



Groundswell Services, Inc.

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Office of the Attorney General  
Washington State

Mr. McIlhenny and Ms. Coats,

In response to your referral, I have prepared a report detailing my opinions regarding reasonable timeframes for the completion of competence to stand trial evaluations, and deadlines for the hospitalization of jail inmates found incompetent. My understanding is that this referral was prompted by a class-action lawsuit facing the state of Washington, alleging that their Department of Social and Health Services has not adequately met the needs of two classes of individuals: 1) those awaiting an evaluation of their competency to stand trial, and 2) those awaiting transfer from a jail setting to a hospital setting after they have been adjudicated as incompetent to stand trial. Plaintiffs petition that defendants should wait no more than seven days for a completed evaluation of their competence to proceed, and that defendants should wait no more than seven days after they are adjudicated incompetent for transfer from a jail to a hospital.

Given this litigation, your office requested a report addressing my opinions regarding the two foci of the pending litigation. Your first question asked: *To what extent is Washington's current 7-day target timeline for competence evaluation reasonable and consistent with national best practices?* As detailed below, there are ample data available to form an opinion on this issue; this report details these data and resulting opinions. Your second question addressed the second time-frame referenced in the lawsuit (i.e. the deadline for hospital transfer of jail inmates found incompetent). However, because I conveyed that there are insufficient national data to answer this question, your office asked for a more general opinion about the advisability of any "bright line," or fixed, deadlines for the hospital transfer of jail inmates.

**Qualifications of the Expert:**

I am a licensed clinical and forensic psychologist with several years' experience in forensic mental health practice, research, and administration with a special focus on competency to stand trial. I began my career in forensic psychology during my internship at the Honolulu Veteran's Administration, where I completed specialized rotations in

forensic mental health settings. I then completed a post-doctoral fellowship in forensic psychology at St. Elizabeth's Hospital in Washington DC, focusing on risk assessment and competency to stand trial. I worked for two years as a staff and supervising psychologist at New Jersey State Prison and became familiar with the challenges of providing mental health care in correctional facilities. I later returned to Hawaii as their first state-employed community forensic psychologist. At that time, the United States Department of Justice was overseeing a transition plan for the Hawaii State Hospital and associated community programs; the oversight was focused on forensic populations, staffing, and programming. I was involved in building and implementing the successful transition plan, which included large competency assessment and restoration components. Federal oversight was lifted a short time after I became the Chief of Forensic Services. As chief, I oversaw all forensic evaluations (including evaluations of competency to stand trial) and outpatient forensic programs. I created a quality-control program for competency evaluators, created an outpatient competency restoration program, began research on competency evaluation methods and outcomes, and hired statewide forensic mental health staff.

I am now a faculty member at the University of Denver's Graduate School of Professional Psychology. I teach in the Masters of Forensic Psychology program, and I created and currently direct the University of Denver's Forensic Institute for Research, Service and Training. The institute provides low-cost, high-quality services to the Colorado community and beyond, and often addresses competency to stand trial. I have published and presented my research on competency to stand trial assessment and treatment nationally and internationally. Shortly after my arrival in Colorado, I maintained a part-time position with the state of Colorado as a competency to stand trial evaluator for nearly two years, during which I completed more than 100 evaluations. I run my private forensic consultation practice through Groundswell Services Inc.

*Publications:* Groundswell Services Inc. published a consultation report to the State of Washington's DSHS in June 2014 titled, "Forensic Mental Health Consultant Review." I have also published several articles during the past four years; the most relevant are listed here, with a full listing in Appendix A:

Gowensmith, W. N., Murrie, D. M., Boccaccini, M. T. (2011). Field reliability of competency to stand trial evaluations: How often do evaluators agree, and what do judges decide when evaluators disagree? *Law and Human Behavior*, 36, 130-139.

Gowensmith, W. N. (2012, winter). Are competency evaluators competent? *American Psychology-Law Society Newsletter*, 16-19.

Gowensmith, W. N., Murrie, D. M., Boccaccini, M. T. (2013). Forensic Mental Health Evaluations: Reliability, Validity, Quality, and Other Minor Details. *The Jury Expert*, 25, 1-8.

*Testimony:* I have provided trial testimony in the following cases during the past four years:

*State of Colorado v Angela Thatcher*, Arapahoe County District Court #12CR647  
*State of Colorado v Puspa Dungal*, Adams County District Court #11M5010  
*State of Colorado v Gerald Gurule*, Adams County District Court #13CR773

In preparing this consultation, my understanding is that I will be compensated at the following rates:

\$325 per hour for research, preparation and report writing

\$350 per hour for deposition and trial testimony

\$150 per hour for travel

Additional travel costs will be reimbursed.

In conducting this consultation, I relied on assistance from Dr. Daniel Murrie of the University of Virginia Schools of Medicine and Law, and Dr. Ira Packer of the University of Massachusetts School of Medicine. Both of these forensic psychologists have extensive experience in conducting competence evaluations, leading state forensic systems, and consulting with other states regarding issues related to competence evaluation and forensic services. Further details on all involved experts are available in Appendices A & B.<sup>1</sup>

#### **Methodology and sources of information**

In order to provide appropriate context and comparison for Washington's statutes and practices, I consulted several sources of information.

- I reviewed similar statutes from all 50 states and the District of Columbia.
- I sent a survey to each state forensic administrator in the United States, asking for descriptions of their state competency evaluation time frames and their opinions on fixed deadlines. I received and reviewed 11 completed surveys.
- I interviewed ten state forensic administrators (eight of whom did not overlap with returned surveys) to collect more in-depth information regarding the same issues, and on their perspectives on the merits of the timelines in their state.
- I reviewed data collected in previous research studies relating to competency opinions and outcomes within certain time frames.
- I reviewed best practices in competence evaluation, as detailed in *Mental Competency: Best Practices Model* (see [mentalcompetency.org](http://mentalcompetency.org)), a project of the National Judicial College
- Finally, I relied on my own expertise and experience (as well as that of my two consultants) as forensic administrators, competency evaluators, and consultants to other forensic systems.

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<sup>1</sup> Throughout this report, except where otherwise noted, the word "I" will include work and opinions shared with these two consultants. For the ease of readership I will not delineate specifics regarding which of the three of us collected particular data, etc. In forming my opinions in these matters, I relied on the work, materials and input from my professional colleagues.

History and context for efforts to expedite competence evaluation and restoration

Nationally, requests for court-ordered evaluations for competency to stand trial (CST) continue to increase. Referral rates for many states have doubled or even tripled during the past ten to twenty years. According to the 2014 report from the Joint Legislative and Audit Review Committee (JLARC), Washington has seen a 76.3% increase in evaluation orders between 2001 (1667 evaluations) and 2012 (2939 evaluations).

One of Washington's efforts to address the challenge of increasing referrals was to revise statutes governing the CST evaluation and restoration process. Washington state statute RCW 10.77.068 (see Appendix C) sets guidelines for individuals who have been ordered to undergo an evaluation for their competency to stand trial. Target timelines for individuals awaiting a CST evaluation are seven days for those held in a correctional facility and 21 days for outpatient defendants. Target timelines for individuals awaiting transfer from a jail to a hospital for CST evaluation are seven days, and the target date for the inpatient evaluation is within the first seven days of admission. Finally, the guidelines set a target date of seven days for the transfer of defendants adjudicated as incompetent to stand trial (IST) from a jail to a hospital. All of these time frames are aspirational targets, rather than fixed or mandated deadlines.

By all accounts, these timelines were implemented with the worthwhile goal of reducing defendants' lengthy waits for CST evaluations and restoration. Many defendants await their evaluation or transfer while residing in local jails, where mental health services may be inadequate, particularly for the acutely ill inmates who are mostly likely to require competence evaluations. These time frames have been a significant focus among DSHS administrators, policy makers, legislators, and auditors for the past several years. However, DSHS has rarely met these target timelines, as detailed in the JLARC 2014 final report.

There appears to be no single, simple explanation for the failure to meet these timelines. A variety of contributing factors have been detailed in the 2014 JLARC report and the 2014 Groundswell Services consultation report. Primary reasons include both structural problems (low workforce capacity, steadily increasing referrals, absence of a statewide forensic mental health department, low hospital capacity) and organizational problems (too few evaluators, insufficient salaries for evaluators, remote locations for evaluations and transfers, and variable evaluation methodologies).

The time frames in Washington's current statute are best characterized as aspirational guidelines. The seven-day time frames are written as targets, not requirements or mandates. Even so, the statute further appears to recognize that certain circumstances may be most likely to preclude the DSHS from meeting the CST-related target timeframes. These include long delays in obtaining medical clearance, long delays in gathering critical medical records, lack of cooperation from individuals throughout the CST evaluation process, and unusually high numbers of referrals. Finally, the statute prescribes measurable changes that DSHS should make to improve their efficiency in reaching the time frames. In this sense, the current statute provides aspirational deadlines for the completion of CST evaluations and the transfer of IST defendants rather than

fixed “bright line” deadlines, and it also recognizes specific extenuating circumstances that are most commonly associated with delays. My understanding is that the plaintiffs maintain that because these timeframes have not been met by DSHS, fixed deadlines are therefore required.

Given this context, and your referral question, this report seeks to address reasonable time frames for CST evaluation in Washington, as well as the utility of fixed deadlines for transferring incompetent defendants from jail to the hospital.

## **1. Deadlines for evaluations of competency to stand trial**

### Comparative review

In order to assess the practicality and potential benefit of a 7-day deadline for competence evaluations in Washington, my colleagues and I reviewed the guidelines and deadlines surrounding competence evaluations in all other states. *Nationally the average deadline for competency evaluations is 31 days*, according to our comparative review. In other words, state statutes and departmental policies average a mandated maximum of 31 days for CST evaluations to be completed, once ordered by the court. To be clear, this figure reflects an overall, crude average and does not account for differing time frames based on evaluation locations, charges, or other factors.

