

Texas Outpatient Competency Restoration Programs

EVALUATION REPORT

AUGUST 2015

Texas Outpatient Competency Restoration Programs

CATE GRAZIANI

MICHELE R. GUZMÁN

MICHAEL MAHOMETA

ALAN SHAFER

PREPARED BY:

The Hogg Foundation for Mental Health in collaboration with the Department of State Health Services

RECOMMENDED CITATION: Hogg Foundation for Mental Health (2015).

EVALUATION REPORT: Texas Outpatient Competency Restoration Programs.

FOR ADDITIONAL INFORMATION, PLEASE CONTACT:

Lynda Frost, JD, PhD

Director of Planning and Programs

Hogg Foundation for Mental Health

lynda.frost@austin.utexas.edu

(512) 471-5041

ACKNOWLEDGEMENTS

The Hogg Foundation evaluation team would like to thank the Department of State Health Services (DSHS) for its willingness to partner with the foundation on learning from and about the Outpatient Competency Restoration (OCR) Program. We particularly want to thank the DSHS OCR staff, especially the OCR program directors and staff who took the time to fill out the surveys and talk with us about their programs. We want to acknowledge the time and energy taken by Ms. Jennifer Swinton and Dr. Alan Shafer to provide us with information and data for the OCR programs. Dr. Courtney Heard, the current OCR Program Director provided valuable feedback on the final draft of the report.

Our thanks to Dr. Michael Mahometa for providing his expertise in the area of statistical analysis to this evaluation project.

We appreciate the time and energy of the Hogg Foundation staff members who provided feedback on earlier drafts of this report and who lent their expertise to the project along the way.

TABLE OF CONTENTS

| | |
|---|----|
| Executive Summary | 2 |
| Introduction | 3 |
| Evaluation Design and Methodology | 4 |
| Background | 4 |
| Evaluation Questions | 7 |
| Process Evaluation | 7 |
| Program and Participant Descriptions | 7 |
| Methodology and Analysis | 7 |
| Findings | 8 |
| Outcome Evaluation | 17 |
| Participant Demographic | 17 |
| Data Analysis | 18 |
| Program Outcomes at Pilot Projects | 18 |
| Summary | 23 |
| Recommendation | 24 |
| References | 25 |



Hogg Foundation
for Mental Health

ADVANCING RECOVERY AND WELLNESS IN TEXAS

EXECUTIVE SUMMARY

Competency restoration is the process by which defendants who have been found incompetent to stand trial (IST) are provided treatment and education so that they have a rational and factual understanding of the legal proceedings they will encounter. Historically, competency restoration was provided in an inpatient setting, but due to a shortage of psychiatric beds in Texas psychiatric facilities, the state began to utilize outpatient competency restoration in 2007.

Texas operates twelve outpatient competency restoration (OCR) programs, constituting the largest initiative of its kind in the country. Four pilot programs were created in 2007-2008, followed by seven new programs in 2011-2012 and one additional program in 2013.¹ These programs are located across the state and served 1,061 individuals as of the end of FY 2013.

The Hogg Foundation for Mental Health has maintained a strong interest in identifying potential benefits and challenges of outpatient competency restoration. While the state collected substantial data on the existing pilot programs and has some positive preliminary findings, further analysis of this data was needed. Therefore, in collaboration with the Department of State Health Services (DSHS), the foundation conducted an evaluation of eleven of the twelve OCR sites.

The evaluation focused on the program design and implementation process for the eleven OCR sites in operation during the time of the assessment, and outcomes for the four pilot sites. More specifically, the goals of the evaluation were to:

- Conduct a process evaluation using qualitative interviews of staff at the eleven sites, as well as with judges and district attorneys, to clarify program design and identify best practices and implementation problems.
- Examine the program outcomes at the four pilot OCR projects in Travis, Bexar, Dallas, and Tarrant counties.
- Report on demographics of defendants participat-

ing in each of the pilot projects; and

- Make connections, to the extent possible, between patient characteristics, program activities, and outcomes.

The outcome evaluation examined a sample of 644 participants who completed OCR services between June 2008 and June 2012. Quantitative analysis showed that prior hospitalizations were a significant indicator in a defendant's likelihood to have a successful outcome, defined as being restored to competency or having charges dismissed. Greater length of stay in the OCR program contributed to a higher likelihood of a successful outcome up to 21 weeks, but longer lengths of stay were not associated with being restored to competency.

Responses from 28 surveys collected from eleven programs, six site visits, and numerous interviews revealed that each program is unique, yet most implement a similar model. Qualitative data revealed that program staff relationships with their local courthouse had a large impact on their ability to serve clients, with newer programs having somewhat more difficulty in developing those relationships. In addition, community factors such as the availability of housing and substance use programs, as well as a jail diversion program, played important roles in the challenges and successes OCR programs face.

¹ The newest program, Heart of Texas Region MHMR Center, was not included in this evaluation.

INTRODUCTION

In the criminal justice system, defendants are found **I**ST when they are so functionally impaired as to lack the ability to consult with their attorney or have a rational and factual understanding of the legal proceedings facing them. In this situation, due process requires suspending the legal process until a court finds the defendant competent to stand trial. Restoration to competency is the process used to provide treatment aimed at improving the defendant's functional abilities to the legally-required level.

Inpatient competency restoration can be costly. The average daily cost for inpatient restoration was \$421 in Fiscal Year (FY) 2012 (Legislative Budget Board (LBB), 2013). Furthermore, when a state hospital bed becomes available, it may be in a facility many hours away from the defendant's community. Safely transporting the defendant to the facility can require significant law enforcement resources. Over the past several years, states have begun to fund alternative competency restoration programs, allowing both community-based, or outpatient, competency restoration (OCR) and jail-based competency restoration. In 2003, the Texas Legislature added articles to the Code of Criminal Procedure to allow outpatient competency restoration (Texas Code of Criminal Procedure, 2015). While Texas was not the first state to develop outpatient competency restoration programs, the size of its programs is significant nationally.

The Hogg Foundation for Mental Health has maintained a strong interest in identifying potential benefits and challenges of outpatient competency restoration. While the state collected substantial data on the existing pilot programs and has some positive preliminary findings, further analysis of this data was needed. Therefore, in 2012, in collaboration with DSHS, the foundation conducted an evaluation of eleven outpatient competency restoration sites.

The project focused on the program design and implementation process for the eleven outpatient competency restoration sites in operation during the time of the evaluation and outcomes for the four pilot sites. More

specifically, the goals of the evaluation were to:

- Conduct a process evaluation using qualitative interviews of staff at eleven current sites, judges, and district attorneys to clarify program design and identify best practices and implementation problems
- Examine the program outcomes at the four initial pilot outpatient competency restoration projects in Travis, Bexar, Dallas, and Tarrant counties
- Report on demographics of defendants participating in each of the pilot projects
- To the extent possible, make connections between patient characteristics, program activities, and outcomes
- Conduct a basic cost comparison of inpatient versus outpatient OCR

While this last item was originally a goal of the evaluation, it was learned fairly early on in the project that the LBB was conducting a cost analysis of OCR along with other inpatient competency restoration alternatives for their 2013 *Texas State Government Effectiveness and Efficiency Report* (GEER; LBB, 2013). Therefore, the reader is referred to the LBB report for cost analysis information. Conducting a more sophisticated cost analysis was beyond the scope of this project, but it is acknowledged that an in-depth cost analysis that compares the costs associated with both inpatient and outpatient competency restoration services would be beneficial.

EVALUATION DESIGN AND METHODOLOGY

Institutional Review Board Approval

The Hogg Foundation for Mental Health received Institutional Review Board (IRB) approval from DSHS to access and analyze the quantitative data utilized in the outcome evaluation. Client-level outcomes from the four DSHS pilot sites were analyzed. An IRB application was submitted to the University of Texas at Austin's IRB for the process evaluation portion of the project which consisted of site visits and interviews with the four pilot programs as well as two new programs, survey data collected from eleven sites, and meetings and phone calls with OCR program staff and the DSHS OCR program director. The protocol was reviewed by the Office of Research Support, which determined it did not meet the requirements for human subjects research. Therefore, IRB review and oversight were not required for the process portion of the evaluation.

Participants and Procedures

Qualitative data for the process evaluation was collected through a survey, site visits, interviews, and meetings. All sites participated in the survey, with a total of 28 completed surveys. In addition, site visits and interviews were completed at each of the four pilot sites and a sample of two programs established in 2012. Many of the new sites that began in 2012 were not serving clients at

the time of data collection; therefore, only two were visited by the evaluation team. A pre-determined set of questions were used at each visit; however, each site is distinct. Site visits included meeting with multiple program staff, local judges, prosecutors, and/or jail staff.

The outcome evaluation was conducted utilizing data from the four OCR pilot programs in Austin, San Antonio, Dallas, and Fort Worth. The data set consisted of 644 participants who completed outpatient competency restoration services between June 2008 and June 2012 at one of the four sites. The participant records for this study were created by matching data extracted from the state mental health database and data submitted to the state by the four local mental health authorities (LMHAs or centers) conducting outpatient competency restoration. Outpatient competency restoration service records were obtained directly from the centers. These records were then matched with state quarterly mental health assessments, diagnoses, monthly service records, and hospitalizations to create each client's research data record which consisted of an initial assessment, demographic and diagnostic information, prior hospitalizations, service information about outpatient competency restoration, and final assessment. However, because these data are collected for administrative rather than research purposes, not all clients had complete data.

BACKGROUND

In Texas, the restoration process typically occurs in state-run psychiatric hospitals funded primarily with general revenue. Currently, Texas operates ten adult psychiatric hospitals and most receive both civil and forensic commitments. In FY 2012, 16,796 adults and children were served by one of these hospitals, with 14 percent of those individuals on forensic commitments (LBB, 2013). A person who is forensically committed usually has a longer length of stay than someone who is civilly committed. In FY 2012, the average length of stay for a person who was civilly committed was 36 days compared to 120

days for a person found IST and 227 days for a person found not guilty by reason of insanity (LBB, 2013). For this reason, approximately 37 percent of all state hospital beds are allocated for forensic commitments (LBB, 2013).

