Prepared for the State of Washington's Department of Social and Health Services in response to contract # 1532-37719

Analysis of Current Washington Competency Restoration Services

April 1, 2017

Prepared by: Groundswell Services, Inc.

W. Neil Gowensmith, Ph.D.
University of Denver
Daniel C. Murrie, Ph.D.
University of Virginia
Ira K. Packer, Ph.D.
University of Massachusetts

Groundswell Services, Inc.

Groundswell OCRP initial review

Overview of Contents

I. Sources of Information

Meetings and Phone Interviews (see appendix A for full list of attendees):

- 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

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

II. Washington's challenges and recent progress

The issues addressed in *Trueblood*[1] are challenging many other states. The volume of requests for inpatient evaluation and treatment of incompetent defendants exceeds the number of inpatient beds for forensic patients. Thus, many individuals adjudicated as mentally ill and incompetent to stand trial languish in jails, awaiting treatment and restoration services. There has been significant national focus on attempts to divert individuals from the criminal justice system at all levels (beginning at initial police contact, and continuing through detention, court hearings/trials, re-entry, and community corrections), and Washington State has made efforts to develop models at all points across the sequential intercept model.[2] Our initial report[3] focused broadly on issues related to evaluation and treatment of forensic patients referred for competence to stand trial and legal sanity evaluations. For the current report, we were asked to focus more narrowly on issues related to competency restoration. *Specifically, we were asked to assist in developing recommendations and RFPs for programs to provide competency restoration for out-of-custody defendants (i.e., outpatient competency restoration programs, or OCRPs) in King, Pierce, and Spokane Counties*. This report reflects our first impressions of promising strategies for OCRP in these three Washington counties.

Trueblood and Progress to Date

The *Trueblood* decision (as amended after appeal) set a standard of no more than 14 days wait for jailed defendants awaiting an evaluation of competency and no more than 7 days wait for an inpatient bed for those jailed defendants ordered for inpatient evaluation, or who have been adjudicated as incompetent to stand trial and ordered for

---

[1] *Trueblood v. State of Washington Department of Human and Social Services*, No. 2:2014cv01178, Washington Western District Court, 2015.

[2] Munetz, M. R. & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57*, 544-549.

[3] Gowensmith, W. N., Murrie, D. M., & Packer, I. K. (2014). *Forensic mental health consultant review final report* (Contract No. 1334-91698). State of Washington Department of Social and Health Services.

inpatient restoration. At the time of the original case (April, 2015), wait times for competency evaluations for defendants in jails averaged 20.7 days in the Western part of the state and 66.5 days in the Eastern part. For inpatient evaluations of competency, wait times averaged 25.5 days at Western State Hospital (WSH) and 91.8 days at Eastern State Hospital (ESH). Most relevant to the current project, for individuals adjudicated incompetent to stand trial, the wait times until admission for restoration averaged 39 days at WSH and 90.8 days at ESH.

The State of Washington responded to the *Trueblood* decision by adopting a number of significant reforms and innovative practices. These included:

- Creating the Office of Forensic Mental Health Services to provide better coordination, management, and oversight of forensic evaluations and treatment across the state;
- Creating two alternate, locked facilities to provide competency restoration. One of these facilities is in Centralia on the west side of the state (Maple Lane Competency Restoration Program), and one on the east side (Yakima Competency Restoration Program). These facilities, as of January 31, 2017, had a joint capacity of 54 beds (46 occupied);
- Adding 15 beds at WSH and 30 beds at ESH that could be used for a variety of forensic populations, including competency evaluation and/or restoration;
- Increasing the forensic evaluation capacity by 45%, through hiring 13 additional forensic evaluators;
- Creating four off-hospital locations to allow for more expedited evaluations of competency;
- Developing a pilot program in King County involving a shared calendar system to more efficiently schedule competency evaluations;
- Establishing pilot programs to divert individuals from the criminal justice system;
- Revamping and expanding the data collection and management of class member information statewide;
- Implementing uniform court orders for hospital admissions.

Hospital Census and Wait Times

Recent data (as of January 31, 2017) point to significant reductions in wait times for mentally ill defendants in jails, but continued difficulty in the western part of the state in meeting the required timelines established by the court. The improvements at ESH are particularly impressive, according to data provided by DSHS:

- Wait times for competency evaluations at county jails decreased from 61.3 days in April 2015 to 11.5 days in January 2017;
- Wait times for inpatient competency evaluations decreased from 56.3 days in April 2015 to 6.4 days in January 2017;
- Wait times for inpatient competency restoration services decreased from 54.7 days in May 2015 to 7.5 days in Jan 2017.[4]

At WSH:

- Wait times for evaluations at the jails decreased from 14.6 days in April 2015 to 12.8 days in January 2017;
- Wait times for inpatient evaluations decreased from 22.2 days in April 2015 to 19.2 days in January 2017;
- Wait times for inpatient restoration services decreased from 38.6 days in April 2015 to 28.8 days in January 2017.

Despite dramatic improvements, the state still has difficulties meeting the timelines established by the court order, and in February 2017 incurred fines of approximately $2,000,000, with nearly $9,000,000 incurred to date. Although there was better performance in meeting deadlines in January 2017, nevertheless 60% of defendants requiring competence restoration were not admitted within the required 7 days. There are concerted efforts to address this problem, including attempts to divert individuals from

[4] The initial wait time comparison month used here is May 2015 rather than April 2015, due to a possible anomaly in April 2015.

the criminal justice system at arrest[5] and creating additional inpatient space by more expediently transitioning inpatient insanity acquittees to community-based settings. However, as discussed in our 2014 Groundswell report, and confirmed by our recent discussions with stakeholders, there are other factors that constrain bed availability for defendants awaiting restoration, including continued barriers to discharging NGRI acquittees, increasing referral rates for competency evaluation, and the use of beds by forensic patients who are "flipped" to civil status.

Recent Competence Restoration Efforts

Washington opened two new sites (informally referred to as "Maple Lane" and "Yakima") that, together, have the capacity to treat up to 54 individuals at a time for restoration to competency. These defendants have fewer acute clinical needs than those requiring inpatient care, but require secure placement for public safety. This population differs from the potential OCRP participants on whom we are focused, because many of the former are not considered suitable for release to the community, given the severity of their charges (although, further analyses may help determine if some of these individuals might be appropriate for OCRP). However, we have reviewed the most recent reports of these facilities (December, 2016) by the Court Monitor's experts, because some of the issues identified with those programs could also be relevant to outpatient restoration. The most salient issue for these comparison purposes relates to the competency restoration curriculum, as this is likely to be comparable to the programs adopted in the outpatient restoration programs. Furthermore, some of the factors associated with the successes in restoring individuals to competency in those sites can inform the OCRPs. However, other issues related to facility and operational functioning will not apply to the outpatient programs.

