Report to the Legislature

Forensic Competency Evaluation and Restoration – Strategies to Minimize Waiting Periods

Chapter 504, Laws of 2005, Section 506(2)

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Department of Social & Health Services
Health and Recovery Services Administration
Mental Health Division
PO Box 45320
Olympia, WA 98504-5320
(360) 902-8070
Fax: (360) 902-0809

EXECUTIVE SUMMARY

Chapter 504, Laws of 2005, Section 506(2) directed the Department of Social and Health Services (DSHS) to develop strategies for addressing increases in forensic population and reducing waiting periods for competency evaluation and restoration.

The Law Review Committee, a workgroup made up of representatives from the three state psychiatric hospitals (Western State Hospital, Eastern State Hospital and Child Study and Treatment Center), was assigned to develop this report. The Law Review Committee consulted directly with the Mental Health Division (MHD), the Division of Developmental Disabilities (DDD) and the Attorney General's office. In addition, the final report reflects the information, opinions and ideas of a wide variety of legal and mental health professionals.

DSHS is mandated to provide forensic evaluation and treatment services when court-ordered. Washington State has during the past ten years seen a steady and steep rise in the demand for pretrial evaluation and competency restoration treatment. This trend is one that is occurring nationwide. *As a result, resources have been severely strained and some persons court-ordered for inpatient evaluations are waiting in county jails for sixty days or more for hospital admission.*

This report reviews several models for the provision of pretrial evaluation and treatment services found in states across the country, including:

- Institution-based inpatient system
- Institution-based outpatient system
- Community-based system (including court clinics)
- Private practitioner system
- Mixed system

The report also analyzed:

- Use of regional jail facilities to complete competency evaluation and restoration
- Co-location of professional persons in jails
- Performing restoration treatment in less restrictive alternatives than the state hospitals.

The state of Washington utilizes a mixed evaluation model.

- The majority of initial evaluations are completed in local jail/detention facilities or in the community.
- State hospitals are the location of some evaluations due to various clinical issues and/or seriousness of charges against an individual.

*The Department **recommend**s that, under current statutory provisions, the legislature stay the course in the further development of the current mixed model. The current model has already*

proven to save resources, serve the court system and facilitate access to treatment for defendants with a mental disorder or disability.

*The Department also **recommends** that innovative programs for alternative restoration treatment of defendants found by the courts to be safe-to-be-at-large continue to be explored. These include the treatment of defendants with developmental disabilities and certain low risk misdemeanant and felony defendants.*

*Finally, the Department **recommends** that the Washington's Criminal Insanity statute, Chapter 10.77 RCW, be comprehensively reviewed to determine if statutory change can assist in the development of new strategies for more efficiently addressing increases in forensic population and reducing waiting periods for competency evaluation and restoration. The Department is currently planning such a comprehensive and anticipates making specific recommendations to the legislature in the fall of 2007.*

The Department does not support locating professionals in local jails for evaluation services.

A complete discussion of the findings and recommendations is contained within the full report. Over the past ten years, Washington State has monitored the various models for the provision of forensic mental health services across the country, and has transformed service delivery to this population in a manner which takes into account the state's own unique needs. The Department will continue its efforts to improve the efficiency of service delivery while maintaining a high level of quality in service provision.

LEGISLATIVE DIRECTIVE

Chapter 504, Laws of 2005, Section 506(2) directed the Department of Social and Health Services (DSHS) to develop strategies for addressing increases in forensic population and reducing waiting periods for competency evaluation and restoration. Specifically, the statute requires the department to:

> "Report to the legislature with an analysis of several alternative strategies for addressing increases in forensic population and minimizing waiting periods for competency evaluation and restoration. The report shall discuss, at a minimum, the costs and advantages of, and barriers to co-locating professional persons in jails, performing restoration treatment in less restrictive alternatives than the state hospitals, and the use of regional jail facilities to accomplish competency evaluation and restoration."

INTENT/PROCESS

This report is a product of the Law Review Committee of the three state hospitals (Western State Hospital, Eastern State Hospital and Child Study and Treatment Center) and is intended to meet this legislative mandate. The report represents a collaborative effort by individuals from the three state hospitals, in consultation with the Division of Developmental Disabilities (DDD), Attorney General's Office and the Mental Health Division (MHD).

In addition, the report is derived in part from information, opinions and ideas of a wide variety of legal and mental health professionals who have working knowledge of the procedures, laws and policies governing these issues. They include individual judges, prosecutors, defense attorneys, Designated Mental Health Professionals and jail mental health staff, but do not represent their organizations' opinions. The recommendations expressed in this report represent the views of the MHD.

Information regarding other states' procedures was gathered from interviews with national experts and from professional literature review. Previous survey research of the practice of other states conducted by Western State Hospital (WSH) for program development and legislative staff consultation was also reviewed.

STATEMENT OF CONCERN

There is growing concern nationwide and within the local mental health and criminal justice systems that the criminal justice system is increasingly involved in the treatment of persons with mental disorder, who would more appropriately be treated and managed by the community mental health system. The community mental health system must have adequate resources and expertise to provide such treatment. The confinement of mentally disordered persons in jails and prisons due to criminal behavior that primarily is the result of untreated mental disorder and an inability to meet health and safety needs challenges

their expectation of receiving the least intrusive and least confining treatments. Failure to treat such persons in the community prior to engagement in illegal and sometimes violent or intrusive behavior also fails to acknowledge the need to adequately protect the public from such preventable behavior on the part of this population. Confinement and hospitalization of this population is enormously expensive when it could be avoided by adequate habilitation, case management and treatment. The civil mental health and criminal mental health systems need to work in concert and share resources in order to better serve this population. It is with this concern in mind that this document is produced.

PRETRIAL FORENSIC MENTAL HEALTH PROGRAMS

DSHS is mandated to provide forensic evaluation and treatment services when court-ordered. Washington State has seen a steady and steep rise in the demand for pretrial evaluations and competency restoration treatment. (See Charts 1, 3, 6) As a result, resources have been severely strained. This trend reflects the trend occurring nation-wide.

Court orders for pretrial evaluations in Washington State have been increasing in numbers for the last two decades, at times more dramatically than others, e.g., the late 1990s and early 2000s. The reasons for the increase are complex, but are believed to include the general national trend toward the criminalization of the mentally ill due to the limitations of the community treatment system; the increasing concern for safety of the public and high profile crimes committed by individuals perceived by the public to be mentally disordered; the increasing sophistication of both the criminal justice and mental health systems regarding violence, mental disorder and crime; the use of forensic reports by the criminal justice system and mental health systems for purposes other than their original intent (e.g., charging decisions, plea bargaining, referral for civil commitment, etc.); the greater apparent ability of the criminal court system over the civil court system to demand resources from the state; and perhaps most importantly, local statutory changes regarding the adjudication of misdemeanor crimes.

It should be noted that Washington State's statutory length of time permitted for the conduct of pretrial evaluations is among the shortest of all the states in the country. The range of time allowed for evaluations across the country is seven days to one year. Washington State allows 15 days (RCW 10.77.060). At the same time, Washington State allows for the greatest number of opinions to be ordered during the initial evaluation of any state in the country and the extensive required components of the report add considerably to the length of time required to compete the evaluation. Any substantial change in cost of such services would be gained by altering the type or scope of the services, the program structure of such services, or the access to such services, rather than by attempting to speed up the evaluation or restoration activity directly.

There are a limited number of models for the provision of pretrial evaluation and treatment services found in states across the country. They vary along the primary dimension of the amount of services provided in the inpatient hospital vs. in the jail/community setting. Several secondary dimensions include: state vs. local funding,

private vs. public employees, single vs. multiple issue evaluations. The models have been used by different states. The success of the models is dependent upon individual state history prior to the use of the model. There is no specific model that can be imported wholesale to meet the unique characteristics of Washington State history and the current programs, policies and laws which are in effect at the time of this report. For clarity of discussion, we consider evaluation services separately from treatment services.

