Washington State Department of Social and Health Services

Transforming Lives

# REPORT TO THE LEGISLATURE

## Forensic Admissions and Evaluations – Performance Targets 2018
## First Quarter (January 1, 2018-March 31, 2018)

Substitute Senate Bill 6492, Section 2 (Chapter 256, Laws of 2012)
As amended by Substitute Senate Bill 5889, Section 1 (Chapter 5, Laws of 2015)
RCW 10.77.068(3)

May 30, 2018

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# Contents

## BACKGROUND

On May 1, 2012, Substitute Senate Bill 6492 added a section to chapter 10.77 RCW that established performance targets for the "timeliness of the completion of accurate and reliable evaluations of competency to stand trial and admissions for inpatient restoration services related to competency to proceed or stand trial for adult criminal defendants." These targets were codified under RCW 10.77.068 and phased in over six months to one year.

After full implementation of each performance target, the bill required the Department of Social and Health Services (DSHS) to report to the executive and the legislature following any quarter in which it does not meet the performance target. This reporting must address (1) the extent of the deviation, and (2) any corrective action being taken to improve performance.

On July 24, 2015, Substitute Senate Bill 5889 amended RCW 10.77.068. The bill retained the performance targets for competency services but added to these a set of "maximum time limits" phased in over one year. After full implementation of the maximum time limits, SSB 5889 required DSHS to report to the executive and the legislature following any quarter in which it does not meet each performance target or maximum time limit.

As a result of these two bills, current performance targets and maximum time limits under RCW 10.77.068(1)(a) are as follows:

> (i) For a state hospital to extend an offer of admission to a defendant in pretrial custody for legally authorized evaluation services related to competency, or to extend an offer of admission for legally authorized services following dismissal of charges based on incompetence to proceed or stand trial:
>
> (A) A performance target of seven days or less; and
>
> (B) A maximum time limit of fourteen days;
>
> (ii) For a state hospital to extend an offer of admission to a defendant in pretrial custody for legally authorized inpatient restoration treatment related to competency:
>
> (A) A performance target of seven days or less; and
>
> (B) A maximum time limit of fourteen days;
>
> (iii) For completion of a competency evaluation in jail and distribution of the evaluation report for a defendant in pretrial custody:
>
> (A) A performance target of seven days or less; and
>
> (B) A maximum time limit of fourteen days, plus an additional seven-day extension if needed for clinical reasons to complete the evaluation at the determination of the department;
>
> (iv) 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, a performance target of twenty-one days or less.

Section (1)(b) of RCW 10.77.068 establishes the beginning and end points for applying the performance targets and maximum time limits set forth above. Section (1)(c) identifies six conditions that shall serve as defenses to an allegation that the department has exceeded the maximum time limits.

As mandated by RCW 10.77.068(3), the following quarterly report explains the extent to which the hospitals deviated from performance targets in Quarter one of 2018 (January 1, 2018-March 31, 2018), and describes the plans to meet these performance targets.

## COMPETENCY EVALUATION AND RESTORATION DATA

RCW 10.77.068(1)(a)(i)(A) and (ii)(A), as amended by SSB 5889, establishes a performance target of seven days or less for the state hospitals to:

1) Extend an offer of admission to a defendant in pretrial custody for legally authorized treatment or evaluation services related to competency; or
2) Extend an offer of admission for legally authorized services following dismissal of charges based on incompetence to proceed or stand trial.

RCW 10.77.068(1)(a)(iii)(A), as amended by SSB 5889, sets a performance expectation that competency evaluations for a defendant who is in jail will be completed and distributed within seven days or less.

RCW 10.77.068(1)(a)(iv), as amended by SSB 5889, sets a performance expectation that competency evaluations for a defendant who is released from custody and makes a reasonable effort to cooperate with the evaluation will be completed and distributed within twenty-one days or less.

## DATA ANALYSIS AND DISCUSSION

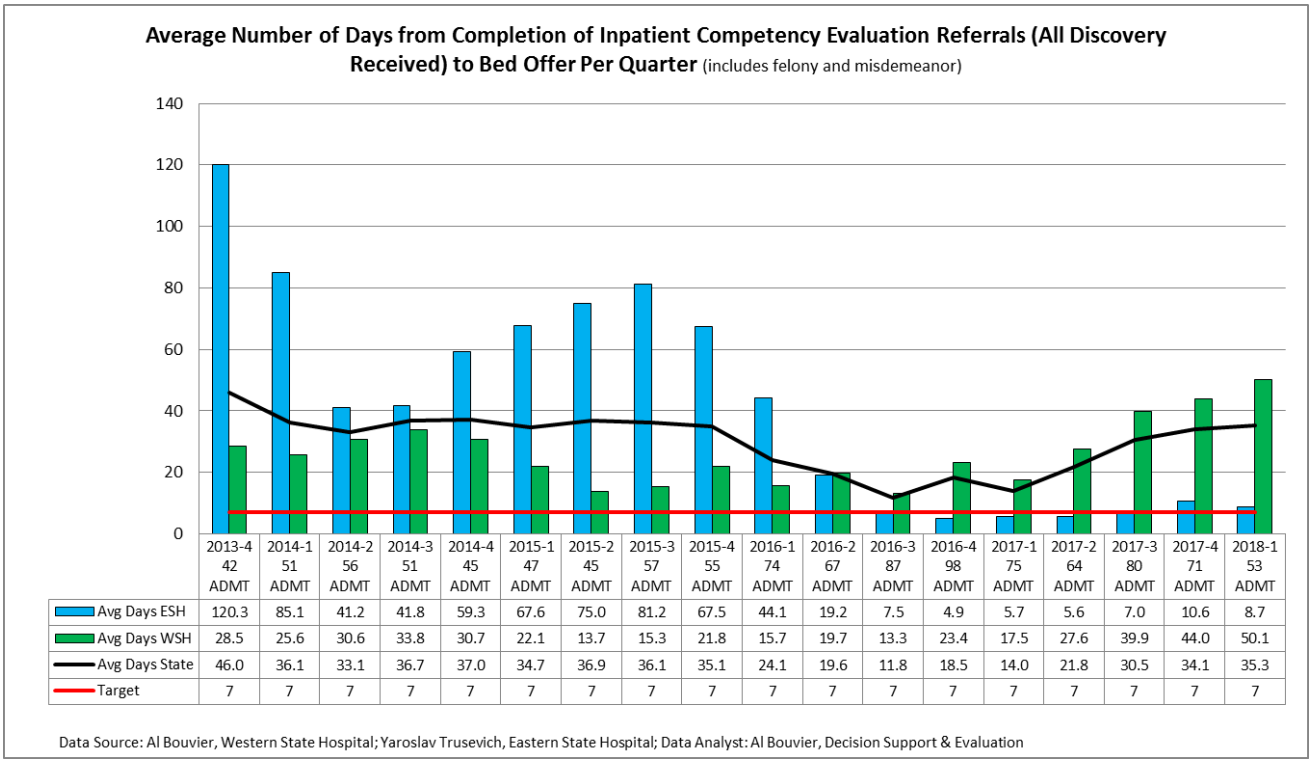
In this section, the report is organized in the following manner: (1) Statewide Forensic System Data and (2) Actions Taken.

Additional detailed data and information about timely competency services is available in monthly reports published by the Department of Social and Health Services in compliance with requirements established in the April 2015 *Trueblood* court order. These reports are available on the Office of Forensic Mental Health Services (OFMHS) website at:

https://www.dshs.wa.gov/bha/office-service-integration/office-forensic-mental-health-services

Once on the OFMHS website, find "Quick Links" and click on "*Trueblood et al v. Washington State DSHS*". Please note that the data presented in this report differs slightly than in the *Trueblood* reports because the statute begins the count for timely service at the date of receipt of Discovery while the *Trueblood* order begins the count at the date the court order for services is signed.

