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**DRAFT**  
**Implementation Plan**  
**for Outpatient**  
**Competency**  
**Restoration**  
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## **Introduction**

Following our analysis of the existing Washington competency restoration services (Deliverable 1, submitted April 1 2017), our draft implementation plan for new services (submitted April 15), and subsequent review of newly received materials and input from a wide range of stakeholders, we submit the following Draft Implementation Plan (Deliverable 2) for pilot Outpatient Competency Restoration Programs (OCRPs) in three Washington counties.

As with our prior deliverables, this document is based on a review of class member data, in-person stakeholder meetings (in Lacey, King Co., Pierce Co., and Spokane Co.), phone calls with additional stakeholders, and the review of multiple written sources of information (including but not limited to court orders, court decisions, RFPs and related plans/proposals, independent consultant reports, and existing planning documents). We analyzed multiple sources of data (including but not limited to hospital census data, class member demographics, referral numbers across settings and legal status, and budget information). We collected and reviewed data and information on restoration programs, initiatives, and component parts nationwide. Finally, we reviewed Washington statutes and rules. Our sources of information are listed in Appendix 1.

As our process progressed, we reviewed additional requested information provided to us by the Department of Social and Health Services (DSHS); again, we appreciate the rapid response to our requests. We also contacted additional stakeholders; at this point, we have spoken with many, but are still waiting responses from others. If we receive further responses that alter our recommendations, we may submit addendums with slight additions or modifications to our recommendations, as appropriate.

As in our prior draft, we recommend that Washington State pilot an OCRP model in the three counties in a manner that incorporates specialized competency restoration services into a broader package of recovery services. Our implementation plan includes a broad overview of recommended procedures (Section I), followed by more specific plans for the three counties: King, Pierce, and Spokane (Section II).

Additionally, a previous draft of the Implementation Plan (submitted for preliminary review April 30, 2017) has been updated in this version, primarily to incorporate updated recommendations for King County and to update / clarify terminology throughout the report.

## **Section 1: General Recommendations for Pilot Outpatient Competency Restoration Programs in Washington**

Washington statutes have provisions for outpatient competency restoration models, so none of the proposed models are incompatible with current law.<sup>1</sup> As in our prior draft, we recommend that Washington State adopt an OCRP model in the three counties (King, Pierce, Spokane) in a manner that incorporates specialized competency restoration services into a broader package of recovery services. These comprehensive services should be tailored to the needs of the individual defendants who have been adjudicated as Incompetent to Stand Trial (IST) and to the jurisdictions in which they are based. But some core features of the Washington OCRP system should be uniform across all sites. Overall, the philosophy of the entire OCRP should be to move eligible class members from local jails and into community-based services as soon as is reasonably possible. Authorities across all three jurisdictions must agree upon a “floor” baseline of eligible charges and mental health conditions, and a “ceiling” set of criteria for revocation (though these may vary slightly among counties). Qualifications for restoration professionals, and staffing ratios for restoration services themselves, should vary little across programs. Each program will likely include a mixed model of state oversight and privately-contracted services through a local behavioral health organization (BHO) community provider. Each program, using the same metrics, should collect data including restoration rates, lengths of stay, financial costs, and outcomes. Specific data elements collected should include, but not be limited to, the following:

- Legal charges
- Misdemeanor or felony

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<sup>1</sup> According to review of statute and consultation with the Office of the Attorney General (OAG). However, some statutory changes (or other authoritative clarification) may be helpful to address some ambiguity in current law. Specifically, some legal representatives expressed disagreement on the statutory language regarding the length of hospitalization that can be ordered for a defendant who was initially diverted to an OCRP, but failed to complete it. Courts and prosecutors may want some assurance that additional inpatient treatment will be available for the small group of such defendants who fail outpatient restoration.

- Diagnoses (intake and discharge)
- Date of admission
- Date of discharge
- Competency status on discharge
- Medication adherence
- Treatment adherence
- Presence of legal order for medication administration
- Rates of restoration
- Rates of findings of unrestorability
- Discharge disposition (remain in community, jail, state hospital)
- Referrals made on discharge
- Housing status (on intake and on discharge)
- Employment status (on intake and on discharge)
- Ideally the majority of the above data would be additionally collected 6 and/or 12 months after discharge from the program to assess long-term impact

**Potentially eligible defendants.** Potential participants should be class members who do not require an inpatient level of hospital care or intensive security. This means that OCRP participants will have been charged with less serious offenses and have less severe (or more currently stable) psychiatric illness than defendants participating in inpatient restoration; some may be defendants for whom intellectual deficits are their primary barrier to competence. OCRPs would provide an option for the courts to consider if the incompetent defendant is: not considered a security risk, is not deemed appropriate for civil commitment on other grounds (e.g., risk to self, others, or grave disability), appears likely to adhere to treatment in the community, and is likely to avoid severe substance abuse.<sup>2</sup> Specific criteria for referral would include:

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<sup>2</sup> Some such defendants may now be sent to the Yakima and Maple Lane Restoration Treatment Facilities, but would be more appropriately sent to OCRP. For example, data from King County (the only one of the three pilot counties from which we could explore such data) indicate that there were a number of King County defendants in the Yakima or Maple Lane who met the criteria of a) Misdemeanor or Class

- Misdemeanor or lower-level felony charges (specific charge eligibility may vary)
- Clinical status appropriate for outpatient treatment, such as:
  - No serious concerns about danger to self or others, nor grave disability
  - Psychiatric illness that is manageable with consistent treatment in the community (which could include injectable medications)
  - Intellectual or cognitive deficits as primary basis for incompetence
- Security status (lifestyle stability) conducive to consistent outpatient participation, including:
  - Minimal risk of absconding
  - Minimal risk of absence due to severe substance abuse
  - Minimal risk of re-offense or violence
  - A court judgment—using standard, well-defined procedures—that the defendant presents a reasonably minimal security risk.

**Necessary services.** Not all IST defendants will require exactly the same package of services. These may differ based on each defendant’s basis for incompetence, clinical condition, and living arrangements, among many other variables. But certain services will be crucial for so many IST defendants that they should be an available component of *any* OCRP. These include:

- *Psychiatric medication:* For most defendants found IST, psychiatric medication is the primary intervention to restore (or attain) competence. Medication management—including long-acting and injectable options where appropriate—should be a core component of all OCRPs.

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C Felony (about 80% of admissions over the past six months) as well as b) willing acceptance of medications (about 75-80%) on admission. There may be other reasons why some of these individuals would not be deemed suitable for OCRP, but it is likely that there are a significant number who might be considered appropriate for more affordable OCRP.

- *Other mental health treatment:* Depending on individual need, some measure of psychological counseling and/or intervention may be necessary. Treatment should be targeted specifically at those systems, behaviors, or beliefs that create barriers to competence (e.g., delusional beliefs, manic thoughts or behaviors, paranoia, PTSD, etc.).
- *Substance use screening (urinalysis and treatment):* Substance abuse commonly co-occurs with psychiatric illness, often hampering recovery, and makes it difficult to disentangle symptoms of illness from symptoms of substance abuse. In order to maximize the effectiveness of a comprehensive approach, programs should include capacity to monitor and minimize any substance use that interferes with the recovery process or threatens defendants' stability and progress towards competence.
- *Housing:* Lack of affordable housing is a primary barrier to consistent participation in community-based mental health treatment and broader recovery. To increase stability, a comprehensive OCRP should have the capacity to provide incompetent defendants access to housing options.
- *Case management:* Participants in OCRPs will need case management from a licensed professional to manage the often-complicated and confusing worlds of benefit acquisition, court appearances, and mandated demands, housing rules, scheduling, and other requirements.
- *Restoration curriculum:* For now, an OCRP should utilize the Breaking Barriers curriculum already in use at Western State Hospital (WSH) and Eastern State Hospital (ESH). It is important to maintain uniformity regarding curricula across hospital, residential treatment facility (RTF), and outpatient sites. There is currently little data to demonstrate any particular restoration curriculum is superior to others. The elements of Breaking Barriers are consistent with those used in other jurisdictions, and we find no reason to abandon this curriculum. Should future research indicate that a different curriculum is more effective than Breaking Barriers, we recommend that DSHS carefully

consider switching to the most effective curriculum possible, and do so uniformly across all sites (inpatient, outpatient, and RTF).

