The Honorable MARSHA J. PECHMAN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

TRUEBLOOD *et al*., Plaintiffs, v. WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES *et al*., Defendants.	NO. C14-1178 MJP DEFENDANTS' REVISED LONG-TERM PLAN

As ordered in the Court's February 8th Order (Dkt. #186), with the due date extended to May 6, 2016 by the minute order entered April 19, 2016 (Dkt. #221), the Department of Social and Health Services respectfully submits its revised long-term plan.

RESPECTFULLY SUBMITTED this 6th day of May 2016.

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Trueblood, et al., v. Washington State Department of Social and Health Services, et al.
Case No. C14-1178 MJP
REVISED LONG-TERM PLAN

May 6, 2016

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EXECUTIVE SUMMARY

This report revises the long-term plan submitted to the United States District Court for the Western District of Washington at Seattle (the Court) on July 2, 2015 in compliance with an order by the Court in the class action lawsuit *Trueblood et al. v. DSHS et al.*, Case No. C14-1178 MJP ("*Trueblood*"). On April 2, 2015, the Court issued Findings of Fact and Conclusions of Law that required the Department of Social and Health Service (DSHS) to, among other things, deliver a "long-term plan" by July 2, 2015. The plan was required to describe not only how DSHS would provide competency evaluation and restoration treatment services (hereafter referred to as "competency services") within seven days of signing of a court order; but how DSHS would also provide competency services within the seven-day standard as demand for services grow.

On December 30, 2015, DSHS filed a motion to modify the Court's injunction, seeking an extension of the deadline to May 27, 2016. On February 8, 2016, the Court issued an Order granting the motion for an extension with certain additional requirements and benchmarks leading up to May 27, 2016. One of these requirements was for DSHS to draft and submit a revised long-term plan to the Court Monitor by March 15, 2016. In doing so the Court clarified:

> "*The revised plan should take into account the actions to date and should include all actions being planned to achieve compliance by May 27, 2016. The revised plan should address DSHS's plan for how it will continue to provide services within seven days into the future as demand grows at a rate of eight to ten percent per year, whether it be through expanded diversion efforts or other means. The revised plan should address Senate Bill 5177 implementation plans, including incentives to promote participation by counties, and should address the plan for returning the beds opened at Yakima and Maple Lane to the accredited clinical setting of the state hospitals. The revised plan should also include plans for evaluating performance in the provision of competency services across the various settings and facilities.*"

This revised long-term plan addresses each of the following points:

1. recounts actions to date and their impact on DSHS's planning, along with all actions being planned to achieve compliance by May 27, 2016;
2. addresses plans to continue to meet demand with 8-10% annual growth and the means for doing so;
3. addresses Senate Bill (SB) 5177 implementation plans, including incentives to promote participation by counties;
4. addresses the plan for returning the beds opened at Yakima and Maple Lane to the state hospitals; and
5. addresses plans for evaluating performance in the provision of competency services.

As noted in the July 2, 2015 Long-Term Plan, DSHS, with the support of Governor Jay Inslee and the Legislature, has taken substantial steps to improve competency services in Washington, including:

1. Increasing funds dedicated solely for forensic mental health services. An investment of over $40 million in Washington's forensic mental health system by the Legislature in the two-year

operating budget for the period of July 1, 2015 to June 30, 2017 (hereafter referred to as the 15-17 biennial budget) will yield a 40 percent increase in Forensic Evaluators and, a 65 percent increase in the number of beds available to provide competency restoration treatment. Table 1 details funding provided in the 15-17 biennial budget:

Table 1: Funding in the 2015-2017 Biennial Budget

Budget Item	FTE's	Dollars (Millions)
Competency Evaluation Staff	18.0	$ 4.67
Competency Restoration Beds	129.2	$26.86
Non-Felony Diversion	0.0	$ 4.81[1]
Office of Forensic Mental Health	11.0	$ 4.18
Total	**158.2**	**$40.52**

2. Enacting supporting legislation to, among other things, allow DSHS to conduct restoration services in the community as well as to compel prosecutors, defense counsel, court administrators as well as jails to expedite the exchange of information, access to defendants, and timely transport to state hospitals; and
3. Establishing the Office of Forensic Mental Health Services.

Appropriation of this funding was a key step toward increasing capacity for competency services. DSHS has since taken actions necessary to implement elements in the July 2, 2015 Long-term Plan. These actions are detailed in the Department's monthly reports to the Court Monitor as well as in the Court Monitor's two quarterly reports.

DSHS has faced challenges in meeting the seven-day standard for the provision of competency services, in particular the ability to hire sufficient staff to support these expansions while maintaining a safe and therapeutic hospital environment. The impacts of this challenge reached a critical point following surveys at Western State Hospital (WSH) from the Centers for Medicare and Medicaid Services (CMS) that ended November 5, 2015 with the issuance of six notices of immediate jeopardy. DSHS successfully abated the immediacy of the deficiencies on November 24, 2015 and continues to work with CMS to correct the underlying deficient conditions of participation. In response to this critical event at WSH, DSHS's Secretary Quigley made the decision to suspend planned expansion of a 30 bed forensic ward at WSH in order to resolve critical safety issues. In place of the ward at WSH, Secretary Quigley directed the short-term use of the Maple Lane facility for competency services.

[1] The 4.81M in the FY15-17 biennium budget was originally comprised of 2.8M in state funds and 2M in federal funds (Medicaid Match). Because the Department elected to distribute the state dollars in pilot projects, it was not able to draw down the federal match funds for this effort. This left the budget for this effort at 2.8M for the biennium. A portion of state funds was eliminated from the total due to underspending, leaving $1.7M as available to be allocated towards the pilot projects.

With the exception of the request to extend the compliance date to May 27, 2016 and the increase in the number of short-term restoration treatment beds in alternate facilities, DSHS' Long-term plan does not deviate from the original commitment to four key elements:

1. Increase the capacity and quality of competency evaluation;
2. Increase the bed capacity for competency restoration;
3. Create robust and reliable data systems, forecast future demand for services, and monitor program performance; and
4. Create opportunities to safely divert people with mental illness from arrest, prosecution or incarceration.

DSHS will continue to employ these strategies, which combined, create a long-term plan that will enable Washington to provide competency services as required by the court.

COMPETENCY SERVICES SYSTEM LONG-TERM PLAN

INTRODUCTION

Historically, Washington has operated a competency services program that has fallen short of expectations. The system in Washington has been characterized as having too few Forensic Evaluators, too few state hospital beds for timely restoration treatment, cumbersome communication across the criminal justice and forensic mental health systems, and inadequate data systems. Wait times for competency services have been too long. Table 2 shows the baseline bed capacity and number of forensic evaluators in Washington's competency services system as of April 2015.

Table 2: Current Forensic System Resources in Washington State

Site	April 2015 Capacity (Beds)	April 2015 Forensic Evaluator Positions (FTE)
Eastern State Hospital	22	6
Western State Hospital	116	24[2]
Total	138	30

Groundwork

Substantial steps have been taken to begin to correct the deficiencies in Washington's forensic mental health system and comply with the seven-day standard established in the *Trueblood* Order. These steps include:

1. Increasing Funding to Improve the Forensic Mental Health System
   The 15-17 biennial budget was enacted by the Legislature on June 29, 2015 and signed by Governor Jay Inslee on June 30, 2015. It includes $40.5 million in new funding to improve competency services. Table 3 shows only the increases in the 15-17 biennial budget for forensic evaluator and competency restoration bed capacity.

[2] The figure for WSH was stated in the original Long-Term Plan as 26.5, but this was corrected to 24 in our monthly reports.

Table 3: Increases in Forensic Evaluators and Competency Restoration Beds in 15-17 Biennial Budget

Site	April 2015 Forensic Evaluator Positions (FTE)	15-17 Biennial Budget Increase (FTE)	Total Forensic Evaluator Capacity (FTE)	% Increase (FTE)	$ Increase (Millions)	April 2015 Capacity (Beds)	15-17 Biennial Budget Increase (Beds)	Total Capacity (Beds)	% Increase (Beds)	$ Increase (Millions)
ESH	6	4	10	**83%**	$1.41	22	30	52	**136%**	$8.72
WSH	24[3]	9	33	**33%**	$2.25	116	15	131	**13%**	$4.44
Maple Lane	N/A	N/A	N/A	**N/A**	N/A	0	30	30	**N/A**	$9
Yakima	N/A	N/A	N/A	**N/A**	N/A	0	24	24	**N/A**	$6.7
Total	**30**	**13[4]**	**43**	**43%**	**$3.66**	**138**	**99[5]**	**237**	**72%**	**$28.86**

This significant investment in the forensic mental health system in Washington State includes, among other things:

- 13 additional forensic evaluators—**a 43 percent increase. As of May 1, 2016, all evaluator positions have been filled.**
- 90 additional beds for competency restoration treatment--**a 65 percent increase.** DSHS is operating 42 of these beds at Western State Hospital and Eastern State Hospital as of April 2016. Additionally, the 24-bed Yakima Facility accepted its first patient on March 15, 2016 and as of May 6th, has 8 patients. Two patients already graduated from the Yakima program, and two more have been found competent as of May 5th. Thirty beds opened at Maple Lane on April 18th, and the facility has nine patients (6 females, 3 males) as of May 6th.
- $4.8 million dollars to finance community-based treatment for people who are diverted from prosecution when their competence to stand trial has been raised but diversion to treatment is more appropriate. Further information on the distribution of these funds is provided below.

