

State of Washington  
Joint Legislative Audit & Review Committee (JLARC)



**Competency to Stand Trial, Phase I:  
Staff Productivity Standards, Data Reliability,  
and Other Parties' Actions May Impact  
DSHS's Ability to Meet Timelines**

**Briefing Report**

December 5, 2012

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The statutory authority for JLARC, established in Chapter 44.28 RCW, requires the Legislative Auditor to ensure that JLARC studies are conducted in accordance with Generally Accepted Government Auditing Standards, as applicable to the scope of the audit. This study was conducted in accordance with those applicable standards. Those standards require auditors to plan and perform audits to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on the audit objectives. The evidence obtained for this JLARC report provides a reasonable basis for the enclosed findings and conclusions, and any exceptions to the application of audit standards have been explicitly disclosed in the body of this report.

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Stand Trial,  
Phase I:  
Staff Productivity  
Standards, Data  
Reliability, and Other  
Parties' Actions May  
Impact DSHS's Ability  
to Meet Timelines**

**Briefing Report**

**December 5, 2012**



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## REPORT SUMMARY

### **Competency Evaluations Are Intended to Prevent Prosecution of Mentally Incompetent Defendants**

The U.S. Supreme Court has held that a criminal defendant is incompetent to stand trial if the defendant does not have the capacity to understand the proceedings against him or her or does not have sufficient ability to assist in his or her own defense (*Dusky v. United States*, 362 U.S. 402 (1960)). Washington State statute also prohibits an incompetent person from being “tried, convicted, or sentenced for the commission of an offense so long as such incapacity continues” (RCW 10.77.050).

If the defendant’s competency is raised as an issue in a criminal or civil case, the court is required to suspend the trial so that the defendant’s competency to stand trial can be evaluated.

Evaluations are usually performed by psychologists from DSHS’s Western State Hospital or Eastern State Hospital. Based on the evaluation, the court may determine either that the defendant is incompetent to stand trial and order a period for competency restoration, or that the defendant is competent and resume the trial.

### **DSHS Has New Requirements for Completing Competency Evaluations**

According to DSHS, the number of court referrals for competency evaluations has increased by 82 percent since 2001, reaching 3,035 referrals in Calendar Year 2011. This has raised concerns about the amount of time defendants spend waiting in jails or in the community for an evaluation.

In 2012, the Legislature passed Substitute Senate Bill 6492 to “substantially improve the timeliness of services related to competency to stand trial.” The bill established performance targets for the timeliness of competency evaluations and requires JLARC to complete two performance assessments of DSHS’s timeliness in completing competency evaluations.

The legislation directs DSHS to meet two targets by November 2012 and another by November 2013. Given the recent passage of these new target requirements, information on meeting the

targets is not available. JLARC's first report focuses on DSHS's plans to meet these new requirements. At this preliminary stage of implementation, DSHS reports that it has plans in place to address these new statutory requirements and related challenges identified by JLARC staff (see Appendix 3)

## **Staff Productivity Standards and Data Reliability Are Two Issues of Concern in DSHS's Early Implementation**

In this first of the two studies, JLARC wants to make legislators aware of two issues we found in early implementation of the bill:

- Based on our review of data provided by DSHS, we estimate that the two state hospitals did not meet the assumed staffing and productivity standards in the first three months of implementation of the legislation (May – July 2012). Meeting these assumptions is key to DSHS meeting the statutory timelines for completion of competency evaluations. DSHS has prepared a plan intended to address staffing and productivity.
- JLARC's request for data on early implementation revealed data reliability issues. If DSHS does not address these data reliability issues, it will impact the agency's ability to report on its progress and JLARC's ability to complete its second study. DSHS recognizes that the state hospitals need to improve data quality.

## **A Third Issue: Competency Evaluations Involve More Than the State Hospitals, and These Parties' Actions Can Delay Evaluations**

State hospitals, county courts and jails, attorneys, and the defendants themselves all have a role in the timely completion of competency evaluations. The cooperation and availability of each of the parties are needed for DSHS to meet the statutory timelines. Some of the potential causes of delay are beyond DSHS's control. The agency reports that it plans to track causes of delay in the completion of competency evaluations.

## **JLARC Next Steps**

JLARC has a second assignment from the Legislature to report on DSHS's timeliness in completing competency evaluations. In early 2013, JLARC will present a Scope and Objectives for the second study. What we learned in this report and in DSHS's implementation plan in Appendix 3 will inform this second study. DSHS's response to this report is also included in Appendix 2. The second study is due in December 2013.

Competency evaluations are intended to prevent the prosecution of mentally incompetent defendants. Part one of this report provides more detail on what comprises a competency evaluation, who conducts them, and the settings where evaluations take place. It also provides a snapshot of evaluation referrals in 2011, showing the counties that refer defendants for evaluations, where the evaluations were conducted, and whether the person being evaluated had been charged with a misdemeanor or a felony. Part one concludes with information on how the increase in the number of competency evaluation referrals compares to other key trends and notes that evaluation referrals have increased in other states as well.