Texas has a shortage of state psychiatric hospital beds for both civil and forensic patients, due in part to an underutilization of alternatives to inpatient commitments. To protect their right to a speedy trial, defendants waiting for competency restoration may take priority over people civilly committed by a court or voluntarily seeking

services. Nonetheless, many defendants were being detained in jail for weeks or months until an inpatient bed became available. In 2007, a lawsuit was filed against DSHS on the grounds that IST defendants' right to due process was being violated if they spent an undue amount of time in jail without treatment. An initial ruling established 21 days as the maximum waiting period for defendants found incompetent to stand trial to be admitted to a state hospital (*Taylor Shearer v. Lakey*, 2012). In May 2014, the ruling was overturned by the Texas Court of Appeals (*Lakey v. Taylor Shearer*, 2014).

The numbers of forensic commitments to state hospitals more than doubled from 2001 to 2012 (399 to 940) (Health Management Associates, 2011; LBB, 2013). At the same time, individuals on the clearinghouse waiting list also increased. The clearinghouse waiting list, comprised of individuals found IST but not waiting for a maximum security unit, reached its peak in July 2010 at 334 individuals, up from 56 in July 2008 (DSHS, 2013). In January 2013, that number was down to 67. In 2012, the average time defendants spent on the clearinghouse waiting list was 41 days (LBB, 2013).

Prior to 2004, all defendants found IST in Texas were committed to an inpatient competency restoration program in a state hospital. In 2003, the Texas Code of Criminal Procedure (TCCP) (2015) was changed to allow OCR. Under the new law, individuals charged with a misdemeanor who are found IST are required to be released on bail. The court is further required to send IST individuals released on bail to an outpatient program if one is available, as long as certain criteria are met, including that they are not deemed a danger to others.² Individuals with felony charges may also be sent to an outpatient program, but the court is not required to do so (Hohengarten, 2008; TCCP, 46B).

In 2007, the Texas Legislature (80th Regular Session) enacted Senate Bill 867 to clarify the law and promote an outpatient option for defendants who are in need of competency restoration and are not a danger to others. In 2008, in response to SB 867, DSHS launched four pilot OCR programs in Travis, Bexar, Dallas, and Tarrant

counties. These four programs were initially selected due to the variation in their approaches. Each program primarily serves a single urban county.

In 2011, House Bill 1 (Rider 78; 82nd Legislative Session) directed DSHS to develop five additional OCR programs. However, the budget allocation allowed for seven new sites to be funded the following year. Andrews Center Behavioral Healthcare System, Community Healthcore, Emergence Health Network, Tri-County Services, Starcare Specialty Health System, Behavioral Health Center of Nueces County, and Spindletop Center all received DSHS funding for an OCR program in 2012. The new sites relied heavily on guidance from the four original pilots in developing their programs. Through conference calls and site visits, DSHS facilitated communications across all programs, assisting new sites in creating programs that built on what was already being done across the state. However, due to a variety of factors, each OCR program remains distinct. Table 1 presents information on each of the eleven OCR programs. At the end of FY 2013, OCR programs in Texas served a total of 1,061 individuals.

Although programs share best practices and utilize similar components, each varies in its implementation. Differences lie primarily in the programs and services that intersect with OCR. For instance, the existence of jail diversion programs for individuals experiencing mental health issues, the availability of affordable housing or supported living, and substance use treatment programs can alter the environment in which OCR is offered. In addition, each agency administering the program is unique, with different structures and scope of services. Finally, the relationships OCR programs establish with their local courthouse and the attitudes of judges and prosecutors can alter the way the OCR program functions. No evidence-based OCR program model exists to date, and no one model is used throughout the state but, rather, each tailors its program to the local context.

² If an individual is deemed IST and there is not an OCR program in the immediate area, the individual may be admitted to a neighboring OCR program with judicial staff (e.g., judge, defense attorney, and prosecuting attorney) approval.

TABLE 1: Twelve Texas OCR Programs

| AGENCY NAME | CITY / COUNTY | DATE OF DSHS FUNDING | PROGRAMMATIC FACTORS |
|--|--|----------------------|---|
| Austin Travis County Integral Care | Austin / Travis | 2008 | Residential program for OCR clients at the LMHA Crisis Respite facility with a strong partnership with the Mental Health Public Defender's Office. |
| Center for Health Care Services | San Antonio / Bexar | 2008 | One magistrate judge handles all OCR program commitments. Strong jail diversion program in the county. |
| MHMR Tarrant County | Forth Worth / Tarrant | 2008 | A County Court at Law judge is primarily responsible for the bulk of commitments to the OCR program. |
| NorthSTAR / ValueOptions | Dallas / Dallas, Rockwall, Ellis, Navarro, Collin, Hunt, Kaufman | 2008 | Core OCR staff person is an employee of Dallas County and housed at the courthouse. Has access to the county's electronic inmate tracking system allowing earlier identification of potential clients eligible for OCR. |
| Starcare Specialty Health System ³ | Lubbock/Cochran, Crosby, Hockley, Lubbock, Lynn | 2012 | Provides mental health services in the jail: medication management, court-ordered medication, and jail-based competency restoration services (services not provided via DSHS funding). ⁴ |
| Emergence Health Network ⁵ | El Paso/El Paso | 2012 | Strong collaboration between El Paso Psychiatric Center, the LMHA, the courts, and probation. Significant input from probation department is a unique program trait. |
| Andrews Center Behavioral Healthcare System | Tyler/Henderson, Rains, Smith, Van Zandt, Wood | 2012 | Began offering OCR before receiving funding; peer component; law enforcement works part-time for the program and assists in completing site visits. Partnership with local university psychology department. |
| Tri-County Services | Liberty, Montgomery, Walker | 2012 | Strong partnership with district court judge. Center has an array of forensic services offered. |
| Behavioral Health Center of Nueces County ⁶ | Corpus Christi/Nueces | 2012 | Strong partnerships with county and district court judges, local bar association, district clerk. Residential program with three contracted beds at the LMHA crisis respite facility. |
| Spindletop Center | Chambers, Hardin, Jefferson, Orange | 2012 | Residential program contract with Wood Group Crisis Respite facility. Strong partnership with probation, as well as state mental health facilities. |
| Community Healthcore | Taylor/Bowie, Cass, Gregg, Harrison, Marion, Panola, Red River, Rusk, Upshur | 2012 | OCR staff have multiple roles at center such as continuity of care liaisons and crisis respondents. |
| Heart of Texas Region MHMR Center ⁷ | Bosque, Hill, McLennan, Falls, Limestone, Freestone | 2013 | One funded OCR position, which is part of their Forensic Assertive Community Treatment (FACT) team. Center has an array of forensic services offered. |

³ Previously called Lubbock Regional MHMR Center.

⁴ Starcare Specialty Health System is no longer providing jail-based competency restoration services.

⁵ Previously called El Paso MHMR.

⁶ Previously called MHMR Center of Nueces County.

⁷ This program was established after the evaluation was conducted and is not included in this report.

EVALUATION QUESTIONS

The evaluation was divided into two parts, an examination of the process of implementing the OCR programs, and an assessment of outcomes thus far at the four pilot sites. The evaluation questions for the process evaluation included:

- Which treatment and education interventions are being utilized in the OCR programs at each site?
- What have been some of the challenges to implementing the programs?
- Which elements have led to successful implementation of the programs?
- How do programs decide who is a good fit for the OCR programs?
- What appears to influence judges' decisions about sending a defendant to OCR (vs. inpatient competency restoration)?

- What are the demographic characteristics of patients in OCR?
- What considerations are taken into account when OCR staff deem someone restored?

The outcome evaluation questions included:

- What are the characteristics of the individuals who have participated in the pilot OCR programs in Texas?
- Which client characteristics, if any, are associated with positive outcomes?
- Which pilot sites appear to be achieving the best outcomes?
- What length of stay is associated with the best outcomes?

PROCESS EVALUATION OF ELEVEN OCR PROGRAMS

Program and Participant Descriptions

Through site visits, conference calls, and survey data, qualitative data was collected over the course of FY 2013. Evaluators were able to gather details about each OCR program across the state in existence at that time. In order to fully understand the differences across sites, every OCR program was surveyed. However, high variation and a small number of programs and survey respondents makes it difficult to generalize across programs. There were nine responses from the pilot sites, and 18 responses from the sites added between 2011 and 2012, from this point on referred to as “second phase” or “phase two” sites. This report serves to summarize findings, while attempting to capture unique site differences.

Methodology and Analysis

SITE VISITS Each of the pilot programs were visited in 2012 to gather more qualitative data, to inform the survey development, and gain an in-depth understanding into

program operations. Because the phase two programs had only recently been established and few were serving clients, only two of these sites were visited.

SURVEY DEVELOPMENT Themes that emerged from the six site visits served to inform development of the survey that was later distributed electronically to all of the programs. The survey was designed to elicit information about the opportunities and challenges being faced by the programs in developing and implementing OCR programs, and other input that may inform future OCR efforts at the state level. Each program participated in the survey, with between one and three respondents participating from each site, resulting in 27 total respondents.

QUALITATIVE DATA ANALYSIS Due to the complexity of each program site, qualitative data was analyzed using grounded theory and case-oriented empirical synthesis (Jansen, 2010). In this method, evaluators used preliminary data (i.e. meetings, site visits) to guide further data

collection (i.e. survey) and evaluation questions. Relevant themes were identified based on initial qualitative data, selecting categories and topics that were reiterated. In addition, categories that arose in the qualitative data that were not pre-identified were noted. Finally, all categories and themes were analyzed based on all qualitative data collected. The narrative portions of the following section contain information from the data collection efforts as a whole, while the figures specifically represent survey responses.

