Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Forensic Admissions and Evaluations – Performance Targets 2019
First Quarter (January 1, 2019-March 31, 2019)

Substitute Senate Bill 6492, Section 2 (Chapter 256, Laws of 2012)
As amended by Substitute Senate Bill 5889, Section 1 (Chapter 5, Laws of 2015)
RCW 10.77.068(3)

May 10, 2019

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BACKGROUND

On May 1, 2012, Substitute Senate Bill 6492 added a section to chapter 10.77 RCW that established performance targets for the "timeliness of the completion of accurate and reliable evaluations of competency to stand trial and admissions for inpatient restoration services related to competency to proceed or stand trial for adult criminal defendants." These targets were codified under RCW 10.77.068 and phased in over six months to one year.

After full implementation of each performance target, the bill required the Department of Social and Health Services (DSHS) to report to the executive and the legislature following any quarter in which it does not meet the performance target. This reporting must address (1) the extent of the deviation, and (2) any corrective action being taken to improve performance.

On July 24, 2015, Substitute Senate Bill 5889 amended RCW 10.77.068. The bill retained the performance targets for competency services but added to these a set of "maximum time limits" phased in over one year. After full implementation of the maximum time limits, SSB 5889 required DSHS to report to the executive and the legislature following any quarter in which it does not meet each performance target or maximum time limit.

As a result of these two bills, current performance targets and maximum time limits under RCW 10.77.068(1)(a) are as follows:

> (i) For a state hospital to extend an offer of admission to a defendant in pretrial custody for legally authorized evaluation services related to competency, or to extend an offer of admission for legally authorized services following dismissal of charges based on incompetence to proceed or stand trial:
>
> (A) A performance target of seven days or less; and
>
> (B) A maximum time limit of fourteen days;
>
> (ii) For a state hospital to extend an offer of admission to a defendant in pretrial custody for legally authorized inpatient restoration treatment related to competency:
>
> (A) A performance target of seven days or less; and
>
> (B) A maximum time limit of fourteen days;
>
> (iii) For completion of a competency evaluation in jail and distribution of the evaluation report for a defendant in pretrial custody:
>
> (A) A performance target of seven days or less; and
>
> (B) A maximum time limit of fourteen days, plus an additional seven-day extension if needed for clinical reasons to complete the evaluation at the determination of the department;
>
> (iv) For completion of a competency evaluation in the community and distribution of the evaluation report for a defendant who is released from custody and makes a reasonable effort to cooperate with the evaluation, a performance target of twenty-one days or less.

Section (1)(b) of RCW 10.77.068 establishes the beginning and end points for applying the performance targets and maximum time limits set forth above. Section (1)(c) identifies six conditions that shall serve as defenses to an allegation that the department has exceeded the maximum time limits.

As mandated by RCW 10.77.068(3), the following quarterly report explains the extent to which the hospitals deviated from performance targets in Quarter one of 2019 (January 1, 2019-March 31, 2019), and describes the plans to meet these performance targets.

COMPETENCY EVALUATION AND RESTORATION DATA

RCW 10.77.068(1)(a)(i)(A) and (ii)(A), as amended by SSB 5889, establishes a performance target of seven days or less for the state hospitals to:

1) Extend an offer of admission to a defendant in pretrial custody for legally authorized treatment or evaluation services related to competency; or
2) Extend an offer of admission for legally authorized services following dismissal of charges based on incompetence to proceed or stand trial.

RCW 10.77.068(1)(a)(iii)(A), as amended by SSB 5889, sets a performance expectation that competency evaluations for a defendant who is in jail will be completed and distributed within seven days or less.

RCW 10.77.068(1)(a)(iv), as amended by SSB 5889, sets a performance expectation that competency evaluations for a defendant who is released from custody and makes a reasonable effort to cooperate with the evaluation will be completed and distributed within twenty-one days or less.

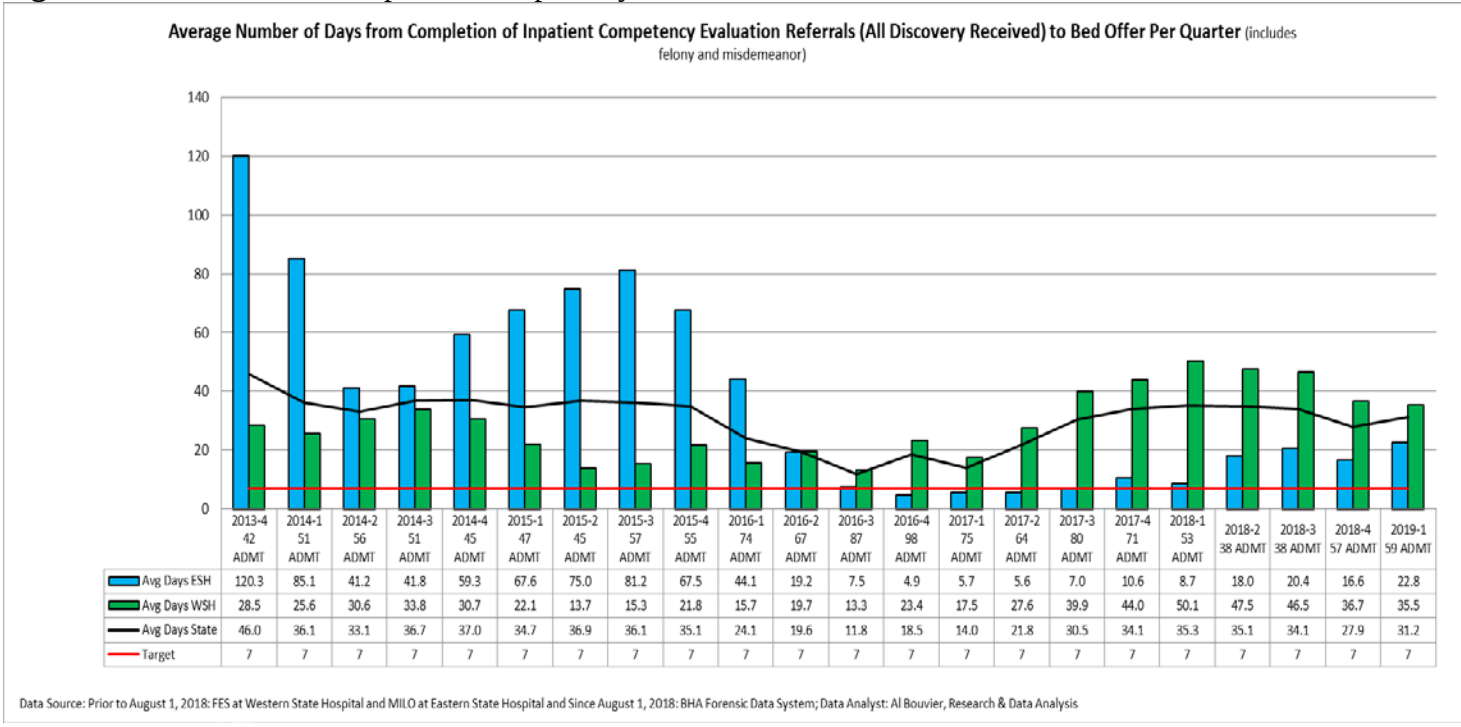
DATA ANALYSIS AND DISCUSSION

In this section, the report is organized in the following manner: (1) Statewide Forensic System Data and (2) Actions Taken. Additional detailed data and information about timely competency services is available in monthly reports published by the Department of Social and Health Services in compliance with requirements established in the April 2015 *Trueblood* court order. These reports are available on the Office of Forensic Mental Health Services (OFMHS) website at:

