6

# The "ROC" Model: Psychiatric Evaluation, Stabilization and Restoration of Competency in a Jail Setting

Jerry L. Jennings[1] and James D. Bell[2]
[1]*Liberty Healthcare Corporation, Bala Cynwyd, PA*
[2]*Central State Hospital, Petersburg, VA*
*USA*

## 1. Introduction

Despite its well-meaning intentions, the movement toward deinstitutionalization has shifted more and more people with serious mental illness and co-occurring disorders from state hospitals to jails and prisons (Lamb and Weinberger, 2005; Human Rights Watch, 2003). There are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals (Torrey, Kennard, Eslinger, Lamb and Pavle, 2010). The trend has intensified in recent years as public mental health resources, both at the state hospital level and at the local community level, continue to shrink. Even before the national recession of 2010 hit government agencies and forced them into profound and drastic cost-saving measures, reductions in public mental health services were already causing high numbers of people with severe and persistent mental illness to land in the criminal justice system. As early as 2007, Wortzel, Binswanger, Martinez, Filley & Anderson (2007) asserted that the systemic decline of public mental health resources had created a national crisis for persons judged Incompetent To Proceed (ITP) who are "log-jammed" in jails and prisons across the country. Calling it "the ITP crisis," the Wortzel group decried the practice of jailing persons with psychotic disorders, often for long periods of time, without adequate psychiatric treatment because there are not enough forensic beds available in state hospital systems.

"Hundreds of patients with severe mental illness deemed incompetent to proceed are languishing in jails around the nation, unable to access meaningful psychiatric care and not moving forward in the legal process as they await admission to grossly undersized and understaffed state hospitals… The combination of inadequate psychiatric care, the stress of incarceration and the long waits involved have yielded nightmarish results…" (Wortzel, et al., 2007, p. 357).

## 2. Alternative approaches

Budget cuts to state hospital systems and deficient community-based mental health resources will continue to shift the cost and services burden to local emergency rooms, county jails and law enforcement agencies. Efforts to address the problems of the ITP crisis have been varied and shown mixed results. Assertive Community Treatment has been

shown to be effective for releasing high risk forensic patients (Jennings, 2009; Smith, Jennings & Cimino, 2010), but it is expensive and rarely available for most community mental health systems. "Outpatient commitment" and "court-to-community programs," used in combination with intensive case management, have been tried with some success to remove mentally ill defendants charged with less serious crimes (Gilbert, Moser, Van Dorn, Swanson, Wilder, Robbins, Keator, Steadman & Swartz, 2010; Loveland & Boyle, 2007; Swartz, Swanson, Kim & Petrila, 2006), but they cannot be used for those charged with violent and dangerous crimes. Housing programs and long-term residential services can help prevent recurrent relapses and reoffending, especially for homeless persons with mental illness (Miller, 2003; Trudel and Lesage, 2006), but these strategies cannot be exercised immediately to avert hospitalizations or detention.

In particular, "mental health courts" have multiplied across the country as a way to divert mentally ill defendants and substance abusers away from incarceration and toward appropriate treatment (Redlich, Steadman, Clark & Swanson, 2006; Grudzinskas & Clayfield, 2005). Mental health courts entail a variety of interventions, including non-adversarial process, training judges in mental health and collaborative inter-agency teams (Wortzel, et al., 2007), but there is no clear model that can be applied across jurisdictions and states.

As jails and prisons have been forced to take responsibility for greater numbers of persons with mental illness, they have had to increase and expand whatever mental health services they can offer. In fact, the largest facilities that house psychiatric patients in the United States are not hospitals, but jails and prisons (Rich, Wakeman & Dickman, 2011; Torrey, et al., 2010). Adding more psychiatry time or mental health clinic hours is not enough when the jail environment itself is highly stressful and can exacerbate symptoms of mental illness. Large state correctional systems may have more resources than local jails to offer emergency psychiatry, intensive stabilization, addictions treatment and even hospital-level inpatient mental health units, but these increased behavioral health services are proportionate to the ever-growing numbers of inmates with serious and persistent mental illness entering corrections. More importantly, this does not address the need to identify, evaluate, treat and stabilize persons with severe mental illness when they are first arrested and detained – well before they are convicted and incarcerated in long-term state and federal prisons.

The Restoration Of Competency ("ROC") model is a new approach to the ITP crisis that can intervene at the earliest point of arrest and detention by delivering forensic psychiatric evaluations and treatment, intensive stabilization and restoration of competency in a local jail setting. The ROC model evolved from a pilot project in Virginia in the late 1990's and has been further developed into a viable alternative to the ITP crisis. It can significantly accelerate needed treatment for mentally ill defendants, cut the demand for costly State Hospital forensic beds, and directly assist local jails and law enforcement in better managing this specialized high-risk population – yielding major cost savings and improved services for all.