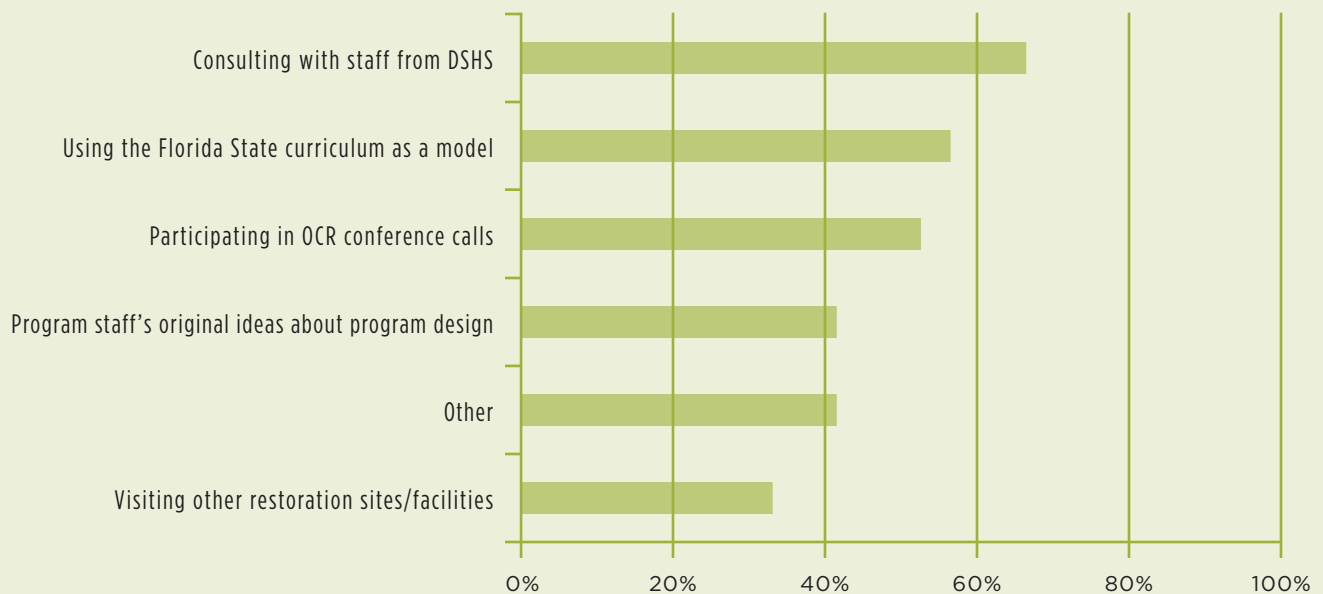
Findings

OCR PROGRAM DEVELOPMENT Although each OCR program is unique, competency restoration programs generally consist of three main components: medication, competency education, and case management.

Survey responses indicated that the four original pilot sites had distinct program development experiences compared to the second phase programs. One pilot program director shared that the first four sites may have been selected as pilots because they were so different, with the hope that a program model might emerge from

one site. However, due to differences in the communities they serve, each program has remained distinct and phase two sites were given autonomy in developing their program. Some program directors and staff had the opportunity to visit an established OCR program in Florida, which utilizes a curriculum developed at Florida State Hospital. This model has been distributed and utilized by many Texas programs. However, one program director explained that policy differences regarding Medicaid housing reimbursements made Texas unique and limited the applicability of Florida’s model. That said, 56 percent of sites indicated that they used the Florida State curriculum in developing their program [Figure 1]. The Florida State model divides competency restoration into two main categories: a factual understanding of the law and legal proceedings, and rational understanding and decision making. Respondents who selected “other” indicated that advice from existing programs, the state-wide in-person OCR meeting, consultations from forensic psychologists and restorative justice experts, meetings with local judges and prosecutors, and internet searches on best practices were some of the most helpful factors in designing their program.

FIGURE 1: MOST HELPFUL FACTORS IN OCR PROGRAM DEVELOPMENT



Establishing community partners and integrating programs into the criminal justice system were reported as key components of program development. Interviews conducted during site visits revealed that OCR programs are established at the LMHA and building relationships with law enforcement, the local courthouse, and other partner systems can take time. Relationship building will be addressed further below.

Although initially the four pilot sites did not share program development strategies, once the phase two programs were authorized, all OCR programs began to share information more regularly. Communication with other OCR program staff, either through individual consultation or by participating in conference calls with all OCR programs, was cited as helpful in developing a program.

ASSESSING INDIVIDUALS' FIT FOR OCR Although there are legal, political, and programmatic factors that influence placements, the law states that defendants must be placed in the least restrictive environment (TCCP, 46B, 2014), which for some may be an OCR program. Competency evaluators, judges, prosecutors,

and community mental health providers, may all have an opinion about what is appropriate for the defendant. However, as programs build relationships with their local courthouse, program staff's opinion may also play an important role in enrolling defendants into an OCR program. Therefore, one goal of the evaluation was to understand which factors and tools OCR program staff consider in deciding if a defendant is a good fit for OCR. Survey responses are reported in Figure 2.

Almost all respondents (96%) indicated that they used the criminal history of a defendant to decide if a potential client is a good fit for OCR. In addition, respondents reported that they used clinical judgment (78%); violence risk assessments (both the HCR-20⁸ [59%] and the TTV⁹ [19%]); and prior hospitalizations (67%) to help make

8 Douglas, K.S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). *Historical Clinical Risk Management-20, Version 3* [Measurement instrument]. Mental Health, Law, and Policy Institute at Simon Fraser University. Distributed by ProActive ReSolutions.
 9 Cheston, J., Mills, J. F., Kroner, D. J. (2014). Two-Tiered Violence Risk Estimates [Measurement instrument] Retrieved from www.researchgate.net/publication/266968507_The_Two_Tiered_Violence_Risk_Estimates_Preliminary_Validity_of_a_Dynamic_Actuarial_Approach_to_Measuring_and_Managing_Violence_Risk

FIGURE 2: TOOLS AND INFORMATION USED TO DECIDE IF AN INDIVIDUAL IS A GOOD FIT FOR OCR

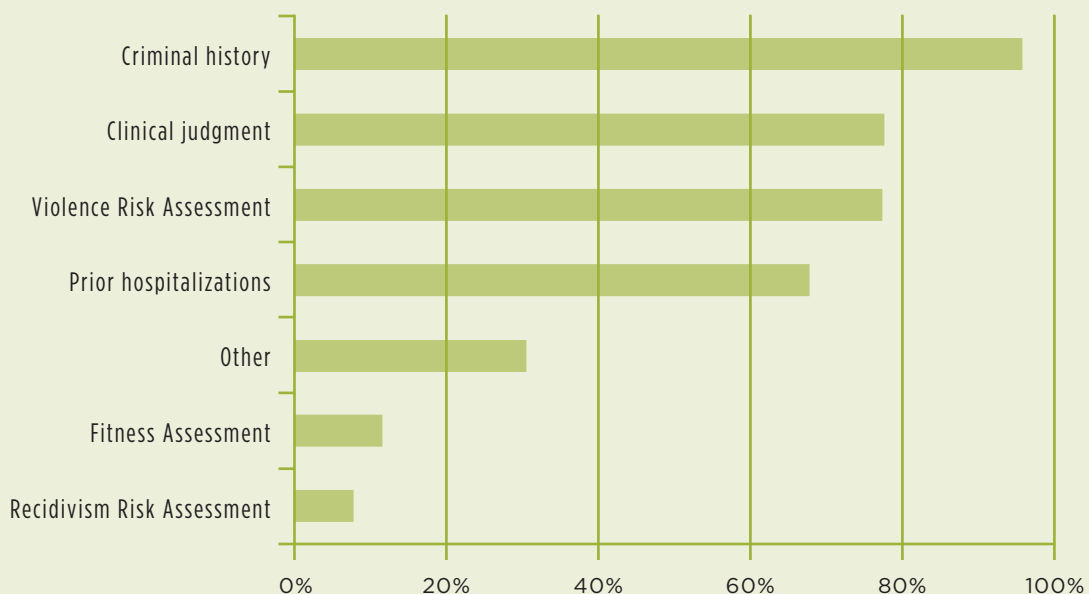
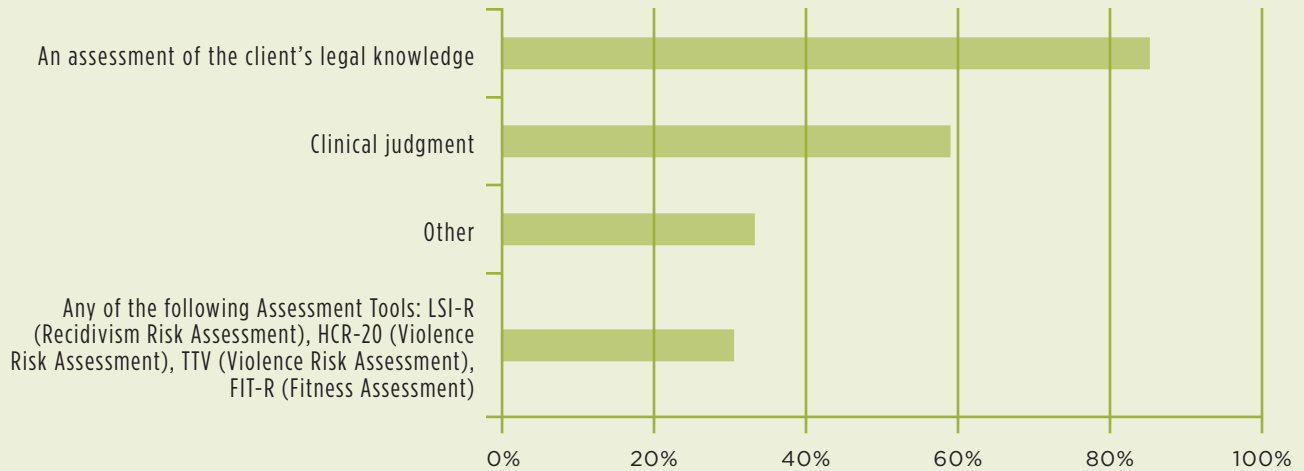


FIGURE 3: TOOLS AND INFORMATION USED TO DECIDE WHEN A CLIENT HAS BEEN RESTORED



that decision. Respondents indicated that clinical judgment included assessment of history of violence, substance use, level of support, developmental disabilities, mental health diagnosis, and likelihood to abscond. Respondents that selected “other” indicated that the defendant’s charges, a screening interview, willingness to participate in the program, willingness to take medications, the competency evaluation, medical history, housing, and family support were considered in deciding if an individual is a good fit for the program.