In addition to funding for the actual OCRP restoration and recovery services, DSHS should consider state funding to allocate at least .5 FTE forensic evaluators to each of the three counties in order to provide post-restoration competence assessments to OCRP participants.



## Section 2: County-Specific Recommendations for Pilot OCRPs

### KING COUNTY

The following plan is an update of the preliminary King County plan we provided in our first two reports. The preliminary plan has been refined based on additional information and data. Additionally, as mentioned previously, a previous draft of the Implementation Plan (submitted for preliminary review April 30, 2017) has been updated, primarily to incorporate updated recommendations for King County and to update / clarify terminology throughout the report.

**Estimate of potential participants in King County.** Our previous estimate for numbers of potential participants in King County (45-60 defendants per year) has been slightly reduced after discussions with the King County Prosecuting Attorney's Office (PAO) and after reviewing additional King County documents. The adjusted estimate is slightly lower, between 36 and 50 per year. Representatives from the PAO estimated that 3-4 new defendants per month is a more realistic starting point, given the volume in similar King County Community Assessment and Referral for Diversion (CARD) and Mental Health Court (MHC) programs. These numbers could grow to 4-6 per month once the program is running smoothly.

**Three potential models for OCRP in King County.** Stakeholders in King County suggested three different models for operating an OCRP. The first model (a "General" model) creates an OCRP without a formal calendar or associated structure; court hearings would be held in currently-existing courtrooms. This would not require dedicated judges, attorneys, and OCRP teams. Although this model would therefore be less expensive than the calendar model, it would introduce more variability across the system, in terms of decisions on eligibility and when a defendant has violated the conditions.

The second model (a "Dedicated Competency Court" model of OCRP) integrates the OCRP as a formal adjunct to the existing Mental Health Court calendar. Essentially, this model would use the existing infrastructure of the MHC and the CARD programs to guide the development and operation of the OCRP. This model comes at a higher cost, however, as the

stakeholders have indicated that additional judicial personnel will be needed to operate an OCRP calendar effectively.

The third model (a “Competency Calendar” model) is middle ground between the two models. King County Superior Court currently operates a competency calendar, in which many cases involving competency are funneled into a specific courtroom. This courtroom handles these cases as they enter and exit the competency restoration process. This provides benefits in efficiency and consistency over the General model, but will fall short of the efficiency and consistency of the Dedicated Court model because no specific personnel are hired for that specific courtroom. The personnel still rotate, with the presiding Superior Court judge overseeing the calendar. However, this model is much less expensive than the Dedicated Court model.

Essentially, the three models are akin to how regular mental health cases might be heard by the court—either through a formal mental health court, a specific calendar, or simply dispersed throughout the court building. Although each model has its merits, given the current existence of a competency calendar in Superior Court, *we recommend that the Competency Calendar receive primary consideration*. Some additional work will need to be completed to ensure that the current calendar can adopt a potentially large influx of outpatient restoration cases, and DSHS is likely to need additional resources to conduct evaluations and program acceptance procedures prior to competency hearings. Still, if these issues can be worked out, it seems that partnering with the current competency calendar could be very fruitful and efficient (in terms of both logistics and financial costs). Given the volume of cases in King County, the Competency Calendar model seems better positioned to maximize efficiency and grow the program to its maximum impact. If DSHS opts not to pursue this model, we recommend that the Dedicated Court model receive secondary consideration, given the very strong track record of the King County MHC and the strong commitment from current MHC stakeholders to “fold in” a formal OCRP calendar. Most of the material gathered and recommendations offered below are therefore focused on the OCRP “Competency Calendar” model.

**Resources currently in place.** King County has many requisite pieces of an OCRP already in place. Three specific pieces are especially critical: stakeholder buy-in, infrastructure, and a large pool of potential referrals. King County has a group of stakeholders with a shared interest in

pursuing OCR, and a strong record of collaboration for similar goals. This group includes representatives from the judiciary (i.e., prosecutors, public defenders, judges) as well as mental health providers and liaisons. In 2015, stakeholders collaborated to produce a diversion plan that recommended OCR in King County, and stakeholders even recently submitted a proposal for a pilot OCRP in King County, although this was ultimately not funded. Clearly there is a supportive foundation for OCR in King County.

This investment among stakeholders is an important, pre-existing infrastructure necessary to support an OCRP. Many similar projects are already running in King County, which can serve as models for a county-specific OCRP. Primarily, a competency calendar is already in operation in King County Superior Court. The country's second-oldest Mental Health Court, with a dedicated calendar and staff, also already exists within the county. A court liaison position also exists, staffed by an expert in community resources and housing. Several provider partners and housing options exist (though housing remains the most significant barrier to successful long-term community tenure for many persons with serious mental illness). Multiple diversion and social programs exist (e.g., veteran's court, drug court, restorative justice project); the two most relevant to an OCRP are the CARD program and the Mental Health Court.

The CARD program currently serves as a mechanism to divert persons with mental illness and low-level charges into services, providing a solid infrastructure from which to build an OCRP.<sup>3</sup> Stakeholders mentioned that the CARD program would be very similar to an OCRP, except that CARD defendants are typically municipal-level defendants whom the government has no compelling interest in prosecuting. OCRP participants will likely be those whom the government does maintain interest in prosecuting; they will not simply have their charges dismissed like those in the CARD program. Perhaps most importantly, the current King County Mental Health Court (MHC) is a national leader among wellness courts and can serve as a model for OCRP. King County stakeholders reported that many of the participants in the OCRP would likely go on to participate in the MHC. The overlap in participants between these two programs is significant. If the Dedicated Court model is adopted, DSHS should partner closely with the stakeholders in each of these programs.

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<sup>3</sup> Funding for the CARD program is due to end in July 2017. Stakeholders reported that they believe funding is likely to be renewed, but this has not been decided definitively.

Finally, King County is home to a large population of misdemeanor and low-level felony offenders. Many options exist for pre-trial diversion of low-level offenders, and many systems (law enforcement, judiciary, corrections) seem to have a shared perspective that misdemeanant offenders are “diversion eligible.”

**Model of service.** If a Competency Calendar model is adopted, DSHS will need to coordinate closely with the existing King County Superior Court competency calendar to ensure that capacity and resources exist to manage a potentially large influx of new outpatient restoration cases. Cases would be heard on a specific day of the week, allowing for hearings to be predictable and consistent. The calendar will manage status updates, revocation proceedings, sanctions, requests for updated evaluations, and similar competency-related matters. The DSHS competency restoration specialist should be present at these hearings to act as a liaison among the court, the OCRP, and DSHS. Additionally, the court is likely to request a fair amount of “front-loading” on new referrals (e.g., securing acceptance, eligibility, benefits, housing placements, etc. as early in the process as possible), so that defendants found IST can be moved to the OCRP quickly. Stakeholders were clear that having the court, attorneys, and defendants agree to OCRP at the hearing, only to have DSHS decline it afterward, would undermine the viability of the OCRP. In this model, DSHS will need to have their figurative “ducks in a row” *before* the court hearing to allow for predictability and efficiency. This would also allow class members to enter the OCRP more quickly after a finding of IST (i.e., well within the seven-day limit), rather than waiting in jail (or WSH) while eligibility or housing determinations are made.

If a Dedicated Court model of OCRP is pursued, the OCRP would essentially operate a “CARD-like” program with incompetent MHC clients. That is, the King County OCRP is well-positioned to operate as a centralized service in urban Seattle for low-level offenders who need wraparound services in order to successfully remain in the community. The CARD program infrastructure is an ideal model to emulate for this OCRP population (though the OCRP will need additional restoration specialists). However, the CARD referral population is different than the OCRP population; the OCRP population has more serious charges than the CARD municipal charges. In this way, the OCRP will operate in parallel to the CARD program—offering a similar breadth and depth of services, with the additional overlay of competency restoration—and will also act as one pathway to enter the MHC. Potential OCRP referrals can be identified

through similar procedures currently in operation for CARD. Most of the OCRP participants are legally and clinically positioned to enter into MHC once they are competent. The program can operate in conjunction with the MHC court/calendar. Similar to the Competency Calendar model, DSHS will need to front-load work on these cases to ensure predictability and efficiency at the actual court hearings.