## 3. Advantages of the ROC model

By diverting state hospital referrals to an alternative short-term restoration program in a local jail, the ROC model can help eliminate waiting lists for state hospital forensic beds, decrease the length of time to restore someone to competency, and relieve local jails from the responsibility of holding mentally ill defendants without adequate mental health resources. It can cost significantly more for a jail to hold an inmate with serious mental illness than a non-mentally ill inmate. This does not include the added liability, cost and personnel strain of managing individuals whose disabilities render them vulnerable to

suicide, violence, medical emergencies and trauma in the non-therapeutic setting of a jail and therefore require much more intensive supervision and intervention.

The amount of time waiting in jail for a competency evaluation and/or a state hospital bed can be significant. There is the time from initial arrest to the defense counsel's recognition of competence as an issue; time from recognition until the competence evaluation can be done; time to complete the evaluation; and time from the receipt of the evaluation report until the court adjudicates the issue (Christy, Otto, Finch, Ringhoff & Kimonis, 2010). These critical delays in gaining needed psychiatric treatment can exacerbate clinical symptoms and problem behaviors. By accelerating access to skilled forensic psychiatric evaluation and treatment in the jail, the ROC model can make clinical interventions at the earliest onset of illness, which reduces risk and makes it easier to stabilize the individual and restore and maintain competency. Moreover, prompt forensic examinations can differentiate the cases that can be resolved more quickly and will not require full hospitalization (Zapf & Roesch, 2011).

In addition, the ROC model has the major advantage of facilitating access to local attorneys and the courts and family support. Individuals with mental illness can be evaluated, stabilized and restored to competency in their home community, eliminating the high cost of transporting patients to and from state hospitals and the courts. In a large and/or rural state, the distances can be enormous and expensive.

Finally, there are major cost advantages of performing competency evaluation and restoration in a local jail setting. The cost of a forensic hospital bed is far higher than a jail bed, even a jail bed designated for mental health. For example, currently in Virginia, where this ROC model was developed, the average cost for a patient bed in the state's maximum security forensic hospital is $776 per day; whereas, the average cost to house an inmate in the local Regional Jail is $70 per day (Commonwealth of Virginia, 2010). The challenge, of course, is how to be able to provide an equivalent level of humane and effective psychiatric treatment in a jail or prison space that is not designed, equipped or staffed to provide a therapeutic environment.

The following Table 1 summarizes the multiple advantages of the ROC model for state hospital systems, local jails, law enforcement and the persons served.

## 4. Transforming a jail pod into a restoration of competency "ROC" unit

*Overcoming the jail environment*: The main disadvantage of the ROC jail-based restoration model, and it is a major one, is that jails and prisons are simply not designed as mental health units. They are built for security, surveillance and control, not therapeutic calm and comfort. Jail buildings and units are typically austere, grim, noisy, crowded and uncomfortable. Even the few classrooms and program areas that are designated for more positive activities of education, recreation, leisure, visitation, or even treatment, are understandably limited in a jail – in number, size, appearance and amenities.

Given the harsh physical plant realities of correctional facilities, the success of the jail-based ROC treatment model therefore depends on how well the available program space can be modified into a therapeutic environment. This entails a creative combination of (1) physical renovations to create a more pleasant and practical space for behavioral health treatment, create a positive environment; (3) specialized behavioral health training and supervision for correctional officers and unit staff; and (4) consistent, well-coordinated interventions by an integrated interdisciplinary team in delivering therapeutic services within the secure setting. while mitigating the environmental risks that mentally ill offenders may use in attempts to inflict injury upon themselves or others; (2) application of behavioral engineering principles to

| Challenges | Benefits |
|---|---|
| For State Hospital Systems | |
| • Increasing proportion of admissions to state hospitals are forensic patients.<br>• State hospital systems have insufficient beds to meet demand.<br>• Large and lengthy "waiting lists" for admission to state hospitals delay needed treatment.<br>• The need to transport and escort forensic patients over long distances causes costly logistical problems.<br>• Increased court pressure and administrative costs due to complications and delays in processing, treating and restoring patients.<br>• Litigation from Advocacy agencies. | • Reduces number of individuals waiting for competency evaluation and restoration services.<br>• Reduces length of stay for restoration through early intervention and targeted treatment.<br>• Eliminates incentive for inmates to malinger by seeking "vacation" from jail or prison.<br>• More convenient access for local courts, defense attorneys, prosecutors and law enforcement, which saves time and money and improves outcomes.<br>• Seamless transition from ROC program helps maintain competence to stand trial. |
| For Local Jails, Emergency Rooms and Law Enforcement | |
| • High numbers of mentally ill patients must wait in the non-treatment jail setting.<br>• Jail setting is not designed for treatment and jail personnel are not trained to manage mental illness.<br>• It costs much more to house mentally ill inmates than regular inmates.<br>• Symptoms and severity of mental illness can exacerbate without prompt psychiatric intervention and can further complicate and extend the time needed to restore competency.<br>• Higher risk of suicide, aggression, injury, trauma and litigation in non-therapeutic jail setting.<br>• High costs of escort staff and long-distance transportation to and from state hospitals, courts and jails.<br>• Increased use of costly hospital emergency room visits to manage mental health crises in the community.<br>• Negative cycle of competency restoration, relapse in jail while awaiting trial and re-hospitalization. | • Local county saves money by reducing the time spent in jail by mentally ill inmates.<br>• County jail can gain new revenue to cover the expenses already incurred by holding mentally ill inmates.<br>• Eliminates the time and cost of transporting patients to and from state hospitals and jails.<br>• Reduces disruptions to jail operations caused by psychotic and disordered behavior.<br>• Reduces risk of suicide, violence, injury and litigation.<br>• Reduces costly Emergency Room visits.<br>• More convenient access for local courts, defense attorneys, prosecutors, law enforcement and family support.<br>• On-site clinical support can potentially be extended to support mental health crises for other inmates. |