As of January 31, 2017 there were 46 individuals being treated at these two facilities (who otherwise would have been at WSH and ESH). Based on the consultants' reports, it appears that of the 60 individuals admitted to Yakima, 18 are still in active

[5] Parties in *Trueblood as Next Friend of A.B. et al v. Washington State Department of Social and Health Services* (2016). *Trueblood* Diversion Plan State of Washington Department of Social and Health Services.

treatment, and of the rest 25 (60%) were successfully restored to competence to stand trial. At Maple Lane, there have been 127 admissions and 64 discharges, of which 36 (56%) were deemed competent to stand trial. These numbers compare favorably to those at WSH (52%) and ESH (57%). Average lengths of stay at the two RTFs (41 days at Maple Lane, 48 days at Yakima) are also shorter than average lengths of stay at the two hospitals (63 days at ESH, 76 days at WSH). These restoration rates are all far lower than the national base rate of approximately 81%; reasons for this discrepancy are unclear. In any event, it seems clear that the two RTFs have restoration rates and lengths of stay that compare favorably to those in the two state hospitals. In addition, closing these facilities would negate any bed day savings brought about by the OCRPs, as there would then be a need to accommodate 46-54 additional pre-trial defendants at the hospitals (save for the relatively low number of cases that could be placed in community-based, outpatient restoration programs).

III. National models and innovations in OCRP: Implications for Washington

In a 2015 national study, state forensic administrators across the country were asked to describe all outpatient restoration activities currently operating in their states.[6] We also reviewed state statutes governing restoration locations. We found that most states (n=36), including Washington, have statutory authority for outpatient competency restoration. Of those 36 states, a total of 16 states were currently operating formal OCRPs. Based on information from previous Washington state administrators, Washington was coded as offering "informal" outpatient restoration. Washington administrators provided anecdotal evidence that a small number of defendants had been released to the community for restoration in previous years, but that no formal outpatient restoration program had been implemented to date.

This same national survey also gathered details about existing OCRPs, and illustrated a variety of models currently in practice. In short, there is no one "right" way to operationalize OCRPs, nor has one model been shown empirically to yield better outcomes than others. OCRPs are a relatively new phenomenon, and most programs have little outcome data suitable for analysis. In addition, programs across states (and at times, within states) have significant differences that make direct comparisons difficult.

However, some trends and patterns across programs do exist. Likewise, there are some specific "choice points" at which programs can differentiate themselves. It appears that every program is at least partially tailored to the specific parameters of the population they serve; no two programs are identical. We will describe the most common models for OCRP here, and we will also discuss the factors that tend to distinguish specific programs from the others.

---

[6] Gowensmith, W. N., Frost, L. E., Speelman, D. W., & Therson, D. E. (2016). Lookin' for beds in all the wrong places: Outpatient competency restoration as a promising Approach to modern challenges. *Psychology, Public Policy, and Law.* Advance online publication. http://dx.doi.org/10.1037/law0000088.
Data was restricted to programs serving adults (no information on juvenile restoration programs was collected), and jail-based restoration programs were excluded from the scope of the project. Ten states currently operate competency restoration in existing or previous jail facilities, with varying degrees of success.

Similarities among programs

Size and longevity of OCRPs. Most OCRPs are relatively new programs with few participants. Eleven of the 16 programs have been operating for fewer than 10 years, with nine of those operating for seven years or less. Typically, these 11 programs have served a small number of jurisdictions or counties. Accordingly, these programs generally serve few individuals; most serve up to approximately 50 defendants per year. However, over time, programs tend to grow in size. Not surprisingly, states with the longest-running OCRPs have the largest number of participants. For example, Ohio, Connecticut, and Florida, had OCRPs since 1997, 2001, and 2002, respectively. These three programs reported large numbers and a large statewide scope relative to most of the newer programs (600 annual participants in Florida, for example). Texas and Virginia were anomalies, as they each began serving more than 100 people per year statewide shortly after implementation. Finally, OCRPs typically operate under the jurisdiction of urban courts; half of existing OCRPs started as pilot programs in their state's major metropolitan area (e.g., New Orleans, Portland, Milwaukee and Little Rock). Washington is targeting three major population centers (King, Pierce, and Spokane counties) for their initial OCRP rollout and as a result will likely be positioned in the midrange of OCRP startup size.

Statutory authority. Each of the 16 states, like Washington, has existing statutes explicitly authorizing competency restoration to occur in outpatient or community-based settings.

Demographics and charges among OCRP participants. The demographic characteristics of OCRP participants generally mirror local correctional populations in terms of ethnicity, age, and gender; typically, participants are disproportionally ethnic minorities and younger to middle-aged males. Females account for about 20% of participants on average. Most live in urban areas.

Participants are typically charged with misdemeanor offenses or non-violent felonies; they do not have lengthy violent criminal histories, and do not present high risk for serious violence. Approximately half of all OCRP participants nationwide are charged with misdemeanor charges, while the other half are charged with non-violent felonies.

Data from the Washington regions targeted for outpatient restoration reflect the typical referral pool. Participants are likely to be defendants facing low-level, non-violent charges. The pool of likely participants, drawn from the larger pool of class members, has a long history of involvement with mental health and crisis services, unstable housing, substance use, and previous court involvement (including competency-related services). This pool of likely participants will be described in more detail in a later section.

Clinical status of OCRP participants. Clinically, OCRP participants tend to be psychiatrically stable and able to take medications voluntarily; 80% of states with formal OCRPs have policies requiring that participants must be clinically stable in order to be accepted into the OCRP. About two-thirds of OCRP participants are incompetent due to psychiatric impairment, whereas about one-third are incompetent due to cognitive deficits and/or developmental disabilities. Finally, most program participants have some sort of substance-use related disorder (and subsequently, most programs include substance use treatment as part of their scope of services). As mentioned above, the pool of likely OCRP participants in Washington will certainly share these types of mental health, cognitive, and substance-use problems.

Admission procedures for OCRPs. Although admission procedures vary, a key component in the success of an OCRP is collaboration among stakeholders. Local criminal courts control which defendants are admitted into various OCRPs. Referrals tend to originate from specific courts or judges with whom good professional working relationships have been established. In Hawaii, for example, every OCRP participant is approved by one of two Honolulu courtrooms that operate mental health calendars. In Nevada, most referrals come from two urban courts (Reno and Las Vegas) that are staffed by dedicated public defenders familiar and comfortable with the Nevada OCRP. Although Washington does not yet operate a formal OCRP, a close network of judicial and mental health professionals in King County (Seattle) operates successful diversion and pre-trial mental health services for low-level offenders (e.g., the CARD program, "competency court"). This model will likely be especially useful in King County's OCRP; however, even if this broad scope of services is not available or appropriate for Pierce and Spokane counties, it is critical that unwavering judicial and mental health

collaboration and support serve as a strong foundation for these other OCRP jurisdictions.

Location, staffing, and scope of restoration services. In all instances, OCRPs provide competency restoration programming in community mental health settings such as community mental health centers, outpatient treatment centers at state hospitals, private offices, or specialized group homes. Louisiana, for example, offers most of its competency restoration programming at an aftercare clinic in the New Orleans metropolitan area. Arkansas began its OCRP as a day program at its state hospital, but has since moved the location to an urban community clinic. Colorado's program was based in a day hospital setting in Denver and has now shifted to a program operated by the University of Denver. Texas has a number of locations at crisis respite facilities and one subsequently closed hybrid criminal justice facility.[7, 8] While Washington may offer services in different types of locations across the three implementation sites, we recommend that the sites be truly outpatient and community-based (i.e., not jail or hospital-based).

Most programs involve multiple-disciplinary staff to provide restoration interventions in OCRPs. These include psychologists, psychiatrists, and forensically-trained licensed social workers or counselors. OCRP services may include, but are not limited to, education about the judicial process, medication management, psychotherapy, group and family therapy, psychological assessments and evaluations, and drug screenings.