https://www.dshs.wa.gov/bha/trueblood-et-al-v-washington-state-dshs

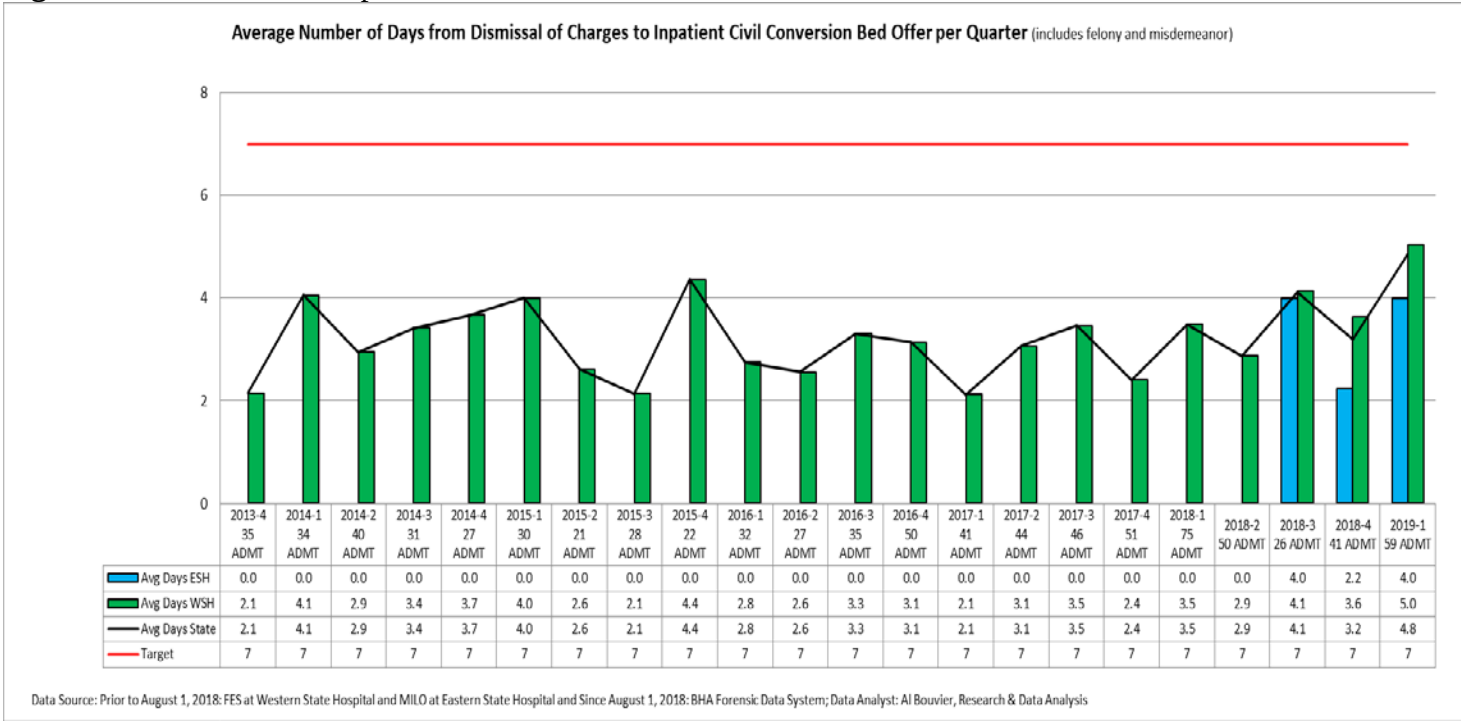
Please note that the data presented in this report differs slightly than in the *Trueblood* reports because the statute begins the count for timely service at the date of receipt of Discovery while the *Trueblood* order begins the count at the date the court order for services is signed, or the date the court order for services is received depending on the number of days between signature and receipt of the order.

Figure 1: shows results for inpatient competency evaluation cases



- **Figure 1.** These are the average wait times related to hospital admission for inpatient competency evaluations only (including PR's (defendants released on Personal Recognizance)).
- ***Outcomes*:** During the first quarter of 2019, the number of admissions, as compared to previous quarters is on the rise again. Wait times at WSH, between referral for evaluation and bed offer, fell for the fourth consecutive quarter. ESH wait times saw an increase in Q1 2019, and is the longest wait time recorded in three years.
- ***Drivers*:** During this quarter, WSH has seen its wait list consistently over 250 individuals on any given day. Despite this wait list, and orders extending restoration times (ie. 90-day orders extended to 180-day orders for additional restoration treatment) as well as an ongoing lack of sufficient capacity, both hospitals were able to increase total admissions, while wait times continued to fluctuate. This was accomplished despite an overall increase in referrals. This is due to the continued efforts of hospital staff to implement the waitlist algorithm and using a bed allocation approach to maximize bed turnover.

Figure 2: shows results for post-dismissal referrals

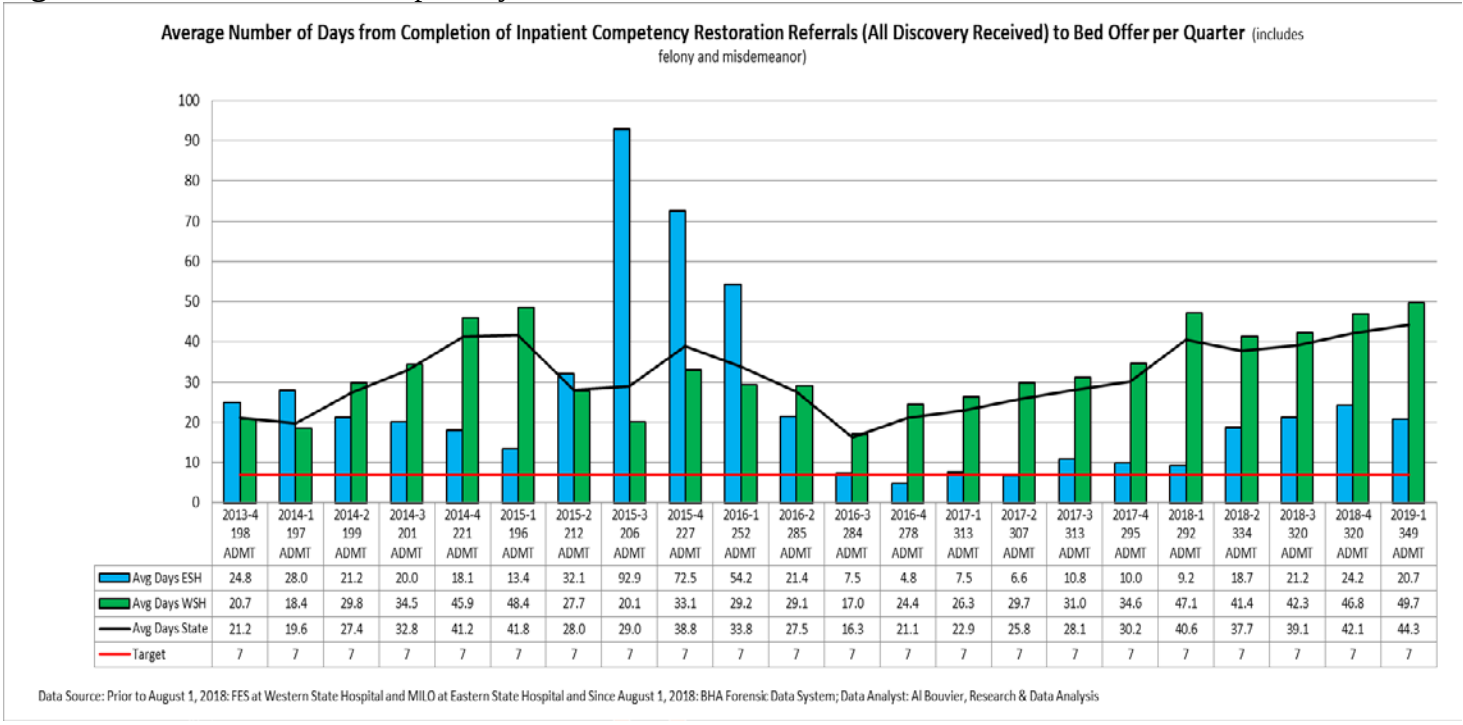


	2013-4 35 ADMT	2014-1 34 ADMT	2014-2 40 ADMT	2014-3 31 ADMT	2014-4 27 ADMT	2015-1 30 ADMT	2015-2 21 ADMT	2015-3 28 ADMT	2015-4 22 ADMT	2016-1 32 ADMT	2016-2 27 ADMT	2016-3 35 ADMT	2016-4 50 ADMT	2017-1 41 ADMT	2017-2 44 ADMT	2017-3 46 ADMT	2017-4 51 ADMT	2018-1 75 ADMT	2018-2 50 ADMT	2018-3 26 ADMT	2018-4 41 ADMT	2019-1 59 ADMT
Avg Days ESH	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0	2.2	4.0
Avg Days WSH	2.1	4.1	2.9	3.4	3.7	4.0	2.6	2.1	4.4	2.8	2.6	3.3	3.1	2.1	3.1	3.5	2.4	3.5	2.9	4.1	3.6	5.0
Avg Days State	2.1	4.1	2.9	3.4	3.7	4.0	2.6	2.1	4.4	2.8	2.6	3.3	3.1	2.1	3.1	3.5	2.4	3.5	2.9	4.1	3.2	4.8
Target	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7

Data Source: Prior to August 1, 2018: FES at Western State Hospital and MILO at Eastern State Hospital and Since August 1, 2018: BHA Forensic Data System; Data Analyst: Al Bouvier, Research & Data Analysis