Additional details shed further light on this average. As detailed in Appendix D:

- 15 state statutes appear to specify *no* deadlines whatsoever for CST evaluations.
- 15 states mandate maximum time frames, without reference to the location of the evaluation. Among these states, the average deadline for evaluations is 31.9 days.
- 16 states mandate specific maximum time frames for defendants committed to an inpatient hospital. Among these states, the average deadline for inpatient evaluations is 33.8 days.
- Four states mandate maximum time frames for defendants awaiting evaluation in jail. (Colorado’s mandates come from a federal settlement agreement rather than statute.) Among these states, the average deadline for jail-based evaluations is 21.3 days.
- Three states mandate maximum time frames for defendants awaiting evaluation in an “outpatient” or “community” setting. Among these states, the average deadline for these outpatient evaluations is 42.5 days.
- As mentioned above, 15 states have generic time frames that are independent of the location of the evaluation. These time frames apply across inpatient, outpatient, and jail settings. Adding this data to those states with specific time frames for those three settings reveals averages of 32.8 days for inpatient evaluations, 34.1 days (outpatient), and 28.1 days (jail).
- 43 states with no specified time frames for outpatient evaluations do not appear to make a distinction between individuals who are awaiting evaluation in jail versus those who are awaiting evaluation in the community. Given that most states conduct most of their CST evaluations in jails, it appears that the lack of time

frames in these 43 states apply to both jail-based and community-based evaluations.<sup>2</sup>

To summarize, many states have no mandated deadline for competency evaluations. Among those that do mandate, the deadlines average 34 days for defendants awaiting evaluations in hospitals and 21 days for those in jail. If states do mandate time frames for competency evaluation, they typically specify evaluations conducted in hospitals (16 states) rather than jails (4 states). States that mandate deadlines for outpatient evaluations, including jail-based evaluations, average 43 days. The target seven-day timeframe for jail-based competency evaluations in Washington is clearly well below the national average. Indeed, Washington's target deadline is the shortest in the country; our review revealed only one other state -- Maryland -- with a seven-day deadline for CST evaluations.

#### States with deadlines most similar to Washington

Only six jurisdictions prescribe evaluation deadlines below 10 days. Because their deadlines are similar to Washington's target dates, I describe their experiences with these deadlines to shed light on the viability of a seven-day target deadline in Washington.

*Maryland:* Maryland statutes require that CST evaluations be completed within seven days. This statute applies to both outpatient and inpatient evaluations of competency. However, in our interviews with two Maryland forensic administrators (one current and one former), both conveyed this timeline has been untenable. Historically, Maryland used this seven-day deadline to conduct a *screening* evaluation of competency. After this screening evaluation, persons requiring additional evaluation were transferred to an inpatient hospital. However, several years ago, policy changes dictated that the seven-day timeframe would apply to full competency evaluations. Subsequently, the state hospitals have seen a significant increase in persons admitted as incompetent to stand trial ("IST").

The forensic administrators reported that inpatient admissions of IST defendants spiked after this policy change for several reasons:

- First, courts consider incomplete evaluations as opinions of IST and remand these quasi-evaluated defendants to the hospital. Incomplete evaluations have increased, given the shortened deadline for full CST evaluation. Evaluators are unable to access the minimal information required to provide an opinion on competence within the seven-day timeframe, and defendants who are not fully evaluated are then considered incompetent, and sent for inpatient hospitalization.
- Second, many persons who are adjudicated IST within the first seven days of referral may appear IST when, in fact, they are not. According to the Maryland

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<sup>2</sup> Again, these figures address only deadlines specified in statute. Obviously, states may convey evaluation deadlines through other means. For example, in Virginia the statute does not specify a particular timeframe for evaluation, but when ordering a competence evaluation, courts usually specify a report deadline of their choosing (usually 30-60 days) in the written court order. But because the focus of this Washington litigation involves *statutory* and constitutional deadlines, I focus primarily on the deadlines that other states have conveyed systematically *in statute* rather than through other means.

forensic directors, defendants evaluated within seven days may *appear* to be IST due to lingering effects of substance use, poor initial cooperation with court processes, or temporarily high levels of anxiety due to the recent onset of their legal problems – rather than due to serious symptoms of mental illness. These administrators stated that these types of individuals typically stabilize without the assistance of mental health intervention, and that therefore inappropriately use limited hospital resources. Such stabilization would likely occur in jail-based or community-based settings.

- Structural issues often exacerbate the above challenges. With only seven days to conduct an evaluation, even relatively slight changes in workforce capacity (sick leave, vacation, maternity leave, unfilled positions), increases in referrals, or problems accessing defendants can again lead to incomplete evaluations – again leading to default adjudications of IST and hospital commitments.

Maryland statutes allow for extensions in certain cases, and the administrators reported that extensions are increasingly necessary. However, despite the use of these extensions, rates of IST opinions and subsequent hospital admissions have increased more than 50% since the change in policy. These IST rates are substantially higher than national norms.

*Rhode Island:* Rhode Island statute specifies a five-day period for defendants awaiting evaluation in correctional facilities. However, evaluators then have an additional ten-day period to submit their report. Therefore, in practice, evaluators have a fifteen-day deadline to complete evaluation reports. Although I was unable to conduct formal interviews with Rhode Island administrators, evaluators familiar with the system reported a shorter timeline is somewhat more viable because of the state's unusually small size (there are far fewer evaluation requests, numerically, than other states, and none require significant travel).

*Nevada:* Statutorily, Nevada has *no* time frames for competency evaluation. However, a forensic administrator in Nevada reported that departmental policy mandates a maximum 10 day window for individuals in one county (i.e., Washoe, which surrounds the city of Reno). Washoe County contracts with private evaluators to conduct all CST evaluations. Under this contract, evaluators are provided with all sufficient records prior to beginning the evaluation. Also, the Sheriff's Department transports all defendants to a centralized forensic evaluation office in Reno, so that the evaluators have efficient access to the defendants. Finally, the administrator reported that in practice, attorneys raising competency typically provide advance notice of intent to raise competency before the evaluation is officially ordered. Evaluators, therefore, are able to begin preparing for the evaluation in advance of the contract start date, and thus typically have around 30 days to complete their evaluations, according to the state forensic administrator. The administrator reported no significant challenges with the ten day deadline given these additional factors. However, the deadline does not apply to Las Vegas or any other areas in Nevada.

*North Carolina:* North Carolina changed their statutes in 2013, tightening deadlines for CST evaluations. Evaluators now have a maximum of 10 days to conduct CST

evaluations on defendants charged with misdemeanors and who are awaiting their evaluations in jail. The time frame extends to 20 days for misdemeanants awaiting CST evaluations outside of a jail. Evaluators have a maximum of 30 days for felony defendants, regardless of the location of the defendant. Extensions are possible for up to 120 days in all cases. A lack of data has prohibited administrators from formally evaluating these new time frames, though the administrator did mention that the 30 day time frame for felony defendants has seemed adequate.

*Washington, D.C.:* Washington D.C. requires evaluators to complete a *screening* evaluation of competency within the first three to five days after the order has been initiated. This screening timeframe appears to apply to all defendants, regardless of location. This screening goes back to the judge, who orders further evaluation if necessary. The more thorough evaluations of trial competence can then take much longer (i.e., 30 days, with an option for a 15-day extension). Although I was unable to conduct formal interview with those in leadership, evaluators familiar with the system reported that, like Rhode Island, the short deadline for screening evaluations is more feasible because Washington DC is such a small geographic region and one in which forensic services are centralized in one facility (St. Elizabeth's hospital).

*Illinois:* Illinois statutes prescribe a maximum CST evaluation period of seven days for individuals committed to a hospital for the evaluation. However, extensions of seven days are allowed, and the report from the evaluator is not required until the 30<sup>th</sup> day after the order was initiated. In short, a hearing on competency is not required within the first 30 days, keeping inpatient defendants in the hospital for up to 30 days awaiting their hearings.

#### Research data

Data from the state of Hawaii further illustrates challenges of conducting evaluations of competency to stand trial within a short timeframe. In Hawaii, all competency evaluations on felony cases are conducted by three concurrent, independent evaluators. Hawaii state statutes prescribe a deadline of 30 days for a competency evaluation, regardless of the defendant's location. I collected data on the dates of evaluation, opinions of the forensic evaluators, and the judicial dispositions on competency for more than four hundred defendants evaluated for competence between 2007 and 2008.<sup>3</sup> In an effort to examine the role of timing on competence findings, I examined cases in which evaluation reports were submitted to the court within 15 days of the initial court order. These exploratory analyses revealed that defendants were twice as likely to be opined as incompetent if the evaluation was conducted within the first 15 days. In contrast, only about 30% of defendants were found incompetent in evaluations that took up to 30 days. This 30% rate is far closer to national norms. I also found that in those cases in which at least one evaluator opined a defendant as IST within the first 15 days of the court order, defendants were ultimately found competent by the court 50% of the time. In other

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<sup>3</sup> Gowensmith, W. N., Murrle, D. M., Boccaccini, M. T. (2011). Field reliability of competency to stand trial evaluations: How often do evaluators agree, and what do judges decide when evaluators disagree? *Law and Human Behavior*, 36, 130-139.

words, some defendants who may have appeared incompetent immediately after incarceration appeared competent after a few weeks.<sup>4</sup>

#### Best practice models

Although there are numerous best-practice guidelines for evaluators conducting competence evaluations, there have historically been fewer best-practice guidelines for *state systems* providing competency-related services. However, over the past few years, the National Judicial College has developed an influential web-based resource that provides detailed best-practice guidance on nearly all aspects of competence evaluation and restoration.

This influential guide, *Mental Competency: Best Practices Model* (see [mentalcompetency.org](http://mentalcompetency.org)), provides detailed recommendations on the timing of a competence evaluation. Consistent with other findings in our review, this model recommends the following (quoted in its entirety):

#### “E. When to Perform a Competency Evaluation

**“Best Practice:** With limited exceptions, it is a best practice for the mental health professional to perform the competency evaluation within these timeframes: For a misdemeanor charge(s), it is a best practice for the competency evaluation to be performed, and the report to be filed, within 15 days of the court order; for a felony charge(s), it is a best practice for the competency evaluation to be performed, and the report to be filed, within 21-30 days of the court order. Limited exceptions include when the defendant appears to be acutely psychotic, or seriously disturbed, or under the influence of substance use or abuse.