Data and outcomes. Most states collect at least some outcome data on their OCRPs. With some exceptions, these outcomes typically measure rates of restoration,

---

[7] Graziani, C., Guzmán, M., Mahometa, M., Shafer, A. (2015). Texas outpatient competency restoration programs. Hogg Foundation for Mental Health. Retrieved from http://utw10282.utweb.utexas.edu/wpcontent/uploads/2015/09/EvaluationReport_091815.pdf.

[8] Beard, A. (2014-2015). Competency restoration in Texas prisons: A look at why jail-based restoration is a temporary fix to a growing problem. *Texas Tech Administrative Law Journal, 16*, 179-198.

lengths of stay, financial costs, and negative outcomes. Outcomes are uniformly strong across all OCRPs. Rates of restoration tend to be similar, or slightly lower than, inpatient rates. Any lower rates are likely attributable to the larger proportion of intellectual and cognitive disorders common in outpatient programs (these defendants, of course, are not as amenable to remediation with psychiatric medication). Similarly, lengths of stay are generally longer in outpatient programs than those found in inpatient programs, but not significantly so. Not surprisingly, there are significant cost savings for outpatient programs. Finally, negative outcomes are rare in OCRPs. Rehospitalization rates are low, and arrests are negligible (e.g., no OCRPs surveyed in the 2016 study reported any arrests for violent offenses). Overall, OCRPs show very promising results across a number of mental health, judicial, and public safety metrics.

Beyond the specific data collected and analyzed, most states have some sort of data collection process in place to monitor the effectiveness of their OCRP. This is essential to ensure that such programs are effective for the defendants they serve, as well as good stewards of taxpayer dollars. Washington's DSHS is currently revamping its data collection and analysis capabilities, and has voiced a commitment to collecting meaningful data on the new OCRP system. As detailed later in this report, we recommend rigorous data collection, using the same metrics across all sites.

Public safety monitoring / revocation. Each program has an identified set of prohibited violations and corresponding graduated sanctions for OCRP participants. These vary among programs, but the overall philosophy is similar: attempt to intervene in ways that promote continued involvement with the OCRP. Minor violations are managed within the program and do not constitute a return to the hospital. The recovery model provides some expectation of minor transgressions and setbacks. However, each program also had identified criteria that prompt rehospitalization. Most programs utilized some sort of external agency to effectuate the revocation process: the local prosecutor's office, pretrial services, or a similar agency. Revocation criteria were agreed upon by all parties prior to the implementation of the OCRP.

Differences among programs

Scope of services. A primary differentiating factor among OCRPs is the level of involvement of state government mental health agencies versus privately-contracted providers. Some states rely heavily on state-operated and/or state-funded mental health agencies to operate the program, while other states rely more heavily on privately contracted providers. Ultimately, *funding* is always provided through government mental health agencies, even if *services* are contracted to private providers. Overall, programs that are operated directly by state agencies tend to provide a broader array of psychosocial services, increased structure for staff and participants, and more intense oversight and monitoring by OCRP administrators than programs relying primarily on private contractors. For example, states operating OCRPs directly tend to provide more housing, substance abuse, and case management services than those exclusively focused on restoration.

This key difference among programs is largely determined by the philosophy of the state's forensic administration. Many states view competency restoration as a circumscribed, ancillary service. An analogy might be the use of physical therapy for stroke patients; medical care and overall decisions are made by the patient's treatment team, but specific services are sub-contracted to specialized providers. In this model, competency restoration provides a targeted, adjunctive service to person's mental health care needs. It does not provide more comprehensive mental health care services.

Other states, however, include a broad array of mental health services as part of their competency restoration programs. A person ordered to outpatient competency restoration in these programs is by default also ordered to comply with other mental health requirements in addition to competency restoration programming (e.g., housing rules, urine analyses, drug screens, injectable medication, specific mental health modalities).

It is critical for stakeholders to be uniform in their philosophy regarding outpatient competency restoration. Everyone must be on the same page regarding the purpose and expected outcomes of the OCRP. Washington stakeholders must decide what the appropriate scope of services will be for their outpatient restoration population

so that programs and infrastructure can be developed accordingly. Defining the roles of BHOs in the Washington OCRP is therefore critical as well.

Admission procedures. Most prospective OCRP participants are first committed to a state hospital prior to entering an OCRP. Typically, state hospital and OCRP staff screen prospective participants' readiness for an OCRP prior to advancing the request to court. Ultimately, court authorization is required prior to transferring participants from inpatient to outpatient settings, though state statutes and court practices determine the level of formal court involvement.

A smaller subset of participants is admitted directly from court or jail. For example, in order to reduce the number of individuals waiting in jail for hospital-level restoration, the Texas OCRP began mental health treatment and competency restoration in jail, concurrently identifying individuals for admittance into their OCRP. Alternatively, Connecticut regularly admits participants into their OCRP directly from court upon an initial finding of incompetence, thus averting the need for an interim hospitalization.

Clearly, direct admissions from court will both accelerate the outpatient restoration process and provide maximum relief to hospital bed pressure. However, direct admissions require the highest levels of coordination, expertise, and trust among judicial and mental health professionals. Risk assessment findings and outpatient program availability must be known and communicated at the competency hearing. Prosecutors and defense attorneys must be comfortable with direct releases to community-based programs. Court orders must be available for immediate use in such situations. It is important for the three targeted jurisdictions in Washington to determine whether and how direct releases to outpatient competency programs can occur.

Eligibility criteria. Similarly, there are differences in what types of charges and clinical conditions are eligible for OCRP referrals. Most jurisdictions allow for non-violent, low-level misdemeanor and felony charges, and most allow for a broad range of clinical conditions (including developmental disorders and substance related disorders). However, some differential criteria exist among programs. Some allow only misdemeanors, while some allow low-level felonies. Some allow violent charges, others do not. Finally, some serve defendants with active substance use or acute significant

mental health symptoms, while others refuse to admit persons who are using drugs and/or alcohol, or those who have experienced a recent psychiatric crisis.

Eligibility criteria are likely to vary among the three Washington sites. Prosecutors and defense attorneys in King County expected more latitude in eligible charges for OCRP then those in Pierce or Spokane Counties, for example. Nevertheless, it seems plausible that the three tests sites could agree upon a baseline of OCRP eligibility criteria (i.e., low level, non-violent charges for persons with stable mental health care and housing needs), but then individually allow additional participants as county-specific capacity and standards dictate.

Adult versus juvenile programs. While some states offer formalized juvenile competency restoration (e.g., Ohio, Virginia), most states have focused their attention on creating restoration options exclusively for adults. Administrators have been frank about the difference in expertise and resources needed for these two different populations, and generally recommend that states start with one population and then modify the existing system for the other population. Washington, at this point, is focused on adult restoration. In time, once adult OCRPs are running smoothly and showing evidence of good outcomes, perhaps juvenile OCRPs can be developed with the lessons learned from the adult system.