## **There Are Competency Evaluation Requirements in Both State Statute and Federal Case Law**

Both state statute and case law guide the requirements for competency evaluations.

### ***Statutory Requirements***

Statute requires two elements for every competency evaluation:

1. Diagnosis of the defendant's current mental status, and
2. An opinion of the defendant's competency, and whether an evaluation for civil commitment is appropriate.

Statute has separate provisions for situations where the court provides a report from an external expert to an evaluator and directs the evaluator to perform an evaluation for insanity or diminished capacity, which is different than competency.

### ***Case Law Requirements***

In addition to state law, federal case law (*Wieter v. Settle*, 193 F. Supp. 318 (1961)) defines eight "functional abilities" that must be present for an evaluator to find a defendant competent. This requires the evaluator to assess each defendant based on these eight categories:

1. Defendant has mental capacity to appreciate his presence in relation to time, place, and things. Defendant's elementary mental processes are such that he apprehends that:
2. He is in a Court of Justice charged with a criminal offense;
3. There is a judge on the bench;
4. A prosecutor is present who will try to convict the defendant of a criminal charge;
5. A lawyer will undertake to defend him against that charge;
6. The defendant will be expected to tell his lawyer the circumstances, to the best of his mental ability, the facts surrounding him at the time and place where the law violation is alleged to have been committed;
7. There is, or will be, a jury present to pass upon evidence as to his guilt or innocence of such charge; and
8. He has memory sufficient to relate those things in his own personal manner.

In a 2011 report, the Washington State Institute for Public Policy noted that, “As is made clear by this list of functional abilities, this assessment of competency to stand trial can be a complex matter and is not a yes/no determination. The consideration of a defendant’s mental state in the context of these abilities requires careful analysis.”<sup>1</sup>

## Competency Evaluations Are Primarily Conducted By Psychologists from Western or Eastern State Hospitals

Licensed psychologists, who are referred to as “forensic evaluators,” work for DSHS and perform competency evaluations for defendants referred for evaluations by county courts. These evaluators are DSHS staff with either Western State Hospital (Western) in Lakewood or Eastern State Hospital (Eastern) in Medical Lake. Most of the evaluators work at, or are based out of, the hospitals themselves, although Western also has an office in King County.

### Exhibit 1 – Counties Served by the Two State Hospitals



Source: DSHS.

## Competency Evaluations Take Place in County Jails, in the Community, or in One of the Two State Hospitals

### Outpatient Evaluations

About 80 percent of evaluations take place in an outpatient setting (i.e., outside of the hospitals). For a defendant in custody, evaluations are conducted in the county jail where the defendant is

<sup>1</sup> Roxanne Lieb & Mason Burley. (2011). *Competency to stand trial and conditional release evaluations: Current and potential role of forensic assessment instruments* p. 6. Olympia: Washington State Institute for Public Policy, Document Number 11-05-3401.

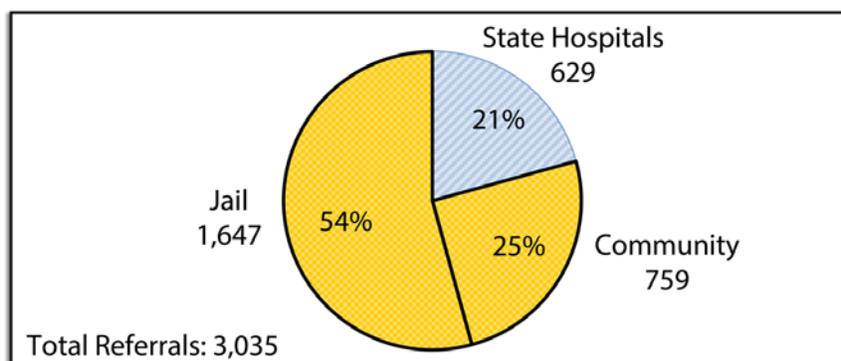
being held. If the person is released on personal recognizance or bail, and is no longer in custody, an evaluator meets with the defendant in a community setting, such as an attorney's office.

### ***Inpatient Evaluations***

A court may refer a defendant for an evaluation at a hospital if it finds that an evaluation in jail is unlikely to produce an accurate evaluation or that an evaluation in a hospital is needed for the defendant's health and safety. In order for a defendant to be admitted to a state hospital, the hospital must have a bed available and an adequate number of psychiatrists. If the hospital does not have an available bed, the defendant will wait in an outpatient setting—usually in a county jail—until the hospital has the capacity to admit the defendant. A defendant cannot receive competency restoration services until he or she has been determined as incompetent.

Exhibit 2 shows the settings for competency evaluations in 2011. The majority of evaluations took place in an outpatient setting, either in a county jail (54 percent) or in the community (25 percent).

**Exhibit 2 – In 2011, About 80 Percent of Competency Evaluations Were Referred to County Jails or the Community**



Source: JLARC analysis of DSHS data.