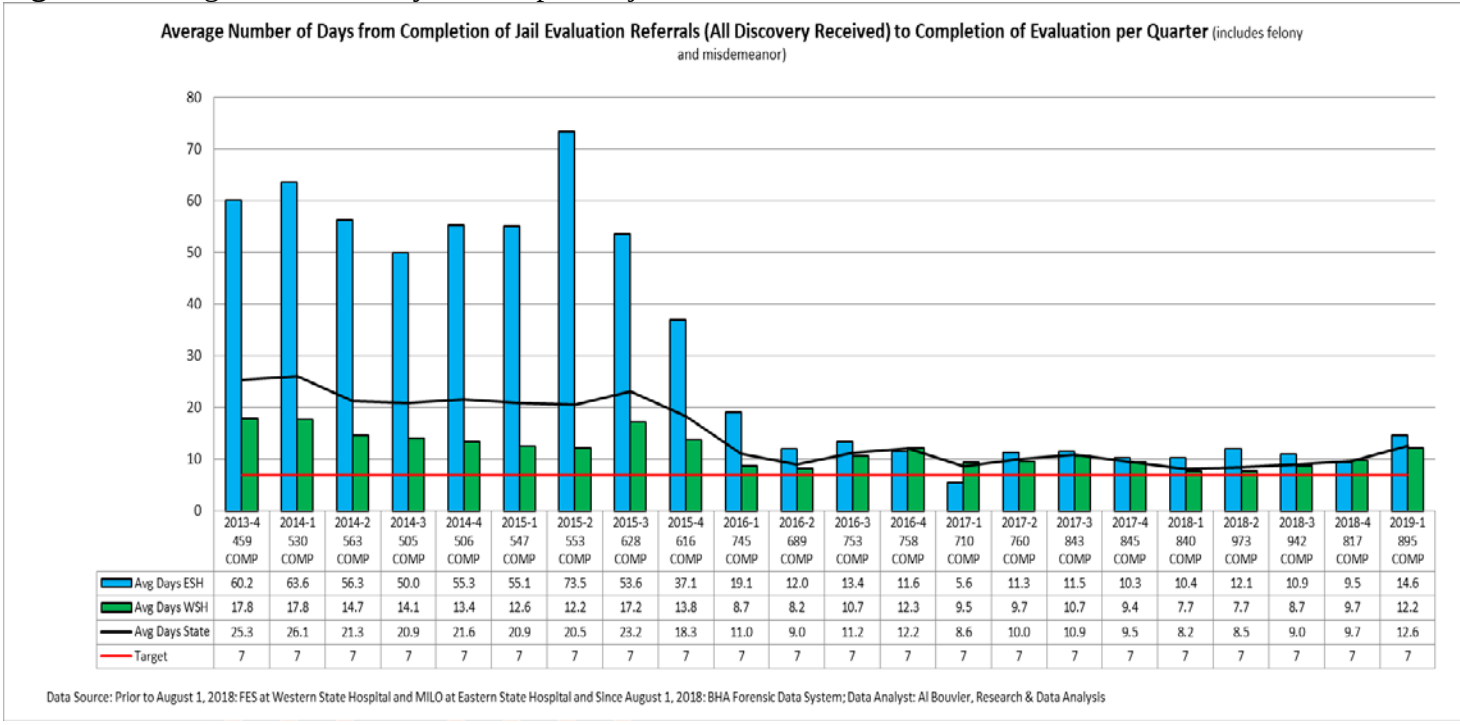
- **Figure 2.** This chart reflects average days from dismissal of charges to an offer of admission at each State hospital and a combined State average.
- ***Outcomes*:** During the reporting period both ESH and WSH continue to be well below the seven day target, despite a slight uptick in wait times.
- ***Drivers*:** The continued positive performance at both hospitals is attributed to staff maintaining clear focus on prioritizing these beds for admissions. One caveat with this prioritization is that it comes with a cost in that *Trueblood* admissions are impacted negatively because of this prioritization.

Figure 3: shows results for competency restoration cases



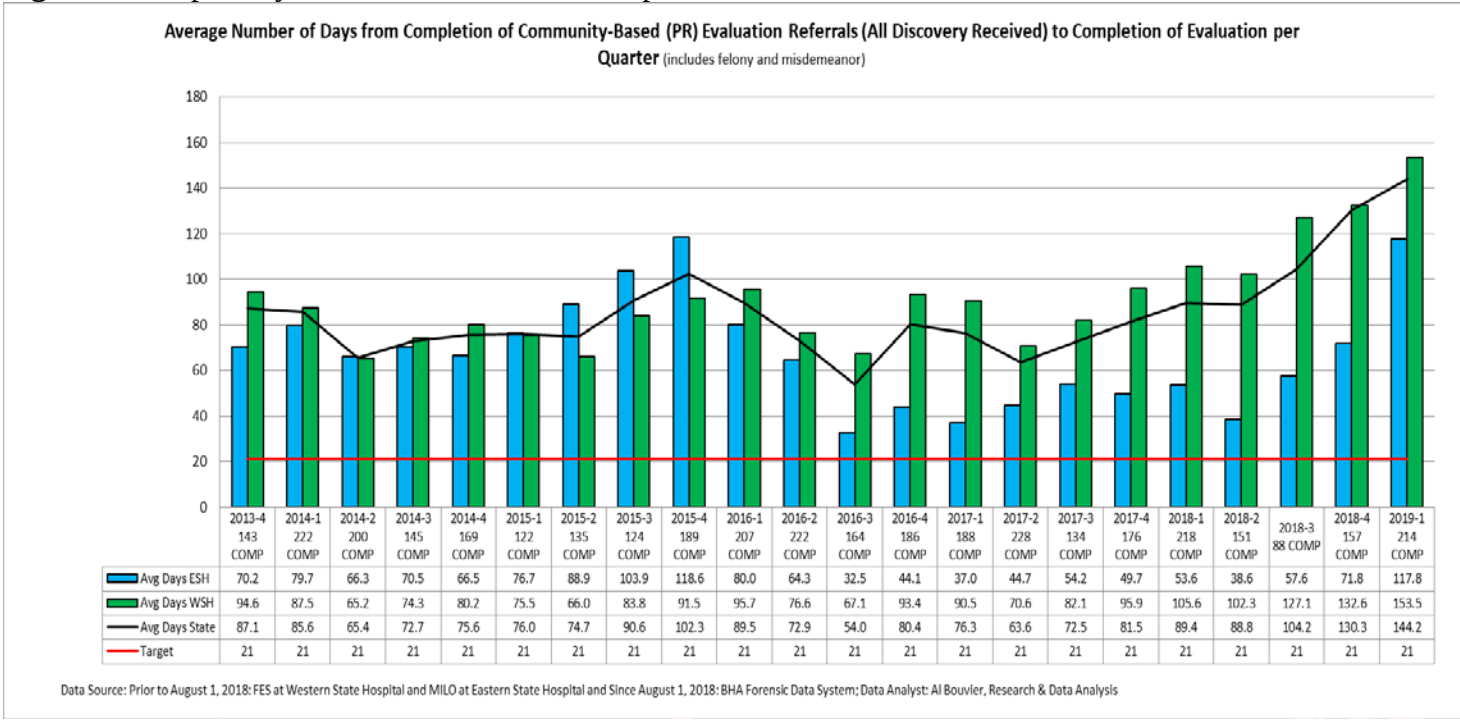
- **Figure 3.** This chart reflects the average wait time for admission for competency restoration referrals only (including PRs).
- ***Outcomes*:** During the reporting period, WSH had a slight increase in wait times, while ESH had a slight decrease. Overall, the statewide average increased by about two days.
- ***Drivers*:** The 349 admissions completed during this reporting period marks the highest number of admissions since reporting began. Such a high volume represents significant progress in serving this population, despite an overall lack of capacity. However, such volumes may impact wait times negatively, as was seen at WSH.

Figure 4: average number of days to complete a jail based evaluation



- **Figure 4.** This chart provides information on the average number of days to complete a jail-based evaluation from the receipt of all discovery.
- ***Outcomes*:** During the reporting period, both WSH and ESH completion times increased to a level not seen since late 2016 and early 2017.
- ***Drivers*:** Within this quarter, the Processing and Referral (PAR) team located at Western State Hospital had a high priority assignment related to data integrity that required services to be split between data clean-up and processing orders. Additionally, the PAR team reviewed current processes for efficiencies and noted a change in processing jail based that was implemented at the end of the quarter to improve the process. Also during this quarter, both the weather and illness impacted evaluators in being able to complete interviews in jails. Weather and illness also impacted the PAR team as well. Furthermore, an increase in DDP cases required staff to be re-assigned to meet the required qualifications to complete the evaluation as ordered.