Funding. Funding is a challenge for all OCRPs. Currently neither Medicare nor Medicaid reimburses competence restoration. Instead, it is coded as a non-reimbursable psycho-educational service. The state of California is pursuing changes to Medicaid reimbursement rules so that outpatient restoration services can be covered; 2017 legislation has been tabled, but committees are preparing to re-introduce related legislative proposals in 2018.[9]

Therefore, all known OCRPs are funded by state mental health dollars or state block grants. Legislative appropriations have been requested by some states to pay for these programs. Alternatively, some states reallocate state hospital dollars to fund outpatient restoration programs, understanding that outpatient programs are far less

[9] We have provided information regarding this California initiative, and the contact information for those leading this initiative, to Washington's OFMHS.

expensive than their inpatient alternatives. The state of Colorado's Office of Behavioral Health Service has submitted legislation to formalize OCRPs in Colorado. The fiscal note attached to the proposal is nearly 1.2 million dollars per year, which will fund several hundred defendants and create three state positions, curriculum development, operating expenses, and contracted services for competency education and case management (nearly $1,000,000 is appropriated for the contracted services). Outpatient programs, although resulting in financial savings long-term, require an initial outlay of funding for development and implementation.

Private-pay approaches are not an option for OCRP. Most defendants are poor or indigent and have little money out-of-pocket to pay for services. The University of Denver OCRP is the only example of a private-pay model; functioning through a university's psychology training clinic, the model only works as a training and mentorship model. The university absorbs most of the cost in order to provide graduate student training opportunities. The sliding scale model used in the university clinic has only generated a few hundred dollars' worth of income for the OCRP; in addition, the clinic is capped in regard to the numbers of participants, primarily to keep funding deficits manageable. Partnerships with local universities could provide additional outpatient competency restoration resources and should be explored, but cannot serve as the backbone of a statewide OCRP network.

Like other states, Washington should be prepared to request a legislative fiscal appropriation to implement and maintain an OCRP system, and should stay updated with efforts around the country to change current Medicare and Medicaid reimbursement criteria. Targeted state block, SAMHSA, or Second Chance Act grants could also be fruitful avenues for initial startup funding.

Location of restoration services. There are differences across states in the location of the restoration sites. Some programs require the participants to come to a central location (e.g., day treatment center, community mental health center). Others use an outreach model, taking the restoration to the participants themselves (e.g., to a residential program or to individuals in remote areas). The three Washington test sites are likely to differ from one another in their service delivery approach. Spokane County is the most rural county of the three and has the largest geographical area in which

services are to be provided; as such, an outreach model may be more effective there. Services could be more centralized in Pierce and King Counties, although the BHOs will determine their own capacities for central versus outreach services.

Restoration curriculum. Different programs use different restoration curricula. Several states have modified Florida's "Compkit" curriculum to fit their state's laws, policies, and procedures. Other programs have developed their own curricula; some of these are sophisticated and well-designed, whereas others are informal and poorly structured. We are currently surveying and collecting the curricula used in existing OCRPs around the country. No particular curriculum has proven more effective than the others (probably because no research has addressed these important issues, not because curricula are truly interchangeable). However, it will be important for Washington to adopt a uniform curriculum for use in its three test sites. Indeed, if Washington were to adopt a uniform, core curriculum across the three new OCRP sites *and* the alternative sites and the state hospitals, this would allow for optimal comparison across programs (in terms of restoration outcomes, length of stay, and other important variables).

Table 1.
Summary of similarities and differences across OCRPs

Similarities	Differences
Low number of participants	Scope and provision of services
Early developmental stage	Admission source
Statutory authorization	Eligibility criteria
Participant demographics and charges	Availability of juvenile programs
Clinical stability of participants	Funding
Court referrals	Outreach models
Community mental health center location	Program curricula
Multidisciplinary staff	
Collection of outcome data	
Monitoring and revocation	

IV. Potential OCRP in Three Washington Counties

Perspectives on OCRP

As the national review of OPCR programs illustrates, there are a variety of approaches to OCRP, and fundamentally different philosophies or values underlying them. At one end of the spectrum is a philosophy that emphasizes defendants found incompetent to stand trial (IST) have not been convicted of any crime, and therefore should only receive the most "narrow" services, which include only education and clinically necessary medication management; other interventions (however therapeutic) are perceived as unfairly restricting the liberties of defendants not (yet) convicted of any crime. At the other end of the spectrum is a philosophy that considers IST defendants to be primarily mental health patients, who should be provided whatever interventions might help their recovery, even if some of those interventions involve restrictions (e.g., substance abuse monitoring). While we acknowledge merits and problems in each perspective, our understanding of the statements from Judge Pechman, the court monitor Dr. Mauch, and other authorities suggest that they all envision this latter model—i.e., a model of broad recovery services for IST defendants—for Washington. Given this clear preference from authorities, we tend to describe Washington's options for these more comprehensive services, but we will remind readers that not all jurisdictions consider these essential (or even appropriate). We also caution readers that developing exceptionally broad competence restoration services—without providing similarly broad services to non-forensic patients—can have the paradoxical consequence of increasing criminal charges against people with mental illness. If competence restoration for defendants appears to be the best (or only) path to treatment available, then authorities tend to turn more patients into defendants. We strongly encourage *all* stakeholders, including the federal judge and monitor, to carefully consider the potential adverse outcomes of building a system that may unintentionally "incentivize" criminal action in order to receive mental health care.

General implications for Washington

The above survey of OCRPs across the country indicates that there are many successful approaches to community-based competency restoration. No single model is the "best," or clearly superior to others. Instead, what appears to work most effectively are *programs tailored to meet the needs of their participants and communities*.

Some elements of the Washington OCRP system should be uniform across all sites, however. A "floor" baseline of eligible charges and mental health conditions should be agreed upon. A "ceiling" set of criteria for revocation should also be established. 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 local BHOs. Each program, using the same metrics, should collect data including restoration rates, lengths of stay, financial costs, and outcomes. Restoration curricula should be uniform. Overall, the philosophy of the entire OCRP program should be to move eligible class members from local jails and into community-based services as soon as is reasonably possible. As discussed by the presiding judge and monitor, a broader array of mental health and psychosocial resources is likely to be necessary to truly address the needs of the class members most likely to benefit from outpatient competency restoration.

However, there are going to be some distinct differences among the three implementation sites. Different BHOs will be involved, some with multiple BHOs or subcontractors. The referral process may differ among sites, with some sites utilizing currently-existing mental health court or diversion program procedures, some sites allowing for direct release to an OCRP directly from the competency hearing, and others requiring an inpatient commitment prior to community release. Some may benefit from a court-based clinician to help advise the court as to eligible defendants, available capacities and resources, and other issues. Some may provide a richer array of services (including housing) than others.

Regardless of the specifics, program administrators of existing OCRPs nationwide have talked frankly about the importance of carefully growing a successful program. OCRPs are alternatives to traditional inpatient restoration, and plans to develop an OCRP can make many stakeholders uneasy. One bad incident could seriously derail efforts to

launch or maintain an OCRP. National administrators encourage jurisdictions considering OCRPs to start small, ensure success, minimize negative outcomes, and develop an excellent track record that can be shared with courts, prosecutors, and other potential stakeholders. After this track record is clear, a program may be met with less resistance and allowed to expand in scope and size. Hawaii's program, for example, was initially housed in a secure, fenced area on the state hospital grounds with exclusionary criteria for felony defendants; however, the program now allows some felony defendants, and participants are housed in a standard group home in urban Honolulu.

Below we describe considerations necessary for implementing OCRP in all three Washington jurisdictions, and then we move towards discussing ways these may differ across the three different jurisdictions:

Potentially eligible defendants. Obviously, across all Washington OCRP programs, potential participants must be class-members who do not require an inpatient level of hospital care or intensive security. In most jurisdictions, this means OCRP participants tend to have committed less serious offenses, and have less severe (or more currently stable) psychiatric illness; some are defendants for whom intellectual deficits are their primary barrier to competence.