Costs: It should be noted that the cost figures used in this report are based on averages of the numbers of cases in each category and the averages of the numbers of admissions, length of evaluations and treatments, and average costs. These figures are used for comparison value between the various systems discussed.

Pretrial Evaluation

Any model for pretrial mental health services must consider the populations to receive those services. The clearest examples are the distinctiveness of the population with psychiatric mental disorder from the population with developmental disability, and that of the adult population from the child/juvenile population. They have differing psychological and psychiatric profiles and needs, as well as different administrations and laws governing them. While the adult population is very appropriate for the regionalization of services, the child/juvenile population is not, due to the differences in the numbers of cases and their geographical distribution in the state. The adult population has developed forensic mental health law but the child/juvenile area does not have developed law in this area. While the population with psychiatric mental disorder often needs hospitalization and medication at some point, a portion of the population of persons with developmental disability instead only needs habilitation and intensive education. And juveniles often require some combination of medication and/or education. However, increasingly, defendants with developmental disability, who in many cases are not otherwise mentally disordered, are being placed in state psychiatric hospital facilities due to the lack of available secure, specialized evaluation and treatment facilities or secure outpatient restoration options for this population. Similarly, juveniles who are immature and in need of education are increasingly placed in the state psychiatric hospitals even when psychiatric services are not their primary need.

Evaluation Models

The following are from a commonly cited typology of pretrial competency evaluation service delivery models, each used by various other states. (Grisso, Cocozza, Steadman, Fisher, & Greer, 1994; Poythress, Otto, & Heilbrun, 1991):

1. **Hospital-based inpatient system -** Predominantly inpatient evaluations conducted by state employees at state-run hospitals that have statewide or large regional catchments.

   Advantages: This model provides the most intensive and thorough evaluation because the defendant is observed 24 hours per day in the hospital setting by experienced and/or trained staff and there is access to medical screening and psychological testing and multiple interviews. This model also allows for a team

evaluation concept involving a variety of professionals including psychiatrists, psychologists, social workers, nursing staff and rehabilitation staff. It is easier to maintain quality and standardization of services. There is generally greater confidence of the criminal justice system in the accuracy and reliability of these evaluations.

Disadvantages: This model is the most expensive evaluation process. It also may violate the defendant's right to be evaluated in the least restrictive environment if the defendant is out of custody at the time of the evaluation order. It does not allow defendants to be evaluated in their local community. It requires transport of the in-custody defendant to the hospital, which is expensive to jails or sheriffs and raises security concerns. The expense of this model does not justify the relatively small increment in accuracy of clinical assessments and legal decision-making in all but the most serious or complicated cases.

Costs: The cost to complete an evaluation for competency/sanity in the state hospitals is approximately $6,000 - $8,000 per patient.

Prior to legislative changes in 1999, most court ordered competency/sanity evaluations were conducted at one of the state psychiatric hospitals. Since then, the Department has been able to evaluate more persons in the community as well as in the state hospital. If the Department were to return to a policy of admitting all persons for competency/sanity evaluation, additional state psychiatric hospital beds would be required, revised legislation would be required, and the state would incur costs in excess of $20 million for all three hospitals (based on the number of off-site evaluations conducted now which would then have to be conducted in the hospital). Physical capacity does not exist at any of the state hospitals to expand to an admission-only policy. Communities would not be in favor of inpatient evaluation only as the length of time to conduct an evaluation would conceivably expand due to unavailability of beds when the allocated beds are full.

2. **Hospital-based outpatient system -** Predominantly outpatient evaluations conducted by state employees at one or two centralized centers having statewide catchment areas, such as state hospitals, with a secondary option for inpatient evaluations, usually at the same site. Evaluations are funded by state mental health departments.

   Advantages: There are significant cost savings due to elimination of hospital admission and discharge processes, such as medically supervised physical examinations and lab tests. It may honor the defendant's right to be evaluated in the least restrictive environment. It is also possible to maintain quality and standardization of services if maintained in a centralized service delivery system.

   Disadvantages: This model lacks the intensive medical evaluation of the hospital-based inpatient model. There is briefer contact between the defendant and the evaluator, and follow-up interviews may be difficult to conduct. It still requires the expense and security concerns of the transport of unstable defendants by local authorities. It does not allow defendants to be evaluated in their local community. On

the rare occasion when it becomes evident that a defendant requires hospitalization, special arrangements must be made following the out-of-hospital evaluation. In-custody defendants may remain in jail (which may be even more restrictive than an inpatient setting) for a longer time without a final evaluation report.

Costs: The costs/savings for implementing this system in Washington State can only be estimated. Experience in Virginia more than 10 years ago showed that several million dollars and extensive collaboration between the state and the local university were required to revamp their system from an inpatient system to a hospital-based outpatient system.

Washington's current system conducts approximately 70-75% of evaluations out of the hospital on an off-site basis. On-site evaluations would involve having the defendant transported to the hospital for the evaluation by law enforcement. Consequently, having the defendants brought to the hospital for an on-site evaluation would save on examiner travel time and expense, a cost savings to the state of about $150 per evaluation. Added to this would be savings from some increase in examiner productivity due to lessened travel time and more time spent on evaluations. It would have some increased cost to the local jurisdictions in officer time and mileage costs to transport in-custody defendants to the state hospital. These costs include: officer salaries (including overtime costs when they must travel long distances (e.g. Clallam Bay to WSH; Stevenson to ESH) and back after transporting a person, mileage , per diem for the officers, etc. There will also be delays in evaluation when officers in small communities are not able to leave their jurisdiction to transport a person outside of their community.

Approximately 10% of patients admitted to the state hospital could be appropriately evaluated at the hospital on an on-site evaluation without admission. This would decrease the number of persons admitted for inpatient evaluation by about 15-30 persons per month. Some cases would still require admission due to the seriousness of the charges and/or the complexity of the clinical issues. This would reduce the inpatient waiting list for evaluation as more are evaluated on-site without admission. Additional costs for professional evaluators would be required ($100,000 per evaluator).

Additional costs would fall to the local governments, including transportation of all evaluated defendants to the state hospital and then staying with the person during the evaluation or waiting until the evaluation is complete (several hours) to return the person to custody. Also, if multiple evaluations were required, the officers would have to transport multiple times, including any additional evaluations when the defense attorney would want to be present.

Consequently, there would be significant savings to the state in reduced evaluator travel time but would have significant increased costs to the local governments in transportation costs. Additional or renovated facilities and security staff would be required to house and secure an on-site clinic at all three hospitals, at a currently undetermined cost

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3. **Community-based system -** Predominantly outpatient evaluations conducted by local or regional community mental health providers employed by mental health agencies or other service provider groups in a variety of evaluation settings that are funded through department of mental health budgets.

   Advantages: There are substantial cost savings due to elimination of the hospital admission and discharge processes. It allows easier access to defendants for multiple interviews given local proximity, which may also yield easier access to relevant records. It may honor the defendant's right to be evaluated in the least restrictive environment and to be evaluated in their local community. Familiarity between examiners and jail staff may improve the quality of the referral process. Reduced need for transportation saves costs and reduces security concerns.

   Disadvantages: This model does not allow for the more intensive and thorough inpatient hospital evaluation, unless special arrangements are made for hospitalization following the out-of-hospital evaluation. It is impractical in regions with few evaluation referrals or lack of professional staff availability. It is difficult to maintain quality and standards of evaluations, as well as to coordinate statewide activities. This model is dependent upon local economic and administrative support for its organization and quality.