2. <u>Enacting Supporting Legislation (Senate Bill 5177)</u>

As outlined in the Court's decision, DSHS is responsible to provide competency services but cannot, by itself, assure compliance with the seven-day standard required in the *Trueblood* order. DSHS is part of a larger system. As the Court's order stated, "Even with more funding and changes to the practices and policies of the Department, Washington's forensic mental health system cannot function efficiently without the help of all of its participants."

In response to this need the Washington State Legislature passed Senate Bill 5177[6] on May 28,

[3] See footnote 1.

[4] This figure does not include five Full Time Equivalents (FTE) for supervisory and administrative support that also are funded in the 15-17 biennial budget

[5] The development of Maple Lane and Yakima has created potential for up to 99 total new beds, compared with the original plan of 90 new beds. We will continue to evaluate the funding and the need for the additional 9 beds.

2015 and Governor Jay Inslee signed the bill into law on June 10, 2015. This legislation supports critical efforts needed to improve the competency service system in general and, more specifically, to successfully meet the seven-day standard for the delivery of competency services.

Key provisions of SB5177 include:

a. *Timely Access to Competency Services*
Every day is critical in meeting a seven-day standard for timely access to competency services. This legislation defines responsibilities for key system partners whose commitment is vital to achieving this goal. The responsibilities include:

i. Transmission of Required Documentation
Within 24-hours of the signing of the court order the following system partners must provide to the state hospital:
- The court clerk must provide the court order and charging documents, including the request for bail and certification of probable cause;
- The prosecuting attorney must provide the discovery packet, including a statement of the defendant's criminal history; and
- The jail administrator must provide the defendant's medical clearance information if the court order requires transportation of the defendant to a state hospital.

ii. Timely Transport of Defendants
Jails must transport a defendant to a state hospital or other secure facility within one day of receiving an offer of admission by DSHS for competency services.

iii. Timely Access to Defendants
Jails must cooperate with DSHS to arrange for evaluators to have timely access to defendants and appropriate space to perform evaluations.

We will continue to work with the court system to improve and streamline these processes.

b. *Standardized Court Orders*--By December 31, 2015, the Administrative Office of the Courts must work with DSHS, the Office of the Attorney General, prosecuting and defense attorneys, counties, Disability Rights Washington, and tribal and community mental health groups to standardize court orders used for competency services. Standardizing court orders will increase system consistency and streamline admissions processes to help ensure the seven-day standard is met. A follow up memo pursuant to the February 8, 2016 court order was addressed on February 26, 2016 to judges, commissioners, county clerks, and court administrators, encouraging parties to utilize the standardized court orders.

[6] The new public law can be found at: (http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/Senate/5177-S2.SL.pdf)

c. *Video Testimony*--The Administrative Office of the Courts must convene a work group composed of representatives of the courts, DSHS, the Office of the Attorney General, prosecuting and defense attorneys, counties, and Disability Rights Washington to consider and facilitate the use of video testimony by state forensic evaluators in court matters involving the forensic mental health system, and present their findings by June 30, 2016. The availability of video testimony will reduce delays caused by unavailability of witnesses and reduce public safety concerns regarding transporting witnesses. The workgroup is on target for providing recommendations to the Court by the June deadline.

d. *Alternative Sites for Competency Restoration Treatment*--There have historically been no alternatives to competency restoration treatment provided in the state hospitals. DSHS is authorized by statute to develop alternative locations and increase access to competency restoration treatment services for individuals who do not require inpatient psychiatric hospital services. DSHS is directed to work with counties and the court to develop a screening process to determine which individuals can safely receive competency restoration treatment outside the state hospitals. Opening new locations for competency restoration treatment can ease the current burden on the state hospitals and free space for in-custody individuals awaiting competency services.

3. Establishing the Office of Forensic Mental Health Services

In 2014, DSHS contracted with Groundswell Services, a consortium of national experts in forensic mental health services, to recommend ways to improve Washington's forensic mental health system. One of the recommendations was to establish a centralized Office of Forensic Mental Health Services to "oversee all forensic evaluation services, assist hospitals and community agencies in implementing best-practice forensic treatment, and liaise across systems to ensure a strategic, integrated approach to the forensic population." [7] Senate Bill 5177 establishes the Office of Forensic Mental Health Services within DSHS.

DSHS is moving forward to establish this new office as the cornerstone for increased accountability, quality, and efficiency in the state's forensic mental health system. With the passage of the 15-17 biennial budget, new positions including a Director for the Office of Forensic Mental Health Services (filled as of 5/4/16); a Competency Restoration Specialist (filled as of 9/1/15); two Workforce Development Specialists (filled as of 4/18/16); and a Liaison and Diversion Specialist (filled as of 9/1/15)—were established. Progress updates regarding the establishment of the new Office of Forensic Mental Health Services are included in monthly reports to the Court Monitor.

In addition to the Office of Forensic Mental Health Services, a Project Manager was hired on

[7] Groundswell Services, Inc. (W. Neil Gowensmith, Daniel C. Murrie, and Ira K. Packer), "Forensic Mental Health Consultant Review – Final Report", Prepared for the State of Washington's Department of Social and Health Services in response to contract #1334-91698 (June 30, 2014) at p. 1 (hereinafter, "Groundswell Report"); Trial Exhibit No. 35.

10/26/15 and a Compliance Reporting Specialist was hired on 10/16/15 to assist in reaching compliance with the *Trueblood* decision. Our Reporting Specialist vacated his position on 4/29/16, and our new hire will begin on 5/9/16. A Web Developer and a Business Analyst were hired on 11/16/15 to assist with the development of a Forensic IT System. A Forecast Analyst was hired and will start on 5/16/16, and a candidate for the Data Manager position has been offered the position.

Guiding Principles for Long-Term Plan Development and Implementation

Four key principles continue to guide development of this long-term plan and implementation of future improvements.

1. *Competency services will be provided promptly and efficiently*
   Washington will meet the timelines and other requirements set forth in the Trueblood order.

2. *Changes implemented will maintain or improve the quality of competency treatment services*
   Washington will create a system to improve the quality of competency services so timeliness is not gained at the expense of quality.

3. *Cross-system collaboration is required to ensure the system achieves desired outcomes*
   The ability to improve Washington's forensic mental health system and to meet the seven-day standard for providing competency services is dependent on the commitment and active collaboration of all system partners including judges, court clerks, prosecutors, defense attorneys, law enforcement, jail managers and others.

4. *Long-term planning to meet Trueblood requirements must be innovative and dynamic*
   This report provides a broad long-term plan for improving competency services and meeting the requirements of *Trueblood*. Although the plan is based on careful analysis of available recent history and projections of future trends, DSHS acknowledges that data integrity and analysis must improve to better inform policy and practice. The system must remain flexible enough to benefit from new or emerging data and experience.

Elements of the Long-Term Plan

Guided by the principles above and building upon the actions already taken by funding and policy changes enacted by the Washington State Legislature, DSHS' long-term plan includes four key elements. Each element will be discussed in detail in subsequent sections of this report.

1. Increase evaluation capacity and improve quality, both in terms of additional evaluators and improved and more timely access to defendants to conduct evaluations;

2. Expand bed capacity for competency restoration treatment, inside and outside the state hospitals;

3. Develop more robust and reliable data systems to better forecast demand for services and monitor program performance; and

4. Create opportunities to safely divert people with mental illness from arrest, prosecution or incarceration.

In this amended Long-term Plan, information has been updated where appropriate, and discussions of progress along with next steps are added to the end of each section.

ELEMENT 1: INCREASE COMPETENCY EVALUATION CAPACITY AND QUALITY

Washington's primary strategy for expediting access to competency evaluations is focused on adding qualified evaluation personnel based on forecasted demand. DSHS also is making several process improvements to increase system efficiency, including:

- More timely access to evaluations by out stationing staff;
- Increase quality through improved training;
- Improve collaboration among system partners;
- Improve clinical placements by developing a triage system; and
- Increase evaluator productivity via internal process improvements.

Competency Evaluation Capacity – Background

DSHS currently operates competency evaluation services out of its two state psychiatric hospitals, Western State Hospital (WSH) and Eastern State Hospital (ESH), and the North Regional Office (a satellite office of WSH in downtown Seattle). The satellite office is primarily dedicated to serving the greater Seattle metro area and Snohomish, Whatcom and Skagit Counties.

When submitting our original Long-term plan, WSH had 24 forensic evaluator positions, including seven and a half at the North Regional Office (NRO).[8] These evaluators were responsible for all competency to stand trial evaluations in Western Washington. Each WSH evaluator was expected to conduct 11 evaluations per month.[9] ESH had six forensic evaluator positions that were responsible for all evaluations in the 20 counties on the east side of the Cascades. Each ESH evaluator was expected to conduct nine evaluations per month.