**Figure 1**: shows results for inpatient competency evaluation cases

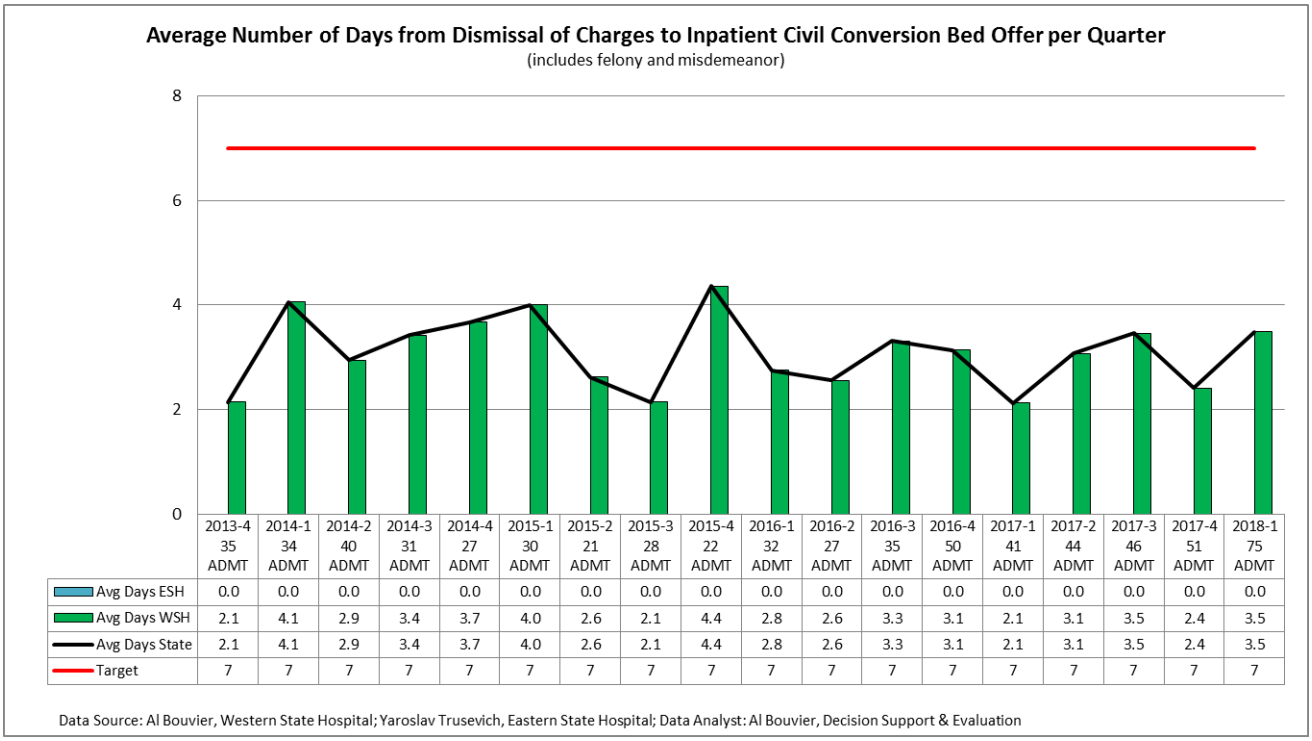



| | 2013-4 42 ADMT | 2014-1 51 ADMT | 2014-2 56 ADMT | 2014-3 51 ADMT | 2014-4 45 ADMT | 2015-1 47 ADMT | 2015-2 45 ADMT | 2015-3 57 ADMT | 2015-4 55 ADMT | 2016-1 74 ADMT | 2016-2 67 ADMT | 2016-3 87 ADMT | 2016-4 98 ADMT | 2017-1 75 ADMT | 2017-2 64 ADMT | 2017-3 80 ADMT | 2017-4 71 ADMT | 2018-1 53 ADMT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Avg Days ESH | 120.3 | 85.1 | 41.2 | 41.8 | 59.3 | 67.6 | 75.0 | 81.2 | 67.5 | 44.1 | 19.2 | 7.5 | 4.9 | 5.7 | 5.6 | 7.0 | 10.6 | 8.7 |
| Avg Days WSH | 28.5 | 25.6 | 30.6 | 33.8 | 30.7 | 22.1 | 13.7 | 15.3 | 21.8 | 15.7 | 19.7 | 13.3 | 23.4 | 17.5 | 27.6 | 39.9 | 44.0 | 50.1 |
| Avg Days State | 46.0 | 36.1 | 33.1 | 36.7 | 37.0 | 34.7 | 36.9 | 36.1 | 35.1 | 24.1 | 19.6 | 11.8 | 18.5 | 14.0 | 21.8 | 30.5 | 34.1 | 35.3 |
| Target | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |

Data Source: Al Bouvier, Western State Hospital; Yaroslav Trusevich, Eastern State Hospital; Data Analyst: Al Bouvier, Decision Support & Evaluation

- **Figure 1.** These are the average wait times related to hospital admission for inpatient competency evaluations only (including PR's).
- ***Outcomes*:** During the first quarter of 2018, there was a decrease in the number of admissions from the previous quarter, and represents the fewest admissions since Quarter 2, 2015. The average wait times at WSH, between referral for evaluation and bed offer, increased each quarter in 2017 and continue to do so in 2018. ESH wait times saw a spike in Q4, but have come back down and are again nearing the target seven days.
- ***Drivers*:** There is a clear correlation between lower admissions and higher wait times. The hospitals are able to admit fewer patients because of a lack of capacity, coupled with an increase in the time it takes to complete inpatient evaluation services. Despite adding 104 beds to program capacity since 2015, increasing demand clearly impacts operations. During this quarter, WSH has seen its wait list consistently over 200 individuals on any given day. This wait list, coupled with orders extending restoration times (ie. 90-day orders extended to 180-day orders for additional restoration treatment) as well as the aforementioned lack of sufficient capacity, dramatically slows through-put of patients, which gives rise to the increasing time between referral and bed offer and the resulting decrease in inpatient competency evaluation admissions.