Table 1. Advantages of the ROC Model

Some of the key ingredients for setting up a ROC program in a local jail include the following:
*Choice of facility*: The ideal site for the ROC model is a jail that has many Incompetent to Stand Trial (IST) or Incompetent to Proceed (ITP) defendants, who are either waiting for admission to the state hospital for evaluation and restoration and/or defendants who have been restored and returned from the state hospital to await court proceedings. Based on the available space in the jail, the ROC program requires about 20 beds to be cost effective, but it can be flexed to accommodate a larger capacity of up to 40 or more.
*Program space requirements*: The ROC provider must work collaboratively with the local Sheriff or jail authorities to assess and configure the pod, unit or area within the jail that can separately house the mentally ill inmates (forensic patients) and provide the primary program space for delivering the restoration of competency services. The main need is to separate the mentally ill inmates from the general population and establish an area that is sufficiently quiet, clean, orderly and safe to serve as the therapeutic environment. As illustrated in the case study below, many activities can be held in the common area of the jail pod, but other cells or multi-purpose rooms in the unit or jail can be adapted, if available, into clinician offices, exam rooms and group rooms. For recreation, the ROC patients should have scheduled access to a gym, recreation room or exercise yard separate from the general inmate population.
*Specially trained security staff*: The ROC unit should have its own dedicated staff of specially trained security officers, who are separate from the traditional correctional officers working in the rest of the jail. The ROC provider must work closely with the jail leadership to select, train and coordinate the work of security officers who will be assigned to the ROC mental health unit. Candidates should be carefully interviewed and evaluated to determine if they are suited to using a very different approach to managing and interacting with inmates. They should demonstrate values, attitudes and behavior that will be congruent with the program's therapeutic orientation. They will be trained in the recovery model and the use of positive behavioral techniques and will continually interact with the inmate/patients and clinical staff alike. They are expected to play an active and meaningful role in maintaining the therapeutic milieu. A designated ROC Deputy is also recommended to supervise the other security officers on the ROC unit, serve as an intermediary with jail leadership, and directly participate as a member of the interdisciplinary treatment team.
*Interdisciplinary treatment team*: The ROC treatment team would be interdisciplinary like that of a traditional forensic psychiatric unit, typically including a forensic psychiatrist, forensic psychologist, psychiatric nurse, social worker, rehabilitation therapist and clerk to coordinate scheduling, court dates, transports and forensic reports. A larger ROC program would have a larger team of professionals. The direct care staff would be security officers (see above), who are dually trained in security and treatment functions.
*Approach to competency restoration*: The ROC program uses a recovery model that focuses on individual strengths and targets abilities that are related to competency, including remediation of deficits and alleviation of acute symptoms. The primary goal for most IST patients is to resolve the psychosis, when present, to enable the patient to regain general thinking abilities. The second goal is to educate the patient in court process such that he is able to cooperate with his counsel in mounting a defense. If there is a failure to achieve either of the these goals, the third goal is to compile documentation to credibly opine that the patient is unrestorable to competency. The ROC team combines the proactive use of psychiatric medications, motivation to participate in rehabilitative activities, and multi-modal cognitive, social and physical activities that address competency in a holistic fashion. This includes the essential component of providing individual tutorials in competency

issues by a psychologist. Some treatment modules/groups can be offered at two cognitive levels to better match higher and lower levels of functioning and understanding. The ROC model also avoids the problem of involuntary psychiatric medication by establishing and delivering incentives that result in voluntary agreement to medication.

*Motivation using a milieu management system*: One of the strongest ways to motivate treatment and medication compliance is the use of a milieu management system that rewards meaningful participation in treatment and positive behaviors with points or privileges, such as points to "buy" various canteen items. It is better to deliver such rewards frequently and at the time of the positive behavior rather than accumulating points over a full day. By breaking the day into short half-hour periods during which one or two points can be gained, patients are better able to comprehend expectations, consequences and progress toward desired goals. For example, if the patient is expected to attend a restoration group at 10 am, he gets one point if he attends and none if he doesn't. But he can earn two points if he exerts earnest efforts to learn the material.