**“Discussion:** Performing a competency evaluation within the best practices timeframes prevents the person from languishing in jail and protects his or her constitutional right to a speedy trial relative to the charges. *Jackson v. Indiana*, 406 U.S. 715 (1972). However, if the evaluation is performed too close in time to when the defendant is taken into custody, it may pose a difficulty for the examiner to rule out the possibility that the defendant's mental state is impaired due to the effects of any potential substance use or abuse. Depending upon the circumstances, it is a best practice to allow enough time for the defendant to withdraw or recover from the effects of any substance use or abuse; or, if the defendant has a history of major mental illness, to be stabilized on a regimen of psychotropic medications before performing the competency evaluation—both may affect a determination as to whether the defendant is competent.”

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<sup>4</sup> To be clear, some defendants may be so acutely ill that evaluators can reasonably find them incompetent at any point in incarceration. But, this exploratory data also suggests a pattern articulated by the forensic administrators from Maryland (site of the seven-day evaluation deadline) and the best practice recommendations from the National Judicial College; that is, some defendants may appear initially incompetent to lingering intoxication or distress, but appear more competent after a period of settling into jail.

### Challenges associated with a seven-day deadline for competency evaluation

I asked forensic administrators to provide their thoughts on conducting competence evaluations within seven days. They described several challenges to this timeframe, which I categorize into two main areas: structural and clinical.

*Structural:* Administrators reported significant logistical concerns about conducting evaluations within seven days. They emphasized certain conditions would be essential in order to meet a seven-day timeframe. First, collateral records should be available prior to the evaluation. Although not as complex as criminal responsibility evaluations, CST evaluations do require certain minimal information in order for evaluators to make informed decision. These include medical and mental health records, collateral information (to potentially include treatment providers, correctional officers, or friends and family), as well as information regarding the offense and the defendant's legal history.

Also, administrators emphasized that structural mechanisms must be in place in order to facilitate face-to-face interviews of the defendants. Access to defendants is crucial. In Washoe County, Nevada, for example, defendants are brought to a centralized location for forensic evaluation; the administrator described this mechanism as essential in meeting their 10 day evaluation window. Poor access to defendants in jail, inadequate evaluation spaces, and limited visitation hours all compromise the ability to meet a seven-day time frame.

Finally, all forensic administrators reported that staffing ratios must be sufficient to meet ever-increasing referrals for CST evaluations, especially with a seven day timeframe. These staffing resources include an adequate number of qualified evaluators as well as adequate salaries to recruit and retain qualified evaluators.

*Clinical:* Structural issues can potentially be addressed by state systems, so they should not, alone, preclude a seven-day timeframe. However, forensic administrators reported additional clinical concerns about a seven-day time frame that are more intractable than structural concerns. Primarily, all forensic administrators reported potential problems with the quality of such exams. Competency exams, as mentioned above, require a reasonable amount collateral information, testing information, and information from the defendant in order for evaluators to formulate informed opinions. Administrators reported significant concerns about evaluators' ability to access and think through all of this information within a seven-day timeframe.

Second, forensic administrators questioned the ability of evaluators to accurately ascertain a defendant's competence within such a short time period. Many administrators echoed the concerns detailed in *Mental Competency: Best Practices Model*, and by the administrators from Maryland who described defendants who appear incompetent within seven days but who nonetheless regain competency a short time later without the assistance of mental health intervention. For example, some defendants are under the influence of alcohol or drugs, fabricating symptoms, or uncooperative within the first few days after such an order is given; however many of these defendants become coherent or

cooperative even in the absence mental health intervention. Administrators reported that trying to accurately gauge a person's level of competence *too* quickly yields more confusion than clarity.

Third, both the courts and treatment facilities rely on accurate determinations of competency. Courts follow the opinion of competency evaluators in anywhere from 80-99% of cases<sup>5</sup>; evaluators need to be able to provide opinions with confidence and accuracy. Low-quality, hasty evaluations only serve to delay the legal process until a subsequent, higher-quality evaluation provides a more trustworthy conclusion.

In addition, administrators emphasized that persons found IST are typically remanded to an inpatient hospital for competency restoration. Hospital beds and resources are at a premium. Inappropriate admissions resulting from inadequate CST evaluations consume limited resources, contribute to over-crowded conditions, reduce bed space for those who need intensive services, increase unsafe conditions, and waste resources by unnecessarily placing individuals into the most expensive level of care.

#### Opinions

Overall, after reviewing comparable state statutes, data from research, forensic administrators, the best practice recommendations of the National Judicial College, and our own experience, it appears that while evaluations of competency conducted within seven days of the court order may certainly identify some genuinely incompetent defendants, they may also over-identify some acutely distressed (or intoxicated) defendants who would appear competent after a slightly longer period of stabilization. Such “false positives” may not only result in using limited hospital resources inappropriately, but also may be detrimental to defendants who are involuntarily hospitalized and whose cases are unnecessarily delayed.

To be clear, defendants with severe mental illness should *not* languish in jail or await treatment longer than necessary. Jails are not appropriate long-term mental health facilities, nor are they appropriate intensive mental health facilities. Persons with serious mental illness require mental health care in psychiatric hospitals. On the other hand, it is also critically important to ensure persons *without* serious mental health needs are not unnecessarily hospitalized, thereby constraining their liberty and consuming treatment resources better provided to others.

Though any system will make some errors in some cases, systems will make fewer errors by facilitating high-quality evaluations. Most defendants undergoing CST evaluation do not have symptoms that compromise their competency or necessitate inpatient treatment. Nationally, around 75% of defendants evaluated for CST are found competent to proceed. Good evaluation can accurately distinguish IST from CST defendants, thereby assisting

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<sup>5</sup> See: Murrie, D.C. & Zelle, H. (2014). Criminal Competencies. In B. Cutler and P. Zapf (Eds.), *The APA Handbook of Forensic Psychology*. Washington DC. American Psychological Association.

the court in hospitalizing those who are in true need and helping to ensure beds remain available for others in need of treatment.

Clearly, one crucial aspect of evaluation quality is punctuality; rarely should evaluations require more than one month's time, and most can be completed more quickly. But hurried evaluations may also compromise quality and, paradoxically, exacerbate some of the problems that tight timelines were intended to remedy. Shorter time frames can lead to inappropriate hospital admissions, which can lead to a reduction in access to inpatient care for the larger population in need – as well as reducing the civil liberties of those defendants inappropriately committed.

Based on the analysis described earlier in the report, it is my opinion that deadlines for competency evaluation should extend beyond seven days. Washington's seven-day target time limit is the lowest in the nation, and appears impractically short. The only other state with a seven-day timeframe reports significant problems with the deadline, including the paradoxical impact of increasing rates of incompetence findings, requiring much greater rates of hospitalization, and reducing bed space for other patients. Without tremendous increases in resources, the seven-day window is unlikely to be met regularly in Washington. Moreover, even if resources are adequate, evaluating a defendant's competency within seven days increases the risk of inaccurate incompetence findings, unnecessary hospital transfers and deprivations of civil liberties.

## **2. Fixed “bright lines” in competency-related matters**

Regarding the referral question addressing appropriate time frames for incompetent defendants to be transferred from jail, my preliminary analysis revealed that there is little national data to answer the question. Whereas the first question (i.e., timelines regarding initial competence evaluation) can be considered in light of many other state statutes and best practice recommendations from the National Judicial College, I could find very few other state statutes or national guidelines that prescribe deadlines for transferring incompetent defendants from jail to hospitals. Settlement agreements and policy decisions exist on a piecemeal basis but do not provide a broad enough basis on which to find trends, patterns, or typical practices. I therefore do not comment on this issue.

However, as requested, I will provide an opinion on the broader issue of fixed “bright lines” (mandated, inflexible deadlines without allowable exceptions) in general. Again, to address the issue of “bright lines” in general, I relied on statutory analysis, information from multiple current forensic directors, and the combined clinical and administrative experience of my consultants and I. The constellation of information was consistent across sources. Ultimately, I find that fixed deadlines without allowable exceptions provide more problems than solutions for state mental health systems.

### Benefits of competency-related “bright line” deadlines

Bright-line deadlines can provide an impetus for a state mental health system to change. Fixed deadlines are one strategy to hold a system's “feet to the fire,” and they allow for easy-to-measure reviews of progress. Without such time frames, systems may act

unnecessarily slowly or inefficiently. In terms of competency-related matters, a lack of any time frames or bright lines could result in unnecessarily long waits for evaluation or transfer to a mental health facility upon a finding of incompetence. Historically, the United States Supreme Court responded to similar unnecessary delays in *Jackson v Indiana* (1972), holding that indefinite commitments for competency restoration were unconstitutional and that states could only hold such commitments for a “reasonable” period of time. This required states to determine appropriate lengths of time for such commitments, with many states identifying an actual maximum number of days for restoration.

#### Risks of competency-related bright lines

Despite the best of intentions, however, bright lines can also undermine some of the goals they were intended to accomplish.

In terms of competency-related decisions, rigid deadlines can extend the process rather than shortening it. As mentioned in the previous section, a wide range of information is necessary to conduct an accurate competency evaluation. Decisions made within a certain time frame may miss important information that could not be accessed quickly – and therefore the decisions will suffer in their quality and reliability. Some defendants may be adjudicated as incompetent and ordered to inpatient restoration more as an artifact of deadlines than of true deficits in competency.

Similarly, defendants ordered to inpatient treatment within a tight deadline run the risk of being inappropriate referrals, and the service providers mandated to treat them may be unable to do so safely or effectively. Hospitals that operate over capacity do so with increasingly unsafe conditions, unable to properly dedicate staff and resources for effective treatment, and unable to prioritize beds for otherwise deserving persons in need of inpatient care. In these types of situations, hospitals act more as holding areas than as safe and effective mental health providers.