**Figure 2: s**hows results for post-dismissal referrals

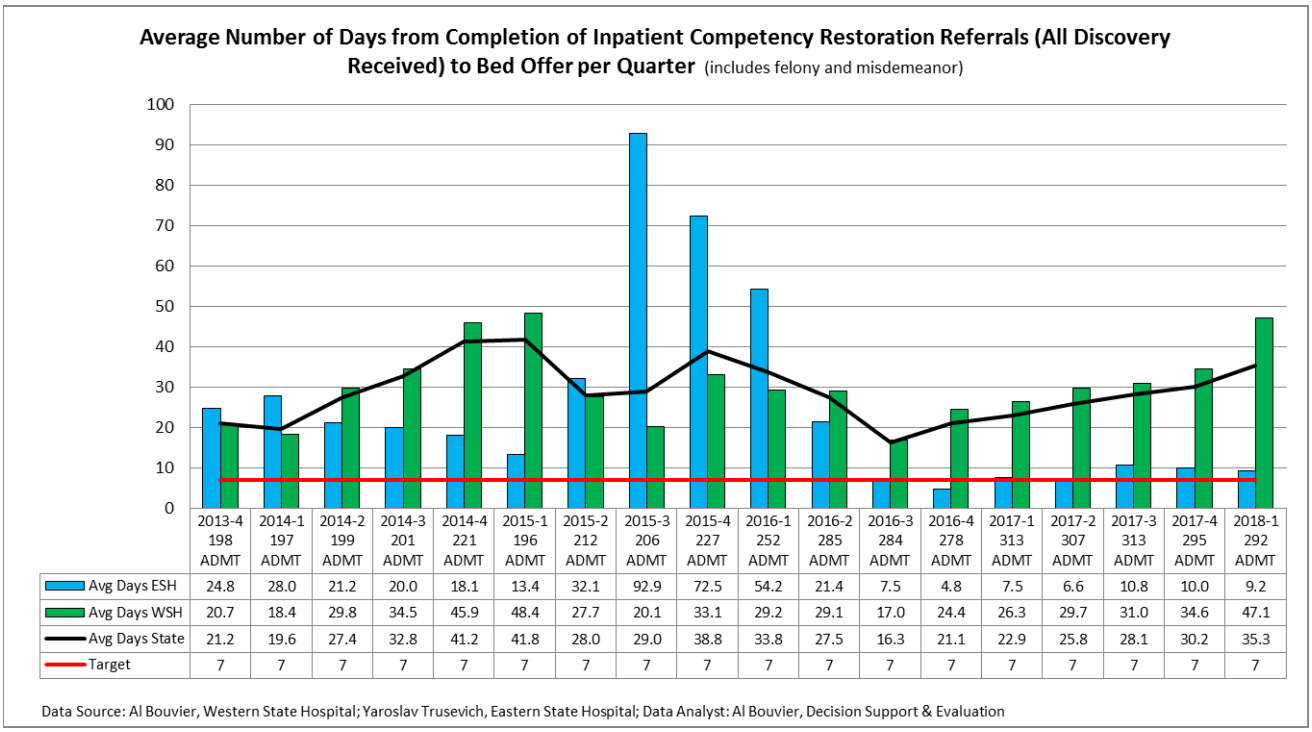



| | 2013-4 35 ADMT | 2014-1 34 ADMT | 2014-2 40 ADMT | 2014-3 31 ADMT | 2014-4 27 ADMT | 2015-1 30 ADMT | 2015-2 21 ADMT | 2015-3 28 ADMT | 2015-4 22 ADMT | 2016-1 32 ADMT | 2016-2 27 ADMT | 2016-3 35 ADMT | 2016-4 50 ADMT | 2017-1 41 ADMT | 2017-2 44 ADMT | 2017-3 46 ADMT | 2017-4 51 ADMT | 2018-1 75 ADMT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Avg Days ESH | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Avg Days WSH | 2.1 | 4.1 | 2.9 | 3.4 | 3.7 | 4.0 | 2.6 | 2.1 | 4.4 | 2.8 | 2.6 | 3.3 | 3.1 | 2.1 | 3.1 | 3.5 | 2.4 | 3.5 |
| Avg Days State | 2.1 | 4.1 | 2.9 | 3.4 | 3.7 | 4.0 | 2.6 | 2.1 | 4.4 | 2.8 | 2.6 | 3.3 | 3.1 | 2.1 | 3.1 | 3.5 | 2.4 | 3.5 |
| Target | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |

Data Source: Al Bouvier, Western State Hospital; Yaroslav Trusevich, Eastern State Hospital; Data Analyst: Al Bouvier, Decision Support & Evaluation

- **Figure 2.** This chart reflects average days from dismissal of charges to an offer of admission at each State hospital and a combined State average.
- ***Outcomes*:** During the reporting period both ESH and WSH continue to be well below the seven day target.
- ***Drivers*:** The continued positive performance at both hospitals is attributed to staff maintaining clear focus on prioritizing these beds for admissions. One caveat with this prioritization is that it comes with a cost in that *Trueblood* admissions are impacted negatively because of this prioritization.

**Figure 3**: shows results for competency restoration cases

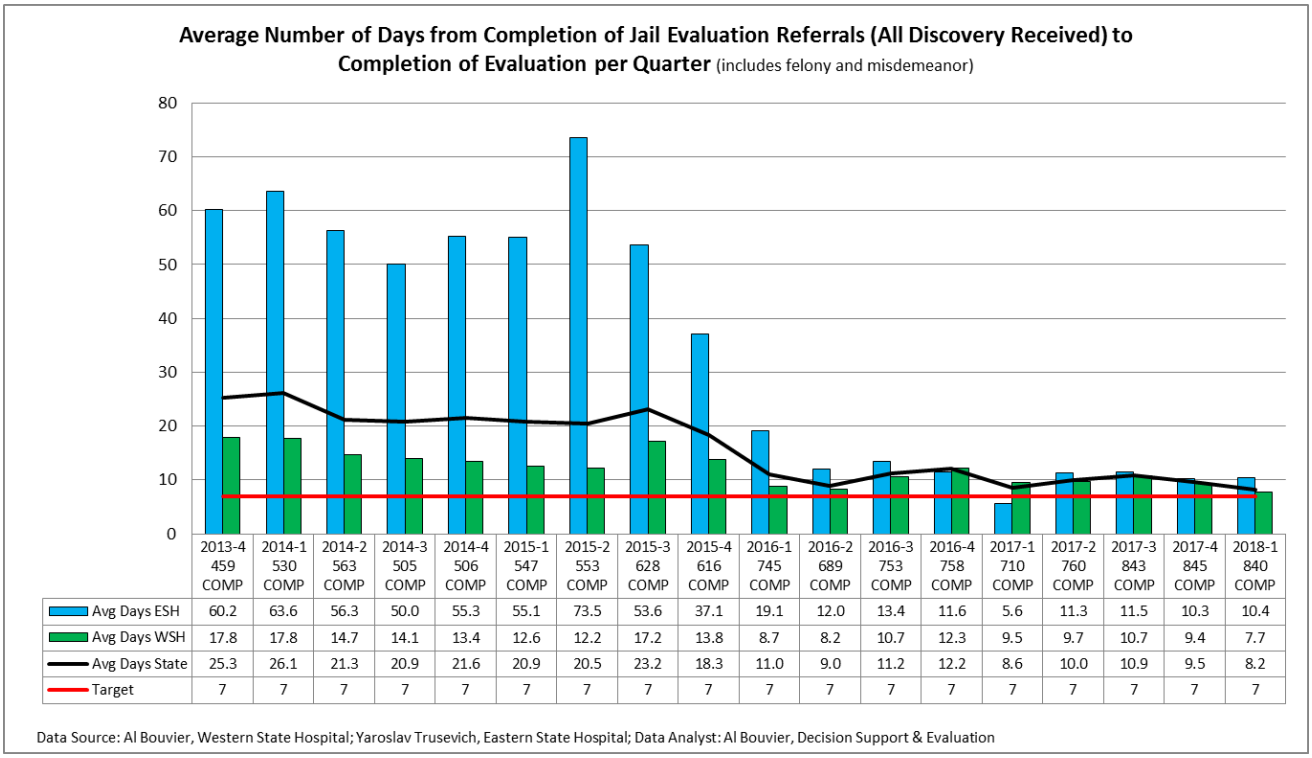



| | 2013-4 198 ADMT | 2014-1 197 ADMT | 2014-2 199 ADMT | 2014-3 201 ADMT | 2014-4 221 ADMT | 2015-1 196 ADMT | 2015-2 212 ADMT | 2015-3 206 ADMT | 2015-4 227 ADMT | 2016-1 252 ADMT | 2016-2 285 ADMT | 2016-3 284 ADMT | 2016-4 278 ADMT | 2017-1 313 ADMT | 2017-2 307 ADMT | 2017-3 313 ADMT | 2017-4 295 ADMT | 2018-1 292 ADMT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Avg Days ESH | 24.8 | 28.0 | 21.2 | 20.0 | 18.1 | 13.4 | 32.1 | 92.9 | 72.5 | 54.2 | 21.4 | 7.5 | 4.8 | 7.5 | 6.6 | 10.8 | 10.0 | 9.2 |
| Avg Days WSH | 20.7 | 18.4 | 29.8 | 34.5 | 45.9 | 48.4 | 27.7 | 20.1 | 33.1 | 29.2 | 29.1 | 17.0 | 24.4 | 26.3 | 29.7 | 31.0 | 34.6 | 47.1 |
| Avg Days State | 21.2 | 19.6 | 27.4 | 32.8 | 41.2 | 41.8 | 28.0 | 29.0 | 38.8 | 33.8 | 27.5 | 16.3 | 21.1 | 22.9 | 25.8 | 28.1 | 30.2 | 35.3 |
| Target | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |

Data Source: Al Bouvier, Western State Hospital; Yaroslav Trusevich, Eastern State Hospital; Data Analyst: Al Bouvier, Decision Support & Evaluation

- **Figure 3.** This chart reflects the average wait time for admission for competency restoration referrals only (including PRs).
- ***Outcomes*:** During the reporting period, WSH had a significant increase in waits times, while ESH had a slight decrease.
- ***Drivers*:** The increases in wait times at WSH are attributed to a lack of capacity, coupled with prolonged through-put due to orders extending restoration times (ie. 90-day orders extended to 180-day orders for additional restoration treatment), and long waiting lists. Despite a slight decrease in referrals from Q4, 2017 (see Figure 12), WSH is unable to admit more patients because of its lack of capacity and restoration times for patients already admitted.