Although the pilot sites and the second phase sites reported using similar indicators in assessing whether or not a person is a good fit for OCR, there was one difference regarding prior hospitalizations. Only 56 percent of respondents from the phase two sites said they used prior hospitalizations to decide if a client is a good fit as compared to 89 percent of respondents from the pilot sites.

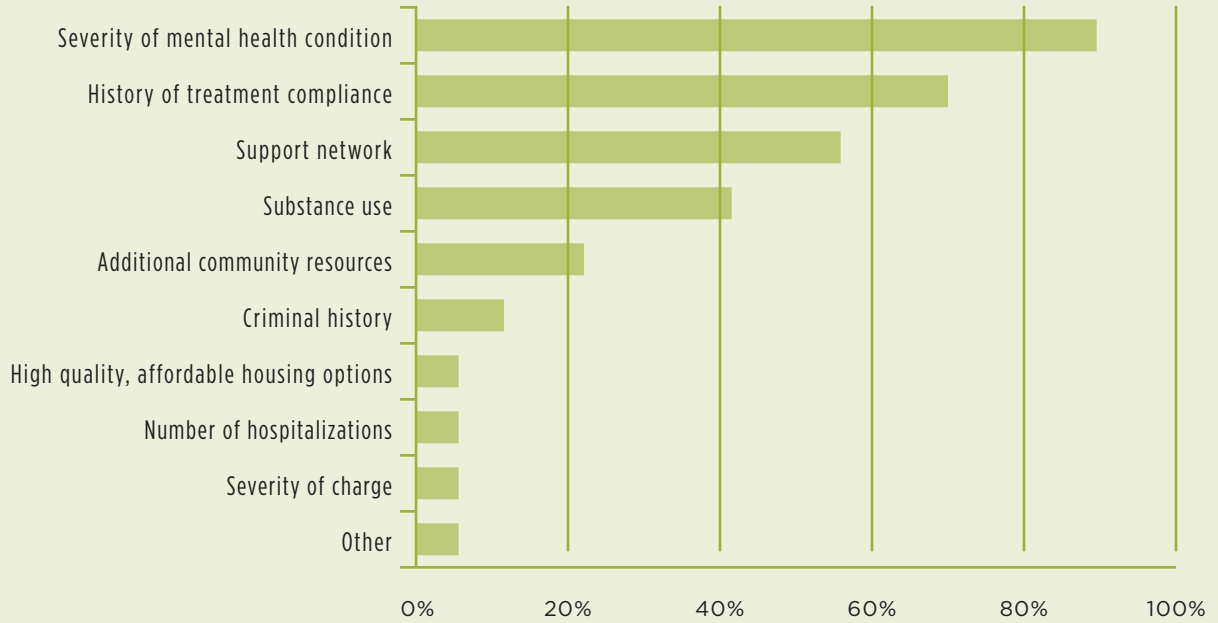
ASSESSING INDIVIDUALS’ RESTORATION TO COMPETENCY Once a defendant has been enrolled in the program, the competency restoration process may progress differently for each person. In some cases, once an individual is taking medications and receiving legal education, restoration to competency occurs fairly rapidly. Others require more time and a higher level of

services and care. Figure 3 shows what information OCR program staff use to decide when a person is restored to competency.

Not surprisingly, most survey respondents (85%) indicated that the client’s legal knowledge was used to decide when someone has been restored. Similarly to how program staff make decisions about a defendant’s fit for OCR, 59 percent of program staff surveyed indicated that they used their clinical judgment to decide when a client has been restored. Respondents who selected “other” indicated that re-evaluation by a forensic psychiatrist is another tool to assess restoration. That person may or may not be the individual who conducted the initial competency evaluation.

The evaluation also explored which client factors were perceived by OCR staff as having an impact on a client’s likelihood to be restored. According to OCR program staff, the severity of a person’s mental health condition was the most important factor (89%), but their history of treatment compliance (70%), support network (56%), and substance use (41%) were also considered important, as shown in Figure 4. It is important to keep in mind that these are perceived factors. Actual client-level factors related to the probability of restoring competency were explored in the quantitative analysis.

FIGURE 4: FACTORS PERCEIVED TO BE RELATED TO A CLIENT’S ABILITY TO RESTORE



Factors Impacting the Success of OCR Programs

RELATIONSHIPS IN THE COURTROOM OCR staff reported that as they built programs, relationships with local judges were critical. At times, especially for second phase sites, qualitative data revealed that establishing good relationships with local judges and prosecutors offices proved challenging. In fact, 44 percent of respondents from phase two sites highlighted the judges’ office as a major barrier to program success, while none of the pilot sites selected this as a barrier. Site visits revealed that urban centers where the pilot sites were created, Dallas, Fort Worth, Austin, and San Antonio, already had some, if not substantial, buy-in from judges when the OCR programs came into existence.

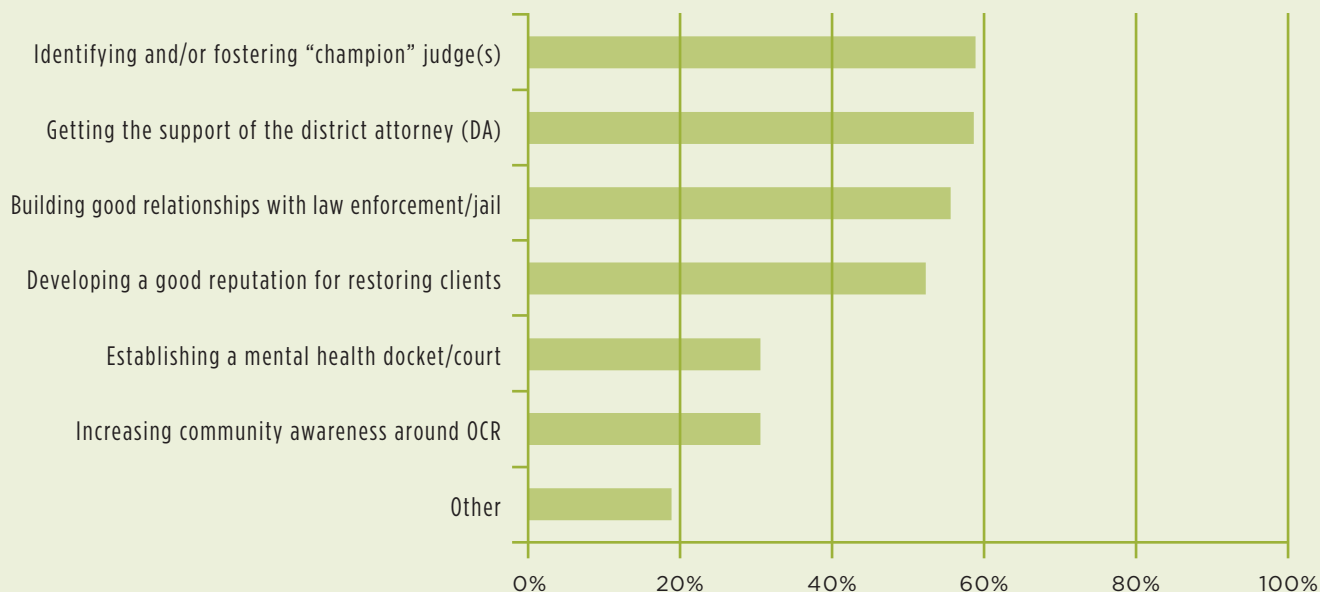
Second phase sites, on the other hand, are generally located in more rural areas, sometimes serving multiple counties. Information from site visits and meetings with DSHS staff revealed that many of the phase two sites’ legal partners were initially unfamiliar with, and some-

times skeptical of, their local OCR programs. One survey respondent wrote, “Judges and DAs often have ‘knee jerk’ reactions when they hear the term ‘outpatient.’” Respondents from second phase sites also highlighted judges’ concerns about the possibility of re-offense on the part of the defendant, uncertainty about the security of OCR sites, and political motivation. When asked about further training that would be helpful, more survey respondents from phase two sites requested support and guidance in bringing judges on board.

The importance of strong partners in the courtroom is echoed in survey responses from the pilot sites. Sixty-seven percent of these sites reported that one of the three most important factors that impacted the success of their program was finding a “champion” judge. As shown in Figure 5, all sites seem to agree that a “champion” judge is a critical element to the success of an OCR program.