Pursuant to additional funding in the Biennial Budget, WSH now has an additional nine evaluator positions, for a total of 33 FTEs. All of these positions have been filled. Nine evaluators are stationed at NRO, one is stationed at the SCORE facility in King County, and one in Snohomish County. ESH now has 10 budgeted Forensic Evaluator FTEs, all of which have been hired. In total, the hospitals have filled 43 out of 43 Forensic Evaluator FTEs.

Nearly 70 percent of evaluations are conducted in jails; however, a small percentage of defendants are ordered to either WSH or ESH for evaluations. In 2013, WSH completed approximately 170 inpatient evaluations, while ESH completed 36. From April 1, 2015 to March 31, 2016, WSH completed approximately 2,351 jail-based evaluations and 158 in-patient evaluations, while ESH completed approximately 471 jail-based evaluations and 72 in-patient evaluations.

[8] See footnote 1.

[9] A baseline target of 12 evaluations per month is adjusted for leave and results in an average target of 11 per month.

Additionally, Washington state counties can contract with private evaluators in certain circumstances[10] and be reimbursed for those costs by DSHS. Pierce County contracts with local evaluators to conduct evaluations outside the state hospital system. In 2014, Pierce County evaluators completed 243 evaluations in the Pierce County Jail. No other counties have pursued this option despite encouragement by DSHS.

In February 2016, a meeting invite was sent to the five counties that were interested. Two counties declined participation due to no longer needing the service and three did not respond. DSHS will move forward with creating standardized reporting requirements, as one of our goals is to ensure consistent data measures and standards between panel evaluations and state-performed evaluations. DSHS continues to post the list of eligible counties every quarter on the DSHS website.

Demand for competency evaluation services has grown steadily over the past several years, roughly 8 percent per year since 2001. To keep pace with future demand for competency evaluation DSHS plans that it will:

a. *Increase the Number of Forensic Evaluators*
Additional funding provided in the 15-17 biennial budget enacted in June 2015 will increase the number of forensic evaluators by 43 percent from 30 to 43 and the ability to provide more timely evaluations.

Table 4: Forensic Evaluator Funding in the 15-17 Biennial Budget

Site	April 2015 Forensic Evaluator Positions (FTE)	15-17 Biennial Budget Increase (FTE)	Total Forensic Evaluator Capacity (FTE)	% Increase (FTE)	$ Increase (Millions)
ESH	6	5	11	**83%**	$1,407,786
WSH	24[11]	8	32	**33%**	$2,252,457
Total	**30**	**13**	**43**	**43%**	**$3,660,243**

To improve recruitment efforts, DSHS negotiated a 15 percent pay increase for forensic evaluators. DSHS began recruiting for 13 new positions in May 2015 and began filling these positions in July 2015. Newly hired forensic evaluators began providing competency evaluations as promptly as practical thereafter, based on training and orientation requirements. As of May 6, 2016 DSHS has hired all of the additional Forensic Evaluator positions funded in the 2015-2017 biennial budget. Early results are showing the impact of these additional resources.

In-Jail Evaluation timeliness has improved at both hospitals:

- Median days from order to completion has decreased

[10] This may apply if the department did not meet the performance target for timely completion of competency evaluations under RCW 10.77.068 during the most recent quarter in 50% of cases submitted by the referring county.
[11] See footnote 4.

        - WSH: 14 days in April 2015 to 7 days in March 2016
        - ESH: 57 days in April 2015 to 10 days in March 2016
    - Average days from order to completion has decreased
        - WSH: 14.6 days in April 2015 to 8.9 days in March 2016
        - ESH: 61.3 days in April 2015 to 12.6 days in March 2016
    - Percentage of completions within 7 days has increased
        - WSH: 14% in April 2015 to 59% in March 2016
        - ESH: 0% in April 2015 to 16% in February 2016

b. *Out Station Evaluators*

DSHS intends to out station forensic evaluators in locations with enough demand to support an out station site. Based on data from April 2014 to March 2015, there is enough demand to support out station sites in Everett, Vancouver and the Tri-Cities. This places forensic evaluators closer to the service area, reducing travel time and delays in evaluation services.

As of March 1, 2016, evaluator out stations have been implemented to include:

- Snohomish County Jail in Everett
- SCORE facility in King County
- Vancouver, WA

The department has identified an evaluator willing to be out stationed in the Tri-Cities areas. The Kennewick outstation will begin operation by Summer 2016.

The department has found success in meeting the seven-day time frame in some counties by stationing evaluators at set times in jail. This model has been implemented in Lewis, Kitsap, Yakima, Thurston, and Benton and Franklin counties. Part of the success of this "shared calendar" is due to:

- a dedicated room at the jail has been secured to accommodate all parties;
- defenders are able to choose evaluation times based on available "slots" and secure interpreters, if needed, as soon as possible;
- there is an evaluator always available during those allotted times

Moving forward, in future hiring for evaluators at both hospitals, we will take into consideration the candidates' ability and willingness to work at sites that have been identified to have sufficient volume to support an outstation.

c. Improve Training and Quality Assurance

Judges rely heavily on the opinions of forensic evaluators to determine a defendant's competency to stand trial. It is incumbent on DSHS to maintain high quality standards for evaluations as capacity to conduct evaluations increases. Performing evaluations is not standard focus in doctoral training for psychologists and psychiatrists. DSHS has a training system in place for forensic evaluators that involves pairing new evaluators with experienced evaluators for several months of mentorship.

DSHS is developing an improved training model to assure that evaluators are offered the tools and knowledge needed to provide consistent and high quality competency evaluations. The training will cover broad conceptual issues related to competency and the "nuts and bolts" of conducting evaluations, such as how to obtain access to critical documents and access to correctional facilities. It will include presentations from forensic system partners, such as the judiciary. DSHS will consult national experts in competency assessment to assist in designing and delivering the training so it is consistent with national best practices. The Office of Forensic Mental Health Services is also developing a comprehensive online training repository that will be available to all forensic evaluators. Until the Department's new training program is available, an interim training model will provide a compressed version of the didactics currently used in WSH's year-long forensic fellowship training program. Quality assessments of systematic enhancements will be made on an ongoing basis.

d. *Improve System Collaboration*

Compliance with a seven-day standard for competency services requires cross-systems commitment and collaboration. Competency services are provided in a larger context that includes courts, prosecutors, defense counsel, jails, law enforcement, and mental health providers. DSHS will take an active role in strengthening collaboration among these system partners.

The successful implementation of SB 5177 legislation is a required to meet the seven-day standard for the provision of competency evaluations. DSHS and the Office of the Governor convened a meeting of representatives from each system partner--prosecutors, defenders, jails, administrator of the courts, and the tribes on July 10, 2015 to begin discussions and implement these collaborative efforts. Progress reports on implementation will be included in the monthly reports to the Court Monitor.

DSHS will lead trainings for forensic system partners involved with evaluation-related issues to foster required collaboration. One indirect impact of the *Trueblood* decision is that attorneys may be more likely to request an evaluation in order to explore mental health or mitigating issues generally, rather than competency specifically, given the promise of a quick conclusion. Many other states provide such education to the judiciary about the nature and circumstances of effective referrals for evaluations. Such training tends to reduce unnecessary demand on system resources, increase reasonable referrals, and help jurisdictions best allocate resources to the defendants who need them most. Doctors Luxton and Zolnikov joined the Office of Forensic Mental Health on April 18, 2016. They are developing a survey to engage stakeholders in a process to determine training topics and processes that would be most beneficial. Based on the information gathered in this survey they will develop curriculum, establish and distribute a schedule, and conduct partner trainings. Updates on the progress for this work will be included in monthly reports to the Court Monitor.

DSHS has been and will continue to work closely with courts, jails, interpreters and attorneys to develop a system to decrease scheduling delays in those cases requiring an interpreter or in which a defense attorney has requested to be present during the evaluation interview. To meet a seven-day standard, scheduling of all parties needs to occur within 48 to 72 hours of the signing of the court order.

A Liaison/Diversion specialist was hired effective September 1, 2015. The following activities have been accomplished since that position came on-line:

- Collaboration meetings have occurred with Forensic Mental Health System partners in Snohomish, Cowlitz, Yakima, Spokane, King, Clark, Pierce, Chelan, Kitsap, Pacific, Lewis, Benton/Franklin counties.
- Presentations regarding actions underway to comply with Trueblood were made at the Washington Association of Sheriffs and Police Chiefs (WASPC) conference in November 2015 and May 2016.
- Funding opportunity was released to support 1.4 million dollars in pilot diversion projects throughout the state.