**Figure 4**: average number of days to complete a jail based evaluation

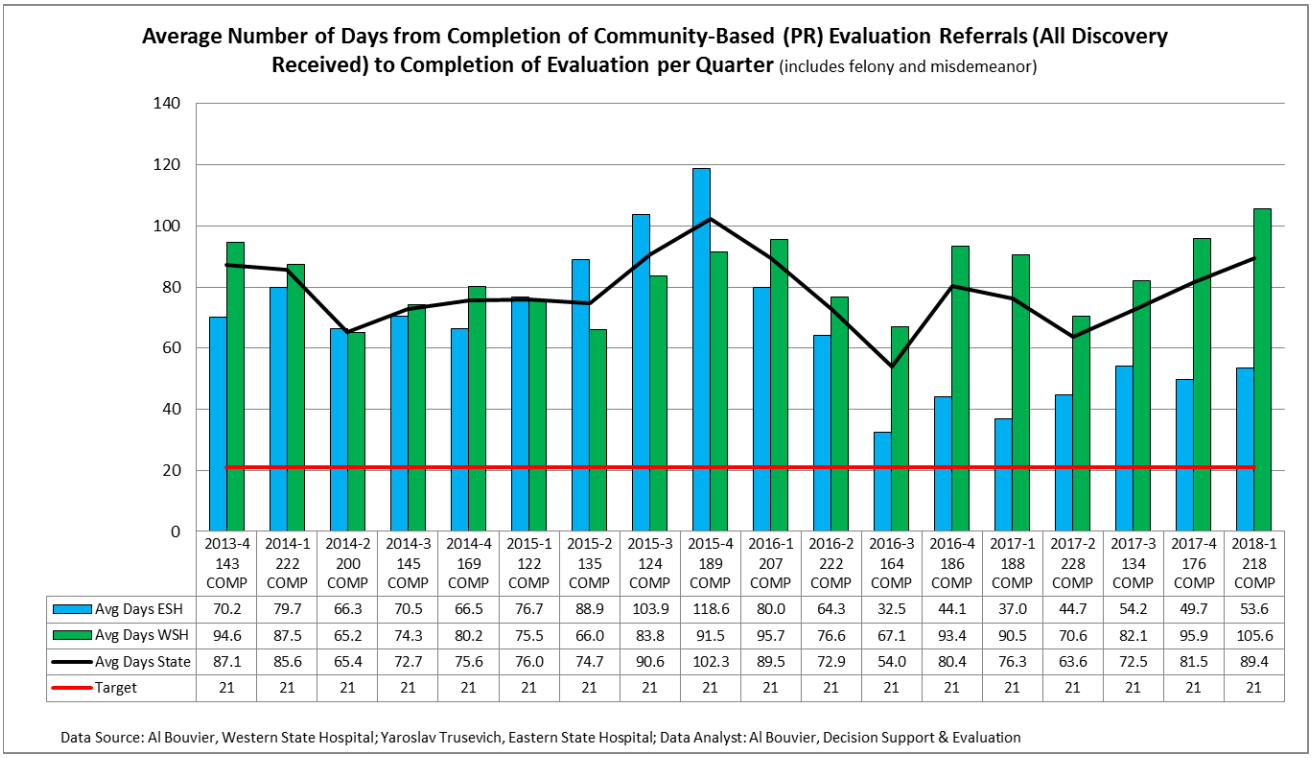



| | 2013-4 459 COMP | 2014-1 530 COMP | 2014-2 563 COMP | 2014-3 505 COMP | 2014-4 506 COMP | 2015-1 547 COMP | 2015-2 553 COMP | 2015-3 628 COMP | 2015-4 616 COMP | 2016-1 745 COMP | 2016-2 689 COMP | 2016-3 753 COMP | 2016-4 758 COMP | 2017-1 710 COMP | 2017-2 760 COMP | 2017-3 843 COMP | 2017-4 845 COMP | 2018-1 840 COMP |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Avg Days ESH | 60.2 | 63.6 | 56.3 | 50.0 | 55.3 | 55.1 | 73.5 | 53.6 | 37.1 | 19.1 | 12.0 | 13.4 | 11.6 | 5.6 | 11.3 | 11.5 | 10.3 | 10.4 |
| Avg Days WSH | 17.8 | 17.8 | 14.7 | 14.1 | 13.4 | 12.6 | 12.2 | 17.2 | 13.8 | 8.7 | 8.2 | 10.7 | 12.3 | 9.5 | 9.7 | 10.7 | 9.4 | 7.7 |
| Avg Days State | 25.3 | 26.1 | 21.3 | 20.9 | 21.6 | 20.9 | 20.5 | 23.2 | 18.3 | 11.0 | 9.0 | 11.2 | 12.2 | 8.6 | 10.0 | 10.9 | 9.5 | 8.2 |
| Target | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |

Data Source: Al Bouvier, Western State Hospital; Yaroslav Trusevich, Eastern State Hospital; Data Analyst: Al Bouvier, Decision Support & Evaluation

- **Figure 4.** This chart provides information on the average number of days to complete a jail-based evaluation from the receipt of all discovery.
- ***Outcomes*:** During the reporting period, WSH had a decrease in completion times while ESH experienced a miniscule increase in average completion times. **It should be noted that the statewide average completion time of 8.2 days is the shortest completion time yet recorded.**
- ***Drivers*:** This time period for completions, since Q1 2016, represents significant improvement over performance prior to 2016. Additionally, the statewide average continued to decline over the second half of 2017 and into 2018. This improvement in performance reflects the work done by DSHS/OFMHS to increase the number of evaluators on staff (added 21 evaluators since 2015), utilizing RCW 10.77 to work with county panel evaluators and independent evaluation providers in the community, hiring two additional supervisors in the Fall of 2017, and working with jails (providing greater access, and assisting in scheduling) to further bolster efforts. Continued utilization of improvements in technology (laptops, digital dictation, and cellular phones) has also helped.