*Admission/assessment and treatment planning*: Treatment begins with the intake assessment. The clinical team evaluates the person's psychological functioning, suicide and behavioral risk, current level of trial competency, and likelihood of malingering. A standard battery of psychological tests is used to evaluate cognitive abilities, social and psychological functioning, psychiatric symptoms and potential malingering. As needed, the ROC psychologist has other tests/screenings available for specific targeted areas of deficit. Assessment continues through the course of the admission to measure response to treatment and identify new problems to target for restoration of competency. A measure such as the self-developed Competence-related Abilities Rating Scale (CARS) can be used to monitor the individual's progress (Hazelwood & Rice, 2011). Based on the assessments, the treatment plan is individualized and geared toward one of two curriculums for lower and higher functioning patients. But treatment planning continues to be flexible and vigorous. It is common for the treatment team to discuss the treatment plan informally on a daily basis and to formally discuss treatment issues at least once a week.

*Rehabilitative services and coordination of medical care*: Individuals in the program typically meet with a treatment professional one-on-one about issues related to regaining their mental health, or competency issues, at least twice daily, and are engaged in 3.5 to 5.5 hours of group-based psychosocial rehabilitative activities each day depending on the individual's current capacities. (Experience showed that the lower functioning patients could not tolerate more than 3 to 4 hours of focused work per day.) For the most part, the clinical professionals can largely work during traditional weekday business hours, but evening and weekend programming is important for maintaining the therapeutic milieu. The clinical team can maintain on-call support during afterhours, and if necessary, come into the jail to evaluate and assist with a psychiatric crisis.

Treatment activities are structured and delivered across four domains: restoration of competency, mental illness and medication management, mental/social stimulation, and physical/social stimulation. Basic residential and health care, including all medical care and medications, can be provided on-site through a service agreement with the Sheriff/jail to utilize its existing pharmacy, medical records and medical service delivery system.

*Discharge planning*: Discharge planning begins at the time of admission. The ROC establishes a link with the designated mental health professional at the referring jail to discuss the case and provide aftercare information that will assist the jail in managing the inmate/patient upon return. Information may include continuation of medications based on those available in the jail's formulary; use of resources at the jail to help with behavior management (e.g., available

mental health cells, paraprofessional assistance, etc.); and recommended protocols for managing the individual, particularly someone who might use malingering for secondary gain (e.g., restrictions on personal property, defined triggers for acting out behaviors, etc.).
*Performance measures*: The ROC model is organized to track multiple measures of efficiency, effectiveness, access to care, reduction in risk, and consumer satisfaction. Key performance measures can include the timeliness and results of evaluations, length of stay to achieve restoration, diagnostic and demographic data, hours of service by type and clinician, interventions, timeliness of court reports, customer satisfaction (including jail personnel, local law enforcement, courts, defense and prosecuting attorneys, state hospitals, patients and patient families, advocates and other stakeholders), recidivism and more.

## 5. ROC Case Study: The Liberty Forensic Unit at Riverside Jail

*The pilot program*: In 1997, Central State Hospital in Petersburg, Virginia needed to renovate its aging forensic units to accommodate a growing state-wide demand for forensic beds. The Department of Mental Health, Mental Retardation and Substance Abuse Services devised a bold plan to temporarily create a licensed forensic psychiatric hospital unit within the newly constructed Riverside Regional Jail in nearby Prince George County. A private company called Liberty Healthcare Corporation was selected to implement the pilot project. In just four weeks, the jail pod was transformed into an inpatient psychiatric unit with a complete staff of forensic clinicians, medical personnel, security and direct care staff and received initial state licensure as an inpatient behavioral health care facility and subsequent JCAHO certification as an inpatient psychiatric hospital unit. The unit then functioned as the acute, male admission unit for the state's maximum security forensic hospital.
*Minimal renovation required*: The first challenge was to modify the two-level jail pod into an acute inpatient psychiatric unit without impacting its correctional functionality. This was achieved with very minimal renovation. Of the 48 single-occupancy cells within the pod, 35 were simply converted into individual patient bedrooms using the original bed, toilet, sink and dresser/desk. Beds were removed from cells in one quadrant of the pod to create ten staff offices, one treatment team room and two behavior stabilization rooms (i.e., quiet/seclusion rooms). Brighter colored paint replaced the original institutional gray. A non-secure page-fence was added to the mezzanine walkway to prevent anyone from falling or jumping.
The creative use of behavioral engineering averted the need for other renovations. As part of the behavior management system, the mezzanine level bedrooms were designated for patients who had earned higher levels of responsibility and privilege in the treatment program. Also, patient movement from the floor to the mezzanine level was restricted to the central ramp, while the stairs on either side were restricted for staff use only. Otherwise patients were free to move about the unit. Boundary lines were marked on the floor using colored tape to delineate the few specific areas where patients were not allowed to travel without permission, such as the medical records room and the staff offices.
*Use of space for treatment and activities*: The pod included one small conference room that could be used for treatment groups, competency groups and other therapeutic activities. Certain subareas of the common area could also be used for community meetings and socialization and group activities at designated hours of the day, such as a "Current Events" discussion group or to watch a psychoeducational videotape or TV program. For recreational activities, the patients could use an enclosed patio/basketball court and enjoyed

exclusive use of the prison's gymnasium at scheduled hours every day, separate from the general inmate population.