If the General model of OCRP is pursued, cases will be distributed throughout various courtrooms in King County. There will be no central coordination of judicial services or personnel. Cases, once adjudicated as incompetent and found appropriate for community release, could be referred to the OCRP provider.

**Implementation.** King County stakeholders suggest that, akin to the CARD and MHC, a specific calendar day be created for the King County OCRP. For either the Dedicated Court model or the Calendar Model, one suggestion was to dedicate one half-day per week to OCRP-related business. This calendar would be used to staff new referrals, determine eligibility, order the OCRP, conduct status hearings or updates, conduct sanctions and revocations, and provide adjudication on competence to stand trial. The OCRP Dedicated Court would comprise a clinical OCRP team, again similar to CARD and MHC teams, including a dedicated judge, Deputy Prosecuting Attorney (DPA), Deputy Public Defender (DPD), and a competency restoration specialist. The team would gather referrals and begin the process of determining eligibility for existing services (e.g., benefits, housing, medication). The team would then utilize the team model to get updates and determine appropriate actions prior to the court hearings on that specific day.

In the Competency Calendar model, cases would simply be funneled to the existing day and time for the current competency court at Superior Court. Coordination between DSHS and existing court personnel would need to occur, to harness the appropriate level of resources for the number of outpatient restoration cases expected to emerge and be managed by the court.

**Referral process.** In the Dedicated Court model, potential referrals will be known to the DPA as they are currently alerted to all competency evaluations scheduled for court hearings prior to those hearings. The PAO suggested that a dedicated DPA be utilized to track these cases specifically. Contact with the King County Jail's mental health specialist will provide additional

clinical information. Upon reviewing the case and competency evaluation, a preliminary determination of eligibility will be made in coordination with the DPD. Once this preliminary determination has been made, the case will be transferred to a clinician for additional pre-screening (to be coordinated with the jail mental health specialist).

In the Competency Calendar model, the competency evaluation will be sent to the court, PD, and DA. The PD and DA offices will discuss potential *eligibility* internally and with each other; if the case appears to merit legal eligibility then the requisite materials will be sent to DSHS for review and processing. DSHS will determine the *appropriateness* of the referral (i.e., determining housing availability, clinical readiness for outpatient treatment, existence of necessary community supports, avoiding waitlists, etc.). DSHS should, in most cases, be able to determine appropriateness within a week of getting the referral from the PD and DA office. The case will be heard during the next calendar date; if all parties continue to agree, the defendant could be released directly from court into the OCRP. If there are snags, the defendant may be transferred to WSH as a temporary “way station” on their way to the OCRP.

In the General model, no such referrals will be coordinated. Defense counsel will raise the possibility of outpatient restoration on a case-by-case basis and argue for outpatient placement at the competency hearing.

**Operation of the calendar.** In the Competency Calendar model, the calendar meets once weekly. Restoration specialists will conduct clinical pre-screens, develop the restoration plan, connect the defendant to resources and case management, assist in the community transition, monitor progress, provide restoration sessions, and report updates to the court. These positions are essentially the point persons for the court. They will know the eligibility criteria for the OCRP, how many slots are open, and what housing options are likely to exist. They will also be experts in restoration. They will likely be BHO or community provider hires, but could potentially be DSHS hires. They will each carry a caseload of 10-15 cases at any one time. Defendants will be required to report to the court every other week, unless significant violations have occurred that could necessitate significant sanctions.

In the Dedicated Court model, the OCRP specialty court will meet for a half-day once per week, in conjunction with the existing MHC calendar. The duties of the restoration specialist

are essentially the same as described above, although they come with the additional supports and consistency of the Dedicated Court structure.

Of course, there is no calendar in the General OCRP model.

**Component parts.** The OCRP would consist of several concurrent parts. Primarily, the defendant will be placed into intensive mental health resources. The resources will be individualized but will likely include forensic assertive case management, medication management, substance use treatment, substance use monitoring, and housing. Competency restoration sessions will be provided in either individual or group settings—whichever is most appropriate for the individual defendant. This model is already in use for the CARD and MHC programs. The Dedicated Court model offers the immediate utilization of resources currently in place with CARD and MHC participants, most of which would be identical for OCRP clients. Both the Competency Calendar model and the General model would likely require the acquisition of new resources or new agreements with providers.

**Sanctions and violations.** The restoration specialist will monitor progress on competency restoration goals as well as violations of the program/court order. Minor transgressions will result in minor sanctions (e.g., warnings from the judge, reduction of some privileges previously attained), while more serious violations could result in revocation and return to WSH. These will include evidence or documented serious threats of harm to self or others, non-adherence to medication as prescribed, and positive drug screens (or a refusal to be tested). Sanctions will be formalized and graduated, depending on the seriousness of the violation. The Competency Calendar and Dedicated Court models offer a consistent approach to sanctions and violations, while the General model would likely lead to significant variations across courtrooms about how sanctions and violations are managed.

**Outcomes.** In the Dedicated Court model, if a defendant is restored, he or she will be screened for the Mental Health Court. DPAs indicated that most defendants will be found eligible for the MHC and enrolled immediately. The small proportion that is not eligible for MHC will be likely be placed in custody, enter into trial proceedings, and be tracked for either traditional or other specialty interventions by defense counsel. If the defendant is revoked, the defendant will be

immediately placed into WSH. In the Competency Calendar and General models, the process for incompetent defendants would be identical to the Dedicated Court model; defendants found competent would proceed with trial and apply for MHC individually. Cases not found eligible for the MHC would return to their courtrooms of origin.

**Current gaps for implementing an OCRP.** King County is largely well-positioned for immediate start-up of either the Competency Calendar or Dedicated Court models of OCRP. The only missing components are funding and a small number of staff positions. Funding is needed for new restoration specialist staff positions, additional case management staff, and housing. Existing behavioral health providers have the history and infrastructure to offer case management, psychiatry, care coordination, treatment, and housing assistance. This population is likely to need FACT-level care, as they carry many psychosocial needs (e.g., housing, substance abuse, mental health, crisis, etc.). The providers should be able to bill and obtain reimbursement from Medicaid for most of these services. However, the identified BHO or community provider will likely need additional funding to staff case management and other psychosocial needs that reimbursement dollars do not cover. The extent of these positions is unknown and will depend on the agency's capacity for obtaining reimbursement.

The identified BHO or community provider will also need funding for housing expenses. Housing is the primary barrier to release and community success for this population as identified in the Diversion Report. A very large proportion of OCRP participants in King County will need housing in order to successfully remain in the community.

Two competency restoration specialist positions are recommended for King County. These can be master's level positions in psychology, social work, or counseling, but they must possess a command of trial competence and related issues.

If the General model of OCRP is pursued, more start-up time will be needed to identify potential providers and community resources, create judicial pathways for legal entry into outpatient restoration, educate judicial personnel about the program, and complete other associated start-up tasks.

**Budget implications.** The estimated budget analysis has been adjusted, based on additional data review and conversations with the Prosecuting Attorney's Office. We maintain an estimate of



\$200 per day per participant, though this estimate could change considerably depending on the OCRP model utilized in King County. Using national norms of 111 days for OCRP participants to be in the program (prior to being restored, found unrestorable, or terminated/revoked), and using the estimated range for numbers of participants by county, the overall cost to DSHS is estimated to fall between \$799,200 and \$1,100,000 (36-50 participants @ \$200 per day x 111 days of restoration services each).

Again, the final annual fiscal cost to DSHS will likely be considerably lower, as many of the services (case management, housing supports, therapeutic activities, medication, etc.) are reimbursable by Medicaid.<sup>4</sup> The only non-reimbursable costs for OCRP are the actual competency restoration sessions, some staff position costs, some travel and coordination, and housing.

For the Dedicated Court model, funding for additional judicial personnel will be required. These costs are likely to be significant. According to the Prosecuting Attorney's Office, this model will require funding for .2 FTE of a dedicated judge, .2 FTE of a court clerk, .4 FTE of a DPA, and .2 FTE of a paralegal. The public defender's office was less specific about personnel requirements, but did state that additional personnel would be required. Justification for these positions, from the PAO, is that the creation and operation of a specialty court requires additional resources from the judiciary and prosecutor's office (e.g., time reviewing cases, preparing court orders, monitoring cases, preparing for sanctions and revocations, etc.), unlike cases sent to WSH who do not need close monitoring or review until a competency hearing is scheduled. The OCRP Dedicated Court will most likely occur in conjunction with the current MHC, requiring the MHC judge to begin hearing District and Superior Court cases which are not typically heard in that courtroom.