Figure 5: competency evaluation time frame completion for PR cases

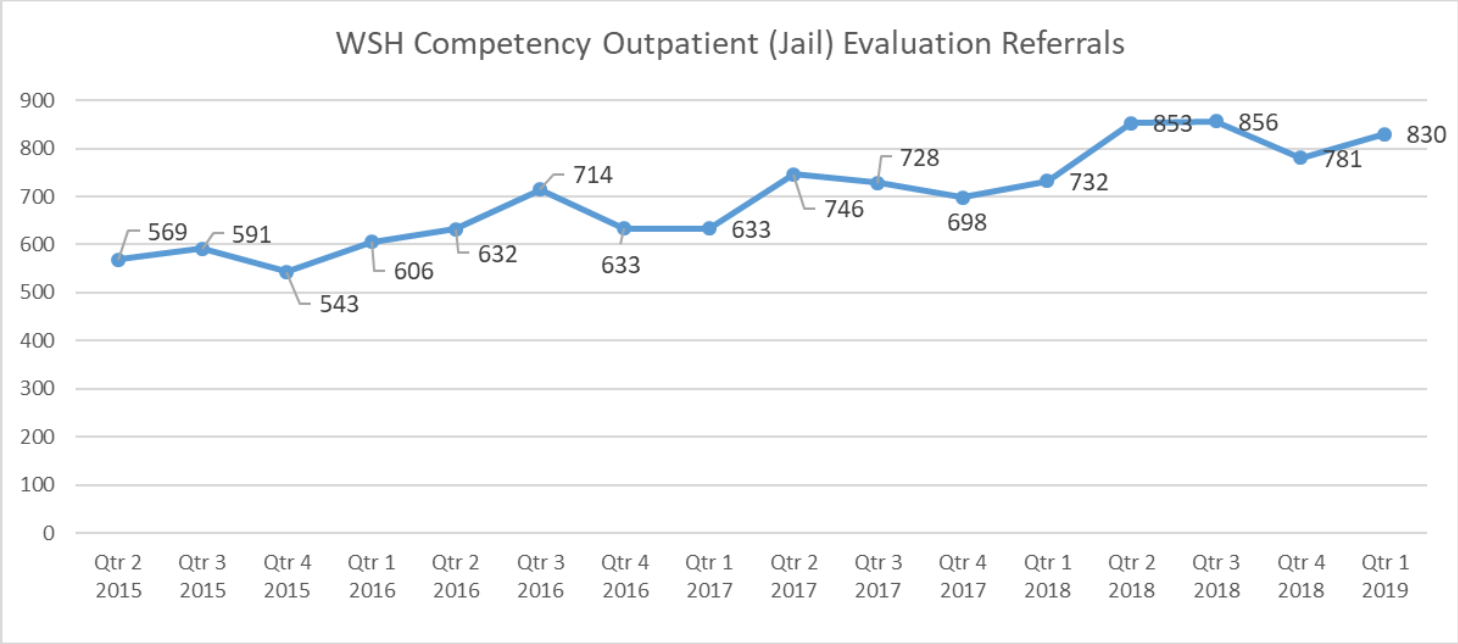


	2013-4 143 COMP	2014-1 222 COMP	2014-2 200 COMP	2014-3 145 COMP	2014-4 169 COMP	2015-1 122 COMP	2015-2 135 COMP	2015-3 124 COMP	2015-4 189 COMP	2016-1 207 COMP	2016-2 222 COMP	2016-3 164 COMP	2016-4 186 COMP	2017-1 188 COMP	2017-2 228 COMP	2017-3 134 COMP	2017-4 176 COMP	2018-1 218 COMP	2018-2 151 COMP	2018-3 88 COMP	2018-4 157 COMP	2019-1 214 COMP
Avg Days ESH	70.2	79.7	66.3	70.5	66.5	76.7	88.9	103.9	118.6	80.0	64.3	32.5	44.1	37.0	44.7	54.2	49.7	53.6	38.6	57.6	71.8	117.8
Avg Days WSH	94.6	87.5	65.2	74.3	80.2	75.5	66.0	83.8	91.5	95.7	76.6	67.1	93.4	90.5	70.6	82.1	95.9	105.6	102.3	127.1	132.6	153.5
Avg Days State	87.1	85.6	65.4	72.7	75.6	76.0	74.7	90.6	102.3	89.5	72.9	54.0	80.4	76.3	63.6	72.5	81.5	89.4	88.8	104.2	130.3	144.2
Target	21	21	21	21	21	21	21	21	21	21	21	21	21	21	21	21	21	21	21	21	21	21

- **Figure 5.** This chart provides information on the average number of days to complete PR evaluations from the receipt of all discovery.
- ***Outcomes*:** During the reporting period, both WSH and ESH saw significant increases in average completion times from the previous quarter.
- ***Drivers*:** The variability in completion times is attributed to resources having been directed to cases involving *Trueblood* class members as the number one completion priority based on established constitutional rights from the *Trueblood* court order. As such, resource allocation demands that DSHS/OFMHS focus its efforts in such a way as to mitigate, as much as possible, the impacts of these constitutional violations and related fines for jail-based evaluations. This has resulted in greater fluctuation with regard to performance measures in this category.

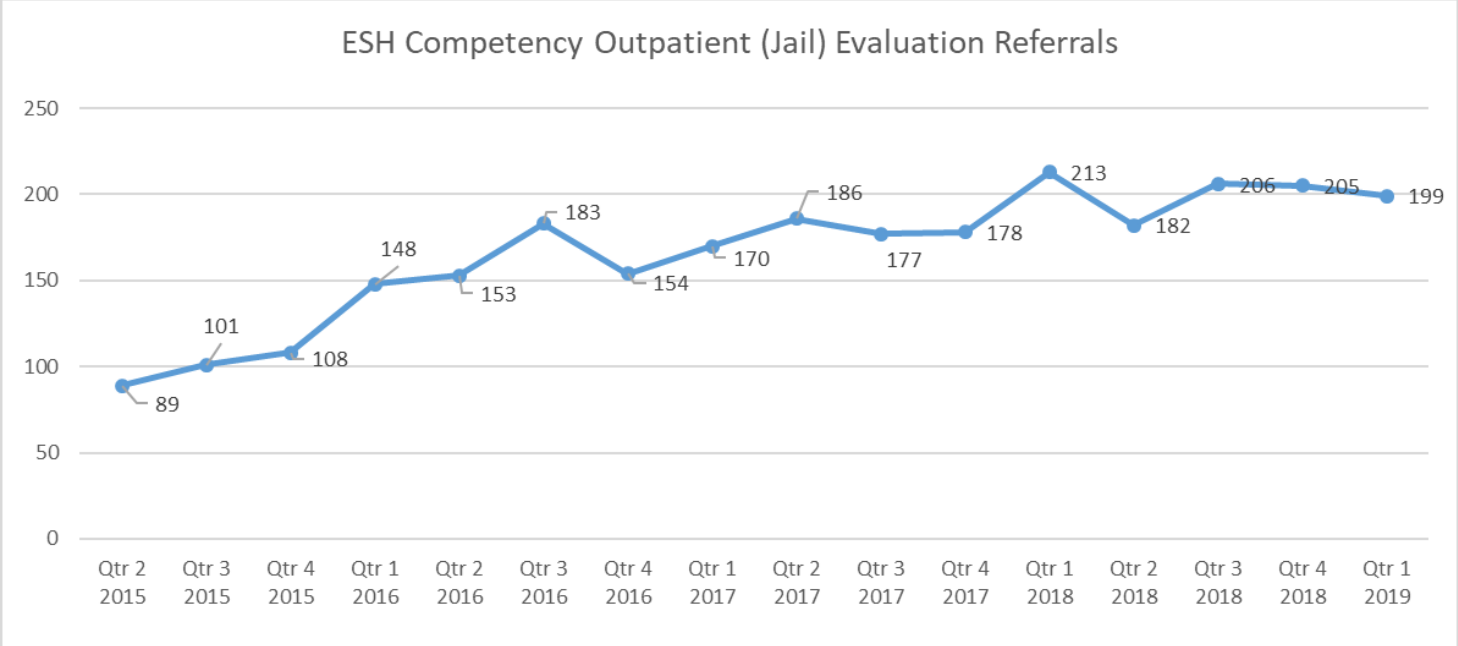
Figures 6-14: show ***global referral data*** to illustrate total orders signed by calendar quarter for jail-based evaluations, inpatient evaluations, and restoration services for WSH, ESH, and both hospitals combined.