To be clear, the proposed OCRPs would primarily serve different class members than the Yakima and Maple Lane facilities, because the OCRP participants would be released from custody, living in the community. It is important to emphasize that the decision to release from custody would be made by the court, based on the same public safety considerations the court currently considers. 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 be adherent to treatment in the community setting, and is likely to avoid severe substance abuse.

Based on stakeholder input, lessons from other jurisdictions, and our own experience, we consider the following defendants most appropriate for OCRP (though we anticipate that programs may grow increasingly flexible with eligibility criteria as programs mature):

- Misdemeanor or less-serious felony charges (specific charge eligibility may vary)

- Clinical status appropriate for outpatient treatment, such as:
    - Psychiatric illness that is manageable with consistent (or injectable) medication and treatment in the community
    - No serious concerns about danger to self or others, or grave disability
    - Intellectual or cognitive deficits as primary basis for incompetence
- Security status (lifestyle stability) conducive to consistent outpatient participation
    - Minimal risk of absconding
    - Minimal risk of absence due to severe substance abuse
    - Minimal risk of re-offense or violence
    - In short, the court—using standard, well-defined procedures—considers the defendant a reasonably small security risk.

Necessary services. Obviously, 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), for example. But certain services will be crucial for so many IST defendants that they should be an available component of *any* OCRP program. These include:

- *Restoration curriculum*: All OCRP programs offer some psycho-educational curriculum to teach participants about court proceedings and help them better understand their legal situation. For certain defendants with intellectual deficits, this may be the most important component of restoration. For some with psychiatric barriers to competence, medication may be more essential than education, but education remains an appropriate adjunct. *Washington will require a uniform curriculum across all sites*. This should be a *well-developed formal curriculum specific to Washington*, not merely informal worksheets, movie viewing, etc.
- *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.
- *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, etc.).

- *Substance use screening (urinalysis) and treatment*: Substance abuse commonly co-occurs with psychiatric illness, often hampering recovery, and making it difficult to disentangle symptoms of illness from symptoms of substance abuse. While substance use treatment and monitoring are *not* a mandatory part of all OCRP programs nationwide, a comprehensive, "wrap-around" approach to OCRP may benefit from any efforts to monitor and minimize any substance use that interferes with the recovery process or threatens defendants' stability and progress towards competence.
- *Housing*: Like substance abuse treatment, housing is not an essential component of all OCRPs nation-wide. But, as stakeholders have emphasized, lack of affordable housing is a primary barrier to consistent participation in mental health treatment and broader recovery. To the extent housing services can be part of an OCRP (at least for those defendants who do not have other housing options) they increase the likelihood of steady participation and eventual restoration.
- *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.

Strengths and Challenges in each Washington County. Each of the three counties that DSHS has proposed for pilot OCRP programs have their own unique strengths and challenges. All have in place some key infrastructure that can be adapted to facilitate OCRP. But all will require some significant modifications and addition, and all carry unique barriers that will require resourceful solutions. We have summarized some of these strengths and challenges in the table below.

Table 2.

Strengths/Resources and Potential Challenges in target counties

	Strengths and Current resources	**Challenges**
King County		
	- Pre-existing exploration of OCRP, and motivation for OCRP including draft proposal - Numerous ancillary services and providers that could be networked into OCRP program - Particularly strong diversion program and mental health court to which OCRP program could be added (using similar infrastructure) - Obviously eligible misdemeanor defendants	- Housing shortages
Pierce County		
	- Strong mental health court that could provide infrastructure - Good communication between the jail and the court - Jail already provides early identification treatment of individuals with mental illness	- Less prior exploration of OCRP - Fewer obviously-eligible defendants because more defendants requiring restoration have felony charges
Spokane County (and surrounding areas)		
	- Strong progress in hospital restoration services - Strong motivation among hospital and other staff, with many willing to use an outreach model (some staff are already experienced with mobile outreach-style services)	- Wide geographic catchment area precludes an OCRP model with single, central location - Wide catchment area will inevitably require staff travel - May have small number of eligible participants from Spokane County

	- Anecdotal experience of successful outpatient restoration in certain cases, reflecting cooperation between prosecution and defense - Strong enthusiasm for outpatient restoration services among the defense bar - Housing resources (e.g., Catholic Charities) that already serve BHO clients - Successful current diversion program includes many procedures and infrastructure that may be adapted to OCRP	

V. Recommendations for OCRP in Each of Three Washington Counties

First, existing statutes appear to be consistent with initiating these programs. Specifically, RCW 10.77.086 (1)(a)(B) provides for felony charges that the court:

> May alternatively order the defendant to undergo evaluation and treatment at some other facility or provider as determined by the department, or under the guidance and control of a professional person. The facilities or providers may include community mental health providers or other local facilities that contract with the department and are willing and able to provide treatment under this section.

RCW 10.77.088 (iii), provides for non-felony defendants that the court: "May alternatively order that the defendant be placed on conditional release for up to ninety days for mental health treatment and restoration of competency." Also, no administrative rules or licensing rules that were made available to us prohibited the development of outpatient, community-based restoration.

One concern that has been identified with the above statutes is that if a defendant is deemed to have violated conditions of release in an OCRP, it is unclear for how long the defendant can then be hospitalized for inpatient restoration. For instance, if the defendant violates after 60 days, and is not yet competent, there is no explicit provision for how long he or she can then be hospitalized for restoration purposes. This is an area that may require some minor modifications in the statutes to allow for an inpatient restoration period if the defendant does not comply with conditions of release for outpatient restoration.

Developing OCRPs will require coordination and "buy-in" from judges, prosecutors, defense attorneys, jails, and community providers. To ensure investment and collaboration, programs should start with stricter eligibility criteria. As the programs develop, and can demonstrate success (using metrics such as percentage restored to competency, length of stay, positive clinical outcomes, uncompromised public safety, etc.), eligibility can expand to include somewhat more challenging cases. Additionally, criteria and policies / procedures that identify sanctions and penalties for violations of OCRP requirements must be created, including revocation and rehospitalization.

In addition, it will be important that the programs have good data collection ability, *consistent across all sites*. This is essential in order to be able to measure the effectiveness of the programs, compare programs to each other, and make improvements as needed. Ideally, data collection should even use similar metrics across hospitals and OCRPs, to facilitate comparison between inpatient and outpatient approaches. The DSHS data collection team should be involved at the earliest stages to make database input easy and accessible for all BHO providers, to allow for accurate and reliable data to be analyzed and compiled into reports, and to allow "crosstalk" among judiciary, mental health, and public safety stakeholders. Data collected should include, but not be limited to, the following:

- Legal charges
- Misdemeanor or felony
- 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)

Estimated numbers of potential participants by county

We have calculated an estimated range of participants for each of the three counties. However, these estimates are not definitive. We caution against deriving any firm or exact numbers at this time. First, the data that supports our estimates are somewhat incomplete. Second, identifying an exact number of referrals is practically

impossible because eligibility determinations are largely case by case decisions, informed by the politics and comfort levels of the court personnel involved, capacity and resources in the programs, case-specific issues, and other factors specific to each jurisdiction. Resource capacity in various BHOs or court calendars may also change the numbers of referrals possible for a particular county. Lastly, most programs around the country have started with fewer participants to ensure success, and then built capacity as programs grow; these initial numbers are likely to be lower than future referral numbers. For these reasons, we have used existing data to derive estimated numbers for each county's potential OCRP referrals, and these numbers will be presented in a range.

