los Angeles County, California, the number of CST evaluations increased by 273% from 2010 to 2015. A significant factor is the number of misdemeanor arrests with orders for a CST evaluation (Murrie et al., 2020). Murrie et al. (2020) indicate that most individuals who come into contact with the criminal justice system are being referred for misdemeanor charges. A contributing factor to the dramatic increase in CST evaluations in Los Angeles County is vastly misdemeanor charges. This is problematic as non-violent crimes are slowing down our court systems and increasing the number of individuals who need competency restoration (CR) services. Studies have shown that defendants facing felony charges are more often found CST, whereas individuals facing misdemeanor charges are incompetent to stand trial (IST) (Murrie et al.,

2020). This poses a significant challenge to both our state court systems and defendants who are awaiting evaluation in jails who are decompensating due to the lack of mental health treatment.

Research Definitions

This literature review section defines and explains specific competency evaluation terms used in this paper. These definitions were sourced from the Substance Abuse and Mental Health Services Administration (SAMHSA), which outlines three types of competency evaluation waitlist categories in which individuals in the competency process are categorized.

The first waitlist is individuals whose CST is questioned and placed on a waitlist for a clinical evaluation to assess their CST. A second waitlist is someone who completes their CST evaluation and is either found CST or incompetent to stand trial (IST). If the individual is CST, their court proceedings will proceed with their court hearings. Individuals found IST are placed on a waitlist to receive competency restoration (CR) services. Most individuals awaiting CR are placed in jail. Some individuals may regain competency while at the jail if the jail has a JBCR, or the individual may regain competency due to regular jail services that include psychiatric medications, medical care, and food/shelter. If the individual regains competency regardless of the setting, they are removed from the psychiatric hospital waitlist and will proceed with court hearings. The third waitlist is an individual who had a CST evaluation and was found IST and not restorable. In these circumstances, the individual may have their charges dismissed and be on a waitlist for community (or hospital) placement or outright discharge. A judge can also issue a civil commitment order and be placed on the waitlist for a civil inpatient bed (SAMHSA, 2023).

Competency Legal Process

After a defendant commits a misdemeanor or felony, law enforcement investigates and refers the police report to the county district attorney (Wisconsin Department of Justice, n.d.). A

Criminal Complaint is filed, which is the document that formally charges someone with a crime. At any point in the court proceedings process, the defense or prosecutor can raise a doubt regarding the defendant's CST (SAMHSA, 2023). Most states have multiple examinations that may occur in jail, the community, and psychiatric hospitals. Examiners evaluate an individual's mental illness, medical issues, cognitive disabilities, and developmental disabilities. Once the examination is complete, a competence hearing will occur, and the court will determine if the defendant is CST or IST. If the defendant is CST, the trial proceeds. If the defendant is IST, the defendant may be ordered to the custody or supervision of an inpatient or outpatient service provider to receive CR services to identify if the defendant can be restored to competence. CR services include court-ordered treatment to receive medical, mental health, cognitive, or developmental issues to allow the defendant to understand their court proceedings and assist in their defense. Each state offers inpatient, outpatient, or both treatment services for CR services. Many times, involuntary medication orders are utilized (SAMHSA, 2023).

If a CST evaluation finds the defendant IST, the court may order the defendant to participate in inpatient or outpatient CR services. This is typically called the initial restoration period, which is approximately three to nine months, but each state varies. The defendant will undergo treatment; however, the provider will simultaneously assess whether the defendant will regain competency within the specified timeline. Suppose the provider identifies that the defendant has restored competency before completing the initial restoration period. In that case, a report is filed with the court, and if the court determines competency is restored, trial proceedings resume. If the defendant is not restored in the specified timeframe, the provider must advise the court if the defendant can be restored and whether it can be accomplished in an allowed time frame. Many states limit how long a defendant can participate in CR services.

Typically, these CR services cannot extend beyond the maximum period of incarceration for the offense that the defendant is charged with. Hearings typically occur every 90 to 180 days in most states. If defendants do not meet restoration in the specific timeframe, many states will either dismiss charges, release the defendant, or initiate civil commitment proceedings (SAMHSA, 2023).

The increased number of CST evaluations is correlated with the increased number of individuals with SMI entering the criminal justice system. Dewa et al. (2018) note that between 25-28% of people with mental illness have been arrested. Those with mental illness have a higher chance of encountering the police than an individual who does not live with mental illness. Those who live with SMI and are experiencing a mental health crisis may appear hostile and resistant and, as a result, struggle with complying with commands from the police (National Alliance on Mental Illness, 2024). As a result, individuals with SMI are over ten times more likely to experience use-of-force interactions with police. Ahern (2021) notes that police officers who lack mental health training conceptualize mentally ill individuals as violent and dangerous, which leads to police having a confrontational attitude towards individuals who have a mental illness. Moreover, police are typically the first responders to individuals in a mental health crisis. Defendants may be cited for disorderly conduct, loitering, and trespassing, which may be misdemeanor offenses in some states. Individuals with SMI have higher chances of experiencing homelessness, which also results in having more contact with police (Lain, 2024).