Because these relationships emerged as a factor that appeared critical to the success of OCR programs, the

FIGURE 5: MOST IMPORTANT FACTORS IMPACTING SUCCESS OF OVERALL PROGRAM



evaluation team aimed to learn how effective relationships were formed. For programs that felt they had a positive relationship with their local judge, sitting in their courtroom was reported as the most effective

strategy (71%) followed by meeting with the judge individually (58%), using cost-benefit arguments (50%), and sending judges materials about OCR (46%) [Figure 6]. Respondents who selected "other" indicated that

FIGURE 6: MOST EFFECTIVE METHODS OF ESTABLISHING A GOOD RELATIONSHIP WITH LOCAL JUDGES

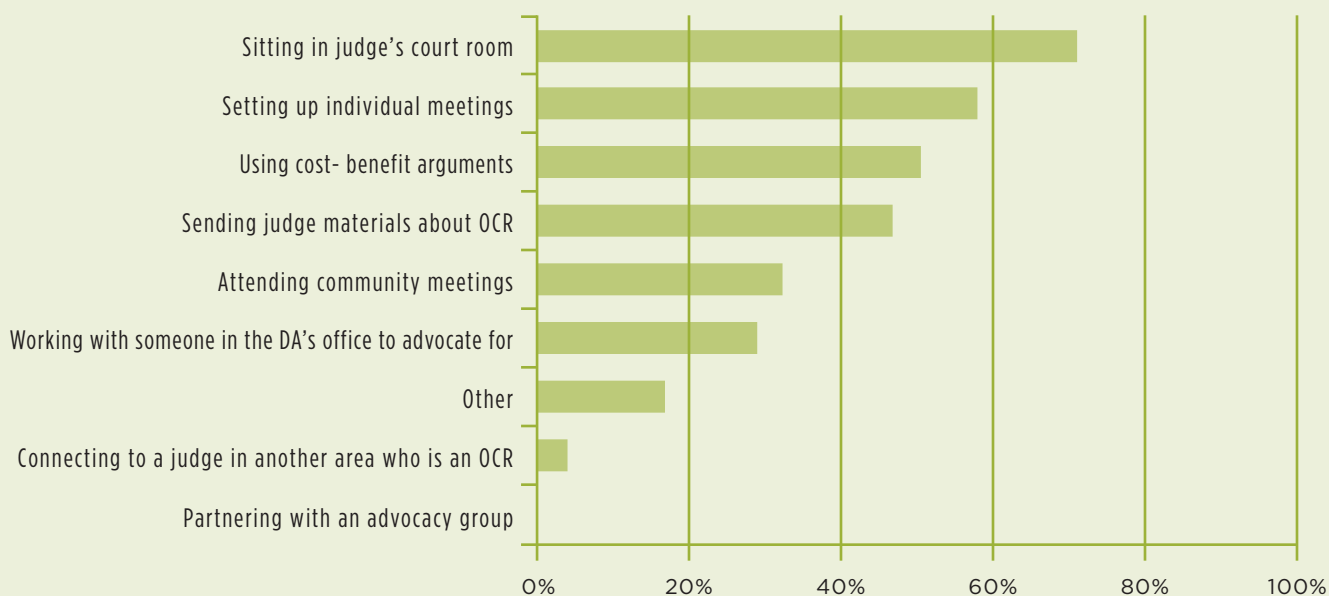
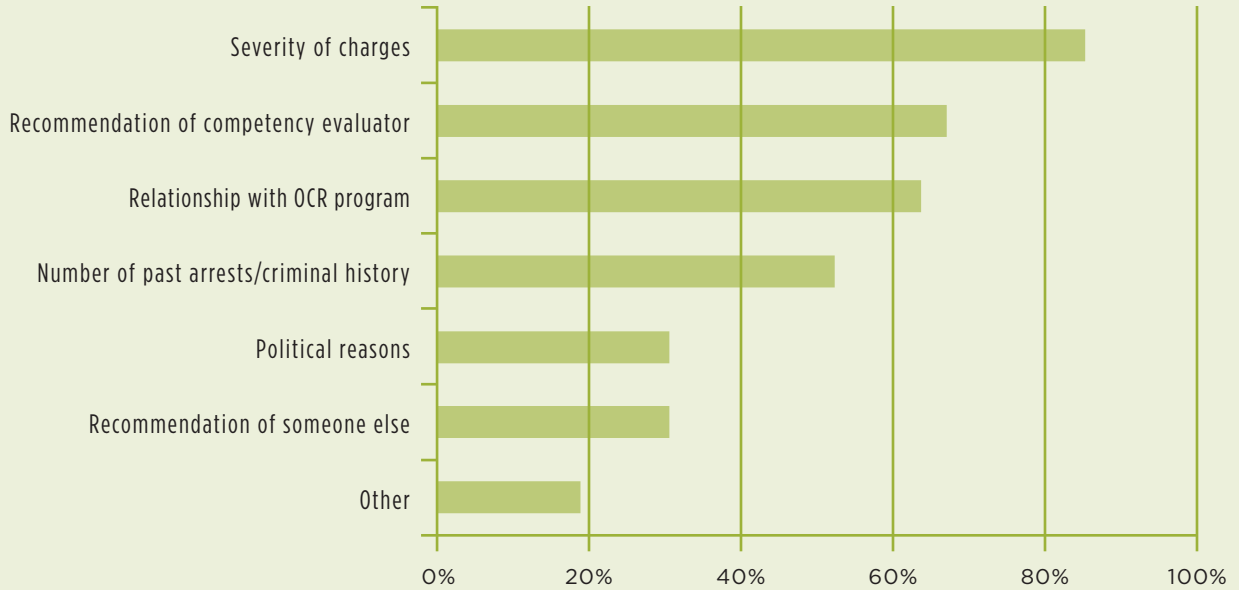


FIGURE 7: FACTORS THAT INFLUENCE A JUDGE'S DECISIONS ABOUT SENDING DEFENDANTS TO OCR

group discussions with judges and the sheriff's department, as well as building relationships with judges' staff and public defenders, were also effective.

Respondents also indicated that a number of factors influence a judge's decision about sending a defendant to OCR. The most important indicator, according to survey responses, was the severity of charges (85%), followed by the recommendation of the competency evaluator (67%), the judges' relationship with the OCR program (63%) and the defendant's criminal history (52%). See Figure 7 below. Respondents who selected "other" indicated that concerns about re-offense and treatment compliance were additional factors.

The political climate of a county also affects the OCR program. Fifteen percent of survey respondents indicated that political reasons were a factor influencing judges' decisions about whether to send someone to an OCR program (n=4) [Figure 7]. When asked to specify, responses included cost aversion, election year pressure, and "headline phobia." Based on the fact that OCR is less expensive than inpatient competency restoration (GEER,

2013), this first factor may be based on misinformation.

HOUSING Once defendants are enrolled in an OCR program, certain factors may pose a challenge. For instance, many clients enrolled in an OCR program do not have stable housing. Quantitative data from the four pilot sites indicated that 28 percent of OCR participants were experiencing homelessness. Across all sites, 59 percent of survey respondents indicated housing was a challenge for their program and it was the only challenge that a majority of respondents identified. However, when the survey responses from the pilot sites and second phase sites were compared, the housing challenges appeared to be more of an issue for the original sites. Only 39 percent of respondents from phase two programs listed housing as a challenge compared to 100 percent of respondents from the pilot sites. See Figure 8, next page.

The difference between responses from the pilot sites and the second phase programs may be partially explained by the fact that at the time the data was collected, most new sites had served very few clients and may not yet have experienced challenges with housing. Housing also varies widely by location and some communities may have housing options that others do not. For instance, site visits revealed that there are some rural counties that do not have any group homes, a housing option often used by OCR programs when available, while three OCR programs have a residential component and can offer on-site housing to clients.

Although the availability of housing options is often outside the control of OCR programs and may be limited in some areas, DSHS reports that programs have always been encouraged to utilize their funds to pay for housing costs for OCR program participants.¹⁰ However, even if housing options are available, criminal background checks create a serious barrier for OCR program participants. In thinking about important factors that affect housing, 78 percent of survey respondents indicated that the stability of the housing options is one

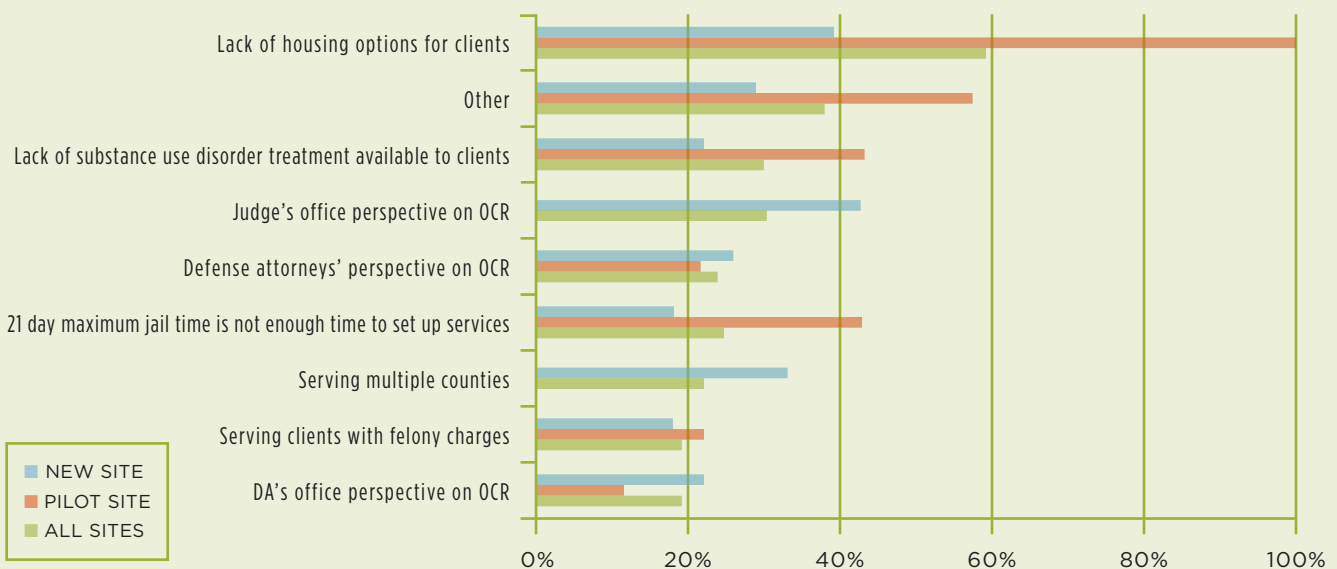
of the most important factors to consider.

Survey respondents indicated that other challenges include the defense counsel wanting their clients to receive time served (accomplished by going to jail or an inpatient setting), a “lock-em-up” mentality, bias toward inpatient treatment, lack of family support, clients not receiving a competency evaluation, willingness and desire to participate, and absence of a mental health court.