To be clear, the downsides of rigid deadlines are tightly intertwined with system limitations. The greatest risk a tight transfer deadline has is that the hospital may not have adequate space for the admission, thereby compromising safety and services. If a state system has enough bed capacity to admit all persons in need, then the bright line issue is less important. But without consistent open bed capacity, hospitals are unable to provide services to both civil populations and forensic populations. Because forensic populations are court-ordered to the hospital, and civil populations are not, forensic admissions become prioritized in hospitals without enough capacity for both. This leads to what is often referred to as the “criminalization of the mentally ill;” essentially, access to inpatient mental health services is increased for those persons with a criminal charge, and reduced for others, until—ultimately—the only gateway to essential treatment becomes arrest.

For states that have ample hospital resources, fixed deadlines for hospital transfer are certainly more feasible. For those that have more limited resources, rigid deadlines may be risky. A safer option may be aspirational guidelines that allow for some extension or

delay (along with appropriate temporary services) if hospital resources are not immediately available.

### Opinions

Based on this analysis, my opinion is that a balanced approach to deadlines provides the optimal solution. Deadlines can be effective if two conditions are met:

1. *If the deadline is of a reasonable length.* Deadlines must be long enough to allow for good clinical decisions. Unreasonably tight time frames lead to hasty decisions, or efforts to “err on the side of caution” that appear prudent in the individual case, but problematic across cases (e.g., transferring all IST defendants without adequate time to triage or prioritize admissions). Alternatively, time frames that involve a reasonable period of time allow for nuanced, comprehensive decisions. Of course, decisions that *can* be made before a deadline *should* be made before a deadline. Evaluators should submit their opinions as soon as they can offer a reliable one, and defendants should be admitted to mental health facilities as soon as suitable accommodations are available. These organizational and professional priorities are important regardless of statute specifications.

The administrative experience of the author and consultants, in addition to information gathered from current forensic administrators, leads to the opinion that caution should be exercised when considering a short deadline for admission to a state hospital. There have been multiple cases in which hospitalization was required due to a mandated time frame but in which no capacity existed at the receiving hospital. These transfers led to patients being placed in non-therapeutic (even unsafe) conditions. In such cases, treatment was replaced by security as a primary concern – again counter to the intent of the transfer.

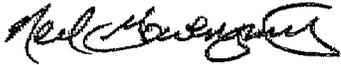
In contrast to an artificially short deadline, state administrators encouraged a reasonable length of time for transfer to allow for triage of waiting admissions to occur. Some states send crisis teams or specialized clinicians to evaluate the clinical status IST defendants awaiting admission, so that the most acutely ill defendants can be admitted first. Persons who are more stable can wait longer for suitable accommodations to open. Inflexible deadlines can make effective triage nearly impossible.

2. *If caveats are included.* Time frames must also allow for exceptions. Some decisions will inevitably, necessarily require more time. In competency-related matters, these might include needing critical mental health records, accessing interpreters, accessing additional neuropsychological testing, and obtaining medical clearance, among other issues. If decisions must be made without the information above, then decisions will likely default to opinions of incompetence simply to provide access to an extended evaluation period, or potentially unsafe individuals will be admitted to a hospital without proper safeguards in place.

I agree that many IST defendants have spent too long in jail awaiting transfer to a hospital. However, as described above, I believe that system improvements are likely to be a more direct and effective solution than short, inflexible deadlines.

Nevertheless, I emphasize that system improvements remain crucial. As soon as incarcerated defendants are adjudicated as IST, they should be prioritized for mental health care in the correctional facilities while they await transfer to a hospital. Crisis and triage teams from DSHS should see the defendant to triage their clinical need for transfer. Competency restoration should begin in the correctional facilities while they await transfer. Involuntary medications should be obtained when necessary, and the orders should follow the individual to the hospital upon transfer. Quick transfer mechanisms should allow for immediate transfer to a local civil hospital if acute symptoms threaten safety of the defendant or others. All of these interventions should occur for every incarcerated defendant awaiting transfer, regardless of how long that wait is. Persons determined to have acute needs should be prioritized for admission; persons determined to have less acute needs will continue to have prioritized and enhanced mental health care while awaiting transfer. This will allow for the transfer of all defendants within a reasonable period of time, and will allow hospitals to maintain a safe environment within which to continue competency restoration services.

Thank you for the opportunity to assist the court in this important matter.



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W. Neil Gowensmith, Ph.D.  
President, Groundswell Services Inc.

**APPENDIX A**  
**Curriculum vitae for Dr. Neil Gowensmith**

William Neil Gowensmith, Ph.D.  
Assistant Professor and Licensed Clinical & Forensic Psychologist

Work Address

2460 S. Vine St, University of Denver  
Denver, Colorado 80208

Contact information

(828) 738-6694 (c)  
[neil.gowensmith@gmail.com](mailto:neil.gowensmith@gmail.com)

EDUCATION

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Post-doctoral Residency in Forensic Psychology

Forensic Psychology (APA Accredited Specialty Practice Program in Forensic Psychology)  
Saint Elizabeths Hospital, Washington D.C.  
Forensic Inpatient Services & Bureau of Legal Services Divisions  
September 1999 to September 2000

Clinical Internship

Internship in Clinical Psychology (APA Accredited)  
Honolulu Veterans Affairs Medical & Regional Office Center, Hawaii  
September 1998 to September 1999

Ph.D.

Counseling Psychology (APA Accredited)  
Colorado State University, Fort Collins, Colorado  
Awarded: Summer 1999 *summa cum laude*

B.A.

Psychology  
The University of Texas at Austin, Austin, Texas  
Awarded: December 1992 *cum laude with honors*

AFFILIATIONS AND PROFESSIONAL ACTIVITIES

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- Licensed Psychologist, Colorado
- Member, American Psychological Association
- Member, American Psychology-Law Society

## CLINICAL AND ADMINISTRATIVE EXPERIENCE

### Clinical Assistant Professor

Graduate School of Professional Psychology, University of Denver

September 2011 to present

Supervisor: Lavita Nadkarni, Ph.D.

Teach multiple courses in forensic psychology to master's level graduate students. Create, prepare, teach, monitor, and evaluate courses and student performance. Advise multiple graduate students on academic and programmatic progress. Oversee research paradigm in forensic psychology, including the supervision of multiple research assistants. Lead writer on six grant proposals for student involvement in research-based grant opportunities, totaling more than \$500,000 in two years. Engage in hiring and student selection committees, student capstone requirements, and other departmental activities. Chair or co-chair doctoral student research committees. Named acting director of Denver Forensic Institute for Research, Service and Training (Denver FIRST), a regional hub for research, consultation, trainings and service to Colorado and adjacent Western states. Led a group of 13 students on a service-learning course to South Africa in 2013.

### Forensic Evaluator

Colorado Mental Health Institute at Pueblo, State of Colorado

September 2012 to present

Supervisor: Thomas Gray, Ph.D.

Conducted more than 100 Competency to Proceed evaluations as ordered by the criminal court. Conduct evaluations in jails and outpatient settings in the Denver metro area and beyond. Incorporate psychological, diagnostic, malingering, cognitive, and forensic testing as necessary. Submit reports in a timely fashion and in accordance with departmental and state regulations. Consult on administrative initiatives such as statutory proposals, outpatient forensic programming, and research proposals. Provide training and consultation to evaluators statewide.

### Lead Consultant

Groundswell Services, Inc

State of Washington's Department of Social and Human Services

December 2013 to July 2014

Provide consultation and for the State of Washington's forensic mental health system. Spoke and survey more than 100 individuals across more than twenty relevant criminal justice and mental health agencies. Produce report with practical and measurable .

Private Practice

Groundswell Services, Inc.

January 2013 to present

Provide evaluations for a host of forensic mental health questions raised in court proceedings, including competency to stand trial, criminal responsibility, violence risk, mitigation, aid in sentencing, immigration, Miranda waivers, second opinions, diagnosis, psychopathy, and other issues.

Technical Assistance and Research Psychologist

Western Interstate Commission on Higher Education

September 2011 to August 2012

Supervisor: Mimi McFaul, Psy.D.

Provided consultation on forensic mental health issues to the 15 westernmost states. Consulted with stakeholders in Hawaii and other experts in Alaska and Colorado to plan, implement, and manage a pre-doctoral psychology internship in Hawaii. The internship includes a forensic mental health rotation, primary training site, and educational emphases. Wrote grants and collaborated on grant-writing and grant-management teams.

Chief of Forensic Services:

Department of Health, State of Hawaii

August 2006 to September 2011

Supervisor: Bill Sheehan, M.D.

Directed the forensic mental health services for the Adult Mental Health Division for the State of Hawaii. This included a statewide population of approximately 1500 outpatient and 500 inpatient consumers per year. Supervised a statewide staff of 20 individuals, including 11 psychologists, across more than 12 programs and services. Chaired several committees, implemented and analyzed data collection for each program, ensured that current best practices were incorporated statewide, and participated and led in several legislative work groups and task forces. Planned, created, implemented and monitored multiple community-based forensic programs, including outpatient competency restoration, pre- and post-bookings jail diversion, step-down housing program for insanity acquittees, court-based clinics, and a phased program for conditionally-released insanity acquittees. Designed and completed several local and national research studies. Created, directed and supervised practicum, pre-doctoral internship, and post-doctoral fellowship programs. Received multiple grants to fund key programs. Oversaw training and quality of all court-ordered mental health examinations and examiners statewide. Earned recognition as a 2008-2009 Department of Health Team of the Year.

Forensic Coordinator:

Department of Health, State of Hawaii

March 2004 to August 2006

Supervisors: Wayne Law and Reneau Kennedy, Ed.D.

Operated as Hawaii's first state-employed community forensic psychologist, with a primary focus on overseeing risk factors for recidivism, violence, and clinical decompensation in Hawaii's legally encumbered mental health population. Provided supervision to non-licensed psychologists, developed forensic workforce, and provided forensic consultation and trainings to staff and consumers statewide.