The Washington Administrative Office of the Courts issued revised forms related to Forensic Evaluation and Competency Restoration Orders in December 2015 in accordance with SB5177 legislation.

e. *Develop Triage Models*

It is important to develop a system to place the right people in the right settings for competency services. Competency evaluations can be used to identify mentally ill inmates who require treatment and, in more severe cases, defendants who require inpatient psychiatric hospitalization. A triage protocol can prescreen individuals in jail who have been referred for competency evaluation, identify those who are acutely mentally ill and would benefit from hospitalization, and then ensure admission to a hospital for treatment as quickly as possible. Effective triage, therefore, benefits not only the defendants but also the availability of scarce inpatient restoration treatment services.

Appendix A includes detailed information about the various models that we have evaluated.

In compliance with the February 8, 2016 Modification Order, the Department developed a plan to Triage class members awaiting evaluation and admission to a forensic bed. Details regarding this plan were submitted to the Court Monitor and will be implemented as of March 15, 2016. Progress updates regarding the implementation of the triage model will be included in the monthly reports to the Court Monitor.

f. *Streamline In-custody Evaluation Processes*

DSHS conducted a Lean process to develop recommendations for streamlining the in-custody forensic evaluation process. Several of these recommendations can be managed internally within DSHS given the recently approved budgetary resources, including:

- Removing administrative duties from forensic evaluators by adding support staff;

- Increasing capacity for transcription services; and
- Modifying the assignment process, so that patients can be assigned to the same evaluator on subsequent admissions.

Lean processes have resulted in the implementation of changes to streamline the evaluation processes. These include:

- Addition of support staff
- Testing and deployment of technological solutions such as transcription pedals, mobile technology and encrypted digital voice recorders are in the process of training and implementation
- Coordination efforts with counties are exploring the use of telephonic solutions for evaluation and testimony

g. *Videoconferencing*

The Department identified two sites as locations for videoconferencing pilots. Benton and Yakima were identified because they had relatively large referral numbers on the eastside of the state, which is where the ability to do evaluations remotely would be of most benefit.

- Yakima – An initial Jabber connection test failed. Yakima County Jail firewall prevents DSHS from accessing their system. Neither Yakima nor DSHS is able to change their security policies to allow for the access. DSHS is going to suggest Webex as an alternative and a test is being arranged.
- Benton County Jail – Jail management are in the process of replacing their firewall, and have another 4-5 weeks before addressing external video conferencing (VCS-E).

The Department sought a list from WASPC of jails with videoconferencing capability. However, they do not have a comprehensive list. Therefore we continue to address this with each county as cross-system meetings are convened. During the WASPC conference in November 2015 jail administrators with videoconferencing infrastructure were asked to contact the Department so that we could coordinate and test solutions. DSHS has been working with multiple jails statewide on testing the capability of each jurisdiction to connect via video conference. DSHS will continue to work with counties and jails to create efficiencies in this area. This will include a system-wide assessment of video-conferencing technology infrastructure and capabilities.

In addition, Dr. Luxton brings experience in the area of videoconferencing and telemedicine technologies. He is currently in the process of conducting a systematic needs assessment, technical infrastructure assessment, developing training on the use of videoconferencing for forensic assessment and establishing effective data collection for quality assessment. Progress updates regarding this work will be included in future monthly reports to the Court Monitor.

ELEMENT 2: EXPAND BED CAPACITY FOR COMPETENCY RESTORATION TREATMENT

Washington's strategy for expanding restoration capacity is based on review of historical data to estimate the number of beds needed in the future. Three different scenarios of potential bed need were forecasted through January 2019 based on varying estimates of increased demand for competency services. DSHS' primary strategy to improve the timeliness of competency restoration treatment is to expand the number of available competency restoration beds at Western and Eastern State Hospitals.

However, given the significant expansion capacity required for compliance with a seven day standard as quickly as is practicable, DSHS formally sought information from private contractors regarding their capacity to provide up to 30 additional beds for competency restoration treatment outside the state hospitals. This is a "stop gap" strategy to assure that the state has enough restoration capacity in the shorter-term while the state develops additional resources at state facilities to address longer-term needs.

DSHS has continued to pursue these objectives regarding increased restoration capacity set out in the original Long-term Plan. However, it has faced unique challenges in this area to expand capacity while also maintaining a safe hospital environment. DSHS continues to predict that 90 additional beds are needed to meet current needs and anticipated growth in coming years. However, it has determined to delay the planned opening of a 30 bed ward at WSH in order to address safety and quality care improvements. In the meantime this bed capacity will be provided in residential treatment facilities in Maple Lane and Yakima.

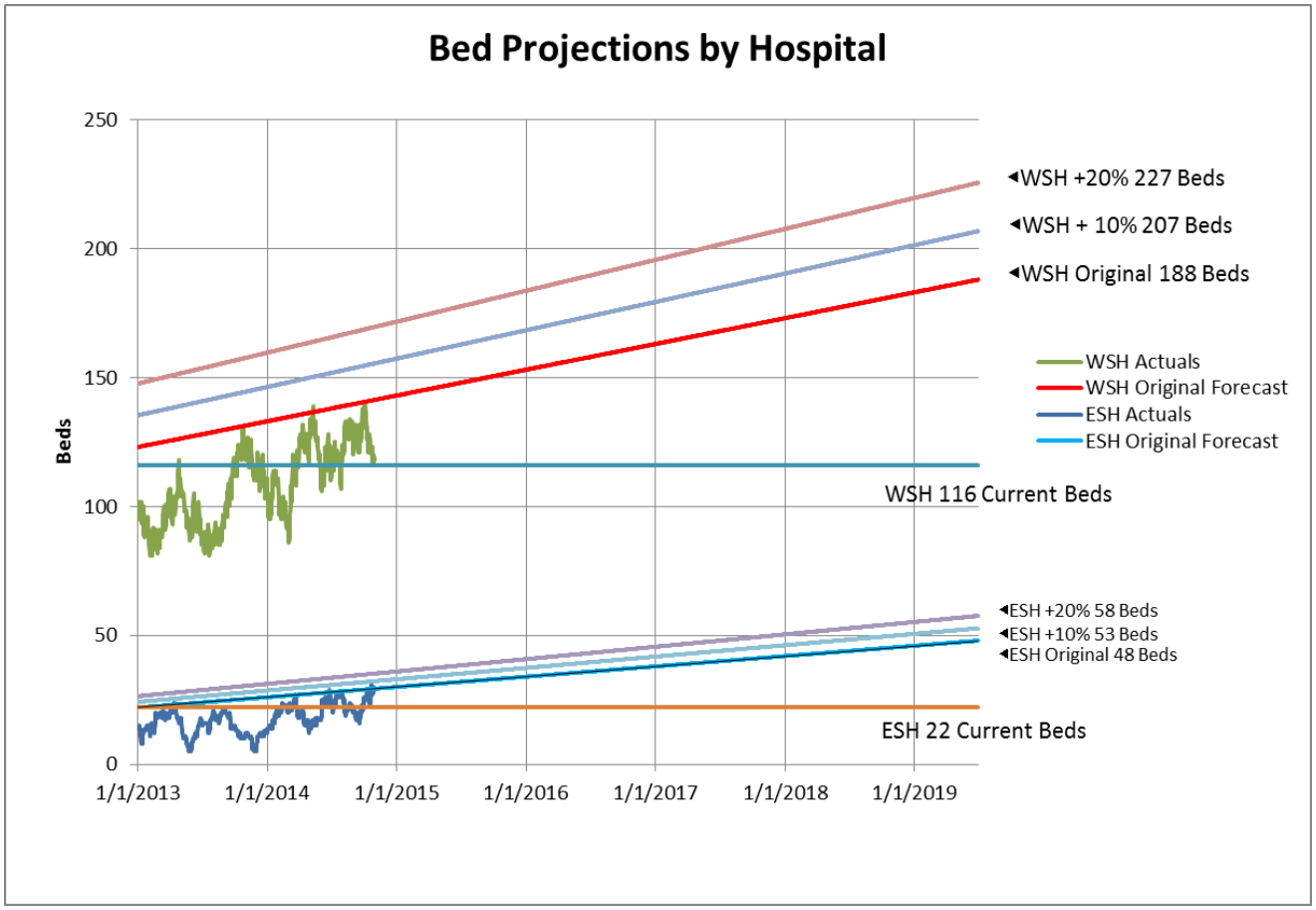
Competency Restoration Treatment Capacity--Background

DSHS provides nearly all of its competency restoration treatment services at either WSH or ESH. Washington's legal process related to forensic services is outlined in Appendices B-C. Prior to the Trueblood related expansion, WSH operated approximately 120 competency restoration treatment beds[12] and ESH operated approximately 20 beds. In 2013 WSH admitted approximately 650 persons for restoration treatment, nearly double the number of admissions in 2011. ESH admitted 92 persons for restoration in 2013. From April 1, 2015 to March 31, 2016, WSH completed 785 restoration referrals and ESH completed 112. Most of the defendants admitted to WSH and ESH for competency restoration treatment are restored to competency and discharged within about 60 days.

Projections for the Future

Fiscal and program staff from DSHS and the Washington State Office of Financial Management modeled additional bed capacity needed to meet a seven-day standard for admission with assumptions of increases in demand at ten percent and twenty percent annually. The following graph illustrates the model as applied to WSH and ESH.