Figure 6: shows total WSH referrals for jail-based evaluations



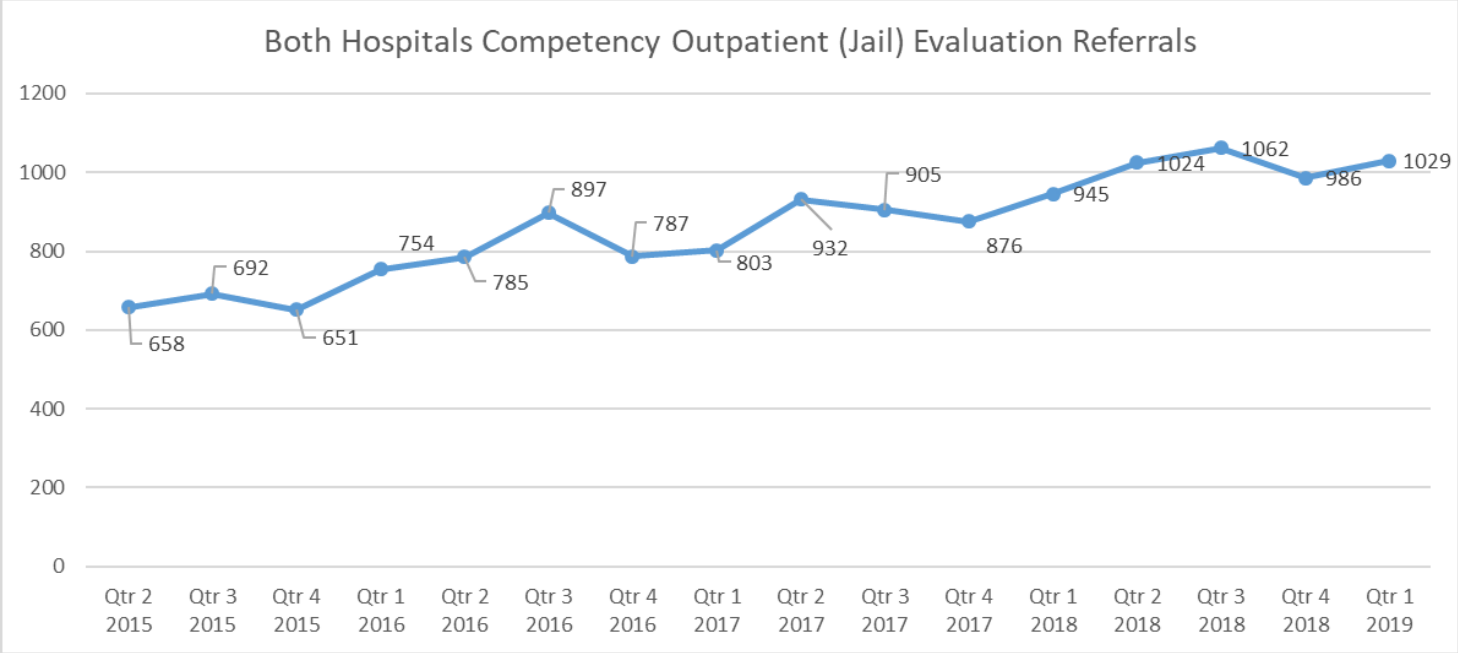
- **Figure 6.** This chart illustrates WSH total quarterly referrals for jail-based evaluations.
- ***Outcomes*:** During the reporting period, WSH hospital saw an increase in referrals from the previous quarter. This number represents the continued high demand in 2019, relative to prior years (annual averages: 2016 = 646.25; 2017 = 701.25; 2018 = 799.5).
- ***Drivers*:** Referrals for competency evaluation have increased significantly over the period illustrated above. This strongly suggests a "build it and they will come" effect; improved efficiency in providing consumers with a highly valued forensic service has itself increased the demand for that service. This is a well-known effect also seen in other supply and demand phenomena, such as the energy industry.

Figure 7: shows total ESH referrals for jail-based evaluations



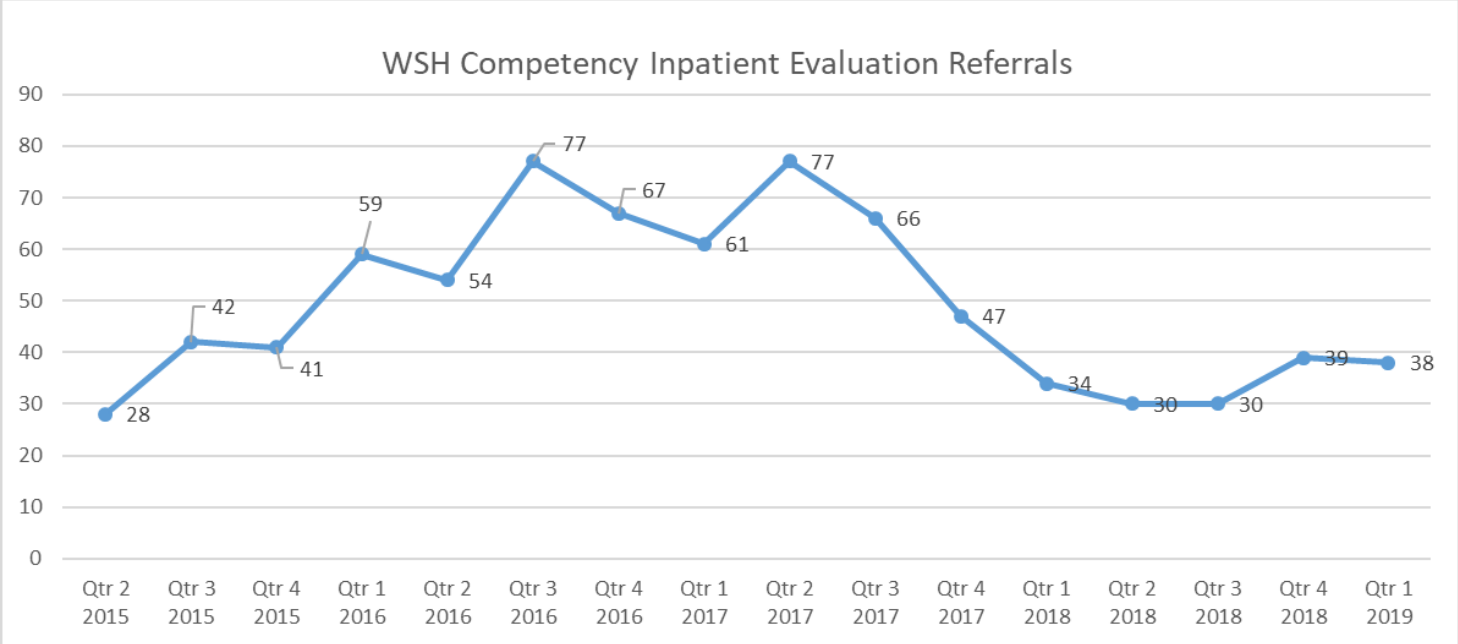
- **Figure 7.** This chart illustrates ESH total quarterly referrals for jail-based evaluations.
- ***Outcomes*:** During the reporting period, ESH saw a slight decrease in referrals, but still more than twice the number seen when reporting began.
- ***Drivers*:** The overall trend of increasing referral totals is driven by demand. As the Department has increased capacity and gained efficiencies in its processes, the criminal court system and mental health community have demanded the Department's services at a pace that has outstripped gains made in capacity and efficiencies.