Team Leader:

South Africa Community Fund, Western Cape, Republic of South Africa

University of Denver

2002-2013

Supervisors: Gordon Aeschliman

Mentored and managed multiple groups of undergraduate students, graduate students, faculty and alumni from multiple US colleges and universities on experiential service learning trips to South Africa. Managed group commitments to service sites, fostered relationship building between sites and host families and students, facilitated individual and group learning environments, managed group dynamics, ensured student safety, and maintained excellent communication with umbrella agency. Number of students across groups exceeds 85. Coordinated logistical concerns and enhanced group immersion into the local community. Emphasized multicultural awareness, social justice, and personal reflection.

Academic Program Director / Instructor:

Global Stewardship Study Program (GSSP), Belize, Central America

January 2003 to January 2004, May 2005

Supervisor: Gordon Aeschliman

Directed international, university study-abroad program located in Belize, Central America. Taught psychology courses, supervised assistant directors, and worked with multicultural, international staff to provide a safe and positive learning environment for students. Oversaw academic integrity of the program while emphasizing social justice and diversity issues.

Staff Psychologist:

New Jersey State Prison, Trenton, New Jersey

January 2001 to December 2002

Lead Psychologist: David Starkey, Ph.D.

Managed multidisciplinary team providing mental health treatment, crisis stabilization, and assessment of risks for violence and suicide to approximately 250 maximum-security inmates. Also provided lead supervision for female inpatient crisis unit, overseeing all components of acute mental health treatment.

Psychology Post-doctoral Fellow:

John Howard Pavilion, St. Elizabeth's Hospital, Washington D.C.

September 1999 to September 2000

Supervisors: Maureen Christian, Ph.D., Sid Binks, Ph.D., Mike Lipscomb, Ph.D.

Provided therapy, psychological assessment, and consultation to forensic populations in inpatient maximum security psychiatric hospital, outpatient forensic department, county jail, and courthouse cell block settings. Developed emphases on assessment of risk for violence, assessment of competency, and competency restoration.

Clinical Psychology Intern:

Honolulu Veterans Affairs Medical & Regional Office Center, Honolulu, Hawaii

September 1998 to September 1999

Supervisor: Kathleen McNamara, Ph.D.

Completed pre-doctoral psychology internship in clinical psychology with rotations in neuropsychology, inpatient acute treatment, day treatment with the chronically mentally ill, health psychology, and forensic psychology.

## TEACHING EXPERIENCE

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### Assistant Professor:

University of Denver

Introduction to Statistical Methods (2011, 2012, 2013)  
Ethics in Forensic Psychology (2011, 2012, 2013)  
Practicum / Case Conference (2012, 2013, 2014)  
Treatment and Evaluation of the Adult Offender (2012, 2013, 2014)  
Public Policy and Forensic Mental Health (2012, 2013, 2014)  
Forensic Assessment (2012, 2013, 2014)  
International Service Learning South Africa: Transitional Justice (2013)

### Instructor:

University of Hawaii at Manoa

Introduction to Statistical Techniques (2005, 2006, 2008)  
Experimental and Research Methods (2006, 2007, 2008)  
Introduction to Forensic Psychology (2008, 2009, 2011)  
Introduction to Forensic Psychology online (2012, 2013, 2014)  
Psychopathology online (2011)

### Adjunct Faculty:

Argosy University, Honolulu

Diagnostic and Assessment Practicum (2011)  
Forensic Assessment (2011)

### Instructor:

Global Stewardship Study Program, Belize

Global Psychology (2003, 2005)

### Instructor:

Colorado State University, Fort Collins, Colorado

Introduction to Psychology (1996)  
Abnormal Psychology (1997)  
Pre-practicum / Introduction to Counseling Techniques (1998)

### Team Leader:

South Africa Community Fund, Cape Town, Republic of South Africa  
2002, 2003, 2005, 2009

## RESEARCH EXPERIENCE

### Current Research Project: "How reliable are forensic evaluations? Evaluator agreement in court-ordered evaluations"

Co-investigators: Murrie, D. C. (University of Virginia) & Boccaccini, M. T. (Sam Houston State University)

Reviewed 600+ cases in the state of Hawaii involving court-ordered mental health examinations focused on determinations of sanity and violence risk to determine the mediating effects that examiner, defendant and offense characteristics have on evaluator agreement and ultimate court disposition. Papers presented at multiple conferences, papers accepted for presentation at multiple upcoming conferences, and manuscripts will continue be submitted for journal publication.

### Current Research Project: "Utility of specialized supervision officers for insanity acquittees mandated to community mental health care"

Co investigators: Skeem, J. L. (University of California, Irvine)

Compares 60 insanity acquittees assigned to specialized mental health probation officers to an equally-matched control group of insanity acquittees assigned to non-specialized probation officers to determine the effectiveness of specialty mental health training on acquittees' rates of recidivism and hospitalization.

### Current Research Project: "Predictive attitudes toward violence risk and mental health recovery in forensic stakeholders"

Co-investigator: McNichols, B. (Argosy University, Honolulu) & Jul, E. (Argosy University, Honolulu)

Examining perceptions of risks for violence from more than 200 judges, attorneys, mental health providers, probation and parole officers, and housing providers. Perceptions of violence risk and recovery potential will be compared between groups, as well as compared to existing research.

### Current Research Project: "The Impact of a Stringent Forensic Evaluator Certification Process on Report Reliability and Quality"

Co-investigators: Sledd, M. (University of Denver) & Sessarego, S. (University of Denver)

Examining qualitative and quantitative program evaluation data for the Conditionally Released insanity acquittee population in Hawaii. Base rates of arrest and hospitalization will be developed, and several comparison subgroups will be identified and analyzed.

Current Research Project: "Decision-making in the Evaluation of Readiness for Conditional Release of Post-Acquittal Insanity Acquittes"

Co-investigator: Vitacco, M. (Georgia State University) & McNichols, B. (Argosy University, Hawaii)

Surveyed more than 50 evaluators of readiness for conditional release evaluations on important elements and factors in their decision to recommend for or against the conditional release of insanity acquittes.

Doctoral Dissertation: "The Effects of Post-Funeral Ritual on Adjustment to Bereavement"

Colorado State University, Fort Collins, Colorado, May 1999  
Advisor: Larry J. Bloom, Ph.D.

Investigated the impact of post-funeral rituals for a diverse grieving population. Results and conclusions focused on the theoretical basis of post-funeral ritual efficacy and implications for grief counseling and theory.

Master's Thesis: "The Effect of Heavy Metal Music on Anger and Arousal"

Colorado State University, Fort Collins, Colorado, October 1995  
Advisor: Larry J. Bloom, Ph.D.

Explored the effects of heavy metal music on listeners' levels of anger and arousal using both objective and subjective assessment methods.

## PUBLICATIONS

- Gowensmith, W. N., Bryant, A. & Vitacco, M. (2014). Decision-making in post-acquittal hospital release: How do forensic evaluators make their decisions? Behavioral Sciences & the Law, 32, 596-607. doi: 10.1002/bsl.2135
- McCallum, K. E., Nassab, N., & Gowensmith, W. N. (2014). The impact of defendant ethnicity on the psycho-legal opinion of forensic evaluators. International Journal of Law and Psychiatry, in press.
- Fuger, K.D., Acklin, M. W., Nguyen, A. H., Ignacio, L. A., & Gowensmith, W. N. (2013). Quality of criminal responsibility reports submitted to the Hawaii judiciary. International Journal of Law and Psychiatry, in press. doi: 10.1016/j.ijlp.2013.11.020
- Gowensmith, W. N., Murrie, D. M., Boccaccini, M. T. (2013). Forensic Mental Health Evaluations: Reliability, Validity, Quality, and Other Minor Details. The Jury Expert, 25, 1-8.
- Gowensmith, W. N., Murrie, D. M., Boccaccini, M. T. (2012). How reliable are forensic evaluations of legal sanity? Law and Human Behavior, 37, 98-106. doi: 10.1037/lhb0000001
- Gowensmith, W. N. (2012, winter). Are competency evaluators competent? American Psychology-Law Society Newsletter, 16-19.
- Nguyen, A. H., Acklin, M. W., Fuger, K., Gowensmith, W. N. , Ignacio, L. A., & Low, S. (2011). Freedom in paradise: Quality of conditional release reports submitted to the Hawaii judiciary. International Journal of Psychiatry and Law, 34, 3410348. doi: 10.1016/j.ijlp.2011.08.006.
- Gowensmith, W. N., Murrie, D. M., Boccaccini, M. T. (2011). Field reliability of competency to stand trial evaluations: How often do evaluators agree, and what do judges decide when evaluators disagree? Law and Human Behavior, 36, 130-139. doi: 10.1037/h0093958.
- Deffenbacher, J.L., Dahlen, E.R., Lynch, R.S., Morris, C.D., & Gowensmith, W. N. (2000). An application of Beck's cognitive therapy to general anger reduction. Cognitive Therapy and Research, 24, 689-697.
- Gowensmith, W. N., & Bloom, L.J. (1997). The effects of heavy metal music on anger and arousal. The Journal of Music Therapy, 34, 33-45.

## OTHER PROFESSIONAL ACTIVITIES

State of Colorado Jail-based Competency Restoration Program Development: Member

American Psychology-Law Society: National conference dissertation review committee member (2010-2013)

National Association of State Mental Health Program Directors, Forensic Div.:  
Vice President (2010-2013)  
State of Hawaii Designee 2006-2011; Representative 2011-present

Mental Health Transformation State Incentive Grant: Vice Chair, Criminal Justice Task Group (2006-2011)

Hawaii Mental Health and the Law Taskforce: Standing member (2007-2011)

Senate Committee Resolution #117 Legislative Taskforce: Forensic mental health designee (2007-2008)

## GRANTS

Public Good Fund (January 2014, \$15,000 / 1 year). *University of Denver*: marketing plan for the College Gateway Program at Red Rocks Community College, a community re-entry program designed for recently released ex-offenders in Colorado.

Walton Family Foundation Bilingual Certificate Program (January 2014, \$450,000 / 3 years). *University of Denver*: Creating a bilingual mental health certificate program to include international exchange with Spanish-speaking countries and an on-line bilingual mental health certificate program

Front End Users Grant (January 2014, \$18,000 / 1 year). *City and County of Denver*: jail-based and community-based assessment of criminogenic and clinical needs of frequent users of mental health and emergency services in Denver, CO.