[12] Actual numbers of restoration patients on any given day may vary in accordance with real-time bed use needs. For example, some patients may be transferred from civil commitment beds into the forensic ward, or there may be an influx of defendants needing in-patient evaluations.



Orders for competency restoration treatment have been expected to increase as more evaluations are completed. However, we have not seen a strong increase due to this factor. To meet current and future capacity for competency restoration treatment services DSHS will:

a. *Increase state hospital capacity to provide inpatient competency restoration treatment*
For mentally ill defendants ordered to receive competency restoration treatment, additional inpatient forensic hospital bed capacity must be developed or made available. Based on projections in the chart above, it is estimated that compliance with a seven-day standard at present and with near-term growth will require 90 beds during the 15-17 biennium. The 15-17 biennial budget funded those competency restoration beds.

42 beds have been opened at WSH and ESH as follows:

WSH Ward S4	15 Beds	Became operational in January 2016
ESH Ward 3S1	15 Beds	Became operational by January 2, 2016
ESH Ward 3S1	12 Beds	Became operational by April 20, 2016

An additional 48 beds are anticipated to be transitioned to the state hospitals from shorter-term contracted or alternate facility operations. It should be noted that the new ward at ESH

was originally anticipated to operate 30 beds; however when constructing the ward the space would only accommodate 27 beds. Therefore, when planning for transition of beds back to the State Hospitals, an additional 3 bed capacity will need to be developed. This will be built into the future planning for transition. Current estimates are that these beds would be opened as follows:

WSH Ward F3	30 Beds	No sooner than July 2017
WSH Ward S4	15 Beds	No sooner than July 2017
Location TBD	3 Beds	No sooner than July 2017

b. *Create short-term strategies to accommodate needed capacity*

DSHS intends to maximize the use of state hospital beds to meet the seven-day competency services standard. However—given insufficient existing physical bed capacity, the challenges of recruiting sufficient state hospital staff, and the need to delay expansion at WSH in order to improve safety and quality care—the Department is contracted to open up to 54 beds in Residential Treatment Facilities in Yakima and Rochester, Washington.

- *Maple Lane*: The Maple Lane Competency Restoration Program (MLCRP) will serve up to 30 low to moderate acuity restoration patients. The program accepted its first two patients on 4/18/16 and is serving 9 patients as of 5/6/16. The MLCRP is contracted as a "hybrid" model in which staff including residential rehabilitation counselors, security guards and maintenance mechanics will be staffed by DSHS, while clinical positions will be provided by a contractor. The contractor chosen for this facility is Correct Care Recovery Solutions. The contract was signed on December 16, 2015 and runs through June 30, 2017.
- *Yakima*: The Yakima Competency Restoration Program (YCRP) became operational on March 1 and serves low acuity restoration patients. The program accepted its first patient on March 15, 2016 and now serves 8 (two recently graduated). The contractor chosen for this program is Central Washington Comprehensive Mental Health, and the facility will not be staffed with state employees. The contract was signed on October 22, 2015 and runs through December 31, 2016.

DSHS has worked with the Court Monitor Dr. Mauch and her consultant Dr. Pinals, along with other stakeholders, to modify the existing structures and to implement programs that maintain a therapeutic level of care. We have detailed these efforts in our monthly reports to the Court Monitor.

The use of these contracted facilities is intended to provide additional bed capacity for 12 to 18 months in duration while staffing, safety and quality improvements can be implemented at the State Hospitals to support safe expansion of forensic beds.

c. *Implement Internal Process Improvements*

DSHS and its consultants identified several improvements to the current competency restoration treatment model that would ensure follow-up competency evaluations occur as

soon as a patient appears to have been restored to competency. Once adopted, these strategies should lead to more timely discharge of restoration patients and contribute to increased bed capacity. DSHS is developing a workgroup involving DSHS administrators, WSH and ESH staff, and consultants to standardize competency restoration treatment models, programs, modules, and resources in ESH and WSH.

By December 31, 2016, DSHS will adopt standard restoration program curricula that include:

- Uniform procedures for reviewing progress in restoration treatment. Frequent review by treatment staff will be targeted to monitor individual patient progress toward restoration. Patients may be restored as competent to stand trial before the court ordered 45 or 90 day restoration period. Regular brief assessments by treatment staff will monitor patient progress so patients are re-evaluated as soon as clinically appropriate;
- Uniform processes for requesting re-evaluation of competency. When treatment staff determines that a patient is ready for re-evaluation of competence, an evaluator will be promptly assigned to conduct a new evaluation. When patients are determined to have been restored to competence they will be expeditiously returned to court to stand trial; and
- Consistent, specialized restoration approaches and resources for populations with special needs, primarily defendants with developmental or intellectual disabilities.

d. *Increase alternatives to inpatient restoration for defendants not requiring hospitalization*
Not all defendants adjudicated as incompetent to stand trial meet the clinical or security need for hospitalization. As a longer-term strategy, DSHS will explore development of outpatient restoration programs for the subset of defendants who have been adjudicated incompetent to stand trial, but do not require inpatient treatment. Community-based outpatient restoration is common in several other states, and has the benefit of providing services in the least restrictive environment. Given the need to balance public safety with individual treatment needs, outpatient programs tend to serve relatively small numbers of competency restoration treatment clients. With the addition of Doctors Luxton, Zolnikov and Kinlen to the Office of Forensic Mental Health, planning will begin related to long-term strategies such as pursuit of community-based forensic evaluation and less restrictive alternatives. Updates on progress towards these alternatives will be included in monthly reports to the Court Monitor.

ELEMENT 3: CREATE A ROBUST AND RELIABLE DATA SYSTEM TO BETTER FORECAST DEMAND FOR SERVICES AND ASSESS PROGRAM PERFORMANCE

Historically, DSHS has not effectively used data to determine program performance or adequately forecast demand for competency services. The state hospitals used different tools and protocols for data collection and reporting and DSHS did not have the staff expertise to analyze data to assess and improve program performance. The *Trueblood* decision, the Joint Legislative Audit and Review Committee (JLARC) 2014 (*Trueblood* trial Exhibit 25) report, and the Groundswell report all make clear that DSHS has to develop and use its data for a more focused look at services provided and their

effectiveness for people who use them. DSHS was allocated the resources in the 15-17 biennial budget necessary to create the infrastructure to gather and analyze data with which to forecast service demands and assess program performance. As part of this effort, DSHS will:

- Acquire necessary staff expertise;
- Improve the use of existing DSHS data; and
- Explore the creation of cross-system automation.

a. *Acquire necessary expertise*
DSHS is adding experts to the Behavioral Health Administration (BHA) Team needed to build a data management and analysis infrastructure. Several steps have been taken to acquire this expertise including:

- The Behavioral Health Administration Chief Information Officer (CIO) joined the BHA team in April 2015.
- A data consultant joined the team in May 2015 and has been responsible to compile data obtained from each state hospital, develop charts, and provide analysis of data used to populate monthly reports to the court monitor.
- A Compliance Reporting Specialist joined the team on October 16, 2015. This position has been responsible to analyze monthly reporting data, identify and resolve anomalies to ensure improved data reporting and reliability.
- A Web Developer dedicated to the Forensic Data Systems project joined the team in November 2015.
- Following unsuccessful attempts to hire a business analyst, the CIO engaged a contracted business analyst in November 2015 to collaborate with the Web Developer on system development.

BHA reorganized the Decision Support Unit to provide a dedicated team to collect, analyze and forecast data for BHA. To support this unit, a Forecast Analyst has been hired and will start on May 16, 2016. A data manager will also be hired, and the top candidate was offered the position the week of May 2, 2016.

b. *Improve the use of existing DSHS data*
In the short-term, DSHS will develop and institute standard protocols for data collection and reporting using existing systems. In the long-term, a new information system will be needed to replace disparate applications currently in use that are not integrated and require redundant effort.

DSHS has made substantial progress toward implementing a new forensic data system. The Cerner Millennium Electronic Health Record system will be implemented at the state hospitals during calendar year 2016, which will provide improved timeliness, quality reporting, access, management visibility and continuity of care for forensic services:

- *Timeliness:* Streamlined processes and improved speed of document transmittal by using electronic entry at point of origin for court orders, discovery documents, and

scheduling competency evaluations reducing unnecessary delays. Opportunity for management to intervene prior to missed deadlines.

- *Quality Reporting:* Consistent definitions of data used for reporting to the court, legislature and DSHS. Completeness of reporting enhanced by proactive measures to identify problems or missing data.
- *Access:* Concurrent access to the system from throughout the system, allowing jurisdictions to view the status of any of their individuals being tracked; i.e. are there any delays (for medical clearance, waiting on defense, waiting on interpreter services), has an evaluator been assigned and who, has the evaluation been completed and the outcome, has the individual been transferred to one of the hospitals or an alternate site for restoration services?
- *Management Visibility:* Up-to-date management dashboard which provides drill-down capability to explore any outliers from the expected timeliness standard.
- *Continuity of Care:* Integration of three new key systems which track the provision of mental health services and care to individuals in the community, at the state hospitals, and those designated as Trueblood class members. These new systems include the Behavioral Health Data System which covers clients receiving services in the community through

The Behavioral Health Administration Chief Information Officer (CIO) has lead responsibility for these efforts. As of March 7, 2016 the following deliverables have been completed:

- Finalized a data dictionary to catalogue information maintained at both state hospitals
- Designed an infrastructure schematic
- Completed an initial database diagram and a preliminary workflow diagram
- Drafted an initial systems requirements document.
- Develop a task list and a timeline for implementation.