SUBSTANCE USE Another challenge OCR programs reported is serving defendants with co-occurring substance use disorders. Forty-one percent of survey respondents reported that substance use was one of the most important factors in a client’s ability to regain competency. For some programs, this means that substance use and the defendant’s willingness to receive treatment help determine whether that person is a good candidate for OCR. Survey responses revealed that substance use assessments are used as part of staff’s clinical judgment in determining if they are a good fit for the program. Additionally, although OCR programs have the ability to

¹⁰ C. Heard, personal communication, July 20, 2015.

FIGURE 8: BIGGEST CHALLENGES TO IMPLEMENTATION



NOTE: Missing bars indicate no survey respondents selected that option as one of the top three challenges.

pay for substance use treatment, 30 percent of survey respondents indicated that the lack of available substance use treatment programs was one of the three biggest challenges they faced in implementing the OCR program. Perhaps because of this, one survey comment proposed that locked substance use treatment facilities “would make a world of a difference.”

FELONY CHARGES The severity of a defendant’s charges plays a significant role in the competency restoration process. Eighty-five percent of survey respondents indicated that severity of charges is one of the most important factors that a judge considers in deciding whether to send a defendant to OCR. Survey responses indicated that many judges are concerned about safety and risk; judges may be hesitant to be responsible for allowing an individual with a felony charge into the community. Furthermore, according to one judge, because prosecutors are often unwilling to drop a felony charge, the judge has little choice but to continually extend the OCR commitment if a defendant is unrestorable. Conversely, if the charges are dropped, the court no longer has legal authority to force treatment compliance.

Interview information gathered during site visits indicated that clients with felony charges can be a complex and challenging population to serve. Although many misdemeanor charges are dropped once a client is complying with OCR program requirements, prosecutors are unlikely to dismiss a felony charge. For clients with more complex issues, such as Alzheimer’s disease, traumatic brain injury (TBI), or developmental delays, felony charges present a unique challenge. These clients are unlikely to be restored and are also unlikely to have their charges dropped, leaving them in a limbo of sorts. Some program and DSHS staff have concluded that these individuals are not a good fit for OCR. At the same time, some OCR programs have served clients with felony charges successfully. Therefore, for defendants with more severe charges, it becomes especially important to identify their mental health needs up front to determine if they are a good fit for OCR.

Each OCR program may face unique challenges in serving individuals with felony charges due to the wide variation

in local context. For instance, jail diversion programs have a significant impact on people experiencing mental health problems who are brought to jail and charged with a crime. In some counties where there is a strong jail diversion program, OCR program staff share that far fewer individuals with mental illness are charged with misdemeanors. While this is the intended outcome, it also means that those counties’ OCR programs may serve more individuals with felony charges. For instance, in one county with a strong jail diversion program, 52 percent of the OCR clients have felony charges, the largest among all OCR programs.

Legal Factors Affecting OCR Programs

When asked to describe what changes to Chapter 46B of the TCCP survey respondents felt would facilitate OCR participation, responses mainly centered around two themes: being given time credit for OCR and OCR being a stronger “first option.” Responses are presented here regardless of their legal correctness.

TIME CREDIT One theme that emerged from the survey comments was the desire to have time spent in OCR count as time served on the client’s charges, should he or she be found guilty and sentenced to confinement. As the law currently reads, the court only credits confinement in a mental health facility, residential care facility, or jail (Article 46B.009). One respondent commented that, “The attorneys like their clients to go to a hospital so the client can get time served on their charges.” One respondent suggested this language, “A court sentencing a person convicted of a criminal offense shall credit to the term of the person’s sentence the time the person is confined in a mental health facility, ordered to an outpatient competency restoration program, residential care facility, or jail...” While two of the OCR sites are residential programs, they are not locked facilities, and clients participating in those OCR programs do not receive credit for time served.

OCR AS FIRST OPTION. Comments from the survey respondents stress that OCR should be the first option and hospitalization the last. One participant commented that all individuals who have been charged with a low

level misdemeanor should be ruled out of OCR, first, before an inpatient option is considered. This respondent suggested that if judges, prosecutors, and attorneys had to say why an outpatient treatment program would not work, then the number of defendants being referred to OCR versus inpatient would increase. One survey participant expressed that the court should have to send an IST defendant to OCR if the LMHA and the forensic psychiatrist agree that outpatient restoration best meets the patient needs. Other respondents stated:

Amend 46B to read that OCR should be the default judgment for an IST and inpatient hospitalization should be used only when OCR is not available

and/or is not suitable for the defendant.

I also recommend that TCCP Article 46B.071 be revised to read: On a determination that a defendant is IST, the court shall: (1) commit the defendant to a facility under Article 46B.073; or (2) release the defendant on bail under Article 46B.072; and shall (3) order the defendant released on bail to participate in an outpatient competency treatment program, rather than inpatient treatment, if an outpatient competency restoration program is available to the defendant and is appropriate for the defendant as defined in Art. 46B.072.

OUTCOME EVALUATION OF FOUR PILOT OCR PROGRAMS

Participant Demographics

The quantitative research sample consisted of 644 participants who completed outpatient competency restoration services between June 2008 and June 2012. The typical participant was a 38 (SD = 13) year old Black (46%) or White (32%) single (87%) male (72%) diagnosed

with schizophrenia (63%) or bipolar disorder (21%) and whose criminal charge was not a felony (60%). A substantial number of participants were homeless (28%).

Detailed descriptive statistics for the sample are displayed in Table 2. Statistics in the table are based on the final subject count of 589 that resulted from data cleaning (described later in this section).

TABLE 2: Participant Demographics

| | | AUSTIN | BEXAR | DALLAS | TARRANT | TOTAL |
|-------------------------------|-------------|--------------|-------------|--------------|--------------|--------------|
| | Overall | 120 (20.4%) | 94 (15.9%) | 237 (40.2%) | 138 (23.4%) | 589 |
| Restored (Dependent Variable) | Yes | 97 (80.8%) | 88 (93.6%) | 169 (71.3%) | 86 (62.3%) | 440 (74.7%) |
| | No | 23 (19.2%) | 6 (6.4%) | 68 (28.7%) | 52 (37.7%) | 149 (25.3%) |
| Ethnicity | Other | 6 (5%) | 0 (0%) | 12 (5.1%) | 4 (2.9%) | 22 (3.7%) |
| | Black | 39 (32.5%) | 26 (27.7%) | 159 (67.1%) | 48 (34.8%) | 272 (46.2%) |
| | Hispanic | 16 (13.3%) | 51 (54.3%) | 18 (7.6%) | 10 (7.2%) | 95 (16.1%) |
| | White | 59 (49.2%) | 17 (18.1%) | 48 (20.2%) | 76 (55.1%) | 200 (33.9%) |
| Married | Married | 4 (3.3%) | 10 (10.6%) | 6 (2.5%) | 5 (3.6%) | 25 (4.2%) |
| | Not Married | 116 (96.7%) | 84 (89.4%) | 231 (97.5%) | 133 (96.4%) | 564 (95.8%) |
| Felony | Yes | 53 (44.2%) | 49 (52.1%) | 86 (36.3%) | 37 (26.8%) | 225 (38.2%) |
| | No | 67 (55.8%) | 45 (47.9%) | 151 (63.7%) | 101 (73.2%) | 364 (61.8%) |
| Previous Hospitalization | 0 Instances | 47 (39.2%) | 47 (50%) | 109 (45.9%) | 77 (55.8%) | 280 (47.5%) |
| | 1 Instance | 16 (13.3%) | 17 (18.1%) | 44 (18.6%) | 21 (15.2%) | 98 (16.6%) |
| | 2 Instances | 13 (10.8%) | 15 (16%) | 21 (9%) | 11 (7.9%) | 60 (10.19%) |
| | 3 or more | 44 (36.7%) | 15 (16%) | 63 (26.6%) | 29 (21%) | 151 (25.64%) |
| Schizophrenia | Yes | 72 (60%) | 50 (53.2%) | 176 (74.3%) | 65 (47.1%) | 363 (61.23%) |
| | No | 48 (40%) | 44 (46.8%) | 61 (25.7%) | 73 (52.9%) | 226 (38.37%) |
| Bipolar Disorder | Yes | 39 (32.5%) | 23 (24.5%) | 33 (14%) | 40 (29%) | 135 (22.92%) |
| | No | 81 (67.5%) | 71 (75.5%) | 204 (86%) | 98 (71%) | 454 (77.08%) |
| Major Depressive Disorder | Yes | 1 (.08%) | 5 (5.3%) | 24 (10%) | 8 (5.8%) | 38 (6.45%) |
| | No | 119 (99.17%) | 89 (94.68%) | 213 (89.87%) | 130 (94.20%) | 551 (93.55%) |
| Length of Stay (Weeks) | Mean | 5.52 | 21.26 | 22.09 | 10.94 | 15.95 |
| | SD | 4.07 | 13.56 | 11.49 | 8.74 | 12.28 |
| | N | 120 | 94 | 237 | 138 | 589 |

Data Analysis

Quantitative data was analyzed by a University of Texas at Austin statistical consultant. Although the original evaluation questions were much broader, an initial analysis yielded few significant relationships due to limitations in the sample and complexity of program components. Therefore, the evaluation questions were narrowed. A series of logistic regression models were run to answer the research questions:

1. What are the characteristics of the individuals who have participated in the pilot OCR programs in Texas?
2. Which client characteristics, if any, are associated with positive outcomes?
3. Which pilot sites appear to be achieving the best outcomes?
4. What length of stay is associated with the best outcomes?

Data obtained from the state mental health database¹¹ contained coding indicating the outcome of the client; Restored, Dismissed, Not Restored, Absconded, or Extended Commitment. The categories were defined as follows:

- Restored - Individual was restored to competency.
- Dismissed - Charges against individual were dismissed.
- Not Restored - Individual was not restored to competency.
- Absconded - Individual did not follow through with OCR program.
- Extended Commitment - Individual is continuing in the program per a judge's order, even though the OCR team does not feel that competency is achievable.

For the purpose of the logistic regression models, original outcomes were grouped into two possibilities: Successful (originally coded as Restored or Dismissed) and Not Successful (originally coded as Not Restored,

Absconded, or Extended Commitment).