Figure 8: shows total WSH and ESH combined referrals for jail-based evaluations



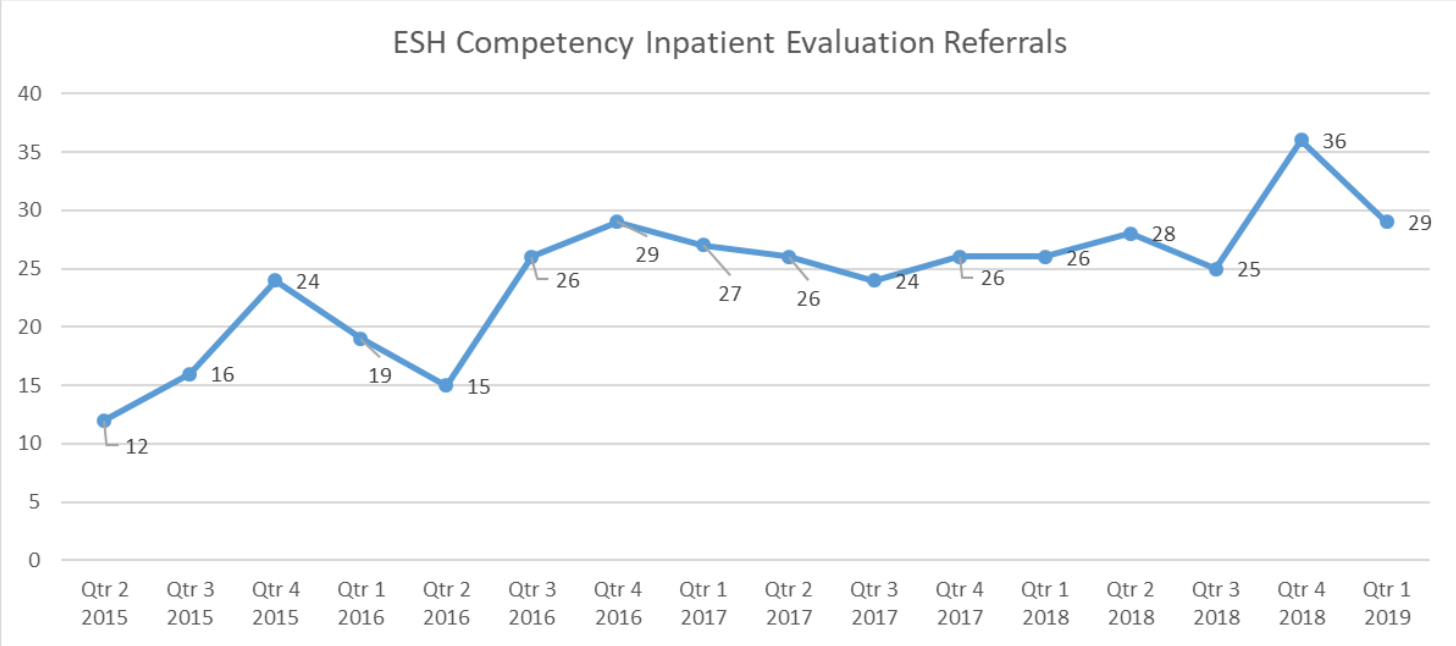
- **Figure 8.** This chart illustrates the combined total quarterly referrals for jail-based evaluations.
- ***Outcomes*:** During the reporting period, there was an increase in total referrals for both hospitals combined as compared with the previous quarter and is the second highest number recorded to date. This number remains significantly higher than when reporting began (a 56.38% increase from Q2 2015).
- ***Drivers*:** The combined number of jail-based referrals to the hospitals, again, strongly suggests a "build it and they will come" effect; improved efficiency in providing consumers with a highly valued forensic service has itself increased the demand for that service.

Figure 9: shows total WSH referrals for inpatient evaluations



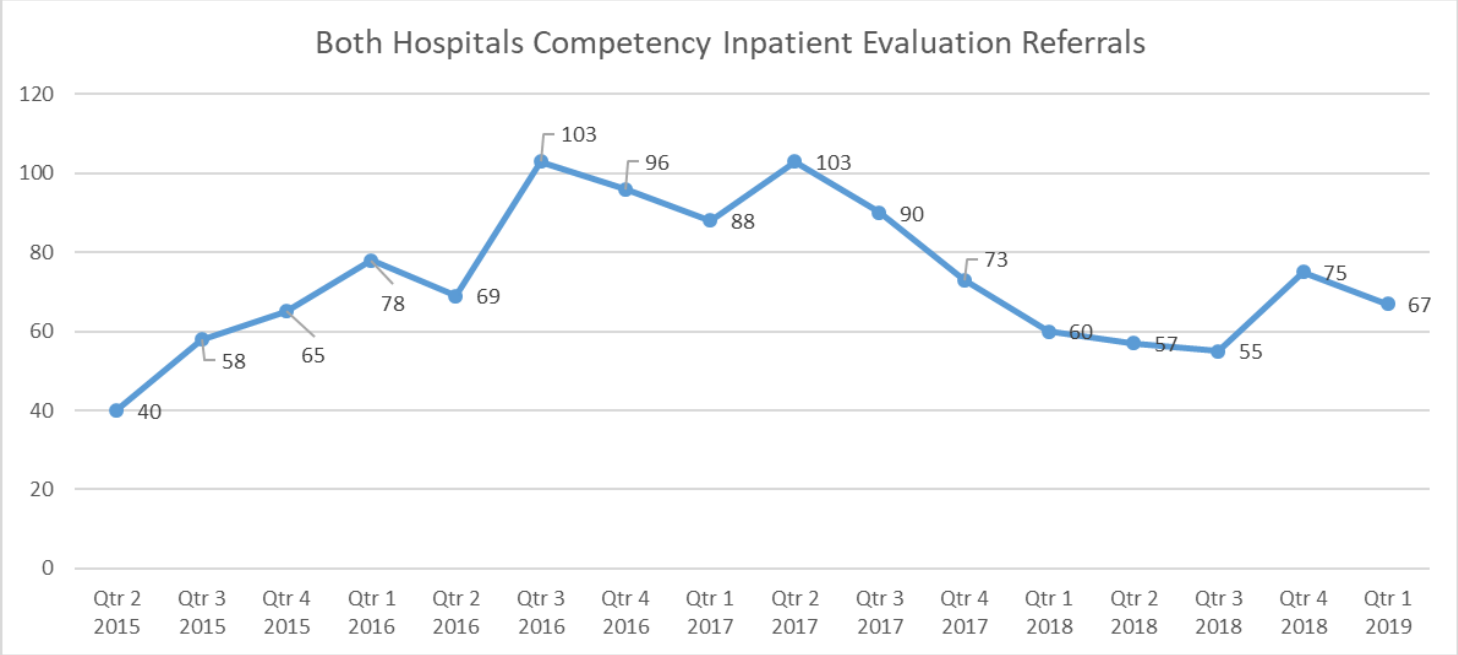
- **Figure 9.** This chart illustrates WSH total quarterly referrals for inpatient evaluations.
- ***Outcomes*:** During the reporting period, referrals to WSH remained static as compared to the previous quarter.
- ***Drivers*:** The large decline in inpatient referrals seen over the previous seven quarters may have been a rebound effect wherein courts had become aware of the fact that, previously, demand had outstripped capacity which resulted in long wait times and completion times. Anecdotal information suggests that courts and defense attorneys are beginning to view the wait times for admission to the hospital for an inpatient evaluation to be so prohibitively long that it is not worth pursuing as an order. Some courts issued new orders that take the defendant off the inpatient wait list, directing DSHS to conduct the evaluation in the jail. In other cases, the defendant has waited for such an extended period for admission that defense counsel motions the court for dismissal of charges.

Figure 10: shows total ESH referrals for inpatient evaluations



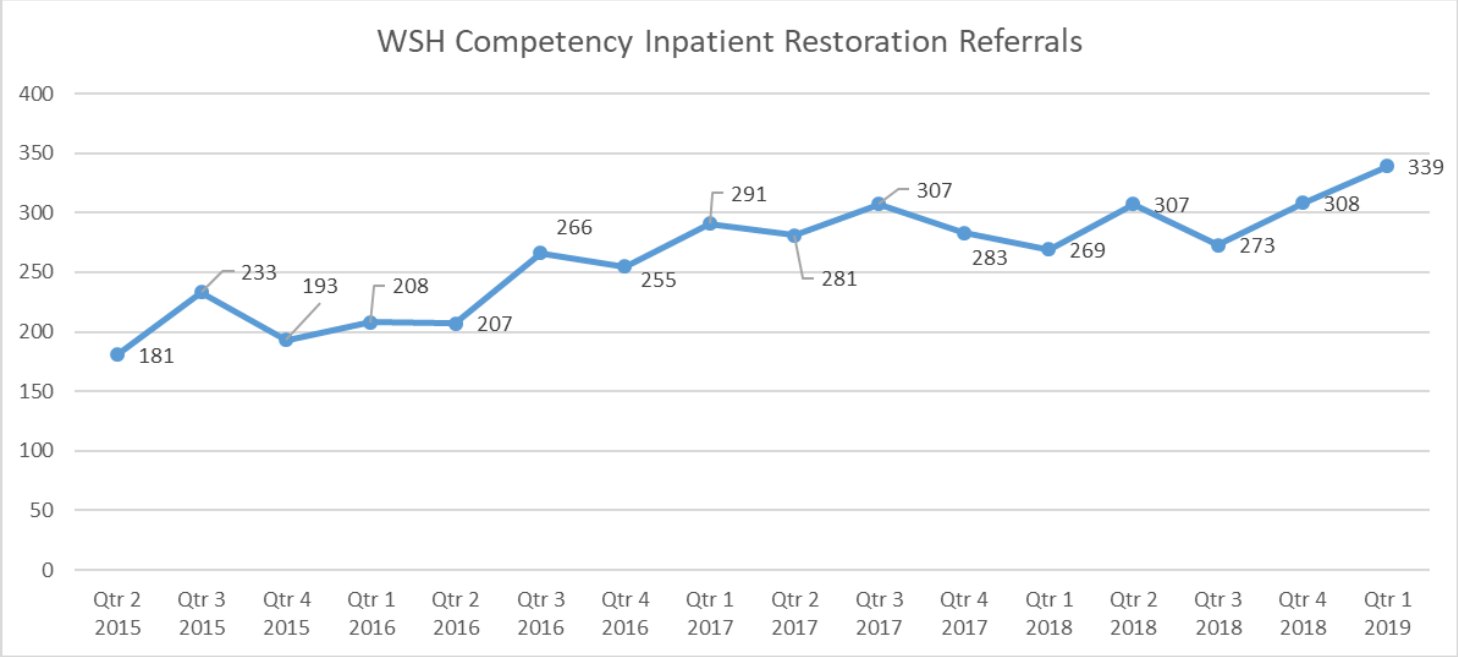
- **Figure 10.** This chart illustrates ESH total quarterly referrals for inpatient evaluations.
- ***Outcomes*:** During the reporting period, ESH saw a decrease in referrals from the previous quarter, returning to numbers seen between Q3 2016 and Q3 2018.
- ***Drivers*:** The overall trend of near-static inpatient evaluation orders illustrates that referrals for inpatient evaluations had remained relatively flat for the previous two and a half years at ESH. That would indicate a preference by the courts, as it pertains to patient evaluations, to have the vast majority of evaluations completed in jail as opposed to inpatient. The significant increase in Q4 2018 may have been merely anomalous.