A high-level work breakdown structure has been developed in MS Project format with summary tasks, dependencies, etc. across a projected timeline for the Forensic System implementation.

c. *Explore the creation of cross-system automation*

The very nature of providing competency services requires communication across the hospitals and with the multiple jurisdictions in the state. There are no standardized platforms or methods of communication to share information across the system in a timely manner. The current system does not make use of 21st Century technology but instead relies on faxes and the U.S. Postal Service. Significant effort and resources are needed to design, build and support a cross-system communication environment. In the future DSHS will collaborate with forensic system partners to explore systemic solutions to these communication challenges.

ELEMENT 4: CREATE OPPORTUNITIES TO SAFELY DIVERT PEOPLE WITH MENTAL ILLNESS FROM ARREST, PROSECUTION OR INCARCERATION

The fourth element of DSHS' long-term plan is to reverse or at least stem the trend of increased demand for competency services. In order to accomplish this, DSHS will work with system partners to agree upon diversion strategies. These include, but are not limited to:

- Pursue misdemeanor diversion options--explore the option of eliminating or reducing unnecessary evaluation and restoration of misdemeanant defendants;
- Apply early intervention diversion opportunities—pre-arrest, pre-charging and post-booking diversion; and
- Expand use of civil Geropsychiatric diversion—WSH provides services for many individuals with personal care and complicated cognitive or behavioral support needs. Active inpatient psychiatric treatment will not meet their needs even though they have a mental health diagnosis, and their behavioral baseline or histories have historically been beyond the capacity of community providers. However, with proper supports, these individuals can be diverted from inpatient psychiatric care. Services could be provided in less restrictive community settings, improving liberty and quality of life.

Background

Washington, like all other states, struggles with the problem of persons with mental illness entering the criminal justice system, creating challenges for courts and jails that go well beyond competency services. This problem is often labeled "criminalization of people with mental illness." While the focus of this long-term plan is on reducing time frames for competency services to meet the *Trueblood* seven-day standard, the problem is broader than this narrow focus and requires a variety of broader systemic interventions.

a. Pursue misdemeanor diversion options

Under current state law, competency evaluations may be provided for people charged with any misdemeanor. However, competency restoration treatment services are only provided to people charged with a non-felony crime that is a serious offense.[13] Part of DSHS' long-term plan is to explore the option of eliminating or greatly reducing unnecessary evaluation and restoration of misdemeanant defendants. This is similar to approaches in other states, such as Florida.

Data from JLARC indicates that 60 percent of misdemeanants had their charges dismissed following a competency evaluation. The data suggest that for *most* misdemeanants, there is no real value in expending forensic evaluator resources to assess competency, because the cases seldom go to trial. Rather, these individuals could better be served by diversion from the

[13] RCW 10.77.088. A non-felony crime which is "serious offense" is defined in RCW 10.77.092. For defendants charged with a non-felony crime that is *not* a serious offense as defined in RCW 10.77.092, the court may stay or dismiss proceedings and detain the defendant for sufficient time to allow the designated mental health professional to evaluate the defendant and consider initial detention proceedings under chapter 71.05 RCW (the Involuntary Treatment Act, which applies to cases involving civil commitment). See RCW 10.77.088(2).

criminal justice system and treated within the civil system (which is necessary for about 26 percent of misdemeanor defendants according to the JLARC report). Table 5 below shows the number of referrals for misdemeanor competency evaluation and misdemeanor competency restoration treatment.

Table 5: Number of Referrals for Misdemeanor Competency Evaluation and Restoration

Calendar Year	Eastern State Hospital		Western State Hospital		Total	
	Evaluations	Restorations	Evaluations	Restorations	Evaluations	Restorations
2012	240	12	1503	111	1743	123
2013	305	17	1509	102	1814	119
2014	350	12	1761	149	2111	161
2015	479	19	2219	151	2698	170

Legislation passed in June 2015 (SB 5177) allows prosecutors to dismiss charges without prejudice for certain nonviolent offenders, and refer them instead for an assessment by a mental health professional, chemical dependency professional, or developmental disabilities professional. DSHS will use the funds appropriated in the 15-17 biennial budget to work with prosecutors, Behavioral Health Organizations (BHOs) and community mental health and chemical dependency treatment providers to match people who are diverted from prosecution to appropriate treatment in the community. Implementing misdemeanor diversion options has significant potential to free up evaluator resources and improve timeliness in the provision of competency services.

The 4.81M in the FY15-17 biennium budget was originally comprised of 2.8M in state funds and 2M in federal funds (Medicaid Match). Because the Department elected to distribute the state dollars in pilot projects, it was not able to draw down the federal match funds for this effort. This left the budget for this effort at 2.8M for the biennium. A portion of state funds was eliminated from the total due to underspending, leaving $1.7M as available to be allocated towards the pilot projects.

The behavioral health system in Washington State operates under the authority of section 1915(b) of the Social Security Act (the Act). Section 1915(b) allows the State to obtain a waiver to require mandatory enrollment of Medicaid participants in a capitated program and to require participants to obtain services only from specified providers. Beneficiaries under the program must obtain services through Pre-paid Inpatient Health Plans (PIHP) which, in Washington state, are referred to as Behavioral Health Organizations (BHO).

BHOs are paid a set amount per Medicaid recipient each month and are required to cover behavioral health services listed in the Medicaid State plan for all participants who meet access standards. BHOs are funded under a risk-based contract, meaning they must purchase covered services regardless of whether a person needs a little or a lot of behavioral health treatment. All participants have the same benefits. The state cannot target an extra amount of money or benefits to some Medicaid recipients but not others.

For Managed Care delivered Medicaid services, the state is required to develop Per Member Per Month (PMPM) rates. These rates are then paid to the managed care entity for every enrolled Medicaid member in our state every month. These rates are developed and certified by independent actuaries per federal regulations, then reviewed for actuarial soundness and approved by the Centers for Medicaid and Medicare services. These rates are then paid to the BHO for all enrolled members and the payment is not tied to whether or not a service was delivered. The BHO accepts this payment as payment in full for all required Medicaid State plan services that are medically necessary for all Medicaid enrollees in their region.

The Social Security Act requires a Medicaid state plan to be in effect in all political sub divisions of the state unless the state obtains a waiver. This type of waiver would require services that are distinct from other state plan services and could only be obtained to serve individuals with certain types of disabilities (*e.g.,* individuals who are blind), or special groups that State or Federal law permits to be targeted for services (*e.g.,* students with disabilities who are receiving special education services).

Second Engrossed Second Substitute Senate Bill (2E2SSB) 5177 (2015) allows a prosecutor to use their discretion to dismiss a nonfelony charge without prejudice if the issue of competency is raised and to refer the defendant for a mental health, substance abuse, or developmental disability assessment to determine the appropriate service needs of the defendant. Mental health and substance use assessments are entitlements for Medicaid participants under the 1915(b) integrated behavioral health waiver.

The Department received a budget allocation to pay for the program that assumed both state funds and federal Medicaid matching funds. Mental health intake evaluation and substance abuse assessments are Medicaid services under the currently approved behavioral health waiver.

Per member per month (PMPM) rate ranges must be actuarially sound (42 CFR 438.6(c)) and based only on approved services. The State's contracted actuary included intake and assessment in the certified rate calculation. Paying for these covered services outside of the rate would constitute double payment and is not allowable. The State can pay outside of the rate but could not collect federal match on those payments.

Similarly, since intake and assessment are entitlements for all Medicaid participants, the State could pay outside of the PMPM to implement in select geographic areas or to implement for a select group but could not collect federal match on these payments.

Given these boundaries on access to federal matching funds, the state could only do one of two things:

1. Place the entirety of the funds (federal and state match) into the RSN rates which would distribute the money across the entire population. This increase on a PMPM level would

be very small in terms of the change in the actual PMPM when it is spread across the entire Medicaid population of about 1.8 million people.
2. Access only the state dollars and target them to specific Diversion programs.

Upon analysis of these options, it was determined that option 1, to incorporate the funds into the RSN rates, did not take into account a number of important criteria: 1) the number of non-felony competency evaluation orders generated by each county; 2) the limited flexibility of community supports required to adequately address the needs of the target population by tying funding to Medicaid and Medicaid restrictions; 3) the amount per RSN would be so small it would not produce significant impact; and 4) the difficulty in tracking meaningful outcomes.

Therefore, option two, to fund several prosecutorial diversion pilot projects throughout the state, was selected. This option would allow communities to develop innovative interventions that address the many factors that lead to an individual's involvement in the criminal justice system that may not be addressed with Medicaid funding.