   Costs: It is not possible to anticipate the costs of a shift in Washington State to this system because it would involve dismantling the current centralized system and the development de novo of a community system in each county or local jurisdiction. Such decentralization results in the duplication of costs for at least the administrative structures that currently are centralized. In addition, local mental health agencies are unlikely to have, to be able to fund, or to be able to even find sufficient professional resources to conduct the number of evaluations required. Recruitment would be a significant problem in many regions. Professional staff that are available are unlikely to be forensically trained and qualified. (One year of training, experience, and supervision is generally required before a professional is regarded as fully competent to conduct these evaluations.) Consequently, funds for staff increases (professional, support and administrative) would need to be available at the local level.

   Costs for evaluations outside of the hospitals vary depending on the case and the type and number of examiners involved. Evaluations range in length of time to conduct the evaluation from five hours to fifty hours, depending on the seriousness of the charges, the legal issues involved, the complexity of the clinical case, and whether testimony is required. Hospital psychologists earn $35 per hour plus benefits and psychiatrist earn $71 per hour plus benefits.

   Statutory change would also be required as the courts have discretion over the place and manner in which the evaluation is conducted. It would also require that other agencies outside of DSHS be involved, e.g. local court jurisdictions, Regional Support Networks, counties, etc. A change to this system would also require changes in the funding and the mission of the community mental health system in

Washington. Criminal forensic evaluations would need to be available without regard to the client's eligibility for Medicare or Medicaid-funded services.

3a**.** **Court clinic -** In general, court clinics may be regarded under the Community model as experimental programs that meet very specific and local needs. They are primarily implemented in densely populated urban areas located in or near a court building to manage various mental health service needs for specific courts, including large pretrial evaluation and treatment caseloads. One state-wide model was found that served a geographically small commonwealth. The clinics typically provide a range of pre and post-trial mental health services for domestic, civil and criminal cases. Services relevant to this discussion include competency screening prior to the entry of an order for a full competency evaluation and some limited pretrial competency restoration treatment services. Clinics are usually funded by local governments or courts, or by state programs. The state-wide model was funded at the state level but administered locally.

Advantages: These include the assignment of a case coordinator, facilitation of professional cooperation, and familiarity with local services. The case coordinator helps determine what the forensic issues are in the case, helps identify potential sources of information about the defendant, and then oversees the coordination of cross-systems services. Court clinics, given their local focus, serve an education and training role for various systems' staff and facilitate communication between legal and clinical professionals. Also because they are local, they are very familiar with the local mental health resources and can help coordinate needed services, such as outpatient restoration treatment if appropriate.

Disadvantages: Court clinics add an additional layer of processing in some cases before the defendant receives treatment services or final disposition, are sensitive to local fiscal and political issues related to service provision, and may not be seen as objective in screening and evaluation. It is unclear whether or not such services would save resources by identifying referrals that did not need full evaluation or expend resources by identifying more defendants in need of services. However, empirical literature supports the use of screening evaluations in individual cases on the issue of competency. In Washington, however, such screening would not provide for diagnostic and dangerousness or risk evaluations currently required by statute on all court ordered competency evaluations.

Costs: It is not possible to estimate the use and costs of a court clinic without specifying the particular jurisdiction, due to differences in referral rates, administrative policies and budgets already in place. Each jurisdiction would need to assess the feasibility and cost-effectiveness of such clinics for their specific needs. The extent to which they are successful could divert some defendants from the need for state evaluation, while also identifying currently un-served defendants who would newly require services. Anecdotal assessments from attorneys and jail staff suggest a high number of defendants heretofore never evaluated also have mental disorders.

The increased or decreased costs to be evaluated include professional time for evaluation, hospitalization for competency restoration, court hearings, transportation of inmates to and from hospitals for evaluation or treatment, etc. A pilot program could be initiated to explore the feasibility, costs and impact of such programs in the larger jails and jurisdictions. However, professional staff must be made available for such a pilot.

Statutory change would not be required on the local level to develop such clinics.

4. **Private practitioner system -** Predominantly outpatient evaluations conducted locally by private practice professionals in jails or professional offices that are provided contractually on a case-by-case basis and funded by courts or other criminal justice or mental health budgets.

   Advantages: There is cost savings due to elimination of hospital admission process. It may honor the defendant's right to be evaluated in the least restrictive environment. If there is a collaborative relationship between examiners and jail staff, it may improve the process of referrals, though not necessarily the quality of those services. There are reduced transportation costs, easier access to the defendant and easier access to relevant court and jail records.

   Disadvantages: This model does not allow for the more intensive and thorough inpatient hospital evaluation. Concerns about the fee-for-service model include that it may reduce referrals for purely strategic reasons rather than clinical reasons, that it raises concerns of the criminal justice system that such practitioners would come under the influence of the local jurisdiction for which they worked and make legal decisions based upon local fiscal and program issues, and that quality and standardization of evaluations would vary with the fees provided. When local jurisdictions experience budget deficits/reductions, or when they are unable to hire qualified Ph.D. or physician level practitioners, they may elect to utilize professionals with less education/experience, e.g. master's level psychologist vs. a Ph.D., It is difficult to find professional practitioners in rural areas. It is difficult to maintain quality and standards of evaluations, as well as to coordinate statewide activities. This model is dependent upon local economic and administrative support for its organization and quality of evaluation and programming.

   Costs: The costs for this system under current statutes would depend on the rate paid for evaluations, the availability of professional staff willing to conduct them, and the number and type of professionals (licensed psychologists or physician) utilized in each case. Experience in other states and anecdotal report of local private practitioners has shown that when flat fees are applied, the extent and quality of the evaluation and report matches the fee. Hourly fees to match the current quality of evaluations and reports may result in very high costs for serious or complicated cases. While actual rates effective in securing professionals to conduct the evaluations can only be estimated, they must be sufficient to attract the necessary number of competent professionals. The rates are higher than for state employed examiners because of the overhead costs of private practitioners. For psychologists the fee per hour would need to approximate $150-200 per hr., though established experts may

command several times that amount. For psychiatrists, the fees approximate $250-350 per hour. Since cases on average for fee purposes take approximately 12 hours, the fee per case for psychologists would be from $1800 to 2400, for psychiatrists $3000 – 4200. However, since it is an average, some cases would cost considerably more, upwards of $7,500 for psychologists and $15,000 for physicians. While it may be possible to contract with a professional agency to conduct such evaluations, the costs would have to approximate these fees in order to be viable. Even at the lowest rate, for psychologists, one psychologist per case, on a 12 hours per evaluation average rate, for 1500 evaluations, would be a minimum of $2,700,000. Actual costs are likely to be much higher, considering two examiners per case, physician involvement, testimony, etc. A more fully developed figure is approximately $5,000,000.

In addition, there would be costs to develop local administrations in each region or jurisdiction, essentially copying the current centralized administration. Also of note is the fact should the state use local and less trained and monitored professionals, the costs of mistakes or misjudgments must be considered. Every mistaken insanity acquittee who is hospitalized as Criminally Insane costs the state approximately $450 - $550 per day at the state hospitals. Using centrally trained and employed professionals reduces this risk through training and standards utilization.

5. **Mixed System –** This is the model that most closely resembles Washington's current system. A relatively balanced combination of inpatient evaluations in state hospitals and various local outpatient evaluation approaches using various funding patterns. Typically they are supported with state departments of social and health funding for the inpatient evaluations and departments of mental health funding or court/county funds supporting the outpatient evaluations.

   Advantages: The strength of this model lies in its ability to take advantage of the benefits of the other models while avoiding their weaknesses. It allows the state to utilize programs and models appropriate to various regions, which may differ from each other substantially in demographics and geography as well as administrative and budgetary structure. It has cost savings from the hospital-based inpatient model due to the reduction of the hospital admission and discharge processes. It allows for court or professional discretion in conducting the evaluation in the hospital, jail, or community as appropriate. It generally honors a defendant's right to be evaluated in the least restrictive environment.

   Disadvantages: The Mixed System has few disadvantages if fully funded. Access to the various services must be evenly proportioned to the various regions. It is difficult to administer unless there is centralized authority.