Figure 11: shows total WSH and ESH combined referrals for inpatient evaluations



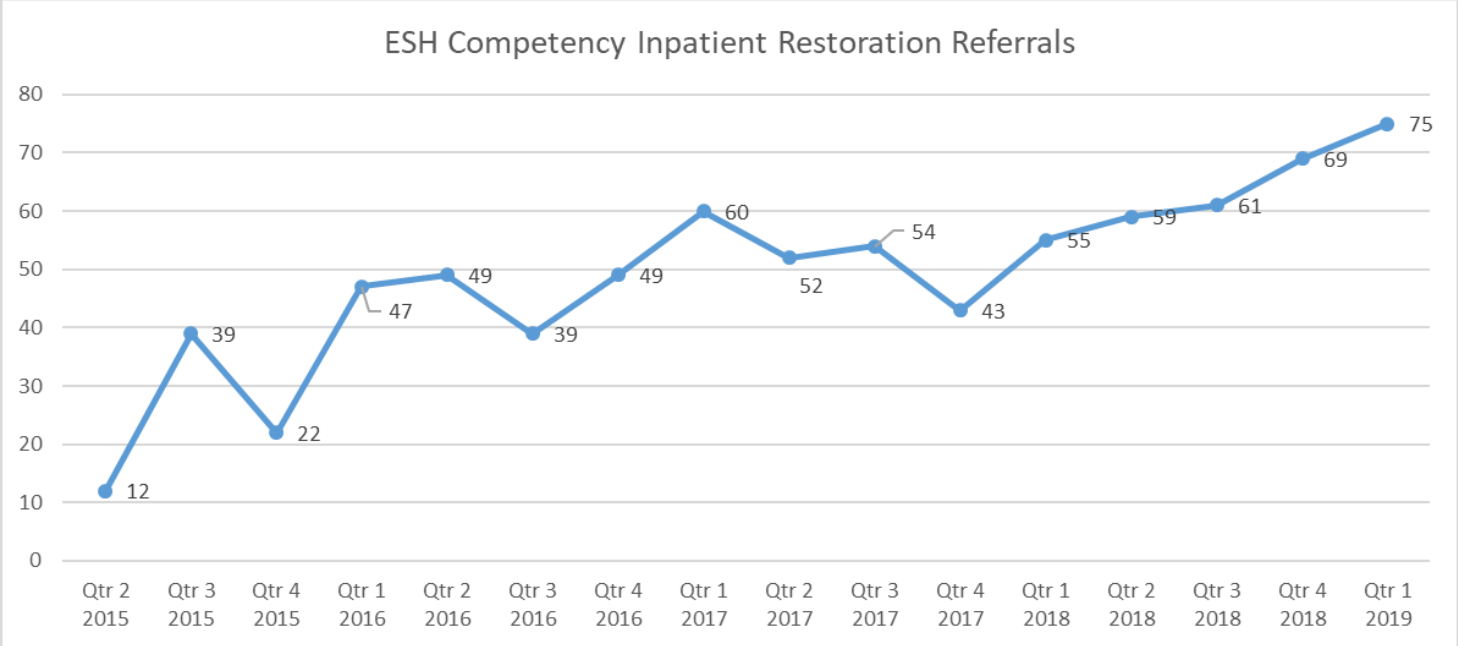
- **Figure 11.** This chart illustrates the combined total quarterly referrals for inpatient evaluations.
- ***Outcomes*:** During the reporting period, there was a decrease in total referrals for both hospitals combined as compared with the previous quarter.
- ***Drivers*:** As contemplated in Figures 9 and 10, it appears as though an apparent preference by the courts and defense counsel, as it pertained to patient evaluations, to have the vast majority of evaluations completed in jail as opposed to inpatient, may have continued in Q1 2019.

Figure 12: shows total WSH referrals for inpatient restoration



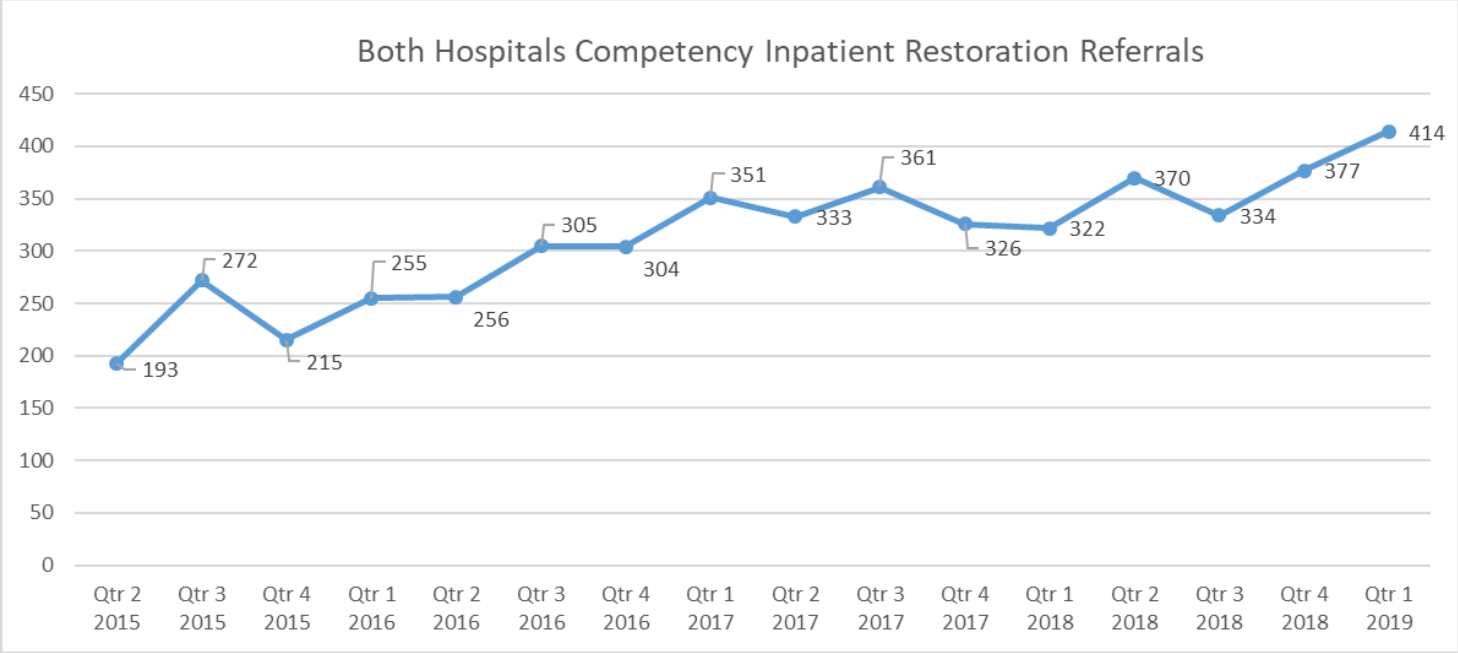
- **Figure 12.** This chart illustrates WSH total quarterly referrals for inpatient restorations.
- ***Outcomes*:** During the reporting period, WSH hospital saw an increase in referrals from the previous quarter, trending back toward record referrals. **The 339 referrals recorded in Q1 2019 is the highest yet recorded.**
- ***Drivers*:** Having seen a sharp increase in referrals since the *Trueblood* decision, the relatively flat number of referrals over the previous ten quarters suggested that supply (bed capacity) had a leveling effect on demand (referrals). However, the referral numbers are clearly on the rise again, as indicated by Q1 2019 numbers.