Various demographic measures were considered for inclusion into the models. Model selection followed the guidelines of Hosmer and Lemeshow (2000), including those independent variables that were significant as individual predictors of the outcomes. After selection criteria, the main logistic regression model contained a total of ten predictors: ethnicity, married (yes/no), felony charge (yes/no), instances of previous hospitalization, total length of stay in the program, schizophrenic diagnosis, bipolar diagnosis, major depression diagnosis, and site location of the program.

Data was cleaned for ease of use in the model. Participants were assigned to one of four ethnicity groups: White, Black, Hispanic, Asian/Other. The number of instances of hospitalization prior to entry into the program was also recoded: zero instances, 1 instance, 2 instances, 3 or more instances. The total length of stay (LOS) was recorded for each subject and reported in weeks. Long-term participants (longer than one year) were excluded, giving a final subject count of 589. The average length of stay was 15.95 weeks (SD=12.28).

Program Outcomes at Pilot Projects

The program outcomes at the four initial pilot outpatient competency restoration projects in Travis, Bexar, Dallas, and Tarrant counties were examined.

Logistic regression was used to compare the sites, while controlling for the included participant characteristics. Results indicate good model fit, likelihood ratio (LR) chi-square (df=15) = 96.80, $p < 0.05$; Pseudo R² = 0.145. See Table 3 (next page) for results of each included coefficient.

¹¹ The Client Assignment and Registration database is a mainframe-based central client registration database for inpatient and community mental health services.

Table 3: Coefficient Table for Logistic Regression Predicting Successful Outcome

| VARIABLE | | BETA | S.E. | ODDS RATIO | SIG |
|----------------------------------|--------------------|---------------|-------|--------------|--------------|
| Ethnicity | | | | | |
| | Other | 0.095 | 0.573 | 1.1 | 0.868 |
| | Black | -0.185 | 0.243 | 0.831 | 0.447 |
| | Hispanic | 0.114 | 0.396 | 1.121 | 0.774 |
| | <i>White ref</i> | | | | |
| Married | | -0.216 | 0.552 | 0.806 | 0.695 |
| Felony | | -0.146 | 0.226 | 0.864 | 0.516 |
| Previous Hospitalization | | | | | |
| | 1 instance | -0.39 | 0.306 | 0.677 | 0.203 |
| | 2 instances | -1.066 | 0.36 | 0.345 | 0.003 |
| | 3 or more | -1.025 | 0.274 | 0.359 | 0 |
| | <i>0 inst. ref</i> | | | | |
| Length of Stay (Weeks) | | 0.061 | 0.012 | 1.063 | 0 |
| Schizophrenia | | -0.046 | 0.413 | 44 (18.6%) | 21 (15.2%) |
| Bipolar Disorder | | 0.32 | 0.439 | 21 (9%) | 11 (7.9%) |
| Major Depressive Disorder | | 0.464 | 0.603 | 63 (26.6%) | 29 (21%) |
| Site | | | | | |
| | Bexar | 0.371 | 0.532 | 1.449 | 0.486 |
| | Dallas | -1.549 | 0.354 | 0.213 | 0 |
| | Tarrant | -1.55 | 0.325 | 0.212 | 0 |
| | <i>Austin ref</i> | | | | |
| Constant | | 1.907 | 0.715 | 6.73 | 0.008 |

NOTE: Variables in italics represent the comparison or reference group for the other variables in the factor list. Table includes both logit (beta) coefficients and Odds Ratios.

The model did not produce any significant effects for ethnicity, marital status, felony conviction, and diagnosis. A likelihood ratio test was performed to investigate the overall effect of previous hospitalization and program. There was a significant effect of both previous

hospitalization (LL difference (df = 3) = 17.57, p < 0.05) and site (LL difference (df = 3) = 42.53, p < 0.05). See Tables 3 and 4 respectively for a full list of post-hoc comparisons and predicted probabilities of a successful outcome for all sites.

Table 4: Predicted Probabilities and Confidence Intervals for All Levels of Previous Hospitalization in the Model, Along With Letter Based Pairwise Comparisons

| PREVIOUS HOSPITALIZATION | PREDICTED PROBABILITY OF SUCCESSFUL OUTCOME | STANDARD ERROR | LOWER 95% CI | UPPER 95% CI | POST-HOC | | |
|--------------------------|---|----------------|--------------|--------------|----------|---|---|
| 0 instances | 85.95% | 2.25% | 81.54% | 90.36% | | B | |
| 1 instance | 80.54% | 4.06% | 72.58% | 88.51% | | B | C |
| 2 instances | 67.82% | 6.71% | 54.67% | 80.97% | A | | C |
| 3 or more | 68.69% | 4.44% | 59.98% | 77.39% | A | | |

NOTE: Instances of previous hospitalization with non-matching post-hoc letters are significantly ($p < 0.05$) different from one another (Piepho, 2004).

Psychiatric Hospitalizations

The predicted probability of a successful outcome for individuals who had two or three prior psychiatric hospitalizations was significantly lower than those with only one or no previous hospitalizations.

Differences Among Programs

Based upon the post-hoc comparisons, both the Austin and the Bexar sites appear to have the highest number of successful outcomes (but were not significantly different

in success rates from one another). Examination of participant characteristics did not provide an explanation for the significant difference between these sites versus Dallas and Tarrant counties. For example, further analysis did not reveal that Dallas and Tarrant counties had a significantly greater number of felony clients or clients with a greater number of previous hospitalizations. An attempt to examine level of service (treatment hours) for each client across sites could not be completed due to lack of data for one site. It appears that factors related to these differences were not captured in the data included in the model.

Table 5: Predicted Probabilities and Confidence Intervals for all Sites in the Model, Along with Letter Based Pairwise Comparisons

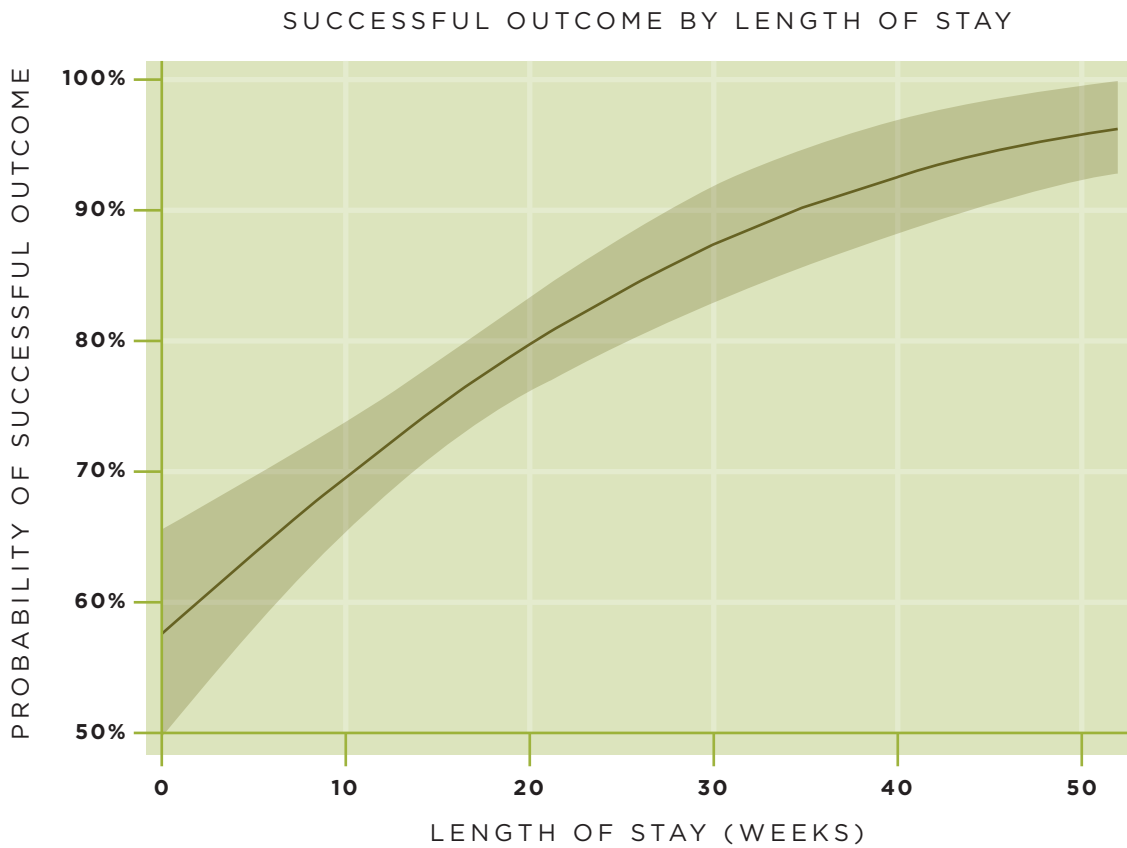
| SITE | PREDICTED PROBABILITY OF SUCCESSFUL OUTCOME | STANDARD ERROR | LOWER 95% CI | UPPER 95% CI | POST-HOC | | |
|---------|---|----------------|--------------|--------------|----------|---|--|
| Austin | 88.05% | 2.48% | 83.19% | 92.91% | | B | |
| Bexar | 91.24% | 3.46% | 84.45% | 98.03% | | B | |
| Dallas | 65.11% | 3.58% | 58.09% | 72.14% | A | | |
| Tarrant | 65.08% | 3.88% | 57.47% | 72.69% | A | | |

NOTE: Note: Sites with non-matching Post-hoc letters are significantly ($p < 0.05$) different from one another (Piepho, 2004).

Length of Stay

Total length of stay (LOS) was also found to be significant (est = 0.061, $p < 0.05$). As length of stay increased, the likelihood of a successful outcome increased (See Graph 1).