*Restoration to competency*: Efforts to restore a defendant to competency to stand trial primarily consist of medications to remediate active symptoms of mental illness, when present, and group and individual education about court and criminal justice processes with correlative documentation of response to these efforts at education. Group-based education included mock court run-throughs in which every patient took a turn at playing the various roles in court. Individual tutorials in court procedure were provided by the unit psychologists to move the patient more quickly toward competency and a defensible opinion for the court (when possible), but also helped document the thorough efforts made by ROC for cases that concluded in an opinion of unrestorability.

Individual forensic evaluations, psychological testing, clinical interviews and counseling could be conducted in one of the single rooms or the small group room. One-to-one sessions were frequent because the psychologist conducted individual competency tutorials with most patients and each patient would meet regularly with his designated primary therapist.

The host jail provided housekeeping, food services, and laundry. The ROC unit provided its own primary medical care and pharmacy and would refer serious and emergent medical issues to the state hospital infirmary or local civil medical hospitals.

*Team-based interventions and milieu management*: The ROC program was highly proactive and preventative. Great emphasis was placed on maintaining a therapeutic environment characterized by calm, quiet, safety, predictability and interpersonal respect. A vigorous schedule of therapeutic activities helped to prevent boredom and provided opportunities for positive interactions. The key, however, was use of intensive team-based staff supervision. The security officers/direct care personnel were trained to be mobile, engaged observers, who could promptly identify and respond to precursors of disruptive behavior on the unit. The goal was to intervene gently as a team at the earliest point of concern – well before the patient might escalate into a full-blown episode of disruption and/or violence that could quickly undermine the vital climate of calm and safety for the rest of the unit.

When disturbances occurred, as expected with an inmate population that was acutely ill and volatile, the ROC staff were trained to quickly, but quietly migrate to the scene as a team. This was accomplished with subtle cues and nonverbal communication between staff and performed without the need for rushing movements, loud verbal commands or calls for emergency assistance. Effective prevention and early intervention had the tremendous advantages of reducing the need for seclusion/restraint as well as lowering the risk of trauma and injury to patients and staff alike (see outcomes below).

As a team, the staff were continually reviewing the therapeutic environment and monitoring patient behavior. This teamwork extended across working shifts. Problematic patient behaviors occurring on one shift were not allowed to carry over onto the next shift. When new risk factors were identified for patients, the team developed strategies to address individual needs. For example, patients themselves were taught and encouraged to use "time out" sessions on a voluntary basis. They understood they could go to a special area with close staff support if they were beginning to feel agitated or losing personal control.

For all these reasons, the use of seclusion and restraint was minimal. When necessary, the team used the same calm efficiency in employing physical intervention techniques that were designed to preclude trauma to patients. In fact, the Local Human Rights Commission commended the unit for creating and implementing a Protocol for Recurrently Aggressive Patients because it introduced a lesser restrictive measure than seclusion and restraint, while enhancing the general safety of the unit.

## 6. Patient data and ROC program outcomes

In five years of operation, the Liberty Forensic Unit at Riverside Jail (LFU) evaluated and treated over 1,400 inmate-patients and completed 572 formal forensic evaluation reports for the courts. The following patient and outcome data summarizes the work and achievements of the ROC model at the LFU.

*Diagnostic profile*: The patients served by the LFU were extremely disordered, suffering from acute psychotic symptoms, extreme behavioral disturbances, substance abuse disorders, impaired cognitive functioning, or combinations of these problems. In fact, half (49%) suffered from a major mental illness, including schizophrenia, schizoaffective, bipolar, Psychosis NOS, dementia, and major depressive disorders. Nearly one quarter (23%) also suffered from substance abuse or substance abuse-induced disorders as the primary Axis I diagnosis. When Substance Abuse was identified as a concomitant diagnosis, the number of patients with substance abuse/dependence increased to 56%. It is notable that well over one third of the admissions to the LFU also had an Axis II Diagnosis (43%), including 34% with a diagnosed Personality Disorder. In particular, 10% of the patients had a diagnosis of Borderline Intelligence or Mental Retardation.

*Criminal offense profile*: The most common criminal offenses were Property Crimes (20%), Assault (18%), Sex Offenses (13%) and Assault on an Officer/Resisting Arrest (13%). Two thirds of the patients who were charged with violent crimes (67%). Of note, over half (54%) had committed violence against persons, including 6% charged with murder.