Costs for the attorney and paralegal time have been calculated from a previous proposal from King County to DSHS ("King County Mental Health Diversion Program Proposal"). In that document, the salary for a DPA is calculated at \$132,650 per year and the salary for a

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<sup>4</sup> Recent analyses have indicated that some states are using the Medicaid code for psychosocial rehabilitation (H2017) to garner reimbursement for restoration services. State eligibility rules differ, and our preliminary analysis is that Washington will not currently provide reimbursement for this service. However, DSHS billing experts should investigate this further.

paralegal is \$83,650. Using the previous ratios, a .4 FTE DPA will cost \$53,060 and .2 FTE paralegal will cost \$16,730. Costs for a .2 FTE judge and clerk are unknown but expected to be significant. To be frank, the mechanism for a state agency to pay for county employees is difficult to envision; we rely on DSHS for guidance on this issue. If this cannot be accomplished, the OCRP Dedicated Court model may need to either be grant-funded or shelved in favor of a different model. Or perhaps the judiciary can find a way to identify and allocate funding, given that they recognize the value in an OCRP.

For the Competency Calendar model, far fewer additional resource costs will be necessary. DSHS is likely to need additional resources to manage the relatively resource-heavy work involved on the front end of referrals. This could mean a .5 – 1.0 FTE DSHS case management or benefits acquisition position, in which the person works with the assigned BHO and provider to determine eligibility for housing and programming, housing availability, the existence of additional community supports (i.e., substance abuse, brain injury remediation), and so on. This position will allow the court to order a defendant into the OCRP with good faith that acceptance is secured and delays in moving the person into the program will be minimal.

For the General model, no additional judicial resource costs will be incurred. However, additional expenses will be incurred to create start-up processes as described above. In addition, regardless of the model chosen, it is possible that demand for forensic evaluator services will increase as more defendants are referred into the King County OCRP. Each defendant will need an objective CST evaluation, and as cases increase so too will evaluator demand. Additional forensic evaluator staff may be hired (likely .5 FTE), or workload responsibilities could be shifted among current evaluators. DSHS will need to examine the workload and available resources for these cases. We recommend that one evaluator be assigned to this program to enhance familiarity and efficiency, rather than assigning these cases across the larger forensic evaluator pool.

**Recommendations for King County.** In light of the above information, we recommend the following:

- DSHS should decide which OCRP model to pursue: the Competency Calendar, Dedicated Court, or Generic model.

- Create an RFP for potential providers in King County to provide competency restoration services, housing, forensic assertive case management, and substance use services.
- If either the Competency Calendar or Generic model is pursued, DSHS will need to coordinate start-up services, marketing, education, and procedures prior to the launch of the program.
- Incorporate District Courts as stakeholders.

## PIERCE COUNTY

The following plan is an update of the preliminary Pierce County plan we provided in our first two reports. The preliminary plan has been refined based on additional information and data. The general elements for data collection, eligibility standards, and necessary services (all described earlier) would apply to Pierce County as well.

**Estimate of potential participants in Pierce County.** Based on all the information provided, we estimate that there will be 30-40 potential participants in Pierce County (approximately three new referrals a month). This appears to be a reasonable starting point, and once the program is running effectively, there should be capacity to expand if needed.

**Resources currently in place.** Pierce County has a Felony Mental Health Court and a Drug Court that have protocols for diverting individuals from jail. The OCRP can build on the foundations developed by these courts for identifying eligible defendants, monitoring progress, and determining standards and mechanisms for revocation when needed. Pre-Trial Services conducts risk assessments at arraignment in felony court, and they may be an asset in identifying appropriate candidates for OCRP. There are also a reasonable number of potential referrals, based on data regarding misdemeanants and lower level felonies found incompetent to stand trial. Pierce County also has a well-developed mental health treatment program in the county jail that provides early assessment and treatment of mentally ill inmates. Excellent communication mechanisms have been developed between the jail and the courts, facilitating identification of defendants with mental health problems. Thus, there are good resources for identifying a pool of defendants who may be eligible for OCRP.

There are potential BHO partners and options for housing. Although there are challenges in finding housing for this population, issues related to finding adequate, affordable housing are not as difficult as those in King County.

**Models of service.** No competency calendar currently exists in Pierce County courts. Therefore, consideration should be given to developing an OCRP based on a special calendar in the existing Pierce County Mental Health Court. The advantages and costs of this model would be similar to those identified in the King County Dedicated Court model. However,

stakeholders from Pierce County identified that a number of potential participants would likely come from Municipal and/or District Court, so provisions would need to be made to coordinate with those courts as well. Also, given the transportation issues and geographical diversity, it is most feasible to have two OCRP sites, one based in Tacoma, and one based in Puyallup. Depending on the resources available through BHOs and community providers, there could be one program with two sites, or two different vendors (one for each site).

Essentially there are two options. One model would be to build on the infrastructure available through the Felony Mental Health Court. For this model there would be an identified session (half day per week) in conjunction with the existing MHC calendar. There would need to be Restoration specialists to conduct pre-screens, aid in the development of the restoration plan, serve as liaisons to community resources and case management, assist in the community transition, monitor progress, provide restoration sessions, and report updates to the court. As with King County, these positions could either be funded through a BHO/community provider or directly through DSHS. They would each carry a caseload of 10-15 cases at any one time. Defendants would be required to report to the court every other week, unless significant violations occurred that could necessitate significant sanctions. Implementation of this model would require discussion and coordination between DSHS and the relevant stakeholders in Mental Health Court to ensure buy-in. The General model, similar to the model discussed above for King County, would embed the OCRP within existing court sessions. Once eligible defendants are adjudicated as incompetent and found appropriate for community release, they would be referred to the OCRP.

However, DSHS should strongly consider working collaboratively with the Pierce County judiciary to encourage, develop, and support the creation of a mental health or competency calendar. These calendars show great promise in terms of consistency and efficiency. Of course DSHS has no jurisdiction or decision-making power regarding the creation of such calendars, and the absence of a current Pierce County competency calendar precludes us from thoroughly considering or recommending that model (as opposed to King County). If such a calendar existed, we would likely recommend that model be adopted and expanded. We therefore encourage DSHS to consider the two most immediately-viable models presented above for Pierce County, while also carefully considering how DSHS could support the development of a Competency Calendar model over the longer-term.

**Implementation.** As with King County, if the program is embedded within MHC, a specific calendar could be created within the MHC for the OCRP to determine eligibility, conduct status hearings or updates, conduct sanctions and revocations, and adjudicate competence decisions. This would require a dedicated judge, Deputy Prosecuting Attorney (DPA), Deputy Public Defender (DPD), and a competency restoration specialist. In the Generic model, coordination would be required between the OCRP, the courts, and DSHS.

**Referral process.** The referral process would come through the courts—primarily defense counsel, although some may be initiated by the judge. The jail mental health service may also be a useful resource in early identification of *potential* referrals (i.e., pre-trial defendants who appear mentally ill, are likely to be referred for a competency evaluation, and who appear to be appropriate for release from custody).

**Eligibility criteria.** We recommend these be very similar across sites. First, these include appropriate charges: misdemeanors or non-violent C-class felonies. Second, eligible defendants must adhere to prescribed medication. Third, eligible defendants must demonstrate recent clinical stability and low risk to public safety (e.g., no violent or reckless behavior). Finally, the defendant must agree to mandated substance abuse treatment as needed, including drug screens. Of course, local experts may amend these criteria to accommodate local customs and norms; what works in King County may not transfer perfectly to Pierce County. Still, the basic eligibility “backdrop” is likely to be largely uniform across the three counties.

**Component parts.** The major elements of an OCRP will be consistent across counties, as described above (Necessary Services). Primarily, the defendant will be placed into intensive mental health resources. The resources will be individualized but will likely include forensic assertive case management, medication management, substance use treatment and monitoring (as indicated), mental health treatment, and housing. Competency restoration sessions will be provided, consistent with an individualized treatment plan, employing a consistent curriculum/approach.