Incorporation of Trauma and Violence Against Women Assessment into a Community Mental Health Clinic (January 2013, \$2500 / 9 months). *Federal Office on Women's Health*: updated and trained university-based community clinic on current strategies for assessing histories of trauma and victimization in potential female clients.

Public Good Fund (September 2011, \$9000 / 1 year). *University of Denver*: conducted program evaluation of the College Gateway Program at Red Rocks Community College, a community re-entry program designed for recently released ex-offenders in Colorado.

Sequential Intercept Model Research (October 2010, \$65,000 / 2 years). *Federal State Block Grant (SAMHSA)*: hires research assistants to develop and implement a research program focused on program evaluation of inter-agency systems of care among mental health and criminal justice agencies throughout the state of Hawaii.

East Hawaii Drug Court Evaluation (October 2010, \$36,500 / 1 year). *Federal State Block Grant (SAMHSA)*: hires a research assistant to perform program evaluation on innovative court program, in partnership with the judiciary.

Maui County Police Training and Forensic Services Implementation (October 2010, \$90,000 / 2 years). *Federal State Block Grant (SAMHSA)*: Trains local police officers in Crisis Intervention Training, and provides funding for transition services for mentally ill offenders leaving correctional facilities or local hospitals. Developed in partnership with county police department, mental health providers, and the judiciary.

Pre-doctoral Forensic Internship (August 2009, \$270,000 / 2 years). *Justice Assistance Grant through the U.S. Department of the Attorney General*: funds the implementation of a post-doctoral psychology internship as well as implementation of key forensic and criminogenic programs and trainings.

Pre-booking Jail Diversion (June 2009, \$300,000 / 2 years). *Justice Assistance Grant through the U.S. Department of the Attorney General*: hires, trains and places multiple psychiatric nurses in police pre-adjudication cellblock.

Translational and Outcome Research on Forensic Programs and Services (September 2009, \$20,000 / 1 year). *Federal State Block Grant (SAMHSA)*: funds implementation of implementation science research to assess viability and outcomes associated with new forensic programs implemented across multiple agencies.

Forensic Licensed Crisis Residential Shelter (September 2009, \$40,000 / 1 year). *Federal State Block Grant (SAMHSA)*: funds planning of a 4-bed unit to be created to provide service and shelter to forensic consumers in crisis, either pre-trial or post-acquittal.

Forensic Examiners and Forensic Professionals Training (September 2008, 2009, 2010, \$135,000 / 4 years). *Federal State Block Grant (SAMHSA)*: funds forensic trainings and collection of forensic resource materials to ensure workforce development.

## PRESENTATIONS

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### Peer-reviewed presentations:

- Gowensmith, W. N., Sledd, M., & Sessarego, S. (2014). The impact of stringent certification standards on forensic evaluator reliability: Further analysis. Paper submitted for presentation for the 2015 annual meeting of the American Psychology – Law Society, San Diego, CA.
- Gowensmith, W. N., Meyer, L., & Robinson, K. (2014). The applicability of traditional risk assessment measures to a chronically homeless population. Paper submitted for presentation for the 2015 annual meeting of the American Psychology – Law Society, San Diego, CA.
- Hanson, L., & Gowensmith, W. N. (2014). The effects of gender, sexual orientation, and diagnostic categories on jurors in sex offense cases. Paper submitted for presentation for the 2015 annual meeting of the American Psychology – Law Society, San Diego, CA.
- Galen, K., & Gowensmith, W. N. (2014). Jail-based competency restoration: A successful case study. Paper submitted for presentation for the 2015 annual meeting of the American Psychology – Law Society, San Diego, CA.
- Gowensmith, W. N., Sledd, M., & Sessarego, S. (2014, August). The impact of stringent certification standards on forensic evaluator reliability. Paper presentation at the 122<sup>nd</sup> annual meeting of the American Psychological Association, Washington, DC.
- Gowensmith, W. N. & Tassin, A. (2014, March). Courts, cops, clinicians and community corrections: Differences in understanding violence risk in the mentally ill. Paper presentation at the annual meeting of the American Psychology-Law Society, New Orleans, LA.
- Therson, D., Spielman, D. & Gowensmith, W. N. (2014, March). Adult outpatient competency restoration: Results from a nationwide survey. Paper presentation at the annual meeting of the American Psychology-Law Society, New Orleans, LA.
- Bryant, A., Gowensmith, W. N., & Vitacco, M. J. (2014, March). Decision-making in post-acquittal hospital release: How do forensic evaluators make their decisions? Paper presentation at the annual meeting of the American Psychology-Law Society, New Orleans, LA.
- Karas, A., Gowensmith, W. N., & Pinals, D. A. (2014, March). States' standards for training and certifying evaluators of competency to stand trial. Paper presentation at the annual meeting of the American Psychology-Law Society, New Orleans, LA.

- Jul, E., Gowensmith, W. N., Ignacio, L.A., & Tanji, J. (2014). Perceptions of Violence Risk Factors Amongst Judges Working with Criminal Offenders with Mental Illness. Unpublished manuscript, Argosy University, Honolulu, HI.
- Gowensmith, W. N. & McNichols, B. J. (2013, August). Decisions, decisions: insanity acquittees, hospital discharge, and the forensic evaluator. Paper presentation at the 121<sup>st</sup> annual meeting of the American Psychological Association, Honolulu, HI.
- Gowensmith, W. N., Skeem, J. L., & McNichols, B. J. (2013, March). Specialty community supervision practices for insanity acquittees: How well do they work? Paper presentation at the annual meeting of the American Psychology-Law Society, Portland, OR.
- Nassab, N., McCallum, K. E., & Gowensmith, W. N. (2013, March). Reliability of diagnoses in forensic evaluation. Paper presentation at the annual meeting of the American Psychology-Law Society, Portland, OR.
- Purta, M., McCallum, K. E., Nassab, N., & Gowensmith, W. N. (2013, March). Consistency of violence risk prediction across professional disciplines. Paper presentation at the annual meeting of the American Psychology-Law Society, Portland, OR.
- Gowensmith, W. N., Musgrove, L., Muller, K., & Henry, K. (2013, March). The College Gateway Program: Case study of a successful offender re-entry program. Poster presentation at the annual meeting of the American Psychology-Law Society, Portland, OR.
- Nadkarni, L., Gorgens, K., Henderson-Metzger, L. & Gowensmith, W. N. (2012, August). Does this ivory tower have a changing table? Managing multiple roles and identities in a professional graduate program. Roundtable presentation at the 120<sup>th</sup> meeting of the American Psychological Association, Orlando, FL.
- Gowensmith, W. N., McCallum, K. & Nassab, N. (2012, August). Does a defendant's ethnicity impact the psycholegal opinion of a forensic expert witness? Paper presentation at the 120<sup>th</sup> meeting of the American Psychological Association, Orlando, FL.
- Gowensmith, W. N., McNichols, B. J., Bauer-Smith, B., & Dolder, S. (2012, June). New dawn or new nightmare? The impact of new mental health legislation in Hawaii. Roundtable presentation at the meeting of the Law and Society Association, Honolulu, HI.

- Kemp, K., Gowensmith, W. N., Boccaccini, M. T., & Murrie, D. C. (2012, March). Predictors of competency to stand trial opinions in 1,318 evaluations of Hawaiian defendants. In L. Kois (Chair), Multicultural considerations in competence to stand trial evaluations. Symposium accepted for presentation at the meeting of the American Psychology Law Society, San Juan, PR.
- Gowensmith, W. N., Murrie, D. & Boccaccini, M. (2011, March). Evaluator agreement in assessing violence risk and need for hospitalization. Paper presentation at the American Psychology-Law Society Conference (Miami, FL).
- Gowensmith, W. N. & Frost, L. (2011, March). Outpatient competency restoration: Promising results from a new frontier. Paper presentation at the American Psychology-Law Society Conference (Miami, FL).
- McNichols, B., Gowensmith, W. N. & Jul, E. (2011, March). Forensic evaluators and conditional release evaluations: Is evaluator agreement of CR readiness related to longer community tenure? Paper presentation at the American Psychology-Law Society Conference (Miami, FL).
- McNichols, B., Jul, E., & Gowensmith, W. N. (2011, March). Conditional release in the state of Hawaii: A qualitative and quantitative analysis. Poster presentation at the American Psychology-Law Society Conference (Miami, FL).
- McNichols, B., Jul, E., & Gowensmith, W. N. (2010, October). Is conditional release working in the state of Hawaii? Rehospitalization and recidivism rates for insanity acquittees. Poster presentation at the Hawaii Psychological Association Conference (Honolulu, HI).
- Gowensmith, W. N., Murrie, D. & Boccaccini, M. (2010, August). How reliable are forensic evaluations? Evaluator agreement in sanity evaluations. Paper presentation at the American Psychological Association Conference (San Diego, CA).
- Gowensmith, W. N., Murrie, D. & Boccaccini, M. (2010, March). How reliable are forensic evaluations? Evaluator agreement in competency to stand trial evaluations. Paper presentation at the American Psychology-Law Society Conference (Vancouver, Canada).
- Gowensmith, W. N. & Frost, L. (2010, March). Outpatient competency restoration: State of the practice for juvenile and adult restoration. Paper presentation at the American Psychology-Law Society Conference (Vancouver, Canada).
- Miller, R., Gowensmith, W. N., Cunningham, S., & Bailey-Smith, K. (2009, October). Community-Based Treatment to Restore Competency to Stand Trial. Symposium conducted at National Association of State Mental Health Directors Forensic Division National Conference (Virginia Beach, VA).