**Figure 5:** competency evaluation time frame completion for PR cases



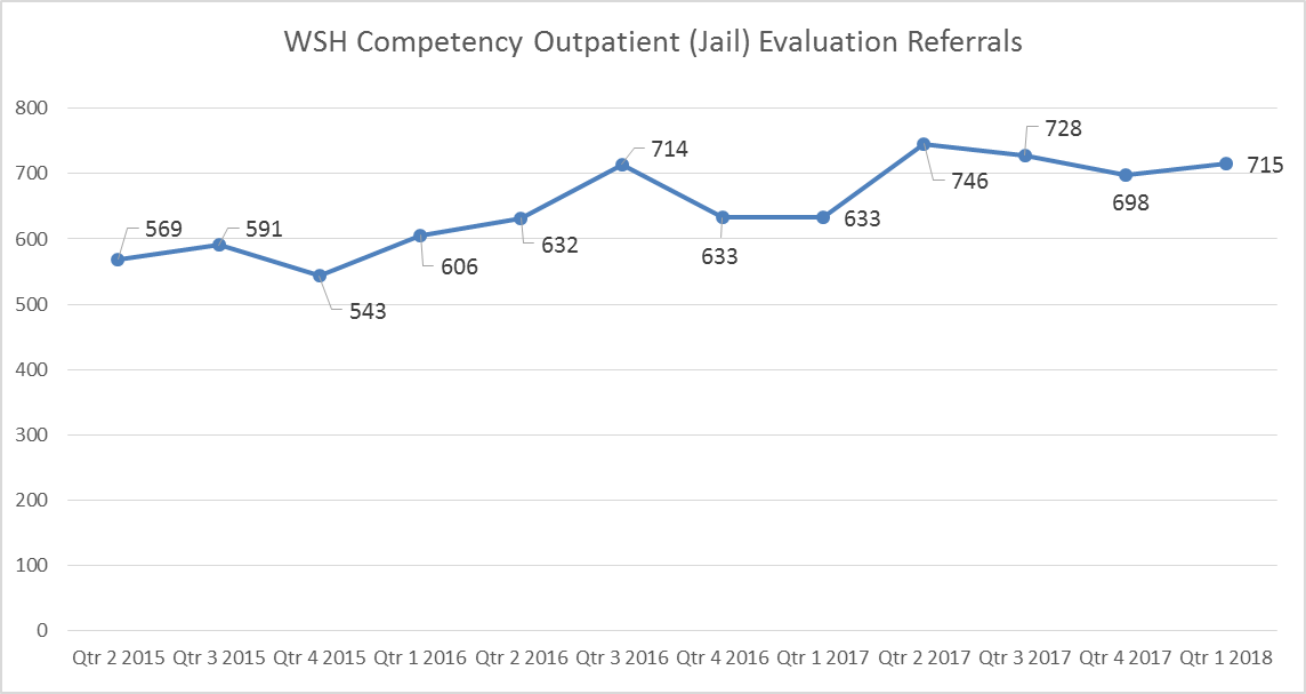

| | 2013-4 143 COMP | 2014-1 222 COMP | 2014-2 200 COMP | 2014-3 145 COMP | 2014-4 169 COMP | 2015-1 122 COMP | 2015-2 135 COMP | 2015-3 124 COMP | 2015-4 189 COMP | 2016-1 207 COMP | 2016-2 222 COMP | 2016-3 164 COMP | 2016-4 186 COMP | 2017-1 188 COMP | 2017-2 228 COMP | 2017-3 134 COMP | 2017-4 176 COMP | 2018-1 218 COMP |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Avg Days ESH | 70.2 | 79.7 | 66.3 | 70.5 | 66.5 | 76.7 | 88.9 | 103.9 | 118.6 | 80.0 | 64.3 | 32.5 | 44.1 | 37.0 | 44.7 | 54.2 | 49.7 | 53.6 |
| Avg Days WSH | 94.6 | 87.5 | 65.2 | 74.3 | 80.2 | 75.5 | 66.0 | 83.8 | 91.5 | 95.7 | 76.6 | 67.1 | 93.4 | 90.5 | 70.6 | 82.1 | 95.9 | 105.6 |
| Avg Days State | 87.1 | 85.6 | 65.4 | 72.7 | 75.6 | 76.0 | 74.7 | 90.6 | 102.3 | 89.5 | 72.9 | 54.0 | 80.4 | 76.3 | 63.6 | 72.5 | 81.5 | 89.4 |
| Target | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 |

Data Source: Al Bouvier, Western State Hospital; Yaroslav Trusevich, Eastern State Hospital; Data Analyst: Al Bouvier, Decision Support & Evaluation

- **Figure 5.** This chart provides information on the average number of days to complete PR evaluations from the receipt of all discovery.
- ***Outcomes*:** During the reporting period, both WSH and ESH had an increase in average completion times; WSH completion times rose by 9.7 days, while ESH completion times rose by 3.9 days. The statewide average completion time rose by 7.9 days. Statewide, 42 more community-based evaluations were completed than in the previous quarter, and is the third highest total completed yet recorded.
- ***Drivers*:** The variability in completion times, with more total completed evaluations during this quarter, is attributed to resources having been directed to cases involving *Trueblood* class members as the number one completion priority based on established constitutional rights from the *Trueblood* court order. In working to meet those constitutional time frames, the Department also is faced with monthly inpatient fines now nearly $4 million each month. As such, resource allocation demands that DSHS/OFMHS focus its efforts in such a way as to mitigate, as much as possible, the impacts of these constitutional violations and related fines. This has resulted in greater fluctuation with regard to performance measures in this category.

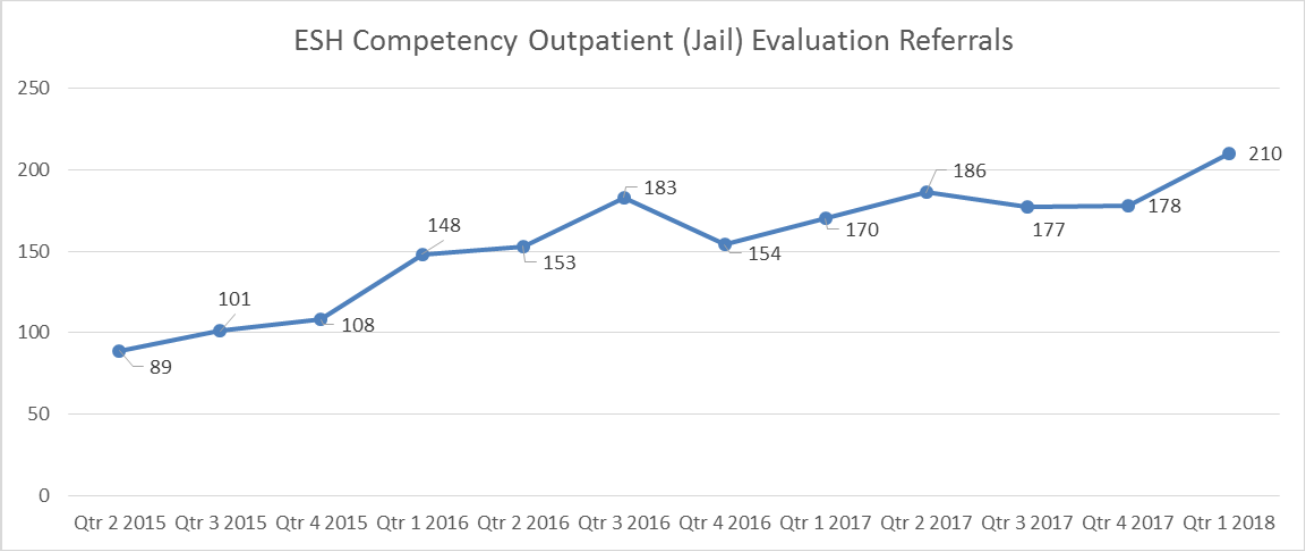
**Figures 6-14:** show ***global referral data*** to illustrate total quarterly referrals for jail-based evaluations, inpatient evaluations, and restoration services for WSH, ESH, and both hospitals combined.

**Figure 6:** shows total WSH referrals for jail-based evaluations



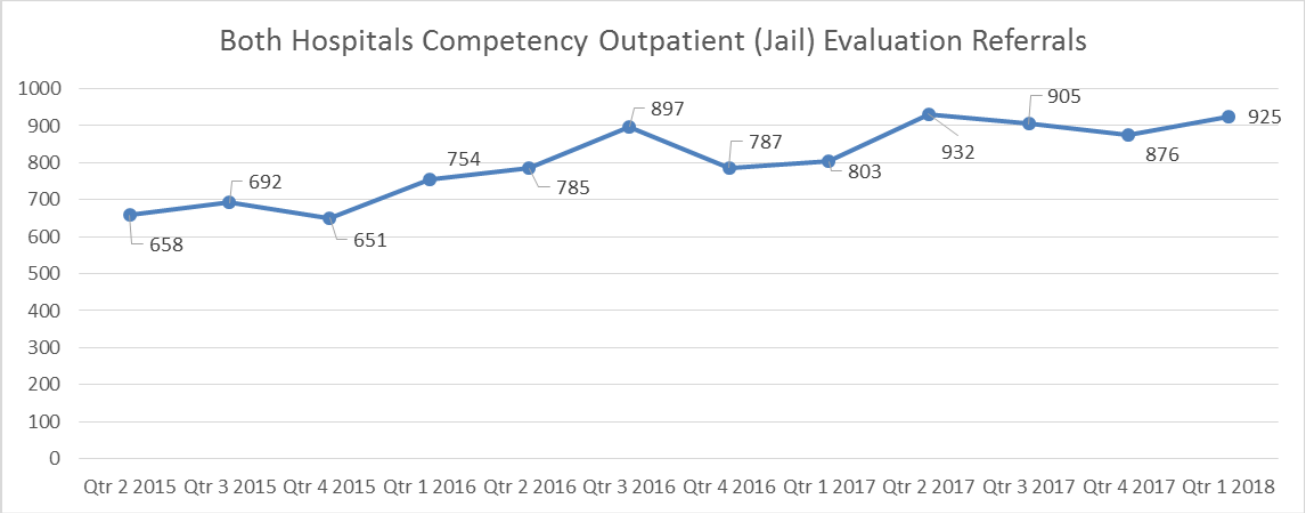

- **Figure 6.** This chart illustrates WSH total quarterly referrals for jail-based evaluations.
- ***Outcomes*:** During the reporting period, WSH hospital saw an increase in referrals from the previous quarter, and is the third highest total yet recorded.
- ***Drivers*:** Referrals for competency evaluation have increased significantly over this the period illustrated above. This strongly suggests a "build it and they will come" effect; improved efficiency in providing consumers with a highly valued forensic service has itself increased the demand for that service. This is a well-known effect also seen in other supply and demand phenomena, such as the energy industry.