Research suggests that the majority of defendants can regain competency through CR services. Despite positive results from CR services, states could not assess the effectiveness of current CR programs or alternative methods to CR services, rather than only having psychiatric hospitalization for CR services (Gowensmith et al., 2016). As a result, psychiatric hospitals have

lengthy waitlists and are overcrowded. This has landed states facing federal oversight and exploring alternatives to psychiatric hospital stays for CR services. Outpatient competency restoration (OCRP) is a CR service that must be explored in the U.S. Not every defendant requires a psychiatric hospital CR service and can have their CR service in the community and have success. In 2016, 37 states permitted OCRP models; however, not all of these states had an active OCRP (Gowensmith et al., 2016).

Stigmas Associated with SMI and Least Restrictive Setting

Similar to police officers, society has misconceptions regarding individuals with SMI. Individuals with SMI, such as schizophrenia, are often characterized as having violent behavioral patterns (Chirita & Palimariciuc, 2019). Individuals who live with SMI may exhibit symptoms and display behavior that is outside the scope of social control, and as a result, society may be fearful of their symptoms. Often, individuals with SMI are victims of violence rather than creating violence, yet the U.S. incarcerates individuals with SMI at higher rates. Studies have shown that people with SMI are most likely to be violent during a psychotic episode (Gordon, 2016). Gordon (2016) notes that violence is not predicted by mental illness alone. When individuals experience psychosis, social media, and news platforms bring attention to the issue and cause society to link mental illness and violence despite the research suggesting that mental illness alone does not cause violence. This causes discomfort in society, and as a result, society has a difficult time accepting mental health treatment in the least restrictive setting. In cases where violence occurs, this is typically the individual's first episode of psychosis where the individual has not received appropriate mental health care treatment. This is problematic as states typically do not intervene until people are dangerous. States can civilly commit individuals who have not yet engaged in criminal behavior if they are a danger to themselves or others. This

poses a significant problem for individuals with SMI to get help before their first episode of psychosis (Gordon, 2016). The statement "danger to themselves or others" poses a negative association with SMI and an individual who is experiencing psychosis. Furthermore, this seems to be the direct link to having an individual with SMI receive proper mental health care treatment, yet this occurs in the most restrictive setting, psychiatric hospitals.

Literature Review Conclusion

The intersection between SMI and the criminal justice system represents a complex public health issue, significantly affecting the court system due to the influx of CST evaluations followed by CR services. The crisis stems from the deinstitutionalization of psychiatric hospitals and the lack of appropriate and accessible community mental health programming. Police officers are the first responders to mental health crises and engage in behavior that may come off as aggressive and hostile. As a result, misdemeanor and felony charges are being referred to district attorneys. Most notably, defendants with misdemeanor offenses are predominately IST yet hold the least amount of punishment necessary. Over half of the U.S. allows for OCRP models; however, they fail to implement these programs. This potentially is a result of the negative stigma associated with SMI and preconceived violence.

Individuals who are referred for CST evaluation are awaiting court-ordered treatment in secure settings such as jails that do not provide adequate mental health services, thus resulting in the defendant's decompensation. State Department of Health Services, court systems, and other criminal justice systems must evaluate current competency programs to reduce the number of defendants incarcerated pending CR services. By building on the successes of current practices throughout the U.S., other states can implement OCRP and JBCR programs to address the

intersection between the criminal justice system and mental health, which will allow a reduction in barriers to accessing appropriate mental health treatment.

Section III: Ideal Program Models – Arguments Framework

The increasing demand for CST evaluations warrants alternative methods to CR programs rather than just psychiatric hospitalization. Most states in the U.S. allow for alternative CR programs such as OCRP and JBCR; however, these programs are not being implemented nationally. The following section will examine two criminological theories that suggest criminal justice agencies can evaluate a defendant's background, identify needs, and determine an appropriate placement option for programming. Moreover, identifying a defendant's strengths can set a foundation to reduce recidivism. The two theoretical frameworks described are the Risk-Need-Responsivity model (RNR) and the Good Lives Model (GLM).

Risk-Need-Responsivity

The risk, need, responsivity model (RNR) is a widely used tool in correctional populations to address criminogenic needs. The risk principle, a key component of the RNR model, involves assessing an individual's risk for reoffending based on static factors such as age of first arrest, history of arrest, and current age (National Institute of Corrections, n.d.). Dynamic risk factors, including antisocial thinking and antisocial peers, are also considered. Antisocial thinking refers to an individual's coping skills, particularly their ability to manage frustrations in a stressful situation. Those with a higher risk for recidivism should receive more intensive interventions, underlining the urgency of the situation (National Institute of Corrections, n.d.).

The need principal assesses the individual's criminogenic needs and identifies these as targets to provide treatment. Criminogenic needs are factors that are directly linked to criminal behavior and can be changed, which is why they are called dynamic. According to Lutz et al.