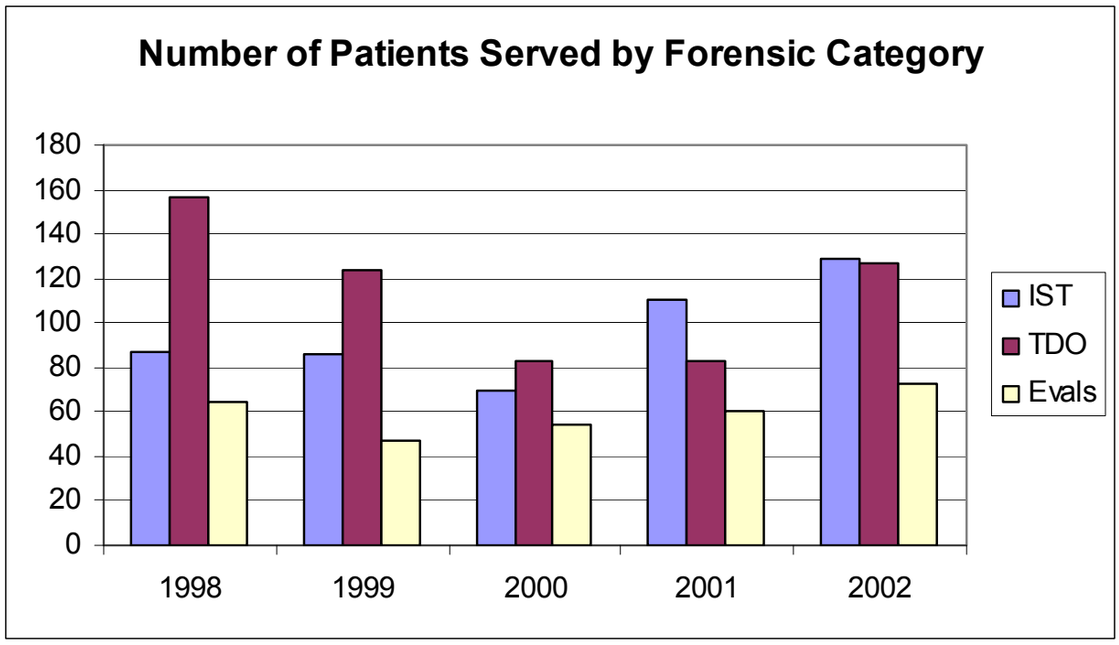
| **Primary Clinical Diagnoses** | | **Primary Criminal Offenses** | |
|---|---|---|---|
| **Psychotic Disorders** | | **Violent crimes** | |
| Schizophrenia | 15% | Assault | 18% |
| Schizoaffective | 10% | Assault on police/Resist arrest | 13% |
| Bipolar disorder | 6% | Sex Offenses | 13% |
| Psychotic Disorder NOS | 8% | Robbery | 8% |
| Major Depressive Disorder | 8% | Murder | 6% |
| Subtotal | 47% | Arson | 5% |
| **Substance Abuse** | | Abduction | 2% |
| Substance Abuse Induced | | Domestic violence | 2% |
| Mood or Psychosis | 12% | Subtotal | 67% |
| Substance Abuse | 11% | | |
| Subtotal | 23% | **Nonviolent crimes** | |
| **Other Disorders** | | Property Crimes | 21% |
| Adjustment Disorder | 16% | CDS Offenses | 6% |
| Dementia | 2% | Weapons (no injury) | 3% |
| Malingering | 2% | Parole/Prob. violation | 3% |
| All other diagnoses | 8% | Subtotal | 33% |
| Subtotal | 28% | | |

Table 2. Diagnostic and Criminal Profile

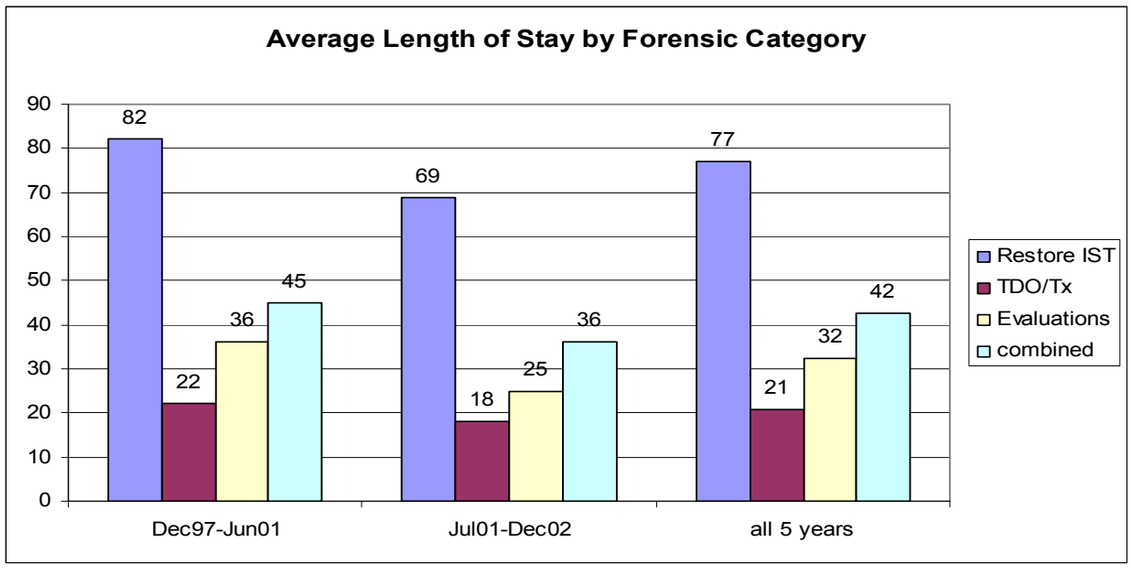
*Forensic categories served*: The Liberty Forensic Unit at Riverside Regional Jail provided three basic categories of forensic psychiatric service:

- The "Evaluation" category was comprised of patients referred specifically for forensic evaluations, including pre-sentence evaluations, Competency to Stand Trial evaluations (CST), Mental Status at time of Offense evaluations (MSO) and combined CST/MSO evaluations.
- The "Incompetent to Stand Trial" (IST) category was comprised of patients admitted for the purpose of restoring them to competency to proceed with the judicial process.
- The "Temporary Detention Order" (TDO) category was comprised of pre-sentence and pre-trial jail transfers in need of acute inpatient psychiatric treatment to stabilize them and enable them to be returned and maintained in the jail setting. Note: The unit received acute referrals from dozens of jails across the Commonwealth.

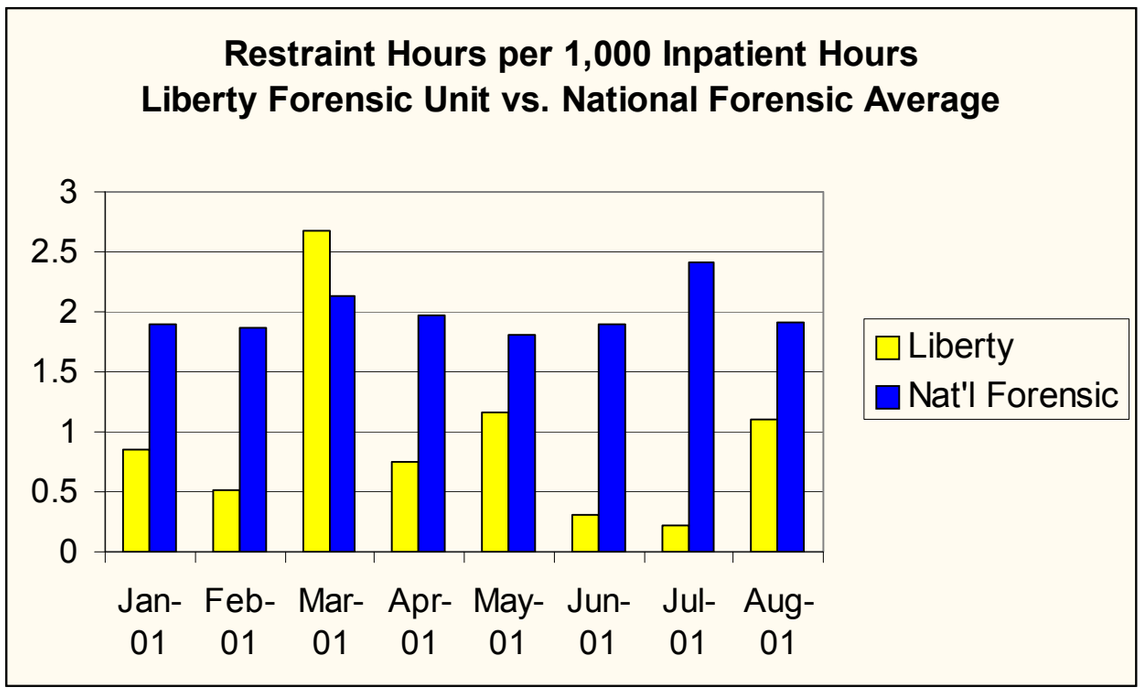
*Volume of forensic services provided by type*: The following chart summarizes the volume of patients served by forensic category over the history of the program operation. It also shows the proportion of patients requiring IST, TDO and Evaluation services shifted from year to year. In particular, the primary focus of the program shifted from the provision of acute psychiatric stabilization (TDO) in the first two years to the restoration of competency in the last two years.




*Length of stay by forensic category*: Over a five year period, the LFU discharged forensic evaluation cases in an average of 21 days and provided psychiatric stabilization to return inmate patients to their referring jails in an average of 32 days. The ROC program achieved an overall competency restoration average of 83% while restoring full competency in an average of 77 days. Notably, in its final year and a half of operation, the ROC program was restoring competency in an average of just 69 days.