   Costs: Washington's current system has developed over time to meet the current circumstances of Washington's administrative, budgetary, criminal justice and statutory status. Currently approximately 400 evaluations per year are conducted on an inpatient basis at a rate between $6,000 and $8000 per evaluation

   Approximately 10% of patients admitted to the state hospital could be appropriately evaluated at the hospital on an on-site evaluation without admission. This would

decrease the number of persons admitted for inpatient evaluation by about 15-30 persons per month. Some cases would still require admission due to the seriousness of the charges &/or the complexity of the clinical issues. This would reduce the inpatient waiting list for evaluation as more are evaluated on-site without admission. Additional costs for professional evaluators would be required ($100,000 per evaluator).

WASHINGTON STATE'S EVALUATION MODEL

Over the last ten years adult forensic services in Washington State has moved away from the hospital-based inpatient hospital evaluation model for adults to a mixed evaluation model. Seventy-five percent of initial evaluations completed by WSH, and 60 percent by Eastern State Hospital (ESH) are conducted in the local jail/detention facility or in the community. The remaining are conducted in the state hospitals because the clinical issues are complicated and cannot reliably or convincingly be conducted in the jail or the community; the charges are sensitive or very serious; or the court for its own reasons requires hospitalization. Court ordered evaluations are conducted by state hospital employed professionals and all programs are administered from the state hospitals. Funding for all evaluations is through the state hospitals. However, the court has the authority to appoint private professionals instead of state examiners. The payment source for private evaluations has varied. Some are funded by the court, the prosecution, or the defense bar and some are charged to DSHS.

The move from the hospital-based inpatient model was initiated following extensive research into the various models and the national trends for the provision of pretrial forensic evaluation services. This direction was taken by the MHD following the rapid state-wide increase in demand for evaluations on the west side of the state (see Chart 1), which occurred over the last 15 years and overwhelmed the resources of the state to provide services.

This model for evaluation services was implemented in coordination with a variety of local and county court jurisdictions and local mental health agencies in a manner designed to work with their specific policies and procedures, which were unique in each case due to their varied political, fiscal and administrative structures. The service provision gradually developed into a consistent and unified model across counties and jurisdictions.

This dramatic change of venue from the hospital-based inpatient model to a mixed model was completed over the course of five years with little direct state administrative cost. This strategy has been extremely successful and has prevented the need for funding additional state hospital beds (23,370 bed days saved)... It has also resulted in more rapid completion of initial evaluations (when fully funded and staffed) that can in turn shorten jail stays and lengths of incarceration, as well as speed access to treatment for those defendants that need it. The nature and quality of services have received general acceptance by the local and state courts and by the prosecution and defense bar. Jails and sheriffs conduct fewer transports of defendants to and from the state hospitals. Problems

which remain are largely due to the continually increasing demand in the number of evaluations requested, lack of adequate/qualified human/professional resources in local jurisdictions, and procedural resistance from some local jurisdictions (e.g. a local jurisdiction that requires all evaluations be conducted on an inpatient basis), rather than to problems with the model or dissatisfaction with the service provision itself.

Paralleling the changes instituted in forensic evaluation service delivery with adults, juvenile evaluations in Washington State have transitioned from a hospital-based inpatient evaluation model to a hospital-based outpatient system in which the state's only state-run psychiatric hospital for children, Child Study and Treatment Services (CSTC), serves as an outpatient evaluation center with a statewide catchments area. This transition was accomplished progressively between 1994 and 1998 (see Chart 6). Whereas evaluations formerly involved a 15-day inpatient hospitalization, they are now typically conducted on the grounds of the hospital over a period of two to three hours with no admission or bed-days sacrificed. When security, clinical need, or logistics demand, valuations are conducted at the local detention centers. On rare occasions (four since 1998), when needed to complete an adequate competency evaluation, the evaluation is conducted on an inpatient basis at CSTC. Now, about 90 percent of evaluations are conducted on an outpatient basis at CSTC, and about ten percent are conducted in the local jail/detention facility or in the community

Local jurisdictions have supported the juvenile forensic services transition to the hospital-based off-site model in that they see that the quality of information they receive has not suffered from this transition, and it allows more of CSTC's 47 beds to be devoted to the long-term inpatient psychiatric needs of children across the state. Regarding the latter, if the practice of inpatient evaluations had continued at CSTC, in 2004, as many as 2,115 of the hospitals' 17,155 annual bed-days would have been devoted to completing competency evaluations rather than providing inpatient psychiatric treatment to Washington State's mentally ill youth. As occurred in the adult system, this transition to the hospital-based off-site system yielded little direct administrative cost and significant fiscal savings for the state (given that a bed-day at CSTC costs approximately $715).

If current trends continue, persons with serious mental disorder will continue to enter the mental health programs of criminal justice system, especially on misdemeanant charges. The criminal justice and mental health systems will require regular increases in resources to meet the increasing demand for forensic mental health services in jails, prisons and state hospitals. If additional resources are not allocated, either services will have to be reduced or the services will continue to be increasingly stretched beyond capacity and usefulness to the courts. As a result, defendants who may pose a risk to the community will more frequently be released to the community while awaiting trial or will have their charges dismissed. Alternatively, defendants awaiting trial may have longer periods of incarceration while awaiting pretrial services.

COMPETENCY RESTORATION TREATMENT

Adult Psychiatric: As a result of the increasing numbers of defendants evaluated for competency to stand trial, there is an unavoidable increase in the numbers of defendants

found incompetent and ordered to restoration treatment in the state hospitals (see Charts 2, 5, 7).

Costs: The cost of inpatient treatment to restore competency to stand trial is relatively easy to estimate, based on the daily hospitalization rate (approximately $ 442 WSH & $551, ESH). In 2005, at WSH there were 341 initial 90 day treatment cases with 76.9 days average length of stay, 146 second 90 day treatment cases with 20.5 days average length of stay, and 39 180 day treatment cases with 151.8 days average length of stay. This results in an approximate cost at WSH for restoration treatment for 2005 of $15,530,000. Figures for ESH are commensurate with their admission rates and costs for these services.

Competency restoration services may also theoretically be provided on an inpatient or out of custody basis, and centrally within the state or locally within jurisdictional communities. However, the perceived potential risk to the community by criminal defendants and their typical resistance to treatment weigh heavily toward the security and supervision of inpatient treatment. Nevertheless, models do exist for the out of custody treatment of defendants. These models tend to follow the models established for evaluations, that is, treatment provided by state-employed providers in central or local venues, or by providers employed in local agencies or in private practice, or by providers employed in court clinics. The same advantages and disadvantages listed for evaluations generally apply, with the additional concern for the availability of treatment staff including psychiatrists, nurses, case managers and didactic psycho-educational group leaders. There is additional concern for the provision of housing and support services for this population, if they are not hospitalized during treatment. This is a cost not currently borne by the state or community providers.

In Washington State, competency restoration treatment has been almost exclusively provided on an inpatient state hospital basis. The main reasons reflect the concerns described above: public safety and defendant initial resistance to treatment. Currently there are no state programs in place to provide off-site treatment for this purpose for adult, juvenile or developmentally disabled defendants.

Provision in the community of restoration treatment to defendants with psychiatric mental disorder has occurred on a case-by-case basis when such treatment is available in the community, the defendant is already enrolled in these services, is regarded as a reasonably low risk to the community and is likely to comply with treatment. However, there currently are not any state programs in place for this purpose.

Costs: The costs of adult community treatment programs are impossible to determine without a reasonable estimate of the numbers of defendants which would be seen as appropriate by hospitals and courts. A very small percentage of all adult defendants would likely be approved for competency restoration. However, there may be sufficient numbers to be cost-effective for urban areas. The percentage of defendants appropriate for such treatment can be increased according to increases in the level of case management and supervision applied to this population in the community. Each case of successful treatment would easily be offset by the savings of inpatient hospitalization costs, as community treatments are generally regarded as less expensive than hospital

costs. However, many individuals needing these services may not be eligible for such services in the current community mental health system and would have needs for housing and other services.