Estimates were generated from DSHS data representing frequencies of competency evaluations and inpatient restorations within the three test counties and further refined from data representing the Maple Lane RTF. Estimated ranges were mostly confirmed by in-person stakeholder meetings in each county (with Spokane County as an exception, as noted below). Initial estimates were derived from the numbers, by county, of competency restoration cases separated into four categories: a cross-sectional quadrant comparing level of charge (misdemeanor vs felony charges) by location of evaluation (in-jail or personal recognizance). For this initial phase, we include every defendant ordered to restoration who had completed an evaluation while on personal recognizance, as well as all misdemeanor defendants ordered to restoration who had completed their evaluations in jail.

We then used RTF data to further refine those estimates. Although the RTF and OCRP populations will not overlap entirely, it seems likely that clinical trends noted in the RTF population could be used to inform similar potential trends in the OCRP population. Maple Lane RTF data indicated that about 25% of their defendants did not adhere to medication, and that 25% did not adhere to treatment recommendations. (We cannot say how much overlap exists between those two populations, but we assume that a fair amount exists.) Medication and treatment adherence are two important eligibility criteria for OCRPs. It seems likely that some proportion of defendants in the initial cross-section above (level of charge vs. location of evaluation) will also be non-adherent to medication and treatment recommendations and will therefore be found ineligible for an OCRP. In the absence of firm numbers, we used the Maple Lane RTF numbers as a

guide to adjust our potential referrals. We therefore reduced the number of participants from the initial phase by 25%. Again, this provides an estimate only – the actual number of referrals for each county may be slightly higher or lower, depending on non-measurable factors.[10]

Using this methodology, we estimated approximately 45-60 defendants per year for King County, 30-40 per year for Pierce County, and 8-12 per year for Spokane County.[11]

Estimated budget analysis

We reviewed national fiscal data from 14 OCRPs around the nation, estimated costs of a recent King County Competency Stabilization Program proposal, estimated costs of a King County Mental Health Diversion Program proposal, and an outpatient competency restoration memorandum ("Proposed community-based Western State Hospital satellite competency restoration services") by Dr. Najolia in 2014 to determine estimated costs for OCRP.

Nationally, program administrators reported a daily cost of approximately $215 per defendant. The King County Competency Stabilization proposal estimates approximately $5000/month per defendant, which includes case management and housing but does not include competency restoration services themselves. Such services will incur costs of staff positions and time devoted to them, bringing the cost per defendant to around $200 per day. Similarly, the King County Mental Health Diversion proposal estimates costs at approximately $4000/month per defendant, again excluding competency restoration services. Dr. Najolia reported in her memorandum that national costs seemed appropriate for OCRPs in Washington. We estimate that daily costs will

---

[10] More precise numbers from the Maple Lane and Yakima RTFs have been requested. If these numbers cause our above estimates to change significantly, the numbers, budgets, resources, etc. will need to be adjusted accordingly.

[11] In some cases, we asked stakeholders in key positions to estimate the number of defendants they excepted could be eligible for an OCRP program. In Spokane County, informal estimates from some stakeholders were significantly higher than those we calculated here.

likely be higher than the two King County estimates (given additional staff and resources needed for competency restoration), but slightly lower than the national average (given the detailed King County estimates). We will use an estimated daily fee of $200 per defendant.

Using national norms of 111 days for OCRP participants to be in the program (prior to being found restored, unrestorable, or terminated/revoked), and using the estimated range for numbers of participants by county, the following overall costs are estimated using an average cost of $200 per day:

- King County (45-60 participants): $22,200 x 45-60 = $999,000 - $1,332,000
- Pierce County (30-40 participants): $22,200 x 30-40 = $666,000 - $888,000
- Spokane County (8-12 participants): $22,200 x 8-12 = $177,600 - $266,400

This produces a range between $1,842,600 - $2,486,400 per year. However, 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 housing. Furthermore, funding will be likely needed to support additional staff required to capably manage the numbers of defendants entered onto specific agency's rolls.

Potential Models for each County

Emphasizing, again, that certain basic criteria and procedures should be consistent across all sites, we also offer some suggestions unique to each county, based on their own current strengths and resources.

King County

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 well-developed group of stakeholders that are interested in pursuing OCR. This includes representatives from all corners of the judiciary (prosecutor's office, public defender's office, 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 requesting funding for an OCRP in King County (though funding was ultimately denied). Clearly there is a supportive foundation for OCR in King County.

The buy-in from stakeholders represents the existing infrastructure that is necessary to support an OCRP. Many similar projects are up and running in King County, which can serve as models for a county-specific OCRP. A competency court, with a dedicated competency calendar and staff, already exists. A court liaison position is currently staffed, and this person is an expert regarding community resources and housing availability. Several BHO 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), with the two most relevant being the CARD program and the Mental Health Court.

The CARD (Community Assessment and Referral for Diversion) program currently serves as a mechanism to divert persons with mental illness and low-level charges into services, giving good infrastructure from which to build an OCRP.[12] Stakeholders mentioned that the CARD program would be very similar to an OCRP, except that CARD defendants are typically municipal-level defendants in whom the government has no truly compelling interest in prosecuting. OCRP participants will likely be those for 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.

[12] Funding for the CARD program is due to end in July 2017. Stakeholders reported that they believe funding is likely to renewed, but this has not been decided definitively.

Finally, King County is home to a large population of low-level misdemeanant 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."

Current gaps for implementing an OCRP. King County is largely well-positioned for immediate start-up of an OCRP. Seemingly, 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 (likely Pioneer Services and/or Sound Mental Health, the major providers for MHC and other King County behavioral health populations) 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.). Drug-testing (urinalysis) is a mandated requirement from the King County Prosecutor's Office. The providers should be able to bill and obtain reimbursement for most of these services from Medicaid.

However, the identified BHO 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 BHO's capacity for obtaining reimbursement.

The identified BHO 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.

Finally, two restoration specialist positions are recommended for King County. These individuals would be responsible for providing the restoration interventions (a non-reimbursable service at this stage) to all OCRP participants, monitoring progress, triggering formal re-evaluations of competence from the forensic evaluation services team, and providing liaison support between the judiciary and the BHO treatment teams. Essentially these positions are 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 would also be experts in restoration. 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. They will likely be BHO hires, but could potentially be DSHS hires. They will each carry a caseload of 10-15 cases at any one time.

Currently, the MHC provides funding for mental health services and housing, but it is unlikely that they will expand funding for this population and program. DSHS is likely to incur costs for these positions, BHO resources, and housing in King County.

Model of restoration. The OCRP should, 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 wrap-around services in order to successfully remain in the community. The CARD program infrastructure is a great model to emulate for this OCRP population (though the OCRP will need additional restoration specialists, as described above). 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 a funnel for 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 under the auspices of the competency court / calendar.

Budget implications. We recommend DSHS funding for two FTE for competency restoration specialists, housing dollars, additional case management and other treatment staff dollars. At this point, we cannot provide a precise cost estimate. Staff position salaries are unknown to us (though DSHS can provide us with existing pay scales for these positions), current housing contracts and priorities vary, and the needs of the selected BHO will vary among providers and over time. However, given CARD expense data, and extrapolating across 111 days for 45-60 individuals, the initial financial request is likely to be significant. With additional data, we can provide estimated start-up and annual costs.