**Sanctions and violations.** The restoration specialist will monitor progress on competency restoration goals as well as violations of the program or court order. Minor transgressions will result in minor sanctions (e.g., warning from the judge, reduction of some privileges previously attained), while more serious violations could result in revocation and return to WSH. These will include evidence or documented serious threats of harm to self or others, non-adherence to medication as prescribed, and positive drug screens (or a refusal to be tested). Sanctions will be formalized and graduated, depending on the seriousness of the violation. The courts can build on existing approaches to sanctions utilized in Mental Health and Drug Courts.

**Outcomes.** Defendants restored to competence (likely a strong majority) may proceed to adjudication. Any revoked defendants may be placed into WSH. In the General model, the process for incompetent defendants would be identical to the calendar model; defendants found competent will proceed with trial and apply for MHC individually. As in the other jurisdictions, it will be important to track rates of restoration, time to restoration, and related details.

**Current gaps in implementing an OCRP.** Based on input from stakeholders, it appears that Pierce County currently has fewer diversion resources currently in place compared to King and Spokane Counties. Also, most of the data and information we have reviewed to date, and the stakeholders with whom we met, focused on Felony Court. However, there are Municipal and/or District Courts that serve many parts of the county, and it will be necessary to incorporate them into the process.

Consistent with the situation in the other counties, funding will be necessary for additional case management staff, as well as a restoration specialist staff position. Existing BHOs should be able to provide clinical and support services, including housing assistance, although additional funding would be needed for housing. Again, similar to the other counties, a significant part of the OCRP population in Pierce County is likely to need FACT-level services. Most of these services are likely Medicaid-reimbursable, other than direct competency restoration services. Based on the anticipated numbers, at least one restoration specialist position would be recommended for Pierce County.

**Budget implications.** We estimate a cost of \$200 per day per participant, though this estimate could change. Using the national average of 111 days of OCRP participation (prior to being restored, found unrestorable, or terminated/revoked), and an estimate of 30-40 participants annually, the overall cost is estimated to be between \$666,000 and \$888,000.

The final annual fiscal cost to DSHS will likely be considerably lower as many of the services (case management, housing supports, therapeutic activities, medication, etc.) are reimbursable by Medicare. The only non-reimbursable costs for OCRP are the actual competency restoration sessions, some staff position costs, some travel and coordination, and any additional housing. In addition, there will be costs to DSHS for additional forensic evaluator resources to re-assess competence to stand trial for this population. Lastly, as with King County, if the MHC model is adopted, there are likely to be additional costs for the judiciary and the prosecutor's office.

**Recommendations for Pierce County.** In light of the above information, we recommend the following:

- DSHS should decide which OCRP model to pursue: the Dedicated Court or the General model.
- If fiscally viable, we strongly recommend the Dedicated Court model of OCRP in Pierce County. This OCRP model will be held in conjunction with the existing MHC.
- Implement an OCRP Dedicated Court in Pierce County, if fiscal analysis allows, for 3-4 new defendants per month.
- Create an RFP for potential providers in Pierce County to provide competency restoration services, housing, forensic assertive case management, and substance use services.
- If the General model is pursued, DSHS will need to coordinate start-up services, marketing, education, and procedures prior to the launch of the program.



## SPOKANE COUNTY

The following plan is an update of the preliminary Spokane County plan we provided in our first two reports. The preliminary plan has been refined based on additional information and data. The general elements for data collection, eligibility standards, and necessary services (all described earlier), would apply to Spokane County as well.

**Estimate of potential participants in Spokane County.** Stakeholders estimated that Spokane could identify at least 3 to 4 defendants monthly for an OCRP, for a total—conservatively estimated—of at least 35 per year. Although all stakeholders emphasized the difficulty in providing firm estimates of defendants who would be eligible for a potential OCRP, all agreed a) enough of these candidates exist to comprise an OCRP, and b) Spokane County has existing mechanisms to review and consider whether candidates are appropriate for release to the community. These conclusions and estimates were largely influenced by considering the population of defendants currently screened for Spokane’s mental-health-focused jail-diversion program (5177 Diversion Program).

**Resources currently in place.** Spokane County has certain existing programs and relationships that may contribute significantly to an OCRP. Regarding relationships, one public defender provided anecdotes of collaboration between defense and prosecution to arrange OCR services in individual cases, such as those cases in which inpatient hospitalization was not clinically necessary and would carry great collateral costs to a defendant (i.e., loss of housing and social security benefits, loss of employment by which defendant supported family). Even such informal arrangements bode well for more formal collaborations for an OCRP. Regarding potential referrals, the public defender estimated that there exists a critical mass of defendants who would meet common eligibility requirements for OCRP and would be much better served by outpatient (versus inpatient) restoration services.<sup>5</sup>

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<sup>5</sup> One stakeholder lamented examples of defendants who “had housing and had their medication managed well at BHOs” but “just needed education to understand their charges and the court system...not inpatient treatment.” The same stakeholder also described defendants who were becoming increasingly stable in the community, but would be “de-railed” (e.g., losing housing, losing the

Spokane County's most significant and relevant infrastructure may be their well-developed pre-trial mental health diversion program, which works closely with the area BHO and other resources. As in other jurisdictions with similar diversion efforts, the 5177 Diversion Program can only accept competent (or restored) defendants, charged with misdemeanors or lower-level non-violent felonies, with a clear history of psychiatric illness, whom the government has no significant interest in prosecuting. So candidates are selected only with the approval of the prosecution. However, the director of the diversion program estimated that 75% of the potential participants she proposes are *declined* by the prosecution, given government interest in prosecuting the case. Thus, any of this large pool (i.e., 75% of those who meet the previous criteria) who require competency restoration would likely be ideal candidates for OCRP. In short, the Diversion and OCR programs target highly similar populations who must be considered safe for community placement (akin to CARD and OCRP in King County); but for any incompetent defendants in that larger group for whom the prosecution will not dismiss charges, OCRP seems an ideal option. Likewise, for those potential diversion candidates who cannot (yet) choose diversion because they are incompetent, OCRP is a preferable path to competence (as compared to inpatient restoration).

Spokane's Eastern State Hospital (site of inpatient restoration services) is also a *potential* resource for outpatient restoration. Although it may be difficult to integrate a state hospital with county-based outpatient efforts, some ESH staff have expressed enthusiasm for potential OCRP efforts, and have considerable expertise in competency restoration. At a minimum, such staff may be potential resources for training, consultation, or technical assistance.

Unlike King and Pierce counties, Spokane County does not currently operate a Mental Health Court or a judicial competency calendar. Thus, these are not current strengths to build on. However, if the judiciary was open to creating a Competency Calendar, this could yield many of the same benefits it may yield in King County. But we understand DSHS cannot

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opportunity to support their family) by inpatient restoration. Thus, OCRP seems much-needed for this small group of defendants. OCRP may allow some class members to avoid some of the collateral costs of inpatient hospitalization.

mandate such a calendar; the judiciary would have to adopt it themselves, and integrate the OCRP services thereafter.

**Model of service.** Just as King County can develop an OCRP that works in parallel to their CARD diversion program, Spokane may benefit from an OCRP that works in parallel to the 5177 Diversion program. The 5177 Diversion program infrastructure or services are reasonable models for this OCRP population (though the OCRP will need additional restoration specialists, as described above). However, the 5177 referral population differs from the OCRP population in that the OCRP population has more serious charges, which the government will want to pursue for prosecution. In this way, the OCRP will operate in parallel to the 5177 program— offering a similar breadth and depth of services, with the additional overlay of competency restoration. Potential OCRP referrals can be identified through procedures similar to those underway for 5177 Diversion (indeed, many of those candidates found incompetent and unsuitable for diversion would likely be ideal for OCRP).

Again, Spokane does not currently follow any calendar, or protected days, specific to competency proceedings. But if the judiciary was willing to adopt such an approach, this may become an even more efficient means of handling OCRP-related proceedings (as detailed in the previous King County Section). Again, akin to our Pierce County recommendations, the absence of a current Spokane County competency calendar precludes us from thoroughly considering or recommending the Competency Calendar model (as opposed to our King County recommendations). If such a calendar existed, we would likely recommend that model be adopted and expanded. We therefore encourage DSHS to consider the most immediately-viable model presented above for Spokane County, while also carefully considering how DSHS could support the development of a Competency Calendar model over the longer-term in Spokane County.