Adult developmentally disabled: In 2004-05 WSH piloted an on-site treatment program on hospital grounds for adults with developmental disability. Although the numbers of defendants treated were small, the program showed promise. The cost of this program, very limited in scope, included four to six hours of one psychologist time per week and costs to the community to provide housing, transportation and supervision during treatment hours (this cost is unavailable due to the lack of resources currently committed to it). Only a few defendants were treated in this manner, though it was regarded as a successful alternative to hospitalization for this population, if housing and transportation are available for them in the community.

When there is no diagnosis of an additional acute mental disorder, this population with developmental disability is generally better served in the community than in psychiatric hospitals. ESH has similarly had limited experiences with out of custody restoration treatment, developed on a case-specific basis for individuals with a developmental disability or with special medical conditions. Recent lawsuits (Allen and Marr) point to the need for viable out of custody services for developmentally disabled persons in psychiatric hospitals who do not have health and safety needs requiring hospitalization. However, secure facilities for this population outside of the hospitals are not available. Out of custody treatment is clinically feasible, provided the defendant can be housed such that they do not pose a risk to themselves or the community. Currently, there is no designated funding to provide those services. However, defendants whose intellectual limitations rather than mental disorder problems result in incompetence should be treated in the community whenever their risk to the community is low or contained.

Juvenile: Juveniles are ordered for competency restoration services under the same statutes that govern adult criminal competency restoration. This is true despite the drastically different clinical profiles of most incompetent adult defendants and incompetent juvenile respondents. Specifically, whereas incompetent adults are most often suffering from a psychotic disorder that is often effectively treated with medication; incompetent juveniles suffer from a wider range of disorders and therefore, a wider range of appropriate treatment interventions are required that interact with their immature development (which is clearly not 'treatable'). Nonetheless, most of these juveniles receive inpatient psychiatric hospitalization. In many cases, this is an over-investment of resources as the youth may simply require education and/or minor adjustments to medications which can be accomplished on an out of custody basis. Furthermore, hospitalization often removes these youth from their home community where they have family and community supports that may help them to achieve competency. There have been previous attempts to provide out of custody juvenile competency restoration, as coordinated with CSTC and the local court, but with no procedural structure in place to guide this service, significant logistic and financial problems arose.

The percentage of juveniles appropriate for out of custody restoration service is likely to be around 50 percent, but since only about nine juveniles are ordered for restoration annually, the actual numbers will be quite small. Given that these youth may come from anywhere across the state, a system for out of custody juvenile competency restoration

must be extremely flexible and may require development on a case-by-case basis. However, a basic structure for how these negotiations would occur could be developed.

Summary: As with evaluation services, if persons with serious mental disorders continue to end up in the criminal justice system, an increasing number of beds in jails, prisons and state hospitals will be occupied with defendants with serious mental disorder. This will result in more persons with mental disorder being evaluated for competency, many of whom are found incompetent (approximately 50 percent). Thus, a greater number of defendants are ordered to inpatient treatment in state hospitals occupying expensive hospital beds.

ALTERNATIVE STRATEGIES

Location of Professionals in Jails

There is little discussion in the literature or with professional contacts concerning the location of professionals in the jails specifically for pretrial evaluation or competency restoration treatment (a variant of community models), regardless of the source of their employment as state-employed, county-employed, or agency/jail employed. There are several disadvantages:

- Workload is only sufficient in larger jails
- Serious concern for the preservation of the objectivity of the evaluation should the professional come to be identified with a particular jail or county
- Professionals would be expected to fulfill additional roles that conflict with their objectivity; and most jails are unable to house additional professional staff and provide adequate assessment facilities.

We share these concerns. In addition, larger jails generally have mental health or medical staff that provide some of this service already, though often on an informal basis. The obvious advantage to having professionals located in jails for this purpose is the direct access of the professional for defendant evaluation.

WSH has relevant experience with locating professionals in jails. One state-employed professional has been located in the Seattle Justice Center to conduct evaluations for the past two years. WSH initially attempted to locate the professional directly in the jail, but adequate facilities could not be found. The professional, the state hospital and the court quickly recognized the need to maintain the professional's administrative separation from the influence of the jail, the county and the court, in order to preserve the reliability and objectivity of the evaluations. It is very clear that both the criminal justice and mental health systems rely on the objectivity of evaluations and insist that the professionals providing that service be removed from local influences which may create bias in their work.

Regional Jails

The regional jails concept is the subject of a recent report to the legislature under development by the Joint Legislative Audit and Review Committee. However, this report addresses the use of regional jails to accomplish competency evaluation and restoration.

Evaluation

This report addresses evaluation services first, for which the regional jail concept has significant merit.

Advantages: The adult regional jail concept for pretrial evaluations would bring defendants with mental disorder issues into one facility from various counties and jurisdictions, which would facilitate the adult state hospitals' ability to provide regionalized services. Regionalization of services makes fiscal sense to most efficiently utilize staff time by reducing travel to various jails around the state. Regional jail facilities could allow for specialized management, evaluation and treatment of mentally disordered defendants and could also allow for better training and experience of correctional staff in the behavior assessment and management of defendants with mental disorders. They could then provide more useful information to the professionals conducting evaluations. Regional jails would also minimize the concerns that the professionals could lose objectivity in evaluations due to influences of a single local court or jurisdiction.

Disadvantages: Providing such treatment services may encourage a trend toward the incarceration of persons with mental disorder for treatment purposes. This concern and support for adequate community services appears universal within the criminal justice community. The disadvantages of regional jails for evaluations include that defendants may not have ready access to attorneys for consultation and attorneys may find it difficult to be in attendance during interviews with professionals during the initial evaluation period, both of which are a defendant's legal right and are sometimes required. Defendants would also be removed from their home communities, as opposed to remaining in local jails for evaluations, as is currently the practice. Access to and management of medical and legal records from other institutions, including the state hospitals, may be more problematic due to restrictions imposed by federal and state confidentiality statutes and case law. Professional staff recruitment in some regions is difficult due to less popular living locations, especially on the east side of the state where even in larger population centers recruitment of professional staff is especially difficult.

For the reasons described in the previous section, professionals providing pretrial evaluation services under RCW 10.77 should remain independent of local jails and jurisdictions. However, the regionalization of evaluation and treatment services is supportable and cost-effective where feasible. The solution discussed locally and nationally is to locate professional staff in regional satellite offices near regional or local jails where the need for service and the demographics of the area support it. WSH currently has three professionals stationed in Seattle and is working to establish office space to support them.

The numbers of evaluations of children/juveniles around the state are too small at this time to consider the usefulness of regional jails for them. Constitutional requirements for separation of sight and sound between adult and juvenile detainees require careful consideration of housing juveniles in regional jails. In addition, children/juveniles are better served closer to their home communities. However, in some cases it would be useful to be able to use such a setting to conduct off-site evaluations when it is a midway point between CSTC and the examinee's home community in order to reduce travel costs for all involved.

Treatment

The use of adult regional jails for treatment to restore competency is more problematic, especially on the east side of the state.

Advantage: Regional jails would reduce transportation costs of moving defendants long distances to state hospitals. Training and expertise of jail staff in management of defendants with mental disorder could also be more easily provided.

Disadvantages: For treatment to occur there must be adequate medical staffing, including nursing and psychiatry, to prescribe, administer and monitor the medications and the defendant's medical condition. Further, there must be access to necessary medical lab facilities to monitor the defendant's medications and medical condition. There must also be adequate psycho-educational staff to provide remedial and educational services to restore competency. If regional jails are to become treatment centers, they will need to meet medical standards for staffing and quality of care, as well. However, this is a duplication of the medical staff already available at the state hospitals.