In addition, it is possible that forensic evaluator service demand may 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 is assigned to this program to enhance familiarity and efficiency, rather than randomly assigning these cases to the larger forensic evaluator pool.

Pierce County

Resources currently in place. Pierce County has a Felony Mental Health Court and a Drug Court that have protocols for diverting individuals from jail. These protocols can be used as foundations for determining eligibility for OCRP, as well as mechanisms for reporting back to the court, and mechanisms for revocation when needed. Furthermore, 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. This program provides early assessment and treatment of mentally ill inmates, among whom some are deemed incompetent to stand trial. Furthermore, there is good communication between the jail and the courts regarding inmates identified as needing mental health treatment. 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 in King County.

Current gaps for implementing an OCRP. Pierce County 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 Courts that serve many parts of the county, and it will be useful for us to obtain more data and input from those courts. Also, given that the county is quite large, it may be difficult for those on the eastern part

of the county to access programming in Tacoma. It is advisable to consider siting programs in both Tacoma and Puyallup. Public transportation options are limited, but if there were sites in those two cities, this would allow access for many eligible defendants.

As with King County, funding would be needed for additional case management staff, as well as a restoration specialist staff position. Existing BHO's should be able to provide clinical and support services, including housing assistance, although additional funding would be needed for housing. Again, similar to King County, 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.

Model of restoration. Given the geographic area, it is likely that two BHOs would need to be involved; one in Tacoma (close to public transportation), and one in Puyallup. The OCRP would build on existing services, with an overlay of competency restoration. For those charged with felonies, the OCRP could serve as an entrée to Mental Health Court for those restored to competency.

Budget implications. As with King County, we do not have a firm dollar amount, but budget items would include 1.0 FTE for competency restoration specialist, housing dollars, additional case management and other treatment staff dollars. Analogous to King County, an additional .5 FTE forensic evaluator may be needed to conduct these outpatient evaluations of CST, depending on current resources and workload as well as increased referral rates to the Pierce County OCRP.

Spokane County

Resources currently in place. Spokane County has demonstrated strong progress in expediting inpatient restoration services, and many stakeholders have expressed enthusiasm for outpatient restoration options. Indeed, members of the bar provided anecdotes of collaborating (defense and prosecution) to arrange OCR services in individual cases, such as those when 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 through which defendant supported family).

Members of the bar estimated there exists a critical mass of defendants who would meet common eligibility requirements for OCRP. Some 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."

Spokane County also includes a significant resource in the form of a 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 their interest in prosecuting the case. Thus, any of this large pool (i.e., 75% of those who meet the previous criteria) who require competence restoration would be ideal candidates for OCRP. In short, the Diversion and OCRP 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 certainly preferable to inpatient restoration.

Although the Diversion program director could not provide firm estimates of the number of incompetent or ineligible diversion candidates who would be eligible for a potential OCRP program, she did offer her opinion that a) enough of these candidates exist to comprise an OCRP program, and b) Spokane County has existing mechanisms to review and consider whether candidates are appropriate for release to the community.

Stakeholders report that Spokane offers some housing resources (e.g., Catholic Charities) with a history of collaboration with BHOs. One stakeholder conveyed that these housing resources provide further rationale for OCRPs. Specifically, she explained that inpatient restoration has paradoxically caused some defendants to *lose* housing (and other resources) once hospitalized, so developing OCRPs may greatly help certain

defendants sustain some of the stability they have begun to develop in the community. Stated differently, OCRP may allow some class members to avoid some of the collateral costs of inpatient hospitalization.

Spokane's Eastern State Hospital (site of inpatient restoration services) is also potential resource for outpatient restoration. The hospital has made tremendous progress in inpatient restoration; perhaps for this reason staff have not described perceiving the same level of need for OCRP that the legal community described. Nevertheless, some staff have expressed enthusiasm for potential OCRP efforts. In particular, ESH has a strong record of delivering "outreach" style services to the broad region surrounding Spokane, and have agreed that a similar mobile outreach approach would be viable for OCR. Obviously, ESH also includes staff who are experienced in providing restoration services.

Given the potential contributions of ESH, it *may* be feasible to consider expanding the OCRP beyond the boundaries of Spokane County. Some ESH staff suggested any mobile services they provide could expand into Yakima, for example. This possibility of a broader catchment area will require better estimates of potentially eligible defendants, and strategies that do not rely on the above-described Spokane County infrastructure.

Current gaps for implementing an OCRP. Although some infrastructure and much enthusiasm is already in place, Spokane requires funding for restoration-specific services. As in the other counties, funding is needed for additional case management staff, as well as restoration specialist staff positions. In Spokane County, it seems feasible (but not essential) to base some restoration specialists in the hospital. Existing BHOs should be able to provide further clinical and support services. As in other counties, some portion of the OCRP population in Spokane County is likely to need FACT-level of services, and additional housing services. Many of these services are likely Medicaid reimbursable, other than direct competency restoration services. Based on the anticipated numbers, at least .5 FTE restoration specialist position would be recommended for Spokane County. This could be increased to 1.0 if the numbers for the Spokane County OCRP are higher than projected, as is predicted by some stakeholders,

or if the program is extended to a wider geographical area that requires additional travel, etc.

Model of restoration. Much of the infrastructure and procedures necessary for OCRP in Spokane County could be adapted from the 5177 Diversion program. If expanding beyond the immediate Spokane metropolitan area, it may work best to adopt an outreach-style approach, based in ESH. OCRP could take services "on the road" to participant homes or BHOs.

Budget implications. As in the other counties, we do not have a firm dollar amount, but budget items would include between .5-1.0 FTE for competency restoration specialist who would oversee the program from ESH, additional housing dollars, additional case management and other treatment staff dollars.

VI. Additional Considerations

Curricula

As mentioned previously, standardized restoration curriculum should be adopted across all of the OCRP, alternative restoration treatment facilities, and inpatient restoration sites. This would allow for optimal comparison across programs (in terms of restoration outcomes, length of stay, and other important variables). We are currently surveying other OCRPs to collect different curricula; although no one curriculum is likely to be identified as the "best" curriculum to use, we hope to present multiple options for consideration by Washington administrators and clinicians.

Court orders

A relatively small but important point is the need for well-written court orders. These orders provide the backbone and impetus for restoration, regardless of the setting. For outpatient restoration, orders must clearly delineate required components of community placement (e.g., sobriety, absence of weapons, adherence to treatment, etc.) as well as potential sanctions (i.e., revocation and rehospitalization). However, court orders should not specify treatment providers by name, such as Sound Mental Health or Optum, as contracts and providers may change. Instead, court orders should order defendants to outpatient restoration as determined and operated by DSHS.

Referral, monitoring, and revocation procedures

We have focused less attention thus far to specifics regarding policies and procedures that will guide referrals, eligibility, monitoring of participants, and managing violations (including revocations). More information is needed from a variety of sources to complete this analysis, and will be requested going forward.