- Morris, J., Pinals, D., Griffin, P., & Gowensmith, W. N. (2009, October). National Jail Diversion Options. Symposium conducted at National Association of State Mental Health Directors Forensic Division National Conference (Virginia Beach, VA).
- Gowensmith, W. N. (2009, April). Evidence-Based Assessment of Dangerousness. Paper presented at Best Practices in Forensic Mental Health: Responsibility and Recovery in the Legal System (Honolulu, HI).
- Polokoff, R., Steffen, J., Gowensmith, W. N. (2009, April). Analysis of the Conditionally Released Population in Hawaii. Poster at the Forensic Mental Health: Responsibility and Recovery in the Legal System Conference, (Honolulu, HI).
- Ehrhorn, E., & Gowensmith, W. N. (2009, April). Outcomes of the CREST (Conditional Release Exit and Support Transition) Program. Poster at the Forensic Mental Health: Responsibility and Recovery in the Legal System Conference, (Honolulu, HI).
- Gundaya, D., Steffen, J., Gowensmith, W. N., & Crisanti, A. (2009, April). Forensic Involvement and Victimization Among AMHD Consumers. Poster at the Forensic Mental Health: Responsibility and Recovery in the Legal System Conference, (Honolulu, HI).
- Gowensmith, W. N. (2008, October). Current Practices in Assessment of Competency. Symposium (Chair), Hawaii Forensic Examiner Training (Honolulu, HI with statewide video-teleconferencing).
- Gowensmith, W. N. (2008, March). The Conditional Release Program in Hawaii: Successes and Challenges. Paper presented at the National GAINS Center Conference (Washington, D.C.).
- Gowensmith, W. N. & Pedro, D. (2008, March). Specialized Forensic Programs in Hawaii: Hale Imua and Community-Based Competency Restoration. Symposium conducted at National GAINS Center Conference (Washington, D.C.).
- Gowensmith, W. N. (2008, February). Overview of Forensic Mental Health. Invited presentation for International Public Health course offered by the University of Hawaii at Manoa (videoconferencing to Hawaii and several Pacific Island nations).
- Gowensmith, W. N. (2007, September). The Big Kahuna: The Conditional Release Program in Hawaii. Symposium conducted at National Association of State Mental Health Program Directors Forensic Division National Conference (San Antonio, Texas).

Gowensmith, W. N. (2007, September). Effectiveness and Future Directions for Forensic Mental Health. Symposium conducted at State of Hawaii Forensic Examiner Training Conference (Honolulu, HI).

Gowensmith, W. N. (2007, January – April). Reducing Risk for Violence in Mentally Ill Offenders. Trainings and consultations to judiciary staff, mental health providers, housing providers, correctional staff, and police. (Statewide, Hawaii).

Gowensmith, W. N. (2007, January). Forensic Services in Hawaii. Presentation to Senate Committee 117 Task Force of the Hawaii State Legislature (Honolulu, HI).

Gowensmith, W. N. (2006, December). The Intersection of Adult Mental Health and the Criminal Justice System on Oahu. Presentation to Senate Committee 117 Task Force of the Hawaii State Legislature (Honolulu, HI).

Gowensmith, W. N. (2006, April). The Conditional Release Process. Symposium conducted at Hawaii Forensic Examiner Training Conference (Honolulu, HI).

Gowensmith, W. N. (2001, 2002, 2003, Summers). Psychology, Racism, and Peace-building. Trainings and consultations for South Africa Community Fund (Cape Town, South Africa).

Deffenbacher, J., Dahlen, E., Lynch, R., Morris, C. & Gowensmith, W. N. (1998, August). Application of Beck's cognitive therapy to general anger reduction. Paper presented at the American Psychological Association conference (San Francisco, CA).

Invited Presentations:

Lachman, C. & Gowensmith, W. N. (2014). The College Gateway Program: Matching Ex-Offenders with their Purpose and Passion. Invited keynote presentation for the Colorado Career Development Association (Aurora, CO).

Gowensmith, W. N. (2013, September). Outpatient competency restoration programs: A national survey. Invited presentation at the Annual Forensic Examiners Training Conference (Denver, CO).

Gowensmith, W. N. (2013, June). Program evaluation of the College Gateway Program: Success in the face of defeat. Invited presentation for Campus Compact of the Mountain West (Breckenridge, CO).

Gowensmith, W. N. (2013, January). Program evaluation of the College Gateway Program: Success in the face of defeat. Invited presentation for Red Rocks Community College administration (Denver, CO).

- Gowensmith, W. N. (2012, September). Forensic evaluation: Reliability, validity, quality, and other minor details. Invited presentation at the Annual Forensic Examiners Training Conference (Denver, CO).
- Gowensmith, W. N. (2012, June). Forensic evaluation: Reliability, validity, quality, and other minor details. Invited presentation at the Annual Forensic Examiners Training Conference (Honolulu, HI).
- Gowensmith, W. N. (2012, June). Assessment and management of violence risk. Invited presentation at the Annual Forensic Examiners Training Conference (Honolulu, HI).
- Gowensmith, W. N. (2010, September). The roles of the police, providers and the public with the criminally mentally ill. Invited symposium for the Society of Police and Criminal Psychologists national conference (Honolulu, HI).
- Gowensmith, W. N. (2010, September). The reliability of forensic evaluations in Hawaii. Invited presentation for the State of Hawaii Forensic Examiner Training (Honolulu, HI).
- Amano, R., Iboshi, C. & Gowensmith, W. N. (2009, September). Intersection of the Criminal Justice and Mental Health Systems: Collaboration or Competition? Symposium conducted at Professionals Redefining Options for the Mentally Ill through Skills and Education (PROMISE) Conference (Hilo, HI).
- Gowensmith, W. N. (2008, March). Eco-worriers to Eco-warriors: The Role of Ecopsychology. Invited keynote at Lualima Conference on Environmental Awareness and Action (Honolulu, HI).
- Amano, R. & Gowensmith, W. N. (2007, September). Mental Health Courts and Calendars: Reducing Recidivism & Risk for Violence. Invited symposium conducted at Kauai Judicial Complex (Lihue, HI).
- Gowensmith, W. N. (2005, May). Ecopsychology: It's not Easy Being Green. Invited symposium for Watada Lecturer of Excellence Series at University of Hawaii. (Honolulu, HI).

#### REFERENCES

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Available upon request

## APPENDIX B

### Qualifications for consultants Dr. Ira Packer and Dr. Daniel Murrie

Ira K. Packer, Ph.D.

Dr. Packer served as Assistant Commissioner for Forensic Services for the Massachusetts Department of Mental Health. In that capacity, he oversaw the statewide Forensic Service, including inpatient and outpatient forensic evaluations and treatment, as well as services to County Correctional Facilities. Since leaving that position, he has directed inpatient forensic evaluation programs in both Maximum Security Forensic facilities (Bridgewater State Hospital), and Department of Mental Health medium security facilities (such as Worcester State Hospital). He has also had experience directing a community based forensic evaluation service that also included provision of treatment services at local county jails, and served as Deputy Director of the UMMS Correctional Mental Health Program, which served the entire prison system in Massachusetts.

In addition, in his current position as Clinical Professor of Psychiatry at University of Massachusetts Medical School (UMMS), he chairs the committee that oversees the training and certification process for all public sector forensic psychologists and psychiatrists in Massachusetts. This committee sets quality standards for forensic evaluations in the public sector, promulgates standards of practice, and reviews reports submitted by candidates for certification. In addition, Dr. Packer directs the UMMS Postdoctoral Fellowship in Forensic Psychology, and is also one of the core faculty for the UMMS Forensic Psychiatry Fellowship.

Dr. Packer has consulted to a number of states regarding their forensic evaluation services. He contracted with New Mexico and Utah to develop a Quality Improvement process for their community-based forensic evaluations, and also provided direct trainings to the community evaluators in those states. During his tenure as Assistant Commissioner, he oversaw the development of the state's review process for forensic patients suitability for discharge to the community (this policy was needed as Massachusetts did not have a Conditional Release program). He has continued to consult to the Department of Mental Health as part of various committees and task forces that have focused on risk assessments of forensic patients in community settings and/or being discharged from DMH facilities.

Dr. Packer regularly presents at forensic workshops presented by the American Academy of Forensic Psychology, and has been invited to present trainings and workshops to a number of states. In addition, he is the author of two books on forensic practice: *Evaluation of Criminal Responsibility* (part of a Best Practices in Forensic Mental Health Assessment series), and *Specialty Competencies in Forensic Psychology* (a review of the standards of practice).

Daniel Murrie, Ph.D.

Daniel Murrie is currently the Director of Psychology at the University of Virginia's (UVA's) Institute of Law, Psychiatry, and Public Policy (ILPPP), as well as an Associate Professor in the Department of Psychiatry and Neurobehavioral Sciences at the UVA School of Medicine and an instructor in the UVA School of Law.

In his role at the ILPPP, Dr. Murrie oversees the training and certification process for all public sector forensic psychologists and psychiatrists in Virginia. He arranges and delivers a curriculum of approximately 20 forensic training days per year, including a standard curriculum as well as special topics selected to meet emerging needs for the state forensic system. In addition, Dr. Murrie directs the UVA Postdoctoral Fellowship in Forensic Psychology, and is a core faculty for the UVA Forensic Psychiatry Fellowship.

Through ILPPP, Dr. Murrie maintains a longstanding collaborating relationship with Virginia's Department of Behavioral Health and Developmental Services (DBHDS), helping to address the state's forensic mental health needs and projects as they arise. For example, a current project involves developing new training and tools for clinicians to provide competence restoration services on an outpatient basis, in jails and community agencies. Dr. Murrie has also provided formal consultation to the Hawaii Department of Health, helping to develop a plan for training and certifying forensic evaluators. He has consulted on criminal justice/mental health issues to the Texas Department of Criminal Justice and the Texas Youth Commission.

As a researcher, Dr. Murrie has published extensively on forensic mental health evaluation, with a particular emphasis on improving the reliability and objectivity of these evaluations. He has published peer-reviewed, empirical studies addressing competency to stand trial, including the chapter on competence to stand trial in the American Psychological Association's *Handbook of Forensic Psychology*. He has also co-authored texts on forensic evaluation.

**APPENDIX C**  
**Current Washington State competency statute RCW 10.77.068**

RCW 10.77.068

Competency to stand trial, admissions for inpatient services — Performance targets —  
Duties of the department — Report — New entitlement or cause of action not created  
— No basis for contempt or motion to dismiss.