The administration of involuntary medications is even more problematic as a court will have to order such administration after court hearings on the issue. It is not clear in current statutes that the courts have the authority to order this treatment in jails and the procedural issues are not outlined in statute. Traditionally, the court originating the competency restoration order addresses the medication issues. The defendant, the defense attorney, the prosecutor and the prescribing psychiatrist need to be made available to that court for the hearing, or arrangements between counties and jurisdictions will need to be made for the provision of those services.

There is a general agreement that jails are not and should not be regarded as first-line treatment centers for voluntary treatment of defendants with mental disorder. There is also the conviction that persons with mental disorders ought to be provided treatment wherever they reside, even in jail or other confinement. On rare occasions a jail may petition a court to provide medication to a defendant. However, most small jails do not have adequate staffing or facilities, and large jails are overwhelmed by the volume of treatment needs. There is general agreement that treatment for mental disorder needs to take place in mental health facilities. However, concerns for security for defendants, especially felony defendants, causes many jurisdictions to be reluctant to release defendants to treatment centers, even at the state hospitals. Local designated mental health professionals have found it difficult to involuntarily commit defendants whose immediate health and safety needs are provided for in jail.

Nevertheless, there is support for the limited use of involuntary treatment for defendants who return to jail after competency restoration treatment in state hospitals, in order to ensure the defendant remains competent for trial. Decompensation of competency-restored defendants in jail is a continuing expensive and time-consuming problem when jails are unable/ to provide involuntary administration of medications due to lack of appropriately qualified professional staff to administer and monitor psychiatric medications, lack of statutory authority to involuntarily administer medication, etc. It often results in another state hospital stay to again assess and restore competency (at a cost of $6,000 - $8,000 per evaluation), especially in felony cases.

RECOMMENDATIONS

The following recommendations are made in light of current programs, fiscal and administrative structures, and statutory and common law histories in Washington State. The recommendations generally support current programs while moving forward to fully realize them in the face of the continuing growth in demand for pretrial evaluation and treatment services.

We strongly recommend that developments be flexible and coordinated with the various agencies and levels of government involved, and that consideration be given to sharing costs among levels of government. In addition, costs need to follow defendants as they pass through the various institutions so that services are reliably available to the defendant and so that lapses in care and management do not occur. Movement between differently funded systems may result in service lapses and defendants may "fall between the cracks."

The state must assess the balance between providing needed services on one side and the resources and social commitment available to provide them on the other side. However, increasing demand will only be reduced by a major commitment to providing effective and adequate treatment and prevention services in the community prior to involvement with the criminal justice system.

Location of Professionals in Jails

The Department recommends against locating professionals in local jails for evaluation services for the reasons discussed above.

Location of Competency Restoration Treatment

The Department recommends that inpatient competency restoration treatment continue to occur at the adult state hospitals which have programs, staff, medical facilities, and professionals with specialized forensic expertise, except as described below. Establishment of procedures, hiring of treatment staff and management of an intensive or extensive medical unit is not justified when such services are already in place at the state hospitals and the court system has little (informal) opinion on the matter.

The Department also recommends that innovative programs for alternative restoration treatment of defendants found by the courts to be safe-to-be-at-large continue to be explored. These include the treatment of defendants with developmental disabilities and certain low risk misdemeanant and felony defendants. However, these may require bridge funding to establish, even though they would be expected to reduce current demand for beds in the adult hospitals and would be expected to be offset by future savings of admissions.

Establishment and Use of Regional Jails

The Department recommends that if adult regional jails are established, provision for state employed professionals to conduct pretrial evaluations should be included, depending upon the service needs and resources of the particular region. Satellite offices with professionals and their support staff could be located nearby. The feasibility and costs of including them depend on the demand for services of the specific region. Primary additional costs to current costs relate to hiring of support staff, leasing of offices for the professionals and support staff, and providing technical support. These costs require an initial investment in staff and offices, but are offset by savings in travel and increases in productivity of staff. Demands for juvenile forensic services are not great enough to require regional offices, yet CSTC serves a statewide catchment area. It is also recommended that resources for flexible interview space be afforded at these regional offices so that juvenile evaluations may occur there on an as needed, sporadic basis.

Continue Implementation of the Mixed Model for Adults and the Hospital-based Alternative Model for Juveniles

The Department recommends that Washington State stay the current course in its movement away from the hospital-based inpatient model and toward a mixed model for pretrial evaluations of adults using state-employed professionals and continue to support and fund current services to keep pace with the increasing demand, especially in the misdemeanant populations. Resources for both alternative staff and inpatient beds must keep pace with demand for services, in order to avoid lack of necessary service provision to courts, early release of defendants to the community or dismissal of charges on defendants, and contempt findings and public embarrassment for failing to meet legal and statutory responsibilities.

The continued support for the hospital-based on-site model for pretrial evaluations of juveniles using state-employed professionals is also recommended, with support and funding to match demand. This course has already made a substantial impact to save resources, serve the court system and to facilitate access to treatment for defendants with mental disorder or disability. If the trend toward the criminalization of persons with mental disorder or developmental disability is accurate for Washington State and it continues, additional professional and support staff will be required for all populations (adult, juvenile, developmentally disabled) with each new budget cycle. The costs of hospitalization for evaluations, however, far outweigh the costs of staffing to provide services outside of the hospitals. Without the off site program the only way to decrease the waiting list is to expand the hospital bed capacity to accommodate the waiting list The alternative is to increase the off site program effort thus saving the cost of adding

additional hospital beds to reduce the waiting list. The bottom line is the hospital could evaluate more cases with less money by expanding the off site program.

Review of Washington Statutory Requirements

The Department recommends that the Washington's Criminal Insanity statute, Chapter 10.77 RCW, be comprehensively reviewed to determine if statutory change can assist in the development of new strategies for more efficiently addressing increases in forensic population and reducing waiting periods for competency evaluation and restoration. Statutory changes in recent years have addressed important but narrow issues related to public safety and clinical and administrative efficiencies. A more comprehensive review, including models used in other states, could lead to recommendations for a model more ideally suited to the needs of Washington.

The Department is currently planning a comprehensive review of the civil commitment and forensic statutes, of their inter-relationship and anticipate making specific recommendations to the legislature in the fall of 2007.

SUMMARY

There are a limited number of models for the provision of pretrial mental health services in use across the country. The use as well as the success or failure of these models depends completely upon the unique needs and administrative structures in place in each state and region within the state. Washington State has monitored these programs for the last ten years and has already transformed service delivery state-wide in a manner which takes into account our own unique needs. Efforts have been conducted over the last ten years with the different regions of the state and their local governments and court jurisdictions through numerous meetings and collaborations and trainings. The effects of these changes are still being assimilated. Washington should continue in this effort as it has already proven to save resources and maintain a high level of quality in service provision. However, due to the growth of the need for mental health services in the criminal justice system seen nation-wide, Washington must keep pace with this growth in order to avoid serious liability for persons with mental disorder and/or disability who are themselves at risk of harm or jeopardize the safety and welfare of the public and those around them. At the same time, the State must examine the nature of this growth in demand for service and determine whether there are other points in the larger mental health system that could better prevent this "criminalization of the mentally disordered." This growth is regarded as out of control by most observers. If Washington State continues current practice, these trends will likely continue, requiring more and more resources to be made available in order to meet the demands of the courts and the public for the management of persons with mental disorder and/or disability. The Department is currently planning a comprehensive review of the civil commitment and forensic statutes, of their inter-relationship and anticipate making specific recommendations to the legislature in the fall of 2007.