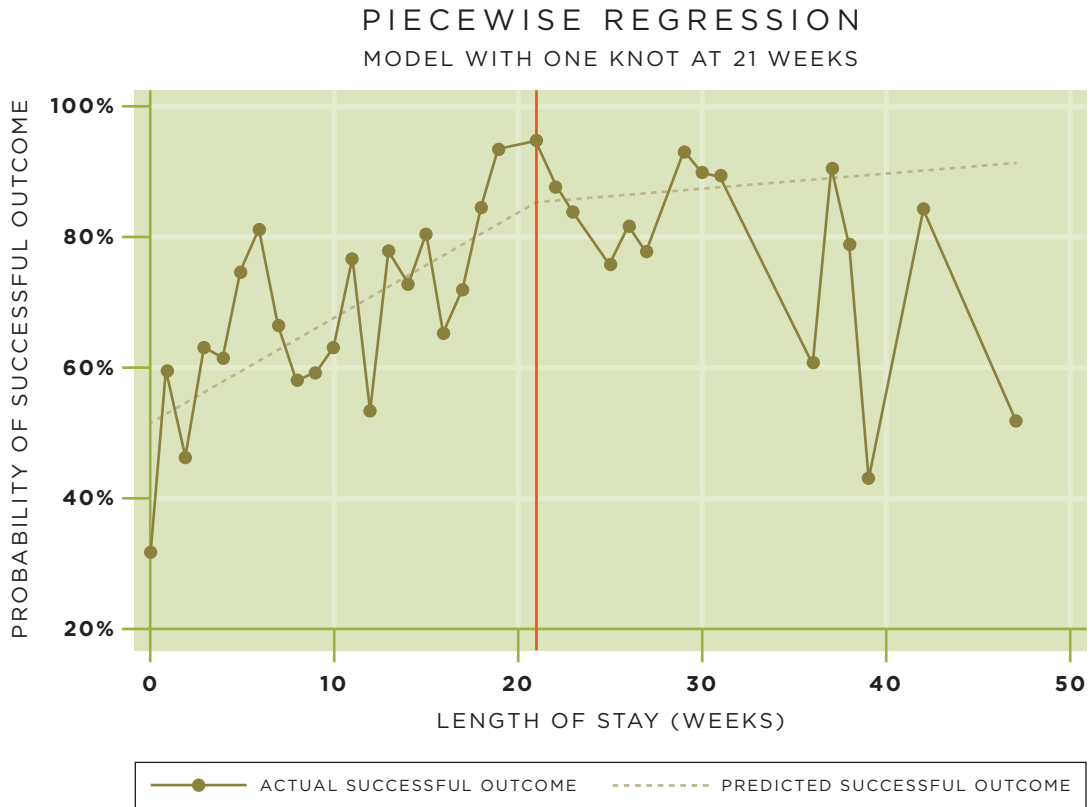
Graph 1: Successful Outcome by Total Length of Stay



While the likelihood of a successful outcome increased with time, we wanted to determine if there was an optimal length of stay. To further explore the relationship between total length of stay and a successful outcome, a segmented (piecewise) regression analysis was performed (Wagner et al., 2002). A model with one knot or segment was deemed appropriate for the

current data. Visual inspection of the actual percent of successful outcomes at each week indicated a potential knot at 20 week. Comparison of Akaike Information Criterion (AIC) fit statistics for piecewise regression models with knot positions ranging from 15 to 25 weeks showed the best fit with a knot at 21 weeks.

Graph 1: Successful Outcome by Total Length of Stay



The results of the piecewise regression model with a single knot at 21 weeks indicate a significant slope in the region prior to the knot at 21 weeks (est = 0.094, $p < 0.05$). Results also indicate a significant difference in the change of slope from the region prior to the knot at 21 weeks to the region after (est difference = -0.074, $p < 0.05$). The slope of the relationship between length of stay and a successful outcome in the second region (after

the knot at 21 weeks) was not significant (est = 0.020, $p < 0.05$). See Graph 2 for a model of prediction.

Total length of stay was also found to be significant, with greater length of stay contributing to a higher likelihood of improvement up to 21 weeks. After that point, longer stay was not associated with greater likelihood of restoration.

SUMMARY

This evaluation of the state's OCR program revealed a number of themes. Relationships with judges and other members of the court and legal system emerged as a critical factor in having defendants referred to OCR programs. Providing information about OCR programs to the legal team, including judges, prosecutors, and sheriff's offices was also an important element in obtaining referrals. According to the OCR program staff, lack of suitable housing appears to be a significant challenge for OCR programs. However, homelessness did not emerge in the quantitative analysis as a factor related to a successful outcome. Program staff also cited co-occurring substance abuse as a challenge.

Communications and sharing among sites about programming appeared to be helpful to staff. It was unclear from this evaluation whether standardizing practices across all OCR programs is warranted and whether it would produce better outcomes. Unfortunately, because the finding that the Austin and the Bexar sites appeared to have the highest number of successful outcomes was not able to be tied to any particular factors included in the analyses, the finding is not particularly informative with respect to best practices. Examination of participant characteristics did not provide an explanation for the significant difference between these sites versus Dallas and Tarrant County. It may be that the contributing factors related to these differences were not captured in the data included in the model. Further exploration of

these differences may reveal useful information and, at the very least, are worth discussing further with the programs in a constructive manner.

The findings about previous hospitalization and length of stay are particularly interesting. The predicted probability of a successful outcome for individuals who had two or three prior psychiatric hospitalizations was significantly lower than those with only one or no previous hospitalizations. Total length of stay was also found to be significant, with greater length of stay contributing to a higher likelihood of improvement up to 21 weeks. After that point, longer stay was not associated with greater likelihood of restoration. While individual factors and context should always be considered, this data set was large enough to instill a good degree of confidence in these findings. The results are worthy of close examination and discussion. The previous hospitalization finding may serve to inform who is a good fit for OCR programs, so that individuals who are unlikely to restore do not utilize resources in programs where someone else is better served. The same applies for the length of stay finding. If individuals who have not had a successful outcome by 21 weeks are not likely to achieve such an outcome after that point, then perhaps resources are better utilized by opening that space up to another person. However, it should be noted that OCR program staff shared that it is often difficult to find a suitable situation for such an individual.

RECOMMENDATIONS

Programmatic

- It would appear beneficial for all judges and legal teams to receive information about OCR and to be actively engaged in learning about the program, including receiving data about OCR outcomes, such as the ones documented in this evaluation and cost information from other sources.
- Relationships with judges should be fostered, and new sites that are added should be informed of how critical this component is to the success of an OCR program.
- Explore how co-occurring substance use and lack of housing may be a challenge for OCR programs.

Policy

- Based on the findings of this evaluation, consider if it is cost effective, a good use of staff resources, and of value to the individual to allow a length of stay in an OCR program longer than 21 weeks.
- Consider whether individuals who have had two or three prior psychiatric hospitalizations are a good fit

for an OCR program, as this evaluation demonstrated that they are significantly less likely than those with only one or no previous hospitalizations to have a successful outcome.

- Examine the issue of time served, as this was perceived by staff as a barrier for having individuals referred to OCR.

Evaluation

- Continue to improve data collection to allow for better comparison among sites in order to identify best practices.
- Examine the long-term outcomes of OCR versus inpatient competency restoration.
- Consider recidivism as a dependent variable.
- If further evaluation demonstrates that OCR has similar or better outcomes than inpatient, explore whether stronger language requiring OCR as a “first option” may be appropriate.
- Conduct a more thorough cost effectiveness study as compared to inpatient.

REFERENCES

- Almquist, L. & Dodd, E. (2009). *Mental Health Courts: A Guide to Research-Informed Policy and Practice*. MacArthur Foundation and the Council of State Governments Justice Center. Retrieved from https://www.bja.gov/Publications/CSG_MHC_Research.pdf
- Health Management Associates. (2011). *Impact of Proposed Budget Cuts to State Hospitals*. Presented to Texas Conference of Urban Counties. Retrieved from <http://www.txcouncil.com/userfiles/file/State%20Hospital%20Final%20Report%203%201%2011.pdf>
- Hohengarten, N. (2008). *Travis County Mental Health and Criminal Justice Initiatives*. 34th Annual Advanced Criminal Law Course, Ch. 36. Retrieved from <http://www.texasbarcle.com/Materials/Events/6709/93336.htm>
- Hosmer, D.W., Lemeshow, S. (2000). *Applied Logistic Regression*. New York: John Wiley & Sons, Inc.
- Jansen, H. *The Logic of Qualitative Survey Research and its Position in the Field of Social Research Methods*. Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, North America, 11, Mar. 2010. Available at: <<http://www.qualitative-research.net/index.php/fqs/article/view/1450/2946>>. Date accessed: 27 Nov. 2012.
- Lahey v. Taylor Ex Rel. Shearer, 278 S.W.3d 6 (Tex. App. 2014). <http://www.search.txcourts.gov/Case.aspx?cn=03-12-00207-CV&coa=coa03>
- Legislative Budget Board. (2013). *Texas State Government Effectiveness and Efficiency Report (GEER)*. Retrieved from <http://www.lbb.state.tx.us/GEER/Government%20Effectiveness%20and%20Efficiency%20Report%202012.pdf>
- Morris, D.R. & DeYoung, N.J. (2012). *Psycholegal Abilities and Restoration of Competence to Stand Trial*. *Behavioral Sciences and the Law*, 30, 710-728.
- Piepho, H. (2004). *An Algorithm for a Letter-Based Representation of All-pairwise Comparisons*.
- Taylor Ex Rel. Shearer v. Lahey (2012). Cause No. D-1-GN-07-837.
- Texas Code of Criminal Procedure (2015). *Subchapter D. Procedures After Determination of Incompetency*. Art. 46B.071-46B.073. Added by Acts 2003, 78th Leg., ch. 35, Sec. 1, eff. Jan. 1, 2004. pp. 789-792.
- Wagner, A.K., Soumerai, S.B., Zhang, F., & Ross-Degnan, D. (2002). *Segmented regression analysis of interrupted time series studies in medication use research*. *Journal of Clinical Pharmacy and Therapeutics*, 27, 299-309.