**Implementation.** If Spokane followed the Dedicated Court model proposed for Pierce County (or even developed a Competency Calendar approach similar to King), a specific calendar could be created for the OCRP, perhaps protecting one half-day per week to staff new referrals, determine eligibility, order the OCRP, conduct status hearings or updates, conduct sanctions and revocations, and adjudicate competence decisions. Participants could comprise

a clinical OCRP team, including a dedicated judge, Deputy Prosecuting Attorney (DPA), Deputy Public Defender (DPD), and a competency restoration specialist. The team would gather referrals and begin the process of determining eligibility and existing services (e.g., benefits, housing, medication) and then would utilize the team model to get updates and determine appropriate actions prior to the court hearings on that day's calendar. However, like King and Pierce counties, an alternative General OCRP model should also be considered if a formal Dedicated Court or Competency Calendar is not feasible in Spokane County; the implications of a General model would be similar to those described in previous sections.

**Referral process.** Referrals may come through two primary means. Defense counsel (and even judges) should raise the possibility of outpatient restoration on a case-by-case basis as defendants are found incompetent. Second, as potential participants are screened for the 5177 Diversion program, the diversion program director may refer those who are ineligible due to incompetence.

**Eligibility criteria.** We recommend these be very similar across sites (i.e., similar to King and Pierce counties). First, these include appropriate charges: misdemeanors or non-violent C-class felonies. Second, eligible defendants must adhere to prescribed medication. Third, eligible defendants must demonstrate recent clinical stability and low risk to public safety (e.g., no violent or reckless behavior). Finally, the defendant must agree to mandated substance abuse treatment as needed, including drug screens. Of course, local experts may amend these criteria to accommodate local customs and norms; what works in King or Pierce counties may not transfer perfectly to Spokane County. Still, the basic eligibility “backdrop” is likely to be largely uniform across the three counties.

**Component parts.** As in the other pilot jurisdictions, the OCRP would consist of several concurrent parts. Primarily, the defendant will be placed into intensive mental health resources. These resources will be individualized but will likely include forensic assertive case management, medication management, substance use treatment and monitoring (as indicated), and housing. Competency restoration sessions will be provided in either individual or group settings—whichever is most appropriate for the individual defendant.

**Sanctions and violations.** As in the other jurisdictions, the restoration specialist can monitor progress on competency restoration goals as well as violations of the program or court order. Minor transgressions will result in minor sanctions (e.g., reprimands from the judge, reduction of some privileges previously attained), while more serious violations could result in revocation and return to ESH. These could include threats of harm to self or others, non-adherence to medication as prescribed, and positive drug screens (or a refusal to be tested). Sanctions will be formalized and graduated, depending on the seriousness of the violation.

**Outcomes.** Defendants restored to competence (likely a strong majority) may proceed to adjudication. Any revoked defendants may be placed into ESH. As in the other jurisdictions, it will be important to track rates of restoration, time to restoration, and related details.

**Current gaps in implementing an OCRP.** In Spokane County, some infrastructure and interest are already in place, but Spokane requires funding for restoration-specific services. As in the other counties, funding is needed for new restoration specialist staff positions, additional case management staff, and housing. Existing BHOs likely have the infrastructure to offer case management, psychiatry, care coordination, treatment, and housing assistance.<sup>6</sup> This population is likely to need FACT-level care, as they carry many psychosocial needs (e.g., housing, substance abuse, mental health, crisis, etc.). The providers should be able to bill and obtain reimbursement from Medicaid for most of these services.

However, the identified BHO or community provider will likely need additional funding to staff case management and other psychosocial needs that reimbursement dollars do not cover. The extent of these positions is unknown and will depend on the agency's capacity for obtaining reimbursement. The identified BHO or community provider will also need funding for housing expenses.<sup>7</sup> Though perhaps fewer than in other counties, at least

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<sup>6</sup> This account is based on a brief, initial response from a BHO representative. We have pursued additional interviews with Spokane BHO leadership, but have not yet been able to conduct the actual interviews.

some proportion of OCRP participants in Spokane County will need housing in order to successfully remain in the community.

A .5 FTE competency restoration specialist position is recommended for Spokane County (though this might expand to 1.0 FTE as the program develops). As in other counties, these can be master's level positions in psychology, social work, or counseling, but staff must possess a command of trial competence and related issues.

**Budget implications.** We estimate a cost of \$200 per day per participant, though this estimate could change. Using the national average of 111 days of OCRP participation (prior to being restored, found unrestorable, or terminated/revoked), and a conservative estimate of 30 participants annually, the overall cost is estimated to be roughly \$666,000 (30 participants @ \$200 per day x 111 days of restoration services each).

Again, the final annual fiscal cost to DSHS will likely be considerably lower as many of the services (case management, housing supports, therapeutic activities, medication, etc.) are reimbursable by Medicare. The only non-reimbursable costs for OCRP are the actual competency restoration sessions, some staff position costs, some travel and coordination, and any additional housing.

**Recommendations for Spokane County.** In light of the above information, we recommend the following:

- DSHS should decide which OCRP model to pursue: the Dedicated Court, the Competency Calendar, or the General model.
- Create an RFI/RFP for potential providers in Spokane County to provide competency restoration, housing, forensic assertive case management, and substance use services.
- DSHS will need to coordinate start-up services, marketing, education, and procedures prior to the launch of the program.

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<sup>7</sup> Stakeholders report that some Spokane housing resources (e.g., Catholic Charities) have historically collaborated with BHOs and may be ideal for OCRP participants. But of course, additional funding is necessary for additional services.

- Discuss the vision of the OCRP with potential bidders and stakeholders prior to the announcement of the RFI/RFP.

**Addendum to the Draft Implementation Report, originally submitted April 30, 2017**

Date of Addendum: May 25, 2017

In continued discussions with King County stakeholders, we have learned about an additional resource in King County Superior Court that could be a significant component of the outpatient competency restoration program (OCRCP) in King County. The King County Superior Court operates a “competency calendar.” Essentially, this calendar funnels most competency-related cases in Superior Court (felony-level charges) to one courtroom, and holds hearings on a specific day of the week. It acts as sort of a “middle ground” between a dedicated specialty court (the competency restoration version of a Mental Health Court) and a more general model in which cases are heard in various courtrooms around the courthouse. We will use these definitions throughout this report; terms in the previous Draft Implementation Plan have been reworded to adopt the new definitions.

- *General Model:* Competence cases are handled as they naturally occur, scattered across dates and courtrooms, with no coordination and no assurance that the same staff handle them. This requires all of the judiciary to have some fluency in competency and OCRP issues. Essentially this is what is already in place in most jurisdictions. The OCRP would essentially be an add-on option for community placement, but would have little role in the courthouse.
- *Dedicated Competency Court Model:* A “deluxe” model with a judge, defense staff, and prosecution staff dedicated (assigned) to handling only competence cases. This will almost certainly require additional funding and resources, though an advantage is the specialized focus and more efficient, expedited services. This model is analogous to specialized Mental Health Courts, and could integrate with existing MHCs as a pre-trial adjunct (it is likely that many defendants who successfully complete the OCRP will be reasonable candidates for a MHC).
- *Competency Calendar Model:* A “middle ground” between the two above models, this approach schedules all competency-related proceedings in a particular courtroom and



perhaps particular day of the week. This tends to promote more consistency and familiarity among some personnel, but requires little in the way of additional staff or funding. Some additional resources may be necessary to conduct pre-screens and logistical workloads so that cases are ready to be heard and adjudicated during the competency hearings, and some resources may be necessary for status hearings, progress updates, or sanctions.

The Competency Calendar model holds great promise for King County specifically. It consolidates most competency-related matters into one courtroom, making the personnel more familiar with competency-related matters (i.e., statutes, programs, procedures, time frames) and making scheduling and future appearances more predictable. No additional judicial personnel are required to make this calendar function, which obviously reduces the financial burden of the model. However, in comparison with the Dedicated Court model, there is a relative loss in consistency and efficiency. There are no dedicated attorneys, judges, or other personnel – the courtroom will still rotate different judicial personnel over time. This leads to a relative net loss of consistency and efficiency. Still, the benefits of this model are significant when compared to the General model, and the financial benefits are substantial when compared to the Dedicated Court model. We believe this model could have significant benefit for King County, and we have incorporated that analysis and recommendations into this revised Draft Implementation Plan.