Figure 13: shows total ESH referrals for inpatient restoration



- **Figure 13.** This chart illustrates ESH total quarterly referrals for inpatient restorations.
- ***Outcomes*:** During the reporting period, ESH again saw an increase in referrals from the previous quarter, **and marked the highest number of referrals since reporting began**.
- ***Drivers*:** Despite slight quarterly decreases in evaluation referrals (see Figures 7 & 10), the relatively static numbers appear to again be a driver in an increased number of restoration referrals.

Figure 14: shows total WSH and ESH combined referrals for inpatient restorations



- **Figure 14.** This chart illustrates the combined total quarterly referrals for inpatient restorations.
- ***Outcomes*:** During the reporting period, the two hospitals saw an increase in restoration referrals from the previous quarter **and is the highest number of combined referrals yet recorded**. The 2018 quarterly average was 346. The 2017 quarterly data (342.75 quarterly average), and the 2016 quarterly data (280 quarterly average) illustrate that, while relatively flat over the past two years, year-over-year numbers continue to climb, and are significantly higher than was seen in 2016.
- ***Drivers*:** The overall trend of a spike in Q1 2019, after relatively flat restoration referral numbers over the previous two years seems to echo what has been seen throughout this report; that after appearing to reach a plateau, restoration referral numbers are again on the rise.

ACTIONS TAKEN

DSHS submitted a Long-Term Plan to the Court in July, 2015 which outlines DSHS' plans for coming into compliance with the timelines established in the *Trueblood* decision. On February 8, 2016, the Court issued an order modifying the original April 2, 2015 order, providing a new timeline requiring full compliance as of May 27, 2016. Pursuant to the Court's February 8, 2016 order, DSHS revised the Long-Term Plan and submitted this plan to the Court on May 6, 2016. The Long-Term Plan can be found here:

https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2016Trueblood/Combined-Long-Term-Plan-2016-05-06.pdf

The Office of Forensic Mental Health Services (OFMHS) is responsible for the leadership and management of Washington's forensic mental health care system, and is addressing the increase in demand for mental health services for adults and youth in the criminal justice system. The OFMHS provides forensic evaluations, competency restoration, Not Guilty by Reason of Insanity (NGRI) treatment services, and liaison services to effectively coordinate efforts with system partners to meet shared goals. The OFMHS additionally provides ongoing training and technical assistance to improve quality and timeliness of: forensic mental health services; data management and resource allocation; training and certification of evaluators; quality monitoring and reporting. The OFMHS works in collaboration with the Governor's office to lead and implement robust diversion efforts to prevent citizens with mental illness from entering the criminal justice system. Significant public resources have been invested in providing the high quality and empirically supported services of OFMHS. Two major goals for OFMHS during this period were to (1) best-utilize current bed capacity, (2) gain efficiencies in the process of evaluation delivery, and (3) prosecutorial diversion programs and implementation of five RFP's using *Trueblood* fines.

Below are the key actions that occurred during this period to decrease wait times.

1. **Best-Utilize Current Bed Capacity**

   During this period, a focus on keeping beds full at all facilities (ESH, WSH, Maple Lane, and Yakima) was a continued key strategy.

   A needs projection and bed capacity study was completed during Q4 2018 with TriWest Group, a consultancy organization, to determine the feasibility of and timeframe for compliance with court orders. The impact of community based competency evaluation on the demand for inpatient competency evaluation and restoration beds were measured by TriWest Group. Results of this study were unable to identify any correlation (e.g. homelessness, arrest rates, etc.) to the increases in referrals.

   The Community Liaison and Diversion Specialist continues OFMHS efforts in reducing demand for beds by working with community stakeholders to find and utilize available resources outside the criminal court system that will meet the needs of this population while fulfilling OFMHS requirements under *Trueblood.*

Triage services have continued in an effort to identify individuals for whom expedited admissions may be appropriate. To date this program, called TCEA (Triage Consultation and Expedited Admissions), has identified and accepted requests for 197 individuals for expedited admissions, out of a total of 307 individual referrals.

Work will need to be undertaken to continue increasing capacity and reducing demand. Actions are anticipated to take place in the next reporting period to address these challenges, and will be included in the next report.

2. Gain Efficiencies in Process of Evaluation Delivery

During the period 2015 – 2017, 21 evaluators were added to current staff levels. Additionally, relationships with community evaluation services providers were established, allowing for panel evaluations to be done by counties and individual service providers to perform evaluations and bill DSHS/OFMHS directly. These relationships have improved evaluation completion times in many instances, despite the ever-increasing demand.

Additional efforts have also been made in the area of workforce development. Specifically, staff evaluators were offered training, with national experts in the field of competency evaluations, as a part of ongoing efforts to create and maintain the most highly trained and efficient staffing possible. Furthermore, use of tele-video services for evaluations continue, with more than 35 of these evaluations having been conducted during the pilot phase of the program.

3. Fund Prosecutorial Diversion Programs & RFP's Using *Trueblood* Fines

During this reporting period, three State prosecutorial diversion pilot programs were funded. These programs allow a prosecutor to use their discretion to dismiss a non-serious charge without prejudice if the issue of competency is raised. The intent of these programs is to divert misdemeanor and low-level felony defendants from incarceration and hospitalization, into needed behavioral health treatment.

Additionally, 13 *Trueblood*-Fine funded programs were awarded funding that began July 1, 2017 include: King County (BHO); Sunrise Services, Inc.; Comprehensive Health Care; Great Rivers (BHO); Kitsap Mental Health Services. Three more programs were awarded funding that began operations in March, 2018 (Catholic Charities, Pierce County, and Thurston-Mason Behavioral Health Organization. These are in addition to state-funded diversion pilot programs; these include: Pacific County (program focused on misdemeanors, began September, 2016); Spokane County (program focused on those with misdemeanor and low-level felonies, began October, 2016); Greater Columbia (program focused on misdemeanors, began November, 2016); and King County (program focused on misdemeanors and low-level felonies, began January, 2017).

NEXT STEPS

Future reports will provide continued progress reporting, with a focus on efforts made in four main areas as it relates to compliance: (1) expanding and best-utilizing bed capacity, (2) increasing throughput for inpatient services, (3) managing in-custody evaluations to reduce barriers so compliance can be reached, and (4) decreasing demand for competency services.

A key area for OFMHS work is to identify and develop, with community stakeholders, programs to reduce the demand of competency services in addition to working with these entities to identify and address the root causes for the continued increases in competency evaluation and restoration referrals.

Additionally, OFMHS has taken steps to create specific standards and expectations for staff evaluators, in adherence with our principals of being the most well-trained and efficient staff possible.

Lastly, the agreed contempt settlement, approved by the court in August, 2018, has given rise to an implementation plan that was preliminarily approved by the court in March, 2019 and will be finalized in June, 2019. OFMHS continues to work with the court and Plaintiffs in a concerted effort to bring components of the settlement to fruition so as to better-serve *Trueblood* class members and all individuals placed in the custody of DSHS for forensic services.

SUMMARY

The Department and OFMHS continue to work on what impacts can be made on these four levers: 1) increase, and best-utilize, bed capacity, 2) increase throughput for inpatient services (quicker turnover in hospitals), 3) manage in-custody evaluations to reduce barriers so compliance can be reached, and 4) decrease demand for competency services.

Ensuring that every bed is best-utilized to meet requirements under *Trueblood*, by maintaining efficient referral and admission practices, is a major key to DSHS/OFMHS work toward achieving compliance.

Continued triage and diversion efforts will also facilitate and improve these efforts by managing the inpatient portion of *Trueblood* class members, while also finding acceptable alternatives for those class members deemed suitable for these alternative options.

With the settlement agreement in place, OFMHS will continue to work with its partners (Health Care Authority, Criminal Justice Training Commission, and others) to implement and administer new programs that, it is hoped, will finally turn the tide and solve the problems that gave rise to the *Trueblood* case to begin with.