(2022), criminogenic needs should focus on "the Big Eight," which include the history of antisocial behavior, antisocial personality, antisocial attitudes, antisocial associates, family/marital relationships, problematic circumstances at work/school, lack of prosocial recreational activities, and substance use. An individual with numerous arrests and lacks prosocial individuals to spend time with will need a higher level of intervention than someone who has only been arrested once and has supportive friends and family and a stable job.

The RNR model's final principle, responsivity, is critical to its effectiveness. It allows individuals to learn rehabilitative interventions tailored to their learning style, motivation, and skills. For instance, if an individual needs to use public transportation for treatment, the RNR model ensures they can participate in a treatment program when the bus is in service. This adaptability is a reassuring sign of the model's effectiveness.

Criminal justice agencies can significantly improve the outcomes of individuals needing CR programming by utilizing the RNR model. This model provides a framework for determining the most appropriate treatment program, whether a psychiatric hospital, JBCR, or OCRP. Understanding the mental health needs of defendants receiving CR services is crucial, and the RNR model can help identify responsivity factors that provide a foundation for their success.

Good Lives Model

The Good Lives Model (GLM) is another theoretical rehabilitation framework used in correctional populations. It was initially developed for sex offender treatment; however, it has shifted to other correctional populations as the model utilizes a strength-based approach (Lutz et al., 2022). The GLM focuses on healthy functioning, which includes managing risk while promoting the individual's well-being. Barendregt et al. (2018) note that when individuals

can focus on their strengths and promote their well-being, their risk decreases as they create a meaningful life that desists from criminal offending.

The GLM focuses on 11 primary human needs: life (including healthy living), knowledge, excellence in work (including mastery experiences), excellence in play, excellence in agency (autonomy and self-directedness), inner peace (freedom from emotional turmoil and stress), relatedness (intimate, romantic, and family relationships), community (connection to a broader social group), spirituality (finding meaning and purpose in life), happiness (feeling good in the here and now), and creativity (Barendregt et al., 2018). Lutz et al. (2022) suggest that individuals engage in criminal behavior implicitly or explicitly, meaning individuals engage in criminal behavior to ensure their daily living needs are met or maladaptive coping strategies. These maladaptive coping strategies directly link with antisocial thinking, which is a dynamic risk factor (criminogenic need) that was reviewed with the RNR model.

The GLM focuses on teaching individuals the necessary skills to meet their daily needs in socially acceptable ways and reduce or manage their risk of reoffending (Barnao et al., 2016)). Individuals with SMI often experience homelessness and poverty, resulting in daily living needs not being appropriately met. Moreover, individuals with SMI often are perceived as dangerous and violent, which leads to a lack of sense of community or relatedness. Society ultimately sets individuals with SMI in a position to struggle with areas outlined in the GLM, which directly links to criminal offending.

States throughout the U.S. must consider RNR and GLM theoretical frameworks when implementing CR services. Both of these theoretical frameworks allow state Department of Health agencies, court systems, and criminal justice agencies to implement JBCR and OCRP with a foundation to set defendants up for success while determining the appropriate treatment

level. CR service programs must utilize the RNR model to place high-risk individuals in secure settings while identifying low-risk individuals for OCRP settings. Placing individuals in the appropriate treatment track will allow CR services to reduce the number of psychiatric hospital admissions and reduce the number of defendants awaiting treatment in jail settings, which reduces jail overcrowding and prevents defendants with SMI from decompensating due to the lack of jail resources. Unfortunately, society has set up individuals with SMI to lack the ability to have their primary human needs met as outlined in GLM. Allowing appropriate individuals for OCRP allows CR service providers to connect individuals back to their community and focus on the 11 primary human needs to improve quality of life and reduce criminal reoffending.

IV: Program Evaluation: Examples of Current Human Service Departments with JBCR and OCRP

The uptick in competency evaluations and restoration in the United States warrants expanding competency restoration beyond psychiatric hospitals. Despite states allowing for community-based evaluations, CST evaluations continued to be completed in secure settings. The majority of CST evaluations stem from misdemeanor arrests, which crowd our criminal court systems with non-violent crimes. Over half of the United States has statutes allowing JBCR and OCRP to be utilized; however, only 14 states currently operate these CR programs. Utilizing the RNR model provides human service departments with the framework to identify which defendants would be appropriate for alternative CR services such as JBCR and OCRP. Below are some examples of states that have implemented JBCR and OCRP, which should be utilized as a foundation for states throughout the U.S. to adopt and implement. These programs will be explored in detail throughout the paper.

Wisconsin

The Wisconsin Department of Health Services (DHS) offers JBCR and OCRP for adult defendants who are charged with a crime but are not competent enough to stand trial but are likely to regain competency (Wisconsin Department of Health Services, n.d.). Wisconsin DHS contracts with Behavioral Consultants to manage this program. OCRP in Wisconsin began in 2008 after statutory language changed, which allowed for defendants, once committed, to be treated for competency restoration on an outpatient basis as deemed appropriate by the DHS. The OCRP offers the least restrictive setting, which is a cost-effective alternative for CR services, as the defendant is not required to be in an inpatient setting such as a psychiatric hospital or jail (Behavioral Measures, n.d.). To determine if the defendant is appropriate for OCRP, clinical and case management staff assess the defendant for the appropriateness of the program.