There are some caveats. First, additional judicial personnel need to be contacted to discuss the viability of a Competency Calendar model. We have not been able to speak with some of the key stakeholders working in the current competency calendar courtroom. Additionally, information for Spokane County has been more difficult to obtain than anticipated; a call is scheduled for May 30, which will hopefully provide additional information. Conversations with each county's stakeholders will continue, and our recommendations may change as a result.

Second, this model seems most viable for King County, simply because such a calendar is already operating. Other jurisdictions do not have this sort of calendar in operation. Moreover, DSHS is not in a position to mandate such a calendar; these calendars lie under the jurisdiction

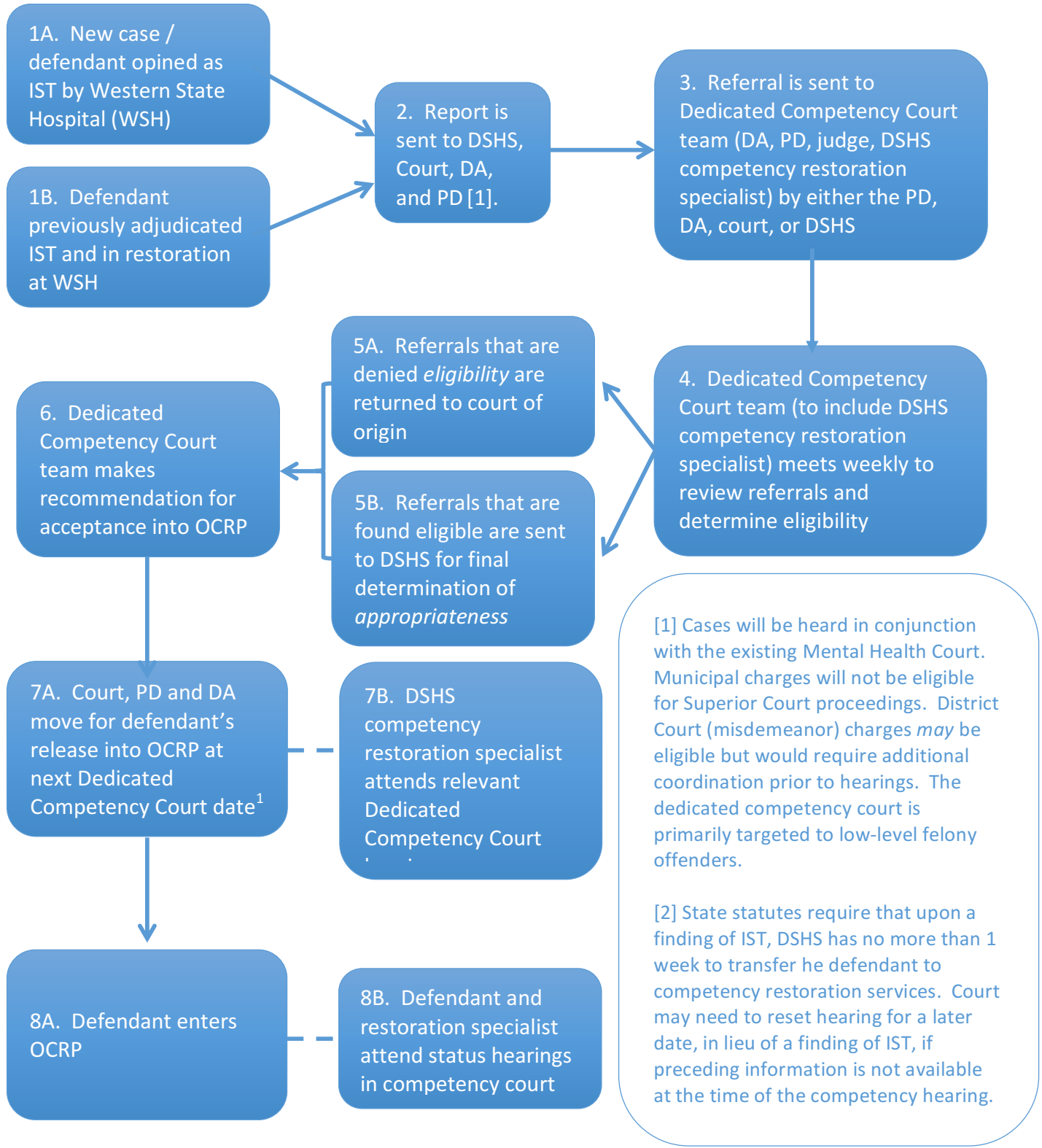
of the judiciary. DSHS may wish to recommend such a model with their counterparts in Pierce and Spokane judiciaries, but at this point it would be premature for DSHS to “adopt” a Competency Calendar model in Pierce or Spokane counties because those calendars do not currently exist. However, it is our recommendation that DSHS pursue discussions with existing collaborative partners and stakeholders in the Pierce and Spokane county judiciaries to encourage, support, and facilitate the creation of these types of calendars, given the significant advantages they possess.

Finally, the Competency Calendar model will require additional DSHS coordination on the “front end,” prior to the hearing on competence. Stakeholders report that DSHS eligibility determinations, housing placements, community supports, and admission decisions must be completed prior to the hearing, so that the court is assured that an order for OCRP can be immediately put into action. Stakeholders report that, essentially, the presiding judge will want to have a fully-informed plan and decision regarding OCRP before the person is moved for release to the program. It is imperative that DSHS provide resources to allow for this “front-loading” of casework so that the defendant can be transferred from jail to the OCRP as soon as possible.

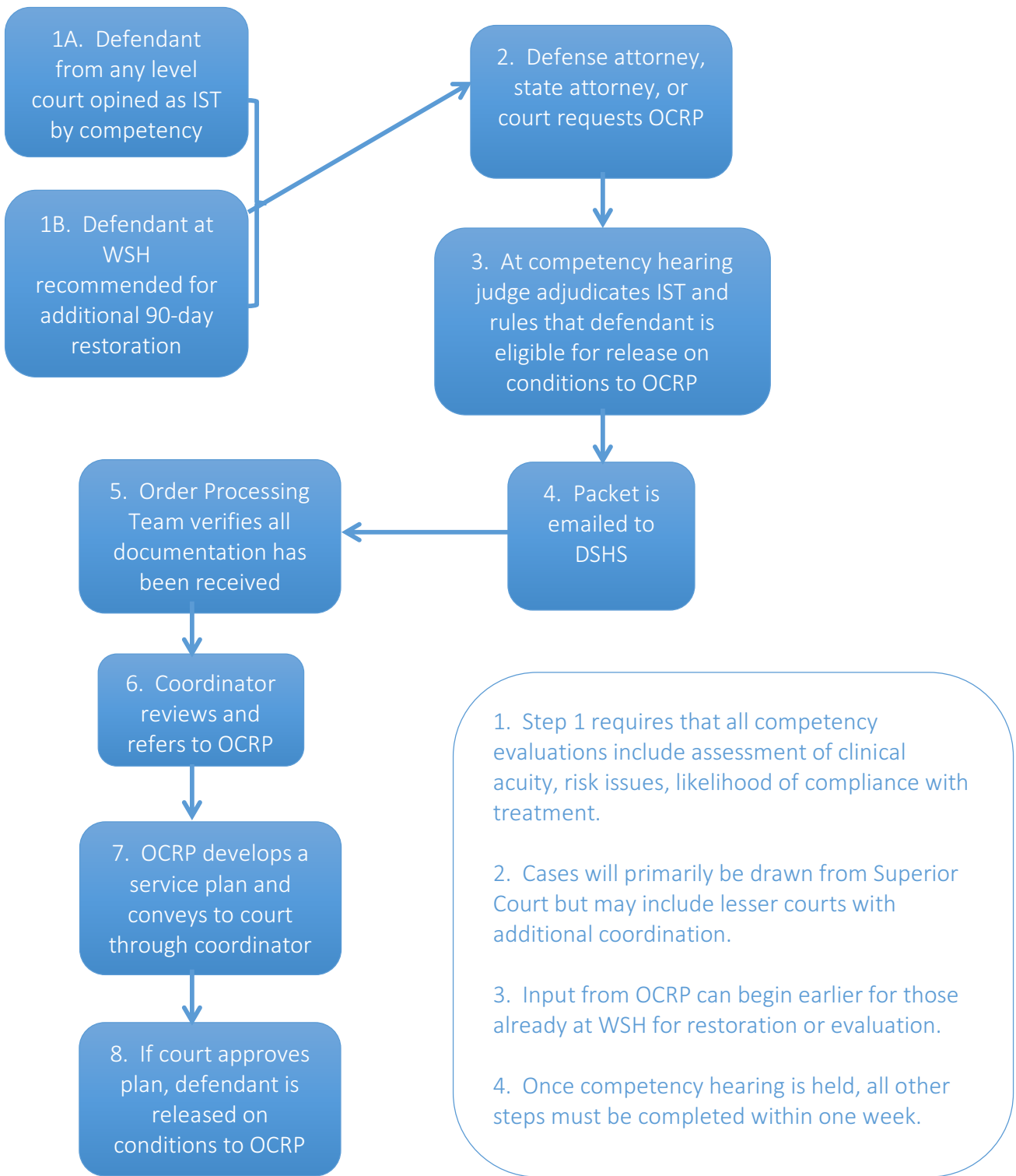
## Appendix 1. Process for Competency Calendar Model