CHART 1

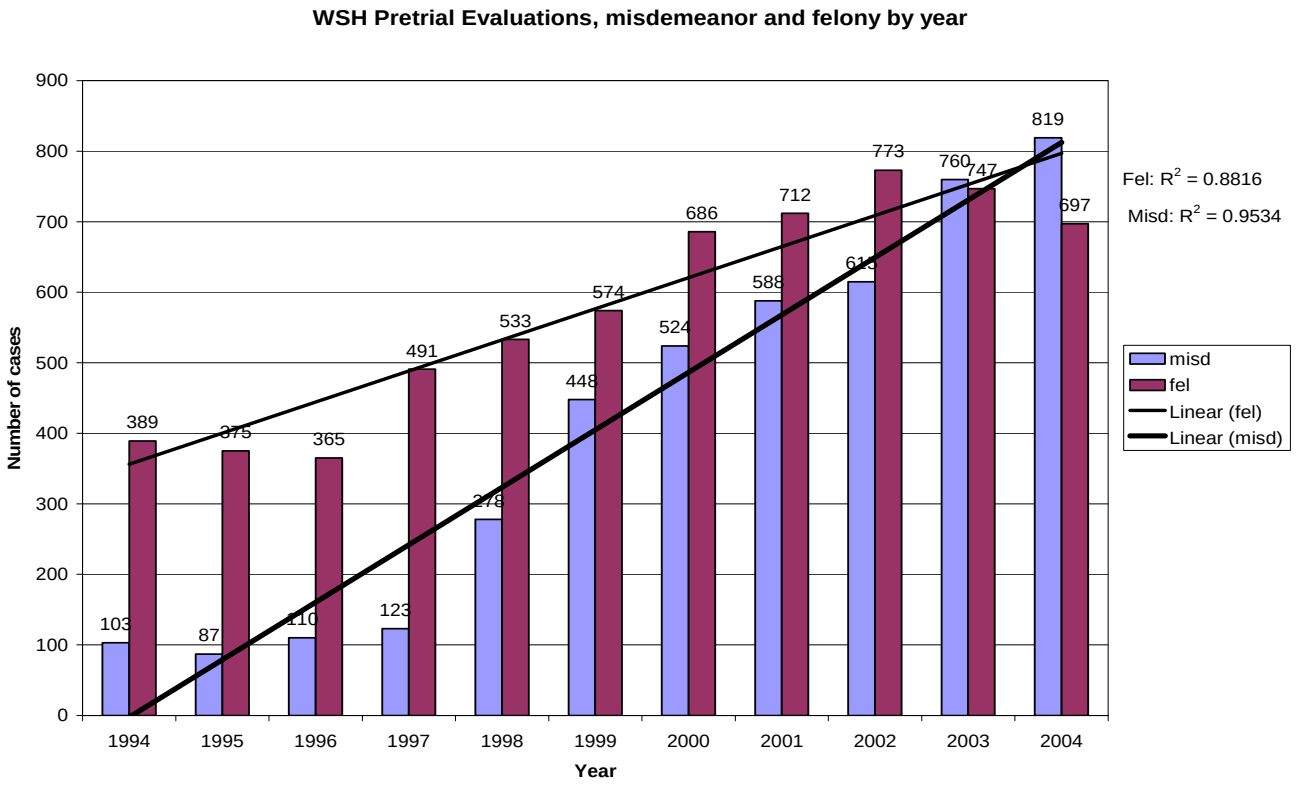


CHART 2

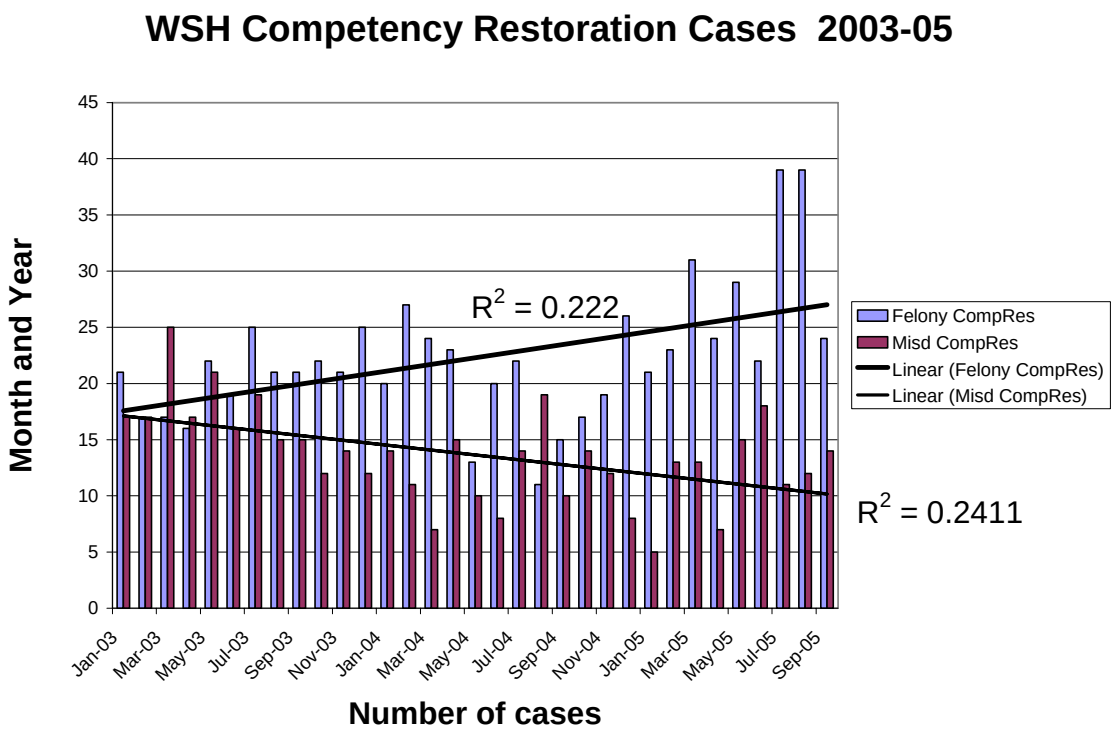
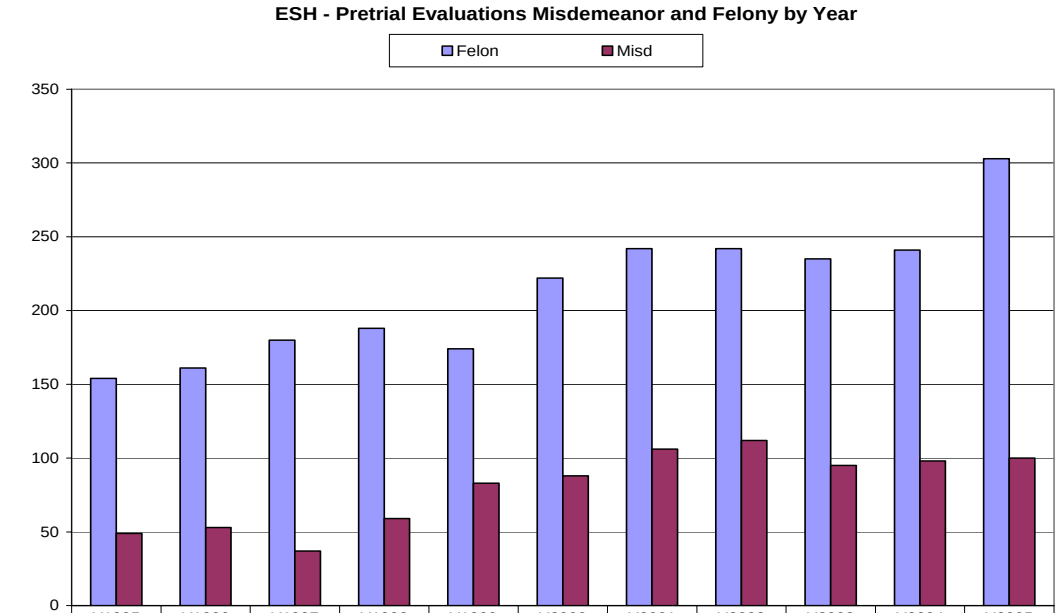