(1)(a) The legislature establishes the following performance targets for the timeliness of the completion of accurate and reliable evaluations of competency to stand trial and admissions for inpatient services related to competency to proceed or stand trial for adult criminal defendants. The legislature recognizes that these targets may not be achievable in all cases without compromise to quality of evaluation services, but intends for the department to manage, allocate, and request appropriations for resources in order to meet these targets whenever possible without sacrificing the accuracy of competency evaluations, and to otherwise make sustainable improvements and track performance related to the timeliness of competency services:

(i) For a state hospital to extend an offer of admission to a defendant in pretrial custody for legally authorized treatment or evaluation services related to competency, or to extend an offer of admission for legally authorized services following dismissal of charges based on incompetent to proceed or stand trial, seven days or less;

(ii) For completion of a competency evaluation in jail and distribution of the evaluation report for a defendant in pretrial custody, seven days or less;

(iii) For completion of a competency evaluation in the community and distribution of the evaluation report for a defendant who is released from custody and makes a reasonable effort to cooperate with the evaluation, twenty-one days or less.

(b) The time periods measured in these performance targets shall run from the date on which the state hospital receives the court referral and charging documents, discovery, and criminal history information related to the defendant. The targets in (a)(i) and (ii) of this subsection shall be phased in over a six-month period from May 1, 2012. The target in (a)(iii) of this subsection shall be phased in over a twelve-month period from May 1, 2012.

(c) The legislature recognizes the following nonexclusive list of circumstances that may place achievement of targets for completion of competency services described in (a) of this subsection out of the department's reach in an individual case without aspersion to the efforts of the department:

(i) Despite a timely request, the department has not received necessary medical clearance information regarding the current medical status of a defendant in pretrial custody for the purposes of admission to a state hospital;

(ii) The individual circumstances of the defendant make accurate completion of an evaluation of competency to proceed or stand trial dependent upon review of medical history information which is in the custody of a third party and cannot be immediately obtained by the department. Completion of a competency evaluation shall not be postponed for procurement of medical history information which is merely supplementary to the competency determination;

(iii) Completion of the referral is frustrated by lack of availability or participation by counsel, jail or court personnel, interpreters, or the defendant; or

(iv) An unusual spike in the receipt of evaluation referrals or in the number of defendants requiring restoration services has occurred, causing temporary delays until the unexpected excess demand for competency services can be resolved.

(2) The department shall:

(a) Develop, document, and implement procedures to monitor the clinical status of defendants admitted to a state hospital for competency services that allow the state hospital to accomplish early discharge for defendants for whom clinical objectives have been achieved or may be achieved before expiration of the commitment period;

(b) Investigate the extent to which patients admitted to a state hospital under this chapter overstay time periods authorized by law and take reasonable steps to limit the time of commitment to authorized periods; and

(c) Establish written standards for the productivity of forensic evaluators and utilize these standards to internally review the performance of forensic evaluators.

(3) Following any quarter in which a state hospital has failed to meet one or more of the performance targets in subsection (1) of this section after full implementation of the performance target, the department shall report to the executive and the legislature the extent of this deviation and describe any corrective action being taken to improve performance. This report must be made publicly available. An average may be used to determine timeliness under this subsection.

(4) Beginning December 1, 2013, the department shall report annually to the legislature and the executive on the timeliness of services related to competency to proceed or stand trial and the timeliness with which court referrals accompanied by charging documents, discovery, and criminal history information are provided to the department relative to the signature date of the court order. The report must be in a form that is accessible to the public and that breaks down performance by county.

(5) This section does not create any new entitlement or cause of action related to the timeliness of competency evaluations or admission for inpatient services related to competency to proceed or stand trial, nor can it form the basis for contempt sanctions under chapter 7.21 RCW or a motion to dismiss criminal charges.

**APPENDIX D**  
**Competency Evaluation Deadlines in State Statutes**

<b>State</b>	<b>Deadline for evaluation (inpatient)</b>	<b>Deadline for evaluation (outpatient or jail)</b>	<b>Text from Statute, or other details</b>
<b>Alabama</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	<i>No deadline specified in statute</i>
<b>Alaska</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	Specifies 60 days for sanity evaluation, but no deadline apparent for competence evaluations.
<b>Arizona</b>	30 days, with option to extend 15 more days	<i>No deadline referenced</i>	Appears to reference inpatient evaluations only
<b>Arkansas</b>	60 days	60 days	60-day deadline appears to apply to both inpatient and outpatient
<b>California</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	Statute references timelines for hearings and other proceedings, but none specific to competence evaluation.
<b>Colorado</b>	<i>No deadline referenced</i>	<30 days	30- day deadline applies to jail-based evaluations. Deadline is <i>not</i> referenced in statute, but is widely disseminated in other ways.
<b>Connecticut</b>	21 days, with the option to extend 14 more days	21 days, with the option to extend 14 more days	Statute specifies exam should be completed within 15 days of order, and report within 21 days of order
<b>Delaware</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	

<b>District of Columbia</b>	Requires a preliminary screening exam within 5 days. If indicated, a full evaluation must occur within 30 days (with a 15-day extension permissible)	Requires a preliminary screening exam within 5 days. If indicated, defendant is referred for inpatient evaluation with 30-day deadline (15-day extension permissible)	
<b>Florida</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	
<b>Georgia</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	
<b>Hawaii</b>	30 days, with extensions possible	30 days, with extensions possible	
<b>Idaho</b>	30 days	<i>No deadline referenced</i>	30-day deadline appears to apply to inpatient evaluations only
<b>Illinois</b>	7 days, with option to extend 7 days.	30 days	When evaluation cannot be completed on an outpatient basis, the defendant may be hospitalized for 7 days, with the option to extend another 7 days, to complete the evaluation. The CST report is then due within 30 days.
<b>Indiana</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	
<b>Iowa</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	Deadline not specified. "If an evaluation has been conducted within 30 days of the probable cause finding, the court is not required to order a new evaluation and may use the recent evaluation during hearing."

<b>Kansas</b>	60 days	<i>No deadline referenced</i>	"If committed to an institution for examination, the commitment cannot exceed 60 days or until exam is completed, whichever is shorter"
<b>Kentucky</b>	30 days	<i>No deadline referenced</i>	Commitment to facility for examination cannot exceed 30 days, but there is no apparent deadline for outpatient evaluations
<b>Louisiana</b>	30 days	30 days	
<b>Maine</b>	<i>No deadline referenced</i>	30 days	"If the defendant is incarcerated, the examination ordered...must take place within 21 days of the court's order, and the report of that examination must be filed within 30 days of the court's order. If further examination is ordered...the report of that examination must be filed within 60 days of the court's order."
<b>Maryland</b>	7 days	7 days	Unless there is a plea that the defendant is not criminally responsible, "the defendant is entitled to have the report within 7 days after the court orders the examination"
<b>Massachusetts</b>	20 days, with the option to extend another 20 days	<i>No deadline referenced</i>	
<b>Michigan</b>	60 days	60 days	

<b>Minnesota</b>	60 days	<i>No deadline referenced</i>	“If the defendant is not entitled to release or the examination cannot be done on an outpatient basis, the court may order the defendant confined in a state hospital or other suitable facility for up to 60 days to complete the examination”
<b>Mississippi</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	
<b>Missouri</b>	60 days	60 days	Report must be filed with the court within 60 days “unless the court for good cause orders otherwise”
<b>Montana</b>	60 days	<i>No deadline referenced</i>	“The court may order the defendant to be committed to a hospital or other suitable facility for the purpose of the examination for a period not exceeding 60 days or a longer period that the court determines to be necessary for the purpose”
<b>Nebraska</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	
<b>Nevada</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	One county requires a 10-day deadline (see report text), unlike the remainder of the state.
<b>New Hampshire</b>	45 days	90 days	
<b>New Jersey</b>	30 days	<i>No deadline referenced</i>	Cannot be hospitalized for the purposes of examination longer than 30 days

<b>New Mexico</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	Time frames for hearing after evaluation: 10 days for misdemeanors; 30 days for felony
<b>New York</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	<i>Statute provides deadlines for holding hearings, and other procedures, but no deadlines for evaluation are apparent</i>
<b>North Carolina</b>	30 days for felonies regardless of setting (two subsequent 30- day extensions possible)	10 days for misdemeanants in jail; 20 days for misdemeanants on bond; 30 days for felonies regardless of setting (two subsequent 30- day extensions possible)	
<b>North Dakota</b>	30 days	<i>No deadline referenced</i>	
<b>Ohio</b>	20-day limit to inpatient stay for evaluation	30 days	Report required within 30 days of court order
<b>Oklahoma</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	<i>Statute provides deadlines for holding hearings, and other procedures, but no deadlines for evaluation are apparent</i>
<b>Oregon</b>	30 days	<i>No deadline referenced</i>	
<b>Pennsylvania</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	

<b>Rhode Island</b>	15 days	<i>No deadline referenced</i>	If defendant is in custody, exam must be completed within 5 days, but report can be submitted within ten days thereafter.
<b>South Carolina</b>	15 days for an exam, within an additional 5 days for report	15 days for an exam, within an additional 5 days for report	
<b>South Dakota</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	
<b>Tennessee</b>	30 days	<i>No deadline referenced</i>	
<b>Texas</b>	30 days	30 days	
<b>Utah</b>	30 days	30 days	
<b>Vermont</b>	30 days with potential 15-day extension	30 days with potential 15-day extension	Report due "as soon as practicable after the examination has been completed"
<b>Virginia</b>	<i>No deadline referenced</i>	<i>No deadline referenced</i>	"Upon completion of the evaluation, the evaluators shall promptly submit a report in writing to the court and the attorneys"
<b>Washington</b>	[focus of current report]	[focus of current report]	
<b>West Virginia</b>	15 days, with reports due within 20 days, and 30-day extension possible	<i>No deadline referenced</i>	
<b>Wisconsin</b>	15 days	30 days	
<b>Wyoming</b>	30 days, with potential for extension up to 90	<i>No deadline referenced</i>	