### Appendix 2: Process for Dedicated Competency Court Model



### Appendix 3: Process for General Model



#### Appendix 4: Comparison Chart Across Counties

	KING	PIERCE	SPOKANE
Potentially Eligible Participants (per year)	36-50 (estimated)	30-40 (estimated)	30 (estimated)
Potential Models *	<p><i>Competency Calendar</i> already exists.</p> <p><i>Dedicated Competency Court</i> is plausible.</p>	<p>-General model, but <i>Competency Calendar</i> is plausible and ideal pending court support, <i>Dedicated Court</i> as secondary option</p>	<p>General model, but <i>Competency Calendar</i> is plausible and probably ideal pending court support, <i>Dedicated Court</i> as secondary option</p>
Existing Resources	<ul style="list-style-type: none"> <li>-Current motivation and interest across most stakeholders</li> <li>-CARD diversion program</li> <li>-Mental Health Court</li> <li>-Competency Calendar</li> </ul>	<ul style="list-style-type: none"> <li>-Felony Mental Health Court</li> <li>-Pretrial assessment services</li> <li>-Jail mental health treatment program (strong communication between jail and court)</li> </ul>	<ul style="list-style-type: none"> <li>-5177 diversion program</li> </ul>
Eligibility Criteria	<p><i>Similarly cross all sites.....</i></p> <ul style="list-style-type: none"> <li>-Eligible charges (misdemeanors or class-C felonies)</li> <li>-Adherence to prescribed medication</li> <li>-Adherence to substance abuse treatment, and monitoring</li> <li>-Clinical stability</li> <li>-Tolerable safety risks</li> </ul>		

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Services Included	<i>Similarly across all sites...</i> <ul style="list-style-type: none"><li>-Case management</li><li>-Mental health treatment including forensic assertive case management, medication management</li><li>-Substance abuse monitoring, and treatment as needed</li><li>-Housing as needed</li><li>-Competency restoration education sessions</li></ul>
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Gaps or Needs	<i>Similarly across all sites...</i> <ul style="list-style-type: none"><li>-“Restoration Specialist” service coordinator staff,</li><li>-Housing resources</li><li>-Most other services can be arranged through BHOs</li></ul>
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## Appendix 5: Sources of Information

### *Meetings and Phone Interviews:*

- Telephone interviews with Ingrid Lewis and Tom Kinlan from DSHS / OFMHS (multiple telephone calls January – March, 2017)
- Telephone interview with Dr. Danna Mauch (Court-appointed special monitor) and Ingrid Lewis (DSHS / OFMHS) on March 10, 2017
- In-person group meeting with DSHS / OFMHS stakeholders on March 13, 2017
- In-person group meeting with King County stakeholders on March 14, 2017
- In-person group meeting with Pierce County stakeholders on March 14, 2017
- Telephone group meeting with *Trueblood* DSHS legal team on March 14, 2017
- In-person group meeting with Spokane County stakeholders on March 15, 2017
- Telephone interview with Tim Lewis and Kit Proctor, Pierce County D.A.’s office
- Telephone interview with Kari Reardon, Spokane County public defender, on March 30, 2017
- Telephone interview with Kathleen Armstrong, Spokane County diversion services, on March 31, 2017
- Telephone interview with Louis Frantz, King County Public Defender’s Office, on May 23, 2017

### *Records Reviewed:*

- “Memorandum: Proposed community-based Western State Hospital satellite competency restoration services,” dated December 29, 2014
- *Trueblood* Diversion Plan, dated August 19, 2016
  - *Trueblood* Diversion Plan Appendix
- “Admissions Screening Criteria for Alternate Site Competency Restoration Patients,” dated August 19, 2016
- “Triage Flow Chart,” dated October 13, 2016
- “Jail Diversion for People with Mental Illness in Washington State: A Study Conducted for the State of Washington Office of Financial Management” by Joplin Consulting, dated November 21, 2016
- “Final Alternative Options and Recommendations Report” by PCG Health, dated November 28, 2016
- “Consultant’s Report Regarding Maple Lane Correctional Complex for the Court Monitor,” dated December 12, 2016
- “Consultant’s Report Regarding Yakima Competency Restoration Center for the Court Monitor,” dated December 12, 2016
- “*Trueblood* Jail Diversion Request for Proposals Application,” dated January 4, 2017
- “State Hospital and Residential Treatment Facility Outcome Data: March 2016 to November 2016,” dated January 17, 2017
- “Request for Triage Consultation and Expedited Admission (TCEA),” dated March 6, 2017



- Washington State Department of Social and Health Services: Alternate Sites for Competency Restoration, undated
- “Triage Consultation and Expedited Admissions Planning Document,” undated
- “Statewide – Count of Referrals by Order Type, CY 2012-2016”
- “Annual Percent Change in Number of Referrals for Inpatient Evaluation and Restoration Competency Services,” date range 2012 to 2016
- Number of Court Orders for Competency Restoration by County, date range January 2016 to December 2016
- “State Hospital and Residential Treatment Facility Outcome Data for Patients Who Received Competency Restoration Services between March 2016 – January 2017”
- Court Orders
  - *Trueblood et al. v. Washington State Department of Social and Health Services et al.*: Findings of Fact and Conclusions of Law, dated April 2, 2015
  - *Trueblood et al. v. Washington State Department of Social and Health Services et al.*: Order Modifying Permanent Injunction, dated February 8, 2016
  - *Trueblood et al. v. Washington State Department of Social and Health Services et al.*: Appellate Decision, dated May 6, 2016
  - *Trueblood et al. v. Washington State Department of Social and Health Services et al.*: Order of Civil Contempt, dated July 7, 2016
  - *Trueblood et al. v. Washington State Department of Social and Health Services et al.*: Order Modifying Permanent Injunction as to in-Jail Competency Evaluations, dated August 15, 2016
  - *Trueblood et al. v. Washington State Department of Social and Health Services et al.*: Order re Status Hearing: Findings and Directives for Compliance with Court Orders, dated February 16, 2017
- Monthly and weekly reports
  - Maple Lane Weekly Report for February and March 2017
  - *Trueblood et al. v. Washington State Department of Social and Health Services et al., Case No. C14-1178 MJP*: Monthly Reports for the Court Appointed Monitor, dated May 5, 2015 – February 15, 2017
- “Proposal for Consideration Submitted to Washington State Department of Social and Health Services, Behavioral Health Administration: King County Mental Health Prosecutorial Diversion Program,” dated February 2016
- “Therapeutic Alternative Units” from King County, undated
- “Proposal 2: Competency Stabilization Program” from King County, undated
- “Profiles of CARD defendants” from King County, undated
- “Referral Assessment and for Diversion (CARD) outcome data 2016-17,” from King County, undated
- Responses from national surveys to state forensic systems administrators regarding outpatient competency restoration programs