VI. Closing / Summary

In summary, we believe that outpatient competency restoration *is* viable in King, Pierce, and Spokane counties. Information gathered from stakeholders, data reports, statutes, and existing diversion programs all suggest that each county could operate an OCRP effectively. Each county reported requisite numbers of potential participants, existing analogous diversion and judicial programs to use as starting or reference points, and broad support among stakeholders. However, the programs in each county will likely operate somewhat differently from one another – the number of participants and wrap-around services differs across counties, and the comfort level from stakeholders regarding outpatient restoration differs across counties. These idiosyncratic differences must be addressed in the infrastructure and policies for each county's OCRP. Still, some similarities also exist – the necessary collaboration of state and contracted BHO resources, the utilization of uniform competency restoration curriculum, the roles of restoration specialists, and the collection of standardized outcome data, to name a few. With a combination of Medicaid reimbursement and dedicated state funding to create necessary positions, pay BHO contracts, and provide restoration sessions, DSHS can capably develop and operate OCRPs in these three pilot sites. Moreover, DSHS should expect the same positive outcomes realized by similar programs in other states: increased flexibility for inpatient hospital beds, improved civil liberty interests for pre-trial class members adjudicated as incompetent, increased access to mental health and other social services by this same population, and low public safety risks.

Appendix A

Attendees at stakeholder meetings

DSHS / OFMHS (March 13, 2017)

Dr. Bryan Zolnikov: Quality Manager, OFMHS
Cathy Hoover: Policy, Litigation, and Integrity Manager, BHA
Darla Dawson: Forensic Admissions Coordinator, OFMHS
Megan Celedonia: Project Manager, OFMHS
Tim Hunter: Competency Restoration Specialist, OFMHS
Dr. Tom Kinlen: Director, OFMHS
Dr. Gina Najolia: Outpatient Forensic Evaluator, WSH/OFMHS
Dr. David D. Luxton: Workforce Development Administrator, OFMHS
Ingrid Lewis: Liaison and Diversion Specialist, OFMHS
David Reed: Chief, Behavioral Health Organizations, DBHR
Amanda Jackson: Compliance Reporting Specialist, OFHMS
Can Du: Chief, Decision Support and Evaluation, DSE
Dr. Theresa Becker: Data Manager, DSE
Paul Davis: State Hospital Technology Integration Manager, BHA
Michael Davis: IT Business Analyst, BHA
(By telephone)
Dr. Randall Strandquist: Director of Psychology, ESH/OFMHS
Karen McDonald: Director, Forensic Services Unit, ESH
Mark Kreilkamp: Director of Social Work, ESH
Stephanie Waterman: Psychiatric Social Worker, WSH

King County (March 14, 2017)

Louis Frantz: Felony practice director, Public Defender's Office
Anita Khandelwal: Policy director, Public Defender's Office
Dave Murphy: Diversion & re-entry services for King County Department of community and Human Services
Manka Dhingra: Senior Deputy Prosecuting Attorney, King County Prosecuting Attorney's Office
Rebecca Vasquez: Prosecutor, King County Prosecuting Attorney's Office
Ingrid Lewis: Liaison and diversion specialist (by videoconference)

Pierce County (March 14, 2017)

Mike Kawamura: Pierce County Public Defender's Office
The Honorable Ed Murphy: Pierce County Superior Court
Dea Finnegan: Deputy court administrator
Carol Mitchell: Pierce County Executive Director's Office for Justice Services
The Honorable Judge Frank Cutbertson: Consulting judge
Matthew Cotton: Felony Mental Health Court coordinator
Karen Bier: Jail Mental Health services
Bea Dixon: Executive Director of Optim Pierce BHO

Chris Gaddis: Court administrator for superior court
Mark Gelman: County Commissioner
Ingrid Lewis: Liaison and diversion specialist (by telephone)

Office of the Attorney General (by telephone, March 14, 2017)
Sally Coates: Assistant Attorney General
Nick Williamson: Assistant Attorney General
Amber Leaders: Assistant Attorney General

Spokane County (March 15, 2017)
Karen McDonald: Forensic services unit director, ESH
Tonya Stern: Integrated behavioral health care manager, Spokane County Regional BHO
Kathleen Torella: Spokane County Assistant director of community services, housing and community development
Kristie Ray: Mental health director at Spokane County Jail
Stacy Cornwell: Director of crisis response services, Frontier Behavioral Health
Jeremy Williams: Nursing supervisor, Sacred Heart Medical Center
Karen Westberg: Administrative support, Spokane County

Appendix B

Examples of current OCRPs

The following table outlines four current OCRPs across the country. Our recommendations for Washington are informed by these and other current programs, and also by stakeholders' interests and capacities at the three identified implementation sites.

	Wisconsin	**Texas**	**Miami – Dade County**	**Arkansas**
Inception date	2008	2008	2009	2012
Setting of program launch	Milwaukee, WI	Bexar, Dallas, Tarrant & Travis Counties	Miami, FL	Little Rock, AR
Statewide versus county program	27 counties	12 localities around the state	County (though other counties in Florida also had OCRPs)	13 localities
Number of participants through 2014	200	1061 (through FY2013)	167	50
Type of provider	Contract providers	Local mental health authorities	Contract with hospital	Community mental health centers
Initial barriers	Funding, statutory restriction, public safety concerns, low workforce capacity	Buy-in from judges and DA, relationships with law enforcement / jail, housing, substance use treatment	Low funding, public safety concerns	Low workforce capacity, low levels of trust among partners
Referral process	All persons undergoing CST eval are screened	Referral from court based in part on recommendation from evaluator	Initial inpatient hospitalization	Most are hospitalized initially, but some are referred directly from court
Eligibility criteria	Low violence risk Clinical stability Stable housing Interest in OCRP	Criminal history, clinical judgment, violence risk assessment, prior hospitalization	Minor charges Low violence risk	Misdemeanant and felony defendants Other criteria unknown
Ancillary services	Case management	Case management, peer support, medication management	Case management Benefit acquisition	Case management Drug screening Family therapy Medication management
Outcomes	Comparable restorations rates; outpatient cost $25,000 per case vs. $63,000 per inpatient case	Comparable restoration rates; LOS related to restoration up to 21 weeks; people with 2-3 prior hospitalizations less likely to restore	Cost of $33,667 per outpatient case vs. $74,419 per inpatient case; fewer subsequent jail bookings	Comparable restoration rates; reduced wait lists; low recidivism; cost savings

Appendix C
Future requests

In order to make more specific financial projections, and to create policies and procedures for the three counties, some additional information is required. The following list is not exhaustive, but should provide a starting point for future discussions.

- Data from the RTFs regarding those defendants who could be eligible for outpatient competency restoration to determine maximum use of the OCRPs and the potential offloading of cases currently referred to both the RTFs and the two state hospitals
- Outcomes of the King County RFP proposal for OCRP and broader diversion services
- Copies of curricula currently in use at WSH, ESH, Maple Lane and Yakima
- Input from consumers and peers on this issue
- Updates on data collection efforts and developments across potential sites
- Statutory analysis of the 90-day maximum time frame for outpatient restoration cases "gone bad" – tweaks may need to be made to satisfy opponents who see no statutory authority to remand a person to longer-term inpatient treatment if outpatient restoration fails
- Potential partnerships with local university training clinics and departments
- Copies of current court orders, policies and procedures from diversion programs, mental health courts, and the like governing referrals, eligibility decisions, monitoring, and managing violations
- Conversations with stakeholders regarding monitoring of these cases from a public safety perspective, and how the policies and procedures should address violations when they occur
- Salary ranges for restoration specialist positions
- DSHS decisions on need for additional forensic evaluator positions