Initial competency evaluators for Behavioral Consultants identify defendants who may be appropriate for OCRP (Behavioral Consultants, n.d.). After a thorough file review, the defendant will complete a clinical assessment with a licensed psychologist. OCRP encourages at least one person from the individual's support system to be present for the assessment. If the licensed psychologist determines the defendant is suitable for OCRP, they will be referred to an Environmental Assessment. This assessment includes an OCRP case manager or supervisor going to the defendant’s home to complete an interview to identify the general safety and stability of the residence, gather information on community providers and the defendant’s support system, and review program expectations and rules related to their home and behavior while participating in OCRP. A suitable candidate for OCRP refrains from drug or alcohol use presents no immediate danger to themselves or the community, has stable mental health, reliable transportation, reliable housing, and is motivated. Defendants participating in OCRP expect to maintain at the residence that they resided upon being approved into the program. OCRP ensures

that the home does not have illegal drugs present, alleged victims are not close in proximity, and the defendant must stay overnight at the home every night. If the defendant wants to move, the case manager and clinical director must approve this. If the defendant has consumed illegal substances, the participant will be immediately removed from the program and placed in an inpatient setting. Suppose the defendant stops attending remediation sessions or refuses to agree to the rules set by the OCRP team. In that case, the OCRP team will arrange for remediation in an inpatient setting (Behavioral Measures, n.d.).

Once the defendant is accepted into OCRP, Behavioral Consultants sends an acceptance letter and program rules to the judge, district attorney, and defense attorney (Behavioral Measures, n.d.). The defendant is assigned a Behavioral Specialist and Case Manager. Their supervisors and the clinical program director support the behavioral specialists and case managers. Behavioral Specialists conduct sessions two times per week for one hour per session in a public location. These sessions include psychoeducational treatment for competency and monitoring of the defendant in the community. A Case Manager meets with the defendant once a week in their home. The defendant can participate in the program for up to nine months (for a misdemeanor) or one year (for a felony). By participating in an outpatient setting, defendants are allowed to continue with employment, maintain housing, continue mental health care with community service providers, have regular access to their support system, and saves a significant amount of money on taxpayers as the defendant can remain in the community rather than be incarcerated. The defendant continues to be evaluated by an examiner every three months while in OCRP, and a written report about the defendant's progress is provided to the court for consideration in determining competency. The role of OCRP staff is to treat every defendant with dignity and respect, maintain neutrality despite what the defendant is being charged with, refrain

from offering legal advice, maintain firm boundaries, and abide by ethical and legal guidelines of the profession (Behavioral Measures, n.d.).

Defendants who participate in OCRP may return to an inpatient setting if a new offense occurs or the defendant experiences suicidality or episodes of violence (Behavioral Measures, n.d.). The OCRP core team will consult and may not refer the individual transfer to an inpatient setting. If the defendant requires an inpatient setting, Behavioral Consultants will request an arrest warrant and order of transport to be issued from the court so that the defendant can be placed at a state mental health institution for continued restoration treatment (Behavioral Measures, n.d.).

In addition to OCRP, JBCR began in 2016 due to the increased number of individuals awaiting competency restoration services waiting to transfer to a state mental health institution for treatment to competency (Behavioral Consultants, n.d.). JBCR has worked with existing mental health services in jail to reduce the overall length of the defendant's commitment by either reaching competency before transfer to a state mental health institution or reducing the length of stay at a state mental health institution. To be eligible for JBCR, the defendant is identified as needing to be admitted to a state mental health institution. If the defendant is incarcerated at a jail contracted with JBCR, the DHS Admissions Team will make a referral to JBCR, and services are automatically initiated. Behavioral Specialists meet with defendants up to twice per week to provide psychoeducation relevant to the court system and ensure the defendant is psychiatrically stable. Independent examiners evaluate the defendant while participating in JBCR. Behavioral Consultant staff will give the independent examiner with a written summary of the defendant's engagement and responsiveness to assist in the evaluation. It should be noted that defendants participating in JBCR are on an admission list to be placed at a mental health

institution. If the defendant is found competent before admission to a mental health institute, a review hearing will be requested within 14 days of the court's notification of the change in status. JBCR will provide services to the defendant until the defendant is found competent or found not competent and is not likely to regain or be transferred to a state mental health institution (Behavioral Measures, n.d.).