**Figure 7:** shows total ESH referrals for jail-based evaluations



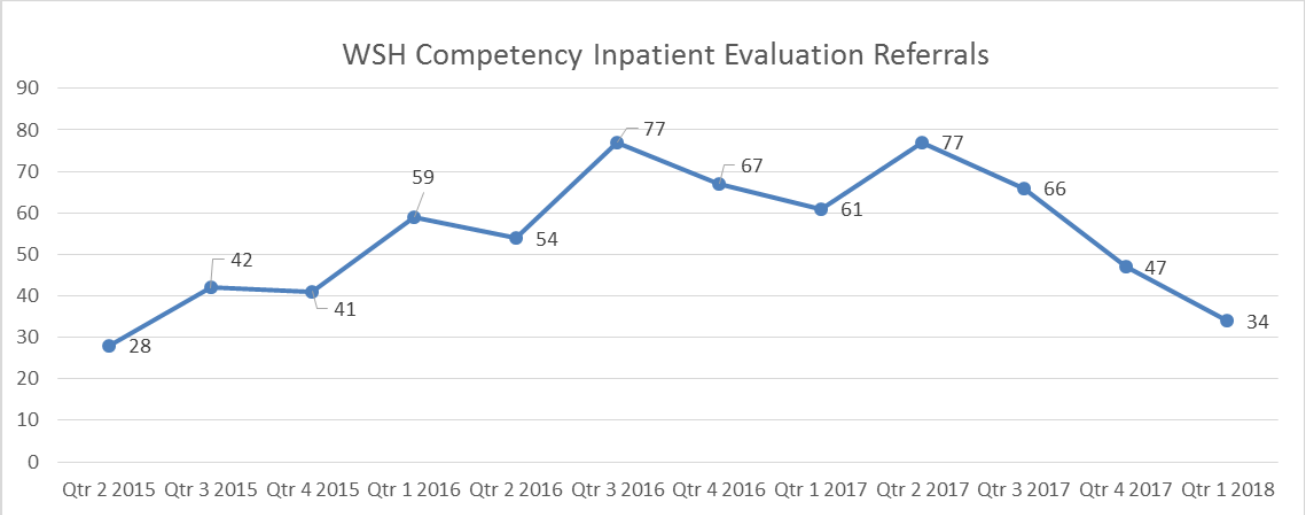

- **Figure 7.** This chart illustrates ESH total quarterly referrals for jail-based evaluations.
- ***Outcomes*:** During the reporting period, ESH hospital saw a significant increase in referrals from the previous quarter. This total is an 18% increase over the previous quarter, and is a 12.9% increase over the highest number of referrals from any previous quarter.
- ***Drivers*:** As with Figure 6, the overall trend of increasing referral totals is driven by demand. As the Department has increased capacity and gained efficiencies in its processes, the criminal court system and mental health community have demanded the Department's services at a pace that has outstripped gains made in capacity and efficiencies.

**Figure 8:** shows total WSH and ESH combined referrals for jail-based evaluations



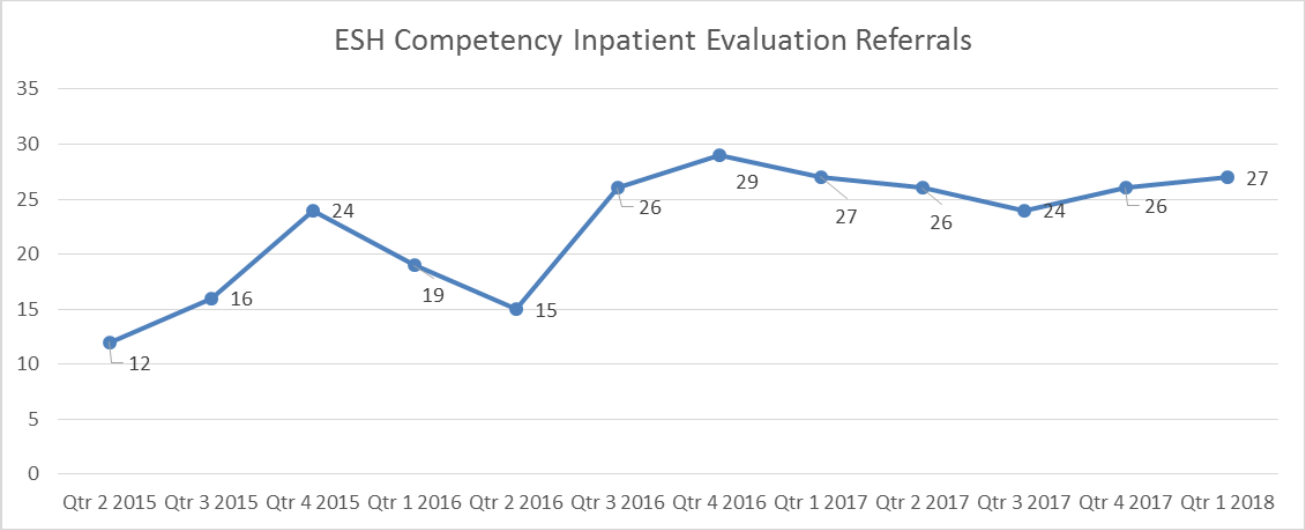

- **Figure 8.** This chart illustrates the combined total quarterly referrals for jail-based evaluations.
- ***Outcomes*:** During the reporting period, there was a significant increase in total referrals for both hospitals combined as compared with the previous quarter. This total is the highest yet recorded; representing a 5.6% increase from the previous quarter, and 40.6% increase from when tracking began in Q2, 2015.
- ***Drivers*:** The combined number of jail-based referrals to the hospitals, again, strongly suggest a "build it and they will come" effect; improved efficiency in providing consumers with a highly valued forensic service has itself increased the demand for that service.

**Figure 9:** shows total WSH referrals for inpatient evaluations



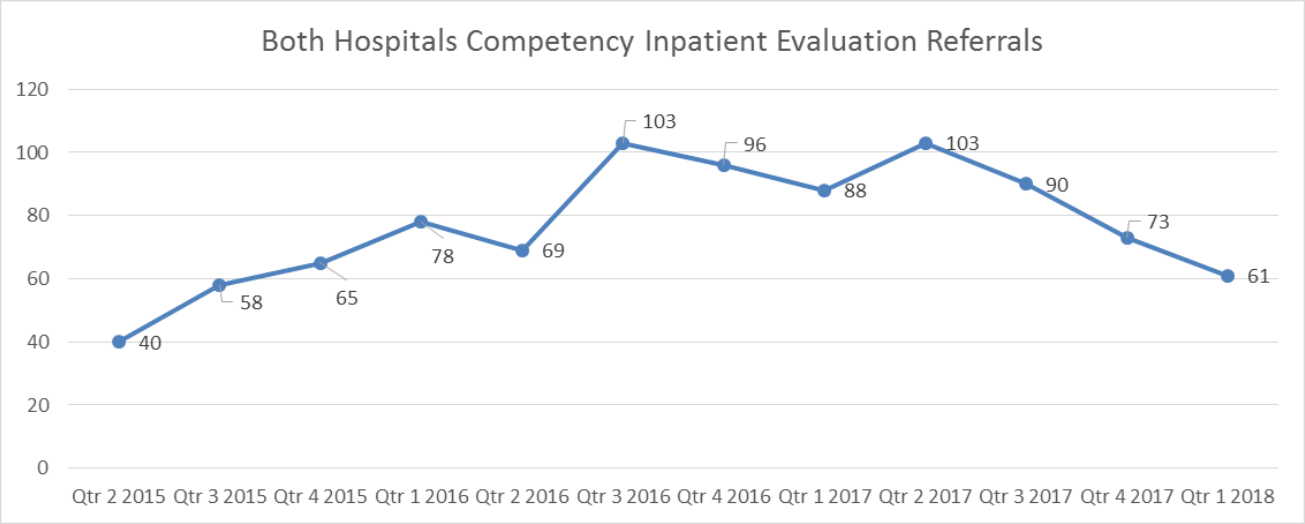

- **Figure 9.** This chart illustrates WSH total quarterly referrals for inpatient evaluations.
- ***Outcomes*:** During the reporting period, WSH hospital again saw a significant decrease in referrals from the previous quarter and was the lowest in nearly three years.
- ***Drivers*:** This large decline in inpatient referrals may be a rebound effect wherein courts have become aware of the fact that, previously, demand had outstripped capacity which resulted in long wait times and completion times. Anecdotal information suggests that courts and defense attorneys are beginning to view the wait times for admission to the hospital for an inpatient evaluation to be so prohibitively long that it is not worth pursuing as an order. Some courts have issued new orders that take the defendant off the inpatient wait list, directing DSHS to conduct the evaluation in the jail. In other cases, the defendant has waited for such an extended period for admission that defense counsel motions the court for dismissal of charges.