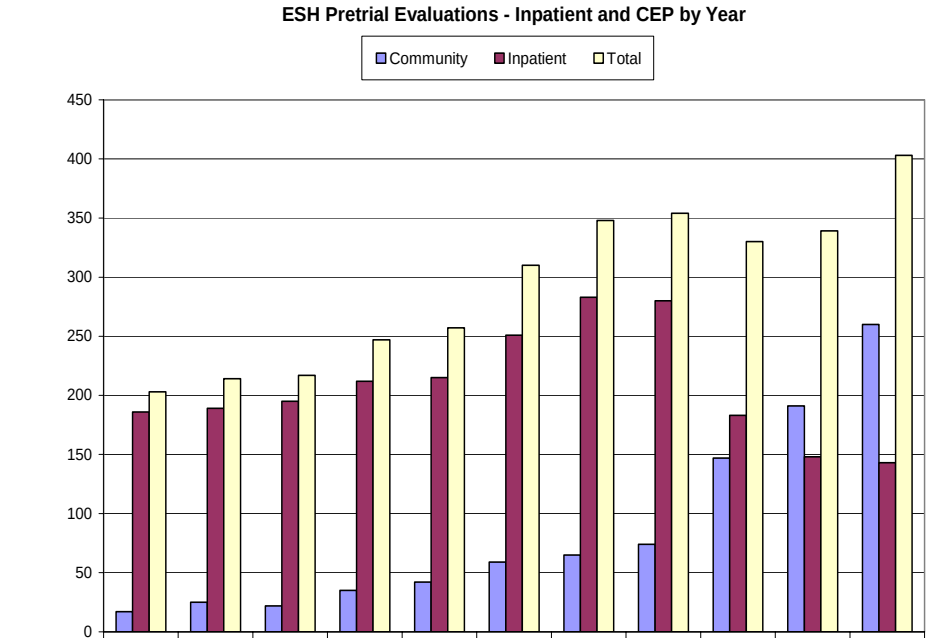
CHART 3



	Y1995	Y1996	Y1997	Y1998	Y1999	Y2000	Y2001	Y2002	Y2003	Y2004	Y2005
Felon	154	161	180	188	174	222	242	242	235	241	303
Misd	49	53	37	59	83	88	106	112	95	98	100

Y2005 is projected by averaging first nine months

CHART 4

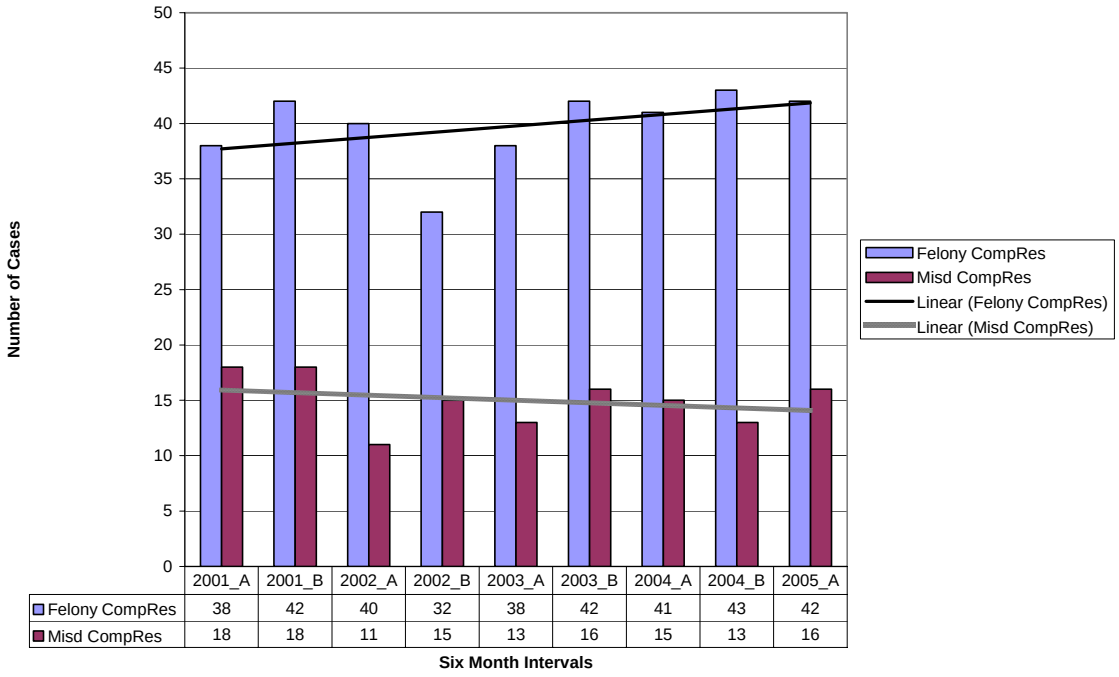


	Y1995	Y1996	Y1997	Y1998	Y1999	Y2000	Y2001	Y2002	Y2003	Y2004	Y2005
Community	17	25	22	35	42	59	65	74	147	191	260
Inpatient	186	189	195	212	215	251	283	280	183	148	143
Total	203	214	217	247	257	310	348	354	330	339	403

Y2005 is projected by averaging first nine

CHART 5

ESH Competency Restoration Cases 2001 - 2005



	2001_A	2001_B	2002_A	2002_B	2003_A	2003_B	2004_A	2004_B	2005_A
Felony CompRes	38	42	40	32	38	42	41	43	42
Misd CompRes	18	18	11	15	13	16	15	13	16

Six Month Intervals

CHART 6

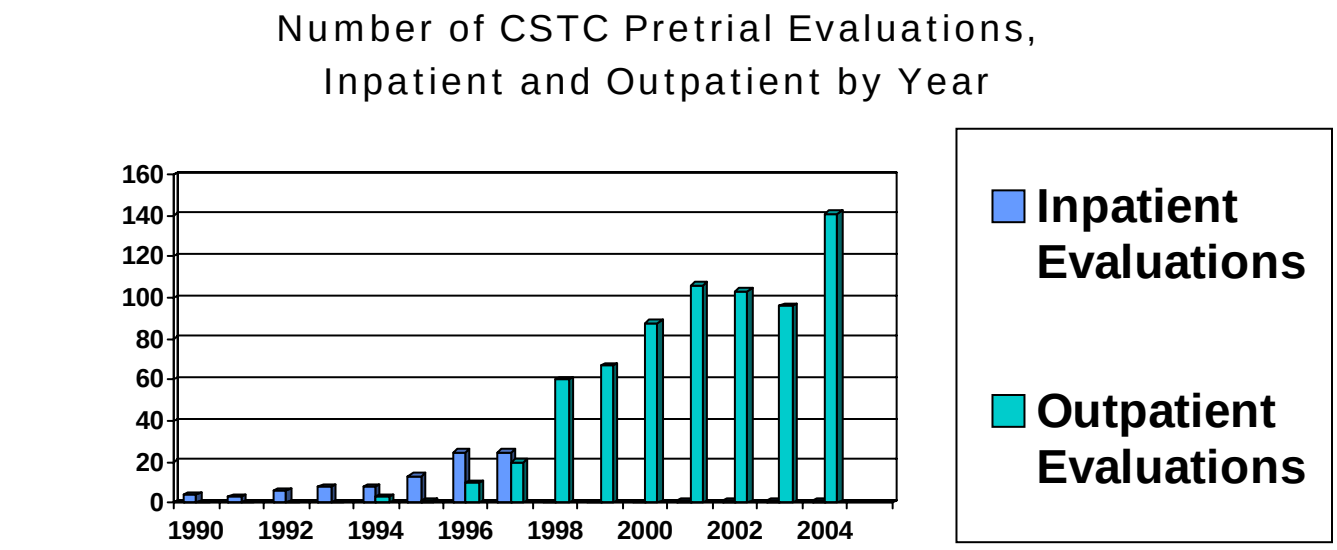


CHART 7