Colorado

Like Wisconsin, Colorado has utilized OCRP and JBCR programs to reduce the number of individuals waiting to be transferred to a state psychiatric hospital. The Colorado Department of Human Services, Office of Civil and Forensic Mental Health's Forensic Services division provides evaluations and treatment services to individuals pending competency restoration Colorado Department of Human Services, n.d). In 2019, Colorado DHS created a triage system to screen each defendant pending CR services and recommend an appropriate level of care the defendant needs to restore competency. The Outpatient Restoration Program services adults who are incompetent to proceed in criminal proceedings and require education and case management services in their community. This was created in January 2018 and has almost doubled in size to the number of individuals they have served. This OCRP model provides CR services in the least restrictive setting, which allows the defendant to participate in local and social support while allowing the defendant to maintain employment and housing. Defendants do not pay for the cost of CR services provided by contracted agencies in the State of Colorado. Behavioral Treatment Services (BTS) is the current contracted provider for OCRP. Colorado contracted BTS to expand the defendant's access to outpatient CR services. Defendants are expected to follow all the rules that the provider gives the defendant regarding attendance and participation, refrain from alcohol or drug use, participate in all behavioral health counseling, and take all medications as

prescribed. This OCRP model is expected to take 90 days; however, some defendants may participate in the program longer. Notably, in the fiscal year 2020-2021, the average number of days a defendant participated in OCRP was 248.1. The defendant's effort in their programming determines how long the program will take. The treatment team routinely assesses defendants to determine the appropriateness for evaluation before the 90-day re-evaluation benchmark or court-ordered due date (Colorado Department of Human Services, n.d).

Upon admission to OCRP, the defendant completes an intake assessment to determine barriers to competency, how the individual best learns information, and individual strengths (Colorado Office of Behavioral Health, 2022). This information is utilized to form a treatment plan. Staff will also complete the Level of Supervisory Inventory-Revised (LSI-R) and report the defendant's criminogenic risk and the intensity of clinical services needed for the community. The LSI-R utilizes the RNR model. The OCRP model with Colorado DHS helps individuals understand criminal proceedings, assists in their defense, and provides various mental health services, such as medication management, case management, and peer support. The defendant may also be required to receive education in other areas, such as coping skills, Dialectical Behavioral Therapy (DBT), substance use, anger management, cognitive remediation, or social skills. The Bridges Liaison Program has a mental health liaison in all judicial districts in Colorado to advocate for timely CR evaluations and services for individuals with SMI to reduce repeated involvement in the criminal justice system. The Rocky Mountain Human Service Momentum Program assists individuals with SMI. This program provides personalized care and support, connecting them to community-based mental health providers and resources. The OCRP model works with the defendant, their identified support system, and community stakeholders to identify temporary and permanent housing. Colorado Coalition for the Homeless has worked

with their OCRP to utilize 53 units for individuals who are ordered competency restoration services. Defendants can reside in independent apartments while receiving case management services, assertive community treatment, integrated healthcare, and transportation assistance. If a defendant is not participating in OCRP, the OCRP team will advise the court. It should be noted that OCRP recognizes that not every mental health crisis warrants an inpatient restoration and community crisis resources should be utilized (Colorado Department of Human Services, n.d).

In 2013, Colorado created a jail-based competency restoration program. There are currently three JBCRs throughout the state, which include 106 available beds (Colorado Office of Behavioral Health, 2022). The average stay for a defendant participating in JBCR is 157.5 days. Defendants only participate in JBCR if OCRP is not an appropriate placement or if the defendant needs to be detained but hospitalization is unnecessary (danger to self or others). Defendants participating in JBCR are housed in different units in detention and jail settings rather than being with the general population. Jail staff who work with the JBCR program are specific to the JBCR program and do not work in other areas of the jail. Staff are trained in behavioral health disorders and Crisis Intervention Training (CIT). The JBCR unit is staffed with a prescriber who is specific to the JBCR program. The prescriber also provides psychoeducation groups. Defendants participate in daily psychiatric care and receive multidisciplinary treatment from psychologists, social workers, re-entry specialists, psychiatric nurses, recreation therapists, activity specialists, and peer support specialists. The goals of restoration treatment are to manage mental health and restore defendants to competency, develop coping skills and decision-making skills to help in their criminal case, incarceration, and community re-entry, and develop an understanding of the court process and the roles of the individuals involved to allow the defendant to participate fully in their defense. The goal of JBCR is to have the defendant restored

in 120 days or transferred to a hospital setting. Similar to OCRP, JBCR staff are contracted providers who regularly audit to ensure compliance. If a defendant participating in JBCR improves and when there is support from the defense attorney, the defendant may request a re-evaluation to determine if competency has been reached before the routine examination is due. Moreover, suppose clinical JBCR staff determine that a defendant is stable through treatment and medication compliance. In that case, OCRP will be explored to have the defendant transition to the least restrictive setting (Colorado Office of Behavioral Health, 2022.