**Figure 10:** shows total ESH referrals for inpatient evaluations



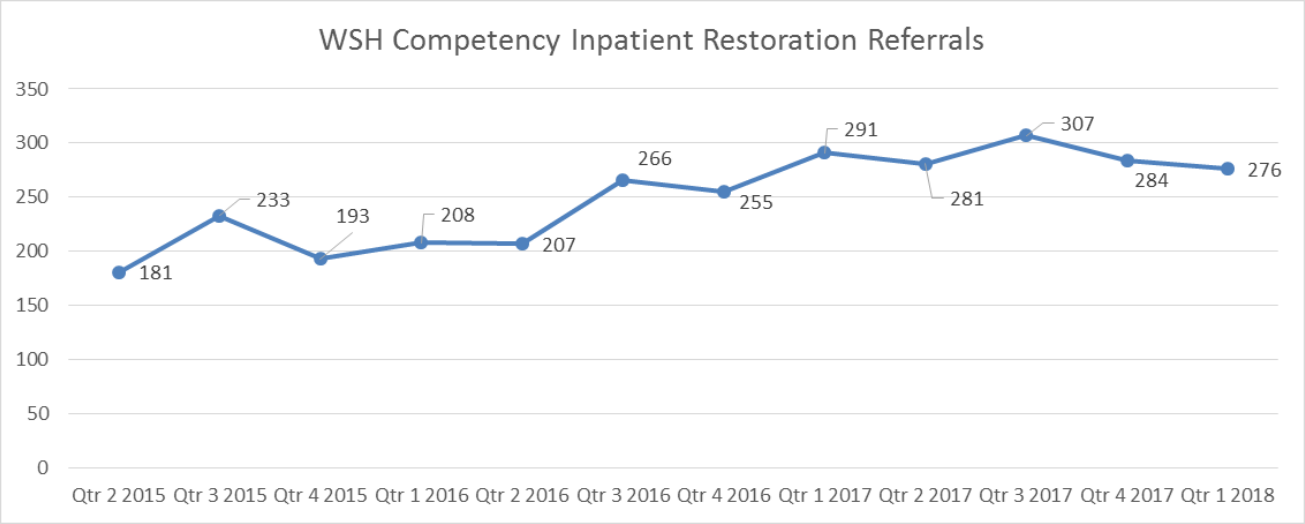

- **Figure 10.** This chart illustrates ESH total quarterly referrals for inpatient evaluations.
- ***Outcomes*:** During the reporting period, ESH hospital saw a slight increase in referrals from the previous quarter.
- ***Drivers*:** The overall trend of near-static inpatient evaluation orders illustrates that referrals for inpatient evaluations have remained relatively flat for nearly two years, at ESH. It appears as though preference by the courts, as it pertains to patient evaluations, is to have the vast majority of evaluations completed in jail as opposed to inpatient (see Figure 7 for ESH jail-based evaluations for comparison).

**Figure 11:** shows total WSH and ESH combined referrals for inpatient evaluations



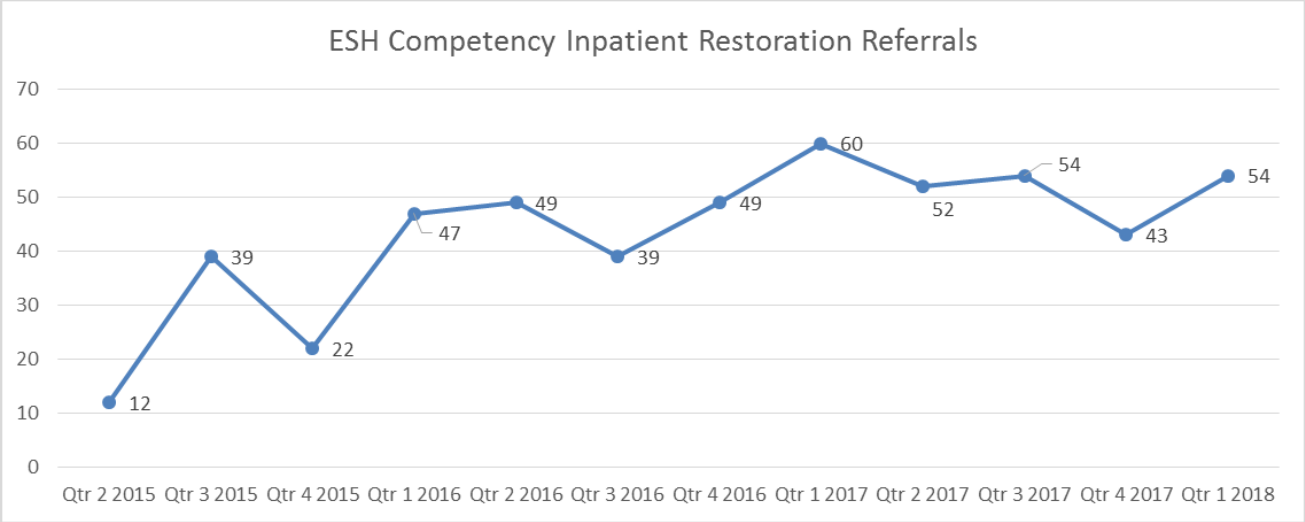

- **Figure 11.** This chart illustrates the combined total quarterly referrals for inpatient evaluations.
- ***Outcomes*:** During the reporting period, there was a significant decrease in total referrals for both hospitals combined as compared with the previous quarter.
- ***Drivers*:** As contemplated in Figures 9 and 10, there may be a number of factors potentially driving the overall numbers seen in Figure 11. Specifically, it appears as though preference by the courts, as it pertains to patient evaluations, is to have the vast majority of evaluations completed in jail as opposed to inpatient. Additionally, defense attorneys are beginning to view the wait times for admission to the hospital for an inpatient evaluation to be so prohibitively long that it is not worth pursuing an order.

**Figure 12:** shows total WSH referrals for inpatient restoration



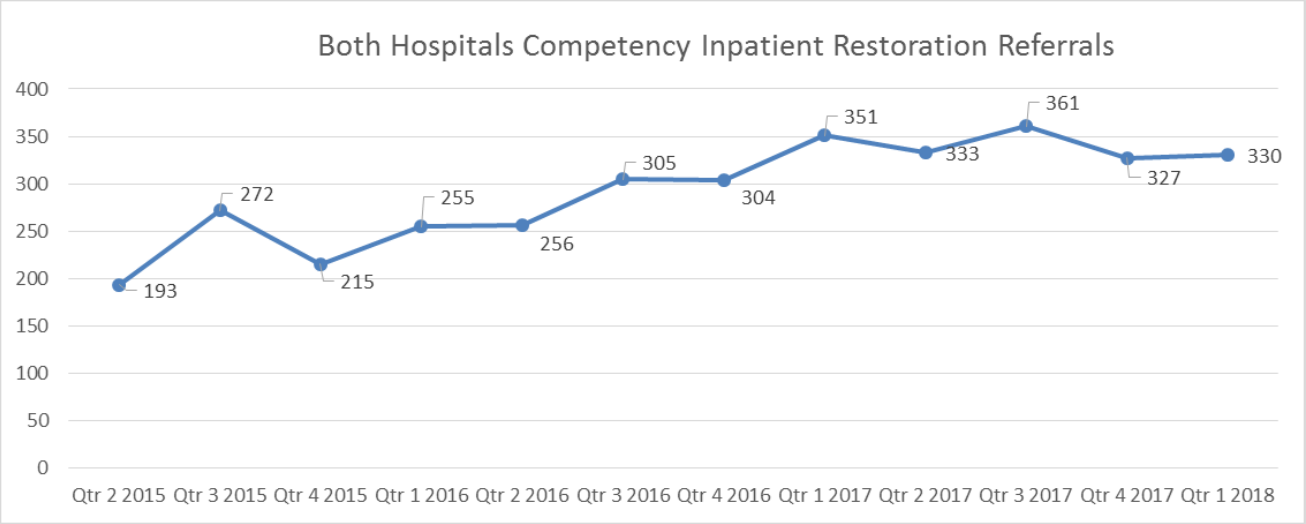

- **Figure 12.** This chart illustrates WSH total quarterly referrals for inpatient restorations.
- ***Outcomes*:** During the reporting period, WSH hospital saw a slight decrease in referrals from the previous quarter. However, the number of referrals have remained fairly flat over the past seven quarters. These referrals still represent a significant increase over the number of referrals seen at the time of the *Trueblood* decision; the average number of referrals since Q3, 2016 (280) is a 54.7% increase from the number of referrals recorded at the time of the *Trueblood* decision (181).
- ***Drivers*:** Having seen a sharp increase in referrals since the *Trueblood* decision, the relatively flat number of referrals over the past seven quarters suggests that supply (bed capacity) is having a leveling effect on demand (referrals).