On February 4, 2016 DSHS released an RFI for the 5177 Prosecutorial Diversion dollars. The RFI was sent to all RSN administrators, HCA, Early Adopter Region contacts, the Washington Association of Prosecuting Attorneys, and the Washington State Association of Counties. Proposals were due 2/26/16. Seven total proposals were received, and a panel of evaluators, including community stakeholders, scored the proposals. Contract recipients were notified on 3/11/16. Contract negotiations took place the week of March 14, 2016 in order to distribute current FY2016 funds to programs that can begin implementation as soon as possible. Contracts were sent to contractors on April 21, 2016. DSHS anticipates fully executed contracts back from contractors by May 20, 2016.

By funding multiple pilot projects throughout the state, DSHS will be able to monitor and assess these programs to more accurately quantify gaps in policy/programs and funding type needs. Project planning and implementation will promote effective collaboration and communication between the behavioral health and criminal justice systems, and establishing common priorities and ensuring efficient use of scarce resources can be prioritized.

Diversion is an agenda item at all cross-system community meetings convened by the Liaison/Diversion Specialist. Meetings have been held in Snohomish, King, Pierce, Thurston, Lewis, Clark, Yakima, Spokane, Benton, Franklin, and Cowlitz counties. Counties are encouraged to discuss the current diversion resource landscape, and DSHS shares information about programs that have shown success in other counties.

b. *Apply early intervention and diversion opportunities*

Governor Jay Inslee's Diversion Initiative--Responding to the *Trueblood* seven-day standard is not only about building capacity in the system to respond to demand for services. The Governor's office has pursued convening a cross-system team to develop and implement strategies that safely and appropriately divert persons with mental illness from the criminal justice system into treatment. The Governor's diversion initiative is planned to engage law

enforcement, courts, DSHS, community mental health providers and consumers of mental health services. As noted above, funding to support this work was included in the Governor's budget, but was not included in the Legislature's final budget. In an effort to continue the work that has already started, the Governor's office is hiring a consultant to perform community stakeholder interviews regarding diversion needs. The consultant's recommendations and report will be shared with the community by end of year.

Washington has adopted some best practice diversion strategies. They begin with interactions between law enforcement officers and citizens. More and more, jurisdictions provide Crisis Intervention Training and because of their success, the 2015 legislature enacted Senate Bill 5311.[14] It will incorporate Crisis Intervention Training into the basic training provided to police officers by the Criminal Justice training Commission starting in 2017. Other diversion strategies occurring in Washington state include establishment of additional mental health courts, increased access to crisis triage/stabilization facilities through funding provided by the 2013 and 2014 legislatures, jail diversion programs, innovative partnerships between community mental health providers and jails to support successful community re-entry (e.g. Clark County) and specialized housing. Mental Health & Addictions Services at Harborview, King County's Forensic Intensive Supported Housing (FISH) program, and King County's Forensic Assertive Community Treatment (FACT) teams also represent good examples of creative, efficient and sensible interventions for individuals with mental illness in the criminal justice system.

However, these innovative approaches currently occur primarily at the local, rather than state-level, and they remain piecemeal across the state. With cooperation from law enforcement, the counties, and other partners, there is significant room to expand and standardize similar types of programs across the state. DSHS is committed to exploring these opportunities.

c. *Expand the use of civil Geropsychiatric diversion*

WSH provides services for many individuals with personal care and complicated cognitive or behavioral support needs. Active inpatient psychiatric treatment will not meet their needs even though they have a mental health diagnosis, and their behavioral baseline or histories have historically been beyond the capacity of community providers. However, with proper supports, these individuals can be diverted from inpatient psychiatric care. Services could be provided in less restrictive community settings, improving liberty and quality of life.

DSHS is engaged in a broad effort across our long-term care and community mental health systems to develop stable and sustainable long-term care placements for state hospital patients who are deemed by their mental health treatment team to be ready for discharge, or who could be diverted from a long-term commitment to a state hospital.

With the support of the Legislature, the Aging and Long Term Support Administration (ALTSA) has been developing new service models for individuals with these especially complicated

[14] Second Substitute Senate Bill 2SSB 5311 (Chapter 87, Laws of 2015).

behaviors. The 2013 Legislature funded a new service, the Enhanced Services Facility (ESF), to support people with complex needs who are not benefitting from active treatment in the state psychiatric hospitals. In accordance with Engrossed Substitute Senate Bill 6656, signed into law on April 19, 2016, the Department of Social and Health Services will transition 30 patients to ESFs and reduce the civil bed census at Western State Hospital accordingly. There are also more than 350 ALTSA residential or nursing facility providers statewide who hold contracts that offer additional residential or nursing support for people with behavioral challenges. These break out as follows:

- 52 adult family home (AFH) providers with a Specialized Behavior Support contract that provides enhanced staffing specific to the client;
- 261 AFH providers with an Expanded Community Services contract that provides support for enhanced coordination of services;
- 39 assisted living providers with an Expanded Community Services contracts; and
- Almost 20 skilled nursing providers with an Expanded Community Services contracts.

Key to the success of these programs is a strong collaboration among DSHS' administrations, including Behavioral Health and Integrated Service Administration (BHSIA), ALTSA, and RSN's to develop strong care planning and support for transitions. The services required to support sustained community placements include behavior support intervention when needed, 24/7 in-person response to clients and providers at times of behavior escalation, cross-system transition and crisis planning, and training of the partners across the systems of care. DSHS will collaborate on a local level with Behavioral Health Organizations and community mental health providers to help develop these enhanced supports. Over the course of the next two years, our goal is to reduce the need for a civil ward and, through patient movement at the state hospitals, create the potential for additional future forensic bed capacity. The DSHS 2015-2025 Capital Plan outlines the funding and planning estimates to build two additional forensic wards in the Center for Forensic Services. Funding was allocated in the 2015-2017 biennial budget for pre-design work.

CONCLUSION

DSHS is committed to meeting the requirements of the *Trueblood* decision and continues to work toward that commitment. That commitment is now financially supported through a state budget that has injected over $40 million into the State's forensic mental health system. These financial resources have been strategically allocated to align with recommendations provided by JLARC and Groundswell, including:

- Significantly increasing the number of forensic evaluators;
- Adding 90 new forensic beds, and the staff to support them;
- Establishing the centralized Office of Forensic Mental Health Services to provide coordination and management of the improvement efforts described in this Long-Term Plan; and

- Investing in diverting people with mental illness from the criminal justice system and into community-based treatment

The passage of Senate Bill 5177 made important contributions to improving forensic mental health services as detailed in this plan. In the ensuing months we have made major strides toward implementing this legislation as part of our Long-term plan. Major accomplishments are noted above and include:

- Creating a new Forensic Evaluator classification with increased pay to increase evaluator FTEs to 43. The addition of these evaluators is primarily responsible for reducing wait-times for jail-based evaluations from a state-wide median of 14 days in April to 7 days in the most recent data from March.
- Adding 27 new beds at Eastern State Hospital and 15 new beds at Western State Hospital to support forensic services, and developing two new contracted facilities to provide additional restoration capacity on a temporary basis while additional capacity is built at the state hospitals.
- Hiring all headquarters staff to support the Office of Forensic Mental Health Services including a competency restoration specialist, a liaison and diversion specialist, a *Trueblood* project manager, a compliance reporting specialist, an office director, two workforce developer positions, a web developer, a business analyst, a forecast analyst, and a data manager.
- Taking substantial steps toward the development of a new Forensic IT System including the completion of a data dictionary, design of an infrastructure schematic, completion of an initial database diagram and preliminary workflow diagram, and drafting of an initial system requirements document.
- Improving monthly *Trueblood* compliance reporting data through consistent monthly analysis of data, identification and resolution of anomalies to ensure improved data reporting and reliability.
- Making systemic improvements to improve evaluator access and efficiency through outstating evaluators at key high-volume locations, improving system collaboration through the work of our liaison and diversion specialist, developing technological solutions for videoconferencing, and streamlining the in-custody evaluation process.

In addition to the support provided by the Legislature, this Long-Term Plan is strongly supported by Governor Inslee. The Governor has worked toward convening a cross-system group to address diversion of persons with mental illness from involvement in the criminal justice system, and continues to do so.

Finally, as better data becomes available and is analyzed, and we have actual experience operating under the new seven-day standard, this plan will be modified to make sure it is yielding the intended positive results.

APPENDIX A: TRIAGE MODELS UNDER CONSIDERATION IN WASHINGTON STATE

National Models

DSHS is studying systems from other states (Massachusetts and Washington DC, in particular) that use screening procedures for evaluations. For example, Massachusetts' statutes explicitly provide an initial screening evaluation for competency to stand trial, prior to referral for a more complete evaluation. Washington D.C. requires evaluators to complete a screening evaluation of competency within the first three to five days after the order has been initiated. This screening timeframe appears to apply to all defendants, regardless of location. This screening goes back to the judge, who orders further evaluation if necessary.