Georgia

Like other U.S. states, Fulton County, Georgia, had a waitlist for defendants to participate in inpatient competency restoration (Ash et al., 2020). As a result, Georgia contracted with the university forensic program to develop a 16-bed pilot unit in the county jail to restore male defendants. This pilot unit was studied for seven years. Jail administrations and the jail's mental health provider were supportive of the jail-based competency program as it allowed inmates pending CR services to receive mental health care and reduced the timeframe defendants were awaiting an inpatient hospital bed. The JBCR model included a psychologist director, social worker, masters-level clinician, psychiatrist, and diversion specialist. Forensic psychology trainees were utilized to work individually with defendants, assist in running groups, and complete psychological testing. Additional jail deputies were present when mental health staff were on the unit. The operation of this JBCR model is similar to that of the inpatient forensic unit at state hospitals. The defendants would participate in a daily group schedule, including legal education, conflict resolution, values clarification, basic reading skills, medication adherence, and individual therapy sessions. The defendant's pending CR services who were residing in the maximum jail unit were not allowed to participate in the program until they could

be reduced to a lower security unit. Defendants who were not medication compliant were able to participate in the program. The study found that 40% of male defendants reached competency restoration by participating in the JBCR program. Georgia's pilot JBCR shows promising results that alternative methods to psychiatric hospitals can be utilized for CR services. Ash et al. (2020) noted that 31% of defendants were diverted out of the criminal justice system, and most were misdemeanor defendants.

The programs discussed throughout this section provide criminal justice agencies, court systems, and Department of Health and Human Service departments with the foundation of the necessary steps to implement OCRP and JBCR programs. As Ash et al. (2020) noted, JBCR provides successful outcomes and even diverts defendants from engaging in criminal behavior. Wisconsin and Colorado have developed an OCRP that allows defendants to remain in the least restrictive environment, which connects defendants with community-based resources to utilize long-term. Defendants' connection to community-based resources allows them to participate in these services after their court proceedings are completed. This allows defendants to have contact with mental health providers who are aware of their mental health history and social support to assist them with being productive members of society while refraining from engaging in behavior that would involve them in the criminal justice system. Furthermore, OCRP is the most cost-effective method as it keeps individuals out of secure settings. OCRP and JBCR programs ensure defendants receive the necessary treatment to regain competency while protecting the community from future victimization.

V. Recommendations for Effective Components for an Ideal JBCR and OCRP

Practical Components for an Ideal JBCR

Utilizing effective and practical components for an ideal JBCR is critical as JBCR programs provide individualized services to defendants awaiting placement at a state psychiatric hospital to regain CR (Behavioral Consultants Inc., n.d.). Regular jail units do not incorporate the mental health treatment necessary for an individual who lives with SMI, and as a result, their mental health symptoms increase (Fader-Towe & Kelly, 2020). As a consequence, individuals decompensate and are typically referred to a psychiatric state hospital rather than being referred to an OCRP. This results in society having a difficult time accepting mental health treatment in the least restrictive setting. It is clear that once an individual's IST is questioned, transitioning the defendant to a JBCR program that includes on-site psychiatric staff, programming to ensure legal education, medication adherence, and mental health therapy is warranted. The reality is that providing these services as soon as reasonably possible can prevent continued decompensation and can allow an individual to transition to an OCRP based on their risk, need, and responsivity (RNR). Furthermore, allowing defendants to participate in a JBCR program may shorten their inpatient stay at the psychiatric hospital as they already participate in CR services.

State human service departments and state court systems must incorporate an evidence-based risk assessment tool to determine the appropriate level of care needed for CR services based on the RNR model. Including static factors such as age of first arrest, history of arrest, and current age allows an assessor to determine the level of risk a defendant presents of committing an additional offense. Dynamic risk factors must also be considered to determine if their need for cognitive-behavioral intervention can be appropriately managed in the community. If not, a higher level of intervention is necessary and can be provided in a confined environment such as a JBCR program. Utilizing an evidence-based validated risk assessment focusing on the RNR

model will allow defendants to be placed in the appropriate setting for CR services and reduce the waitlist to participate in CR services in a psychiatric hospital.

Incorporating the GLM is an additional framework that must be considered in addition to RNR. GLM is a strength-based approach that promotes an individual's well-being, preventing defendants from living a lifestyle of criminal offending. Utilizing an RNR model while also looking at factors such as if an individual has a lifestyle that includes prosocial support from their family and stable housing, their chances of being successful in the community is higher than someone who lacks prosocial support, and their basic living needs not being met. Incorporating both frameworks allows assessors for JBCR and OCRP to place defendants in the least restrictive setting that can still meet their needs to provide CR services.

An effective JBCR program will consist of a jail unit that only houses individuals participating in the JBCR program. The defendants would participate in a daily group schedule, including but not limited to legal education, medication adherence, individual therapy sessions, coping skills (Dialectical Behavioral Therapy), decision-making skills, and community re-entry resources. It is crucial for the jail staff working in the JBCR program to be specific to the JBCR program and receive additional training such as Crisis Intervention Training (CIT) and behavioral health disorders to effectively respond to mental health crises while also keeping the jail facility safe. A treatment director, social workers, master-level clinicians, psychiatrists, recreation therapists, and diversion specialists are necessary to ensure a daily group schedule can be incorporated for consistency but also have trained mental health professionals available to evaluate defendants and provide them with the therapy and medications necessary to assist in their ability to regain competency. JBCR programs must be open to allowing defendants who are not medication compliant to participate in the JBCR program. Allowing defendants who are not

medication compliant to participate in the JBCR program that has on-site psychiatric staff available allows these individuals to be assessed for court-ordered medication adherence before being admitted to state psychiatric hospitals to prevent future decompensation and being a danger to themselves or others. Defendants should remain in the JBCR program for up to 120 days or be transferred to a hospital setting. Suppose a defendant can make positive progress while participating in the JBCR program and can be safely managed in the community based on the RNR model. In that case, diversion specialists should review the defendant's case and suggest that the defendant participate in OCRP. Transitioning defendants to the appropriate level of care when it is safe allows individuals awaiting JBCR to transition into the program and reduce waitlists.