**Figure 13:** shows total ESH referrals for inpatient restoration




- **Figure 13.** This chart illustrates ESH total quarterly referrals for inpatient restorations.
- ***Outcomes*:** During the reporting period, ESH hospital saw a significant increase in referrals from the previous quarter. Over the period between Q2 2015 and Q4 2017, the average quarterly referral total was 42.4. Q1 2018 is well above that average, and is one of the highest numbers yet recoded.
- ***Drivers*:** The quarterly increase in evaluation referrals (see Figures 7 & 10) appears to be the driver resulting in an increase number of restoration referrals. Of the 204 total evaluation referrals in Q4 2017, 43 lead to restoration referrals (21.1%). Q1 2018 saw 237 total evaluation referrals, leading to 54 restoration referrals (22.8%); a proportional result.

**Figure 14:** shows total WSH and ESH combined referrals for inpatient restorations




- **Figure 14.** This chart illustrates the combined total quarterly referrals for inpatient restorations.
- ***Outcomes*:** During the reporting period, the two hospitals saw a slight increase in restoration referrals from the previous quarter; right in line with the 2017 quarterly data, and significantly higher than the 2016 quarterly data.
- ***Drivers*:** The overall trend of relatively flat restoration referral numbers seems to echo what has been seen throughout this report; that supply (bed capacity) has had a leveling effect on demand (referrals).

## ACTIONS TAKEN

DSHS submitted a Long-Term Plan to the Court in July, 2015 which outlines DSHS' plans for coming into compliance with the timelines established in the *Trueblood* decision. On February 8, 2016, the Court issued an order modifying the original April 2, 2015 order, providing a new timeline requiring full compliance as of May 27, 2016. Pursuant to the Court's February 8, 2016 order, DSHS revised the Long-Term Plan and submitted this plan to the Court on May 6, 2016. The Long-Term Plan can be found here:

https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2016Trueblood/Combined-Long-Term-Plan-2016-05-06.pdf

The Office of Forensic Mental Health Services (OFMHS) is responsible for the leadership and management of Washington's forensic mental health care system, and is addressing the increase in demand for mental health services for adults and youth in the criminal justice system. The OFMHS provides forensic evaluations, competency restoration, Not Guilty by Reason of Insanity (NGRI) treatment services, and liaison services to effectively coordinate efforts with system partners to meet shared goals. The OFMHS additionally provides ongoing training and technical assistance to improve quality and timeliness of: forensic mental health services; data management and resource allocation; training and certification of evaluators; quality monitoring and reporting. The OFMHS works in collaboration with the Governor's office to lead and implement robust diversion efforts to prevent citizens with mental illness from entering the criminal justice system. Significant public resources have been invested in providing the high quality and empirically supported services of OFMHS. Two major goals for OFMHS during this period were to (1) best-utilize current bed capacity, (2) gain efficiencies in the process of evaluation delivery, and (3) prosecutorial diversion programs and implementation of five RFP's using *Trueblood* fines.

Below are the key actions that occurred during this period to decrease wait times.

1. **Best-Utilize Current Bed Capacity**

   During this period, a focus on keeping beds full at all facilities (ESH, WSH, Maple Lane, and Yakima) was a continued key strategy.

   A needs projection and bed capacity study has been undertaken with TriWest Group, a consultancy organization, to determine the feasibility of and timeframe for compliance with court orders. The impact of community based competency evaluation on the demand for inpatient competency evaluation and restoration beds will also be measured by TriWest Group.

   A replacement for the previously departed Community Liaison and Diversion Specialist was on-boarded and has renewed OFMHS efforts in reducing demand for beds by working with community stakeholders to find and utilize available resources outside the criminal justice system that will meet the needs of this population while fulfilling OFMHS requirements under *Trueblood*.

Triage services have continued in an effort to identify individuals for whom expedited admissions may be appropriate. This program, called TCEA (Triage Consultation and Expedited Admissions) identified and accepted requests for 18 individuals for expedited admissions during this period, with a total of 128 individuals to date.

Work will need to be undertaken to continue increasing capacity and reducing demand. Actions are anticipated to take place in the next reporting period to address these challenges, and will be included in the next report.

**2. Gain Efficiencies in Process of Evaluation Delivery**

During the period 2015 – 2017, 21 evaluators were added to current staff levels. Additionally, relationships with community evaluation services providers were established, allowing for panel evaluations to be done by counties and individual service providers to perform evaluations and bill DSHS/OFMHS directly. These relationships have improved evaluation completion times in many instances, despite the ever-increasing demand.

Additional efforts have also been made in the area of workforce development. Specifically, staff evaluators were offered training, with national experts in the field of competency evaluations, as a part of ongoing efforts to create and maintain the most highly trained and efficient staffing possible. Furthermore, work on a pilot project to use tele-video services for evaluations continue, with three of these evaluations having been conducted to date.

**3. Fund Prosecutorial Diversion Programs & RFP's Using *Trueblood* Fines**

During this reporting period, prosecutorial diversion pilot programs were funded. These programs allow a prosecutor to use their discretion to dismiss a non-serious charge without prejudice if the issue of competency is raised. The intent of these programs is to divert misdemeanor and low-level felony defendants from incarceration and hospitalization, into needed behavioral health treatment.

*Trueblood*-Fine funded programs awarded funding to begin July 1, 2017 include: King County (BHO); Sunrise Services, Inc.; Comprehensive Health Care; Great Rivers (BHO); Kitsap Mental Health Services. Three more programs have been awarded funding to begin operations in March, 2108 (Catholic Charities, Pierce County, and Thurston-Mason Behavioral Health Organization. These are in addition to state-funded diversion pilot programs that began more than a year ago; these include: Pacific County (program focused on misdemeanors, began September, 2016); Spokane County (program focused on those with misdemeanor and low-level felonies, began October, 2016); Greater Columbia (program focused on misdemeanors, began November, 2016); and King County (program focused on misdemeanors and low-level felonies, began January, 2017).

## NEXT STEPS

Future reports will provide continued progress reporting, with a focus on efforts made in four main areas as it relates to compliance: (1) expanding and best-utilizing bed capacity, (2) increasing throughput for inpatient services, (3) managing in-custody evaluations to reduce barriers so compliance can be reached, and (4) decreasing demand for competency services.

A key area for OFMHS work is to identify and develop, with community stakeholders, programs to reduce the demand of competency services in addition to working with these entities to identify and address the root causes for the continued increases in competency evaluation and restoration referrals.

Additionally, OFMHS has taken steps to create specific standards and expectations for staff evaluators, in adherence with our principals of being the most well-trained and efficient staff possible.

Lastly, an agreed proposal from Plaintiffs and Defendants was submitted to the court in January, 2018 to consider a plan in which a collaborative approach between parties to provide concrete steps to address the forensic mental health system are outlined and submitted to the Governor's office. OFMHS continues to work with the Court and Plaintiffs in a concerted effort to bring components of the proposal to fruition so as to better-serve *Trueblood* class members and all individuals placed in the custody of DSHS for forensic services.

## SUMMARY

The Department and OFMHS continue to work on what impacts can be made on these four levers: 1) increase, and best-utilize, bed capacity, 2) increase throughput for inpatient services (quicker turnover in hospitals), 3) manage in-custody evaluations to reduce barriers so compliance can be reached, and 4) decrease demand for competency services.

Ensuring that every bed is best-utilized to meet requirements under *Trueblood*, by maintaining efficient referral and admission practices, is a major key to DSHS/OFMHS work toward achieving compliance. The outcome and recommendations of the TriWest study may also provide new ways of overcoming current obstacles to compliance.

Continued triage and diversion efforts will also facilitate and improve these efforts by managing the inpatient portion of *Trueblood* class members, while also finding acceptable alternatives for those class members deemed suitable for these alternative options.