*Seclusion and restraint rates*: The LFU maintained very low rates of seclusion and restraint throughout its five years of operation. Seclusion was almost never used on the unit and was not employed at all in the final year of operation. Using data from the NASMHPD Research Institute for comparison, one study compared the number of restraint hours used in the LFU against the national average for forensic psychiatric units for the same period. Despite the high volatility and acuity of the forensic patients served, use of restraint on the LFU was typically less than half of the national average in the same year.



*Customer satisfaction*: The Liberty Forensic Unit at Riverside (LFU) was widely respected for the consistent delivery of excellent psychiatric and forensic services. It received formal commendations by the state chapter of the National Alliance of the Mentally Ill and the Local Human Rights Committee and frequent unsolicited praise from patients, patient families, Judges, State and Defense Attorneys, local jails, Community Service Boards and human rights advocates.

Customer satisfaction surveys were given to referring jails, community mental health centers (called CSBs), courts, attorneys and other entities being served. Results reflected the exceptional forensic services, high quality treatment and the collaborative responsiveness of the treatment team. 96% of the CSBs affirmed that LFU staff contacted them within one week of admission and provided regular clinical updates on the status of the patients. The clinical and treatment follow-up information provided by the LFU was also highly valued by both local jail staff and CSB staff. 90% and 87% respectively indicated that they were better able to manage their patients following treatment at the LFU. 96% of the CSB staff were better able to perform service linkages based on the information provided from the LFU. 87% of the referring jails affirmed that they were able to participate in both treatment and discharge planning for their patients and 93% acknowledged that the LFU treatment had been helpful. 92% of the referring entities received the discharge plan in a timely fashion, 97% acknowledged that aftercare recommendations were helpful, and 97% received some kind of follow-up support from the LFU team. 92% also affirmed that the recommended medication regimens at discharge remained unchanged for the inmate/ patients served.

Commonwealth attorneys and defense attorneys were also satisfied with the quality of services received from the LFU unit. Whether on the side of the defense or the prosecution, the attorneys were nearly unanimous in their satisfaction with the clarity, utility and timeliness of the forensic reports received. Likewise, all but one attorney were satisfied that they could readily communicate with the ROC unit about their patients and that their patients had benefited from treatment at the LFU.

## 7. Conclusion

At a time when state hospital and community mental health resources are increasingly limited by critical financial realities, more and more people with severe and persistent mental illness and co-occurring disorders are becoming involved in the criminal justice system. In turn, the responsibility of caring for the mentally ill has shifted to the jails and prisons of America. One of the major areas is the ITP crisis in which inmates with mental illness are subjected to extended stays in jails awaiting competency evaluation and restoration. The ROC model is a cost-effective, clinically-effective and more humane model for this common problem. It calls for the provision of intensive psychiatric stabilization, forensic evaluation and restoration and maintenance of competency in the local jail

Despite the apparently aversive physical constraints of most jails and prisons, the ROC model shows that mental health providers can transform a jail pod into a true mental health facility with a remarkably therapeutic milieu. By combining an effective behavior management system, a lively treatment schedule, and some simple environmental modifications, such as marking “boundary lines” on the floor, a well-trained team of clinicians and direct care/security personnel can maintained a climate of safety, predictability and respect. The ROC model can accelerate needed treatment and restoration

for mentally ill defendants, cut the demand for costly State Hospital forensic beds, deliver competency services at significantly lower cost per bed and directly assist local jails and law enforcement in better managing this specialized high-risk population – yielding major cost savings and improved services for all.

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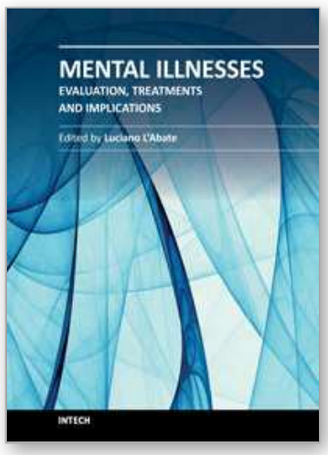


**Mental Illnesses - Evaluation, Treatments and Implications**

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In the book "Mental Illnesses - Evaluation, Treatments and Implications" attention is focused on background factors underlying mental illness. It is crucial that mental illness be evaluated thoroughly if we want to understand its nature, predict its long-term outcome, and treat it with specific rather than generic treatment, such as pharmacotherapy for instance. Additionally, community-wide and cognitive-behavioral approaches need to be combined to decrease the severity of symptoms of mental illness. Unfortunately, those who should profit the most by combination of treatments, often times refuse treatment or show poor adherence to treatment maintenance. Most importantly, what are the implications of the above for the mental health community? Mental illness cannot be treated with one single form of treatment. Combined individual, community, and socially-oriented treatments, including recent distance-writing technologies will hopefully allow a more integrated approach to decrease mental illness world-wide.

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