Practical Components of an Ideal OCRP

OCRP allows defendants to be placed in the least restrictive setting, the most cost-effective alternative for CR services (Behavioral Measures, n.d.). An assessor must complete an evidence-based validated risk assessment focusing on the RNR model, which includes at least one person from the individual's support system to be present for the assessment. Including the individual's support system in the assessment follows the GLM framework to ensure the defendant has prosocial support in the community. Interviewing this person allows the assessor to gather additional information to take into consideration any needs and responsivity issues the defendant may experience, such as lack of appropriate housing or intellectual disabilities that may pose a barrier to legal education. The OCRP must have a case manager complete an environmental assessment that gathers information about the safety and stability of the defendant’s residence and gathers information on community providers. Due to OCRP being an outpatient model, the defendant needs to have stable housing and transportation, refrain from

drug and alcohol use, present no immediate danger to themselves or the community, have stable mental health, and be motivated to participate in the program. The assessor must also consider the victim's proximity and set out the expectations of the rules of OCRP to the defendant, such as staying overnight at their residence each night unless preapproval is given. Ensuring the defendant’s stability is crucial to ensure the defendant is set up for success and plans to overcome barriers can be implemented to avoid setting the defendant up to fail.

Case managers should meet with the client once or twice weekly to provide legal education and skills training in dialectical behavioral therapy to help them learn coping and decision-making skills. This also includes case managers ensuring the defendant is set up with appropriate mental health services to meet their needs and having open collaboration to ensure continuity of care. This may include medication management to ensure medication compliance. Similar to the Colorado Department of Health Services, it is highly encouraged for OCRP to collaborate with homeless shelters to secure housing for individuals who may be appropriate for OCRP but lack suitable housing. This would be a temporary solution until the case manager could assist the defendant with obtaining employment or social security benefits. Utilizing this assertive community treatment (ACT) approach with OCRP participants has evidence to reduce recidivism for justice-involved individuals with severe mental illness (Cuddeback & Morrissey, 2011). Connecting defendants to community-based service providers allows defendants to be set up with resources to utilize post-OCRP, which builds inner peace, healthy living, community, and happiness as outlined in the GLM framework, which reduces individuals from a criminal offending lifestyle (Barendregt et al., 2018).

OCRP shall be able to refer an individual for JBCR programming if the individual is breaking the rules of the program, mental health decompensates, or they are a threat to

themselves or others. OCRP must recognize that not every mental health crisis warrants an inpatient restoration, and community crisis resources should be utilized (Colorado Department of Human Services, n.d.). OCRP should have 24/7 staff availability to ensure defendants who experience a mental health crisis have access to the support needed.

Legal and Ethical Considerations

JBCR and OCRP must consider that most CST evaluations stem from misdemeanor arrests that crowd our court systems with non-violent crimes (Murrie et al., 2020). Assessors from JBCR and OCRP must consider the length of time an individual will need to regain competency if the offense was a misdemeanor. Studies have shown that the number of individuals who are facing misdemeanor charges are found IST at higher rates and, therefore, may be more appropriate for an alternative program, such as a diversion program, to avoid bogging down the waitlist for JBCR and OCRP (Murrie et al., 2020). Individuals who engage in misdemeanor offenses are typically only allowed to participate in CR services for up to nine months, a shorter timeframe than felony offenses. Defendants being IST at higher rates for misdemeanor offenses are likely impacted by the shorter timeframe allowed to engage in CR services. Therefore, it is warranted that our court systems develop an alternative program to prevent non-violent defendants from participating in a highly backlogged program with defendants awaiting CR services. These strategies for OCRP and JBCR programs not only improve the overcrowding of defendants awaiting CR services but also enhance community safety by connecting defendants with community-based resources that ultimately improve their overall quality of life, encouraging defendants to engage in a lifestyle that includes criminal behavior.