Both of these systems are able to accurately achieve the following results:

- Identification of "clearly true positives" (those persons referred for evaluation who are very clearly incompetent to stand trial due to acute mental illness, and who are should be immediately transferred to the hospital for competency restoration treatment services);
- Identification of "clearly false positives" (those persons referred for evaluation who very clearly are competent and do not need competency restoration treatment services); and
- Identification of those remaining persons who do not fall into either of the above categories, and who will proceed towards a full competency evaluation.

Information about how resources are allocated in these systems will be useful in determining how similar procedures could be funded and implemented in Washington to add long-term stability to the system.

Local Models

DSHS is investigating local approaches to screening defendants referred for evaluation. Washington state has at least two counties--King and Snohomish--that use these kinds of early assessment/screening procedures.

Snohomish County Model

The Snohomish County Superior Court implemented a screening process on March 5, 2015 that provides a screening assessment of competency to stand trial by Snohomish County Competency Assessment Management Program at Snohomish County Corrections within three business days of judicial referral. (This is feasible if the product is a very short summative report, much like the model used in Massachusetts) Based on the report, individuals deemed not in need of further evaluation are screened out, thus avoiding the costly and scarce resources of a full evaluation (again, this is a feasible model based on the Massachusetts experience). Those who are deemed in need of further evaluation can either be referred for a more thorough jail-based evaluation, or ordered to have the evaluation completed on an inpatient basis if this is judged clinically necessary (typically based on a finding of circumstances involving the health of the defendant). This triage model serves several functions:

- Eliminates the need for full competency evaluations in cases in which the court agrees with the screening assessment that there are no concerns about competency;
- Moves individuals who are in acute need of hospitalization to inpatient services more quickly (potentially three days required for the screening assessment versus seven days); and

- Identifies those individuals for whom a full evaluation is appropriate and moves them more quickly through that process.

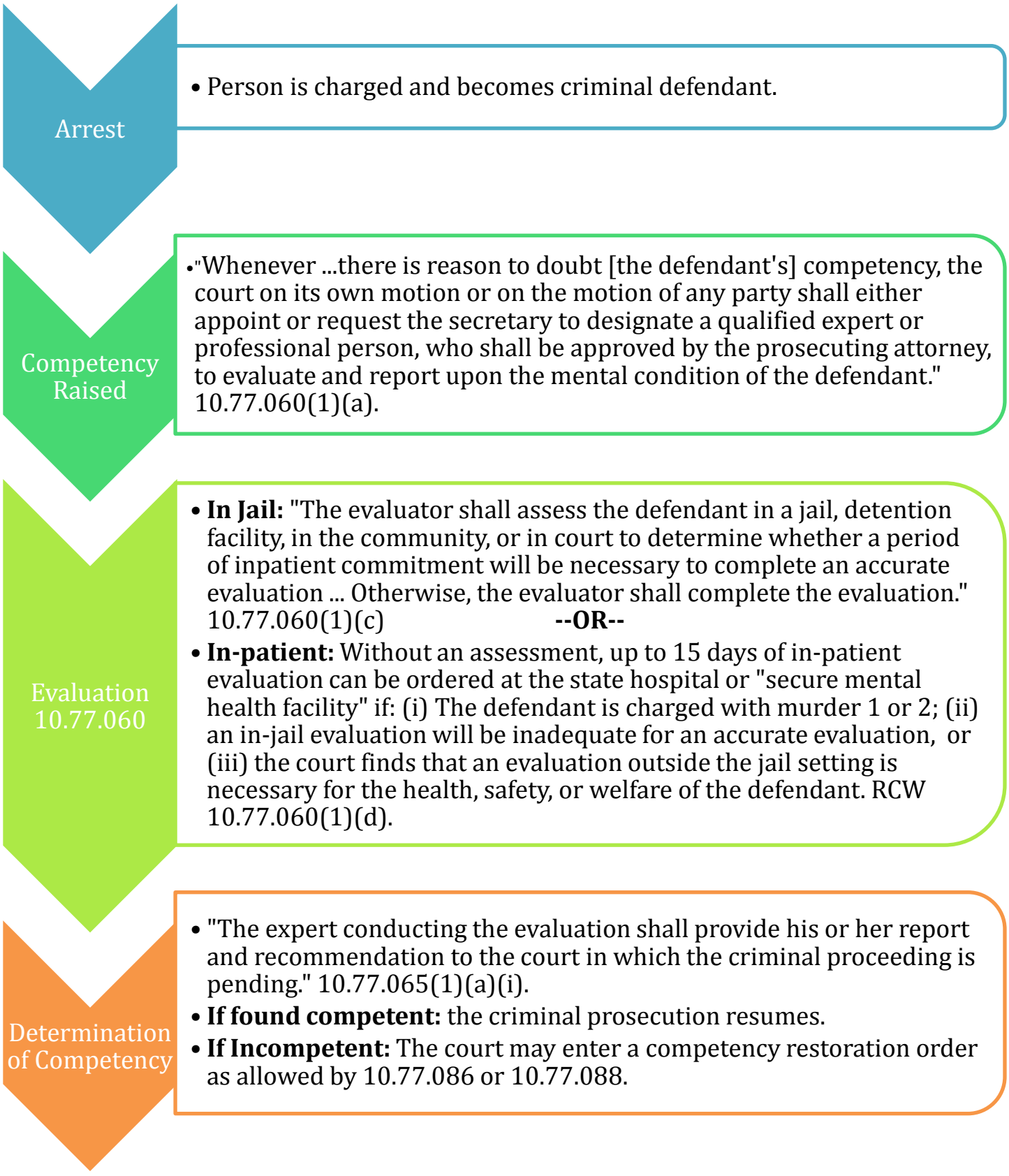
King County Model

There is also a long-standing triage model in the Seattle Municipal Mental Health Court and the King County District Regional Mental Health Court where social workers at the public defense agencies or community mental health agencies (called “mental health court monitors” or “mental health court liaisons”) screen out defendants prior to an order being signed (e.g., defendants who are intoxicated or withdrawing from drugs or alcohol, and who will likely stabilize quickly). These social workers continue to meet with the defendants after the competency order is entered but before the evaluation takes to determine if the order for evaluation needs to be withdrawn once the defendant stabilizes. These two courts also allow the evaluators at DSHS’ North Regional Office to request approval for a "truncated report" for the defense and prosecution for those defendants who are acutely psychotic and clearly incompetent. These truncated reports meet the requirements of Washington law but are substantially shorter. This model may be useful in other counties if courts are amenable to this approach.

<u>Other Models</u>

Another potential interim model could rely on community-based mental health clinicians, rather than jail staff, to conduct the triage. This is more likely to be necessary in smaller counties that do not have comprehensive jail mental health services. This could be an interim model, until there is a larger cadre of well-trained evaluators who would be available to adapt the Snohomish or King County model to these jurisdictions. This model will also be explored by DSHS as part of long-term options.

APPENDIX B: BACKGROUND OF FORENSIC SERVICES IN WASHINGTON STATE



APPENDIX C: RESTORATION PROCESS

Finding of Incompetence

- "If at any time during the pendency of an action and prior to judgment the court finds, following a report as provided in RCW 10.77.060, a defendant is incompetent, the court shall order the proceedings against the defendant be stayed..." 10.77.084(1)(a).

Felony Restoration 10.77.086

- **Felony Restoration**: "Shall commit the defendant to the custody of the secretary who shall place such defendant in an appropriate facility of the department." 10.77.086(1)(a)(i).
  - 45 initial commitment days for class B and C felonies, 90 days for all others. 10.77.086(1)(b).
  - After a hearing, a second period of 90 day restoration may be ordered. 10.77.086(3).
  - If certain conditions are met, a court may order additional restoration for up to six months. 10.77.086(4).

Non -Felony Restoration 10.77.088

- Restoration for **"serious" nonfelony crimes only** . 10.77.088(1)(a).
  - 14 days in addition to any unused time of in-patient evaluation (15 days). This can equal a total restoration period of 29 days.
  - Defendant may be placed in "a secure mental health facility in the custody of the department or an agency designated by the department." 10.77.088(1)(a)(i).
- For **non-serious nonfelony crimes**, the proceedings are stayed or dismissed, and the defendant may be referred for civil commitment under RCW 71.05. No restoration treatment is permitted. 10.77.088(2).

Competency Determination

- If defendant is not restored after treatment, charges are dismissed without prejudice and defendant referred for civil commitment under 10.77.084(1)(c).
- If restored to competency, criminal trial resumes.

CERTIFICATE OF SERVICE

Amber L. Leaders, states and declares as follows:

I am a citizen of the United States of America and over the age of 18 years and I am competent to testify to the matters set forth herein. I hereby certify that on this 6th day of May, 2016, I electronically filed the foregoing document with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the following:

David Carlson: davidc@dr-wa.org

Emily Cooper: emilyc@dr-wa.org

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Kenan Isitt: Kenan.isitt@cgilaw.com

Lisa Daugaard: lisa.daugaard@defender.org

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Dated this 6th day of May 2016 at Olympia, Washington.

/s/Amber L. Leaders
Amber L. Leaders
Assistant Attorney General

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