VI: Conclusion

The number of defendants awaiting competency evaluation referrals and competency restoration has dramatically increased in the United States. Furthermore, the American Psychiatric Association has declared the United States to be in a mental health crisis. (West, 2023). The nexus between the mental health crisis and the number of individuals with SMI entering the criminal justice system warrants attention. Due to the number of state psychiatric hospitals decreasing, the population of SMI individuals entering jails and prisons has grown (Lain, 2024). As a result, state hospital beds are overflowing with defendants pending competency restoration services, and as a result, our local jails have defendants decompensating and waiting for inpatient treatment (Fader-Towe & Kelly, 2020). Fortunately, JBCR and OCRP are alternative methods to address the rise of competency restoration due to the increasing demand for state hospital beds. These programs offer defendants the CR services warranted to proceed with the court process and allow defendants to be connected to psychiatric services to avoid further decompensation that commonly occurs while defendants await CR services in local jails. It is alarming that SAMHSA (2023) indicates that most competency-to-stand trial (CST) evaluations are conducted in jails despite community-based evaluations being allowed. Moreover, despite 32 states allowing alternative competency programs such as OCRPs, only 14 operate OCRPs (Mikolajewski et al., 2017). Not every defendant requires state psychiatric hospital CR services; thus, OCRP and JBCR must be implemented. Implementing alternatives to inpatient state psychiatric hospital CR reduces the length of time a defendant who lives with SMI be admitted to a state psychiatric hospital, and this allows defendants who can be successful in the community to participate in a program in the least restrictive environment. Although there is a lot of stigma associated with individuals who live with SMI, individuals with SMI are more often victims of violence rather than creating violence. Luckily, there are evidence-based

frameworks that JBCR and OCRP can utilize to make informed decisions and determine the appropriate level of care a defendant needs. The risk, need, responsivity model (RNR) is a widely used tool in correctional populations to address criminogenic needs. RNR provides a framework for determining the most appropriate treatment program, whether a psychiatric hospital, JBCR, or OCRP. The RNR model incorporates identifying crucial responsivity factors to determine if a defendant can succeed given the CR services provided. Furthermore, the Good Lives Model (GLM) is another theoretical rehabilitation framework utilized in correctional populations. The GLM focuses on healthy functioning, which includes managing risk while promoting the individuals' well-being. Barendregt et al. (2018) indicate that when individuals can focus on their strengths and promote their well-being, their risk decreases as they create a meaningful life that desists from criminal offending. Several states, such as Wisconsin, Colorado, and Georgia, have JBCR and OCRP actively being utilized. These examples of current human service departments, JBCR and OCRP, provide government officials throughout the United States with the foundation for implementing a JBCR and OCRP. As Ash et al. (2020) note, JBCR in Georgia had found successful outcomes for defendants participating in the program and found a reduction of defendants engaging in further criminal behavior. Furthermore, OCRP is the most cost-effective method for CR services as it keeps defendants out of secure settings.

Limitations and Future Research

It is crucial to recognize some limitations that could impact how state criminal justice agencies implement JBCR and OCRP. One key challenge is the lack of data on CR program waitlists throughout the United States. Without this data, it is difficult to identify the scope of the problem, which may impact available grant opportunities to criminal justice agencies. Although the National Center for State Courts (2021) has determined that some defendants have waited six

months to a year to be provided CR services, grant funders typically want concrete data on the scope of the problem. However, the growing literature supporting the influx of individuals with SMI entering the criminal justice system cannot go unnoticed. Another limitation is that JBCR and OCRP models do not have a set standard of effective components necessary to ensure a successful program. However, this paper has extensively explored three programs currently in effect and determined key components that every JBCR and OCRP model must include. These programs include the evidence-based RNR and GLM framework that has shown a reduction in recidivism, which is crucial to ensure the protection of the public when considering JBCR and OCRP. It is important to note that this literature review predominately focuses on the significant advantages of implementing JBCR and OCRP; it does not explore the obstacles and oppositions that criminal justice agencies may face by implementing these programs in their communities. The stigma associated with individuals with SMI cannot be ignored, as society often views these individuals as outside of our social control, which can be uncomfortable. Lastly, this research undermines the importance of continuing to evaluate the evidence-based practices utilized in these programs. It is crucial to monitor and evaluate the components of a JBCR and OCRP model over time, as evidence-based practices are ever-evolving to ensure individuals receive the best effective treatment possible. By acknowledging these limitations, future studies can address these gaps and explore methods to strengthen JBCR and OCRP models. Future research should include recidivism rates for defendants participating in JBCR and OCRP. If individuals continue to engage in criminal behavior, it is crucial to note if the individual requires CR services or if they can engage in court proceedings without competency being questioned. Future research must also be conducted on states where misdemeanor crimes are not eligible for CR services and utilize a diversion model. This will allow researchers to determine the effectiveness of diversion

programs for these defendants and if they reduce the number of CST evaluations throughout the United States. Due to the mental health crisis in the United States, it is also crucial to determine any public health programs that are addressing the crisis that may desist and provide resources to individuals who may be vulnerable to entering the criminal justice system, as these programs are also ever-evolving. While implementing JBCR and OCRP models throughout the United States looks promising, it is also warranted that research into these programs be continued to ensure effectiveness. Further studies are necessary to understand the lasting effects of JBCR and OCRP in reducing waitlists to state psychiatric hospitals, reducing recidivism, and ensuring individuals remain connected to community mental health providers. By implementing JBCR and OCRP models, we could potentially see a reduction in jail overcrowding, court delays, recidivism, and a cost-effective method to address CR services throughout the United States.

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