### **Snapshot of Competency Evaluation Referrals – 2011**

JLARC members expressed an interest in knowing more about the composition of the defendants receiving referrals for competency evaluations. While DSHS is not tracking factors such as the outcome of evaluations, the agency is tracking information on three factors:

- 1) The county from which the court referral came;
- 2) Whether the defendant was charged with a felony or a misdemeanor; and
- 3) The setting for the competency evaluation (inpatient or outpatient).

Of the 3,035 referrals in Calendar Year 2011, DSHS can identify 2,955 by county. Of these:

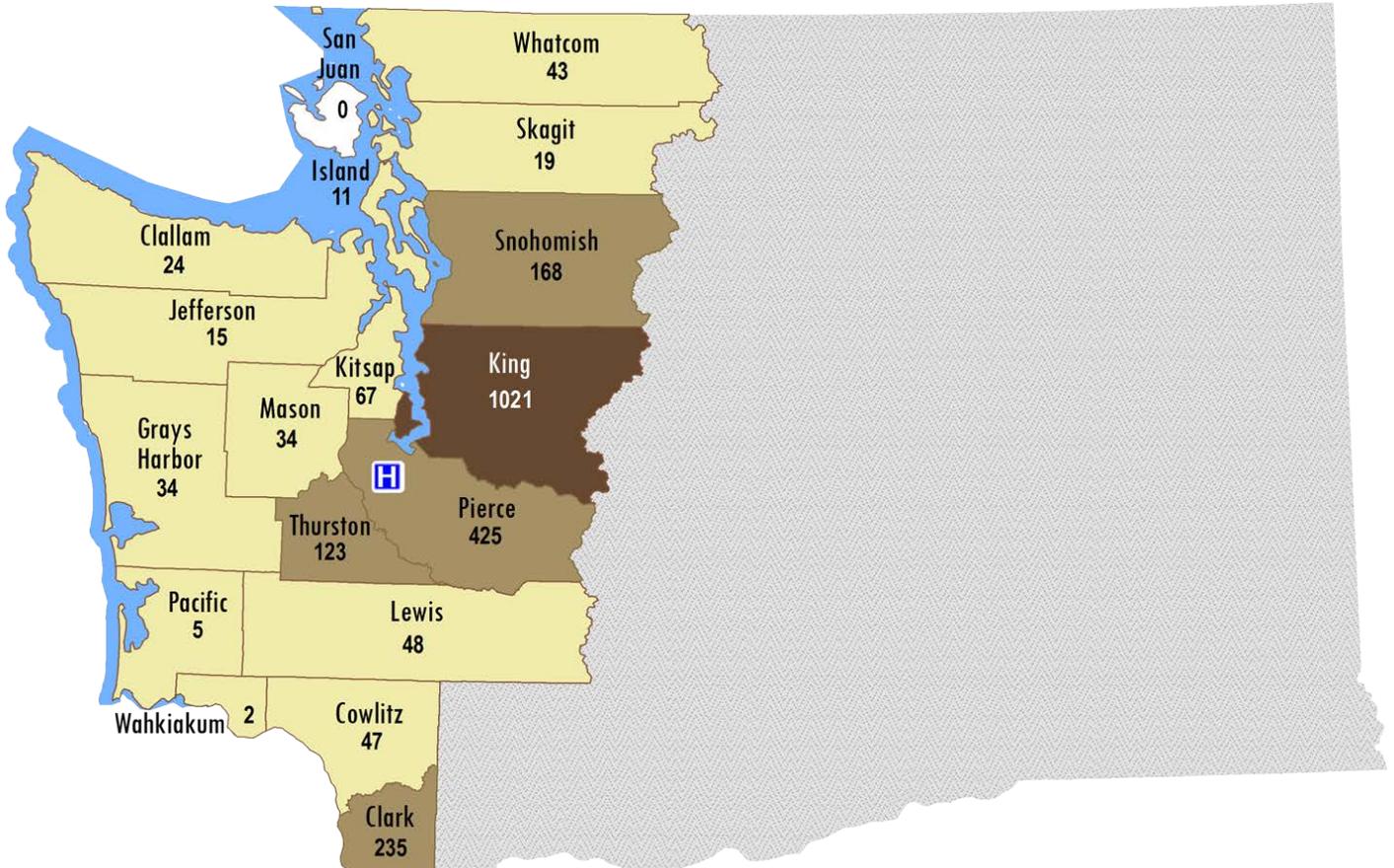
- Western received 79 percent of all referrals in 2011, while 21 percent were referred to Eastern;
- King County referred 44 percent of Westerns' evaluations, while Spokane referred 31 percent of Eastern's total evaluations;
- Misdemeanants accounted for 58 percent of Western's referrals and 47 percent for Eastern;
- Most misdemeanors were referred to an outpatient setting;

Part One: What is an Evaluation for Competency to Stand Trial?

- Western: 98 percent; and
- Eastern: 88 percent; and
- Felony referrals accounted for 42 percent of Western’s referrals and 53 percent of Eastern’s total referrals.

Exhibits 3 and 4 illustrate these results.

**Exhibit 3 – Western State Hospital Received a Total of 2,325 Outpatient and Inpatient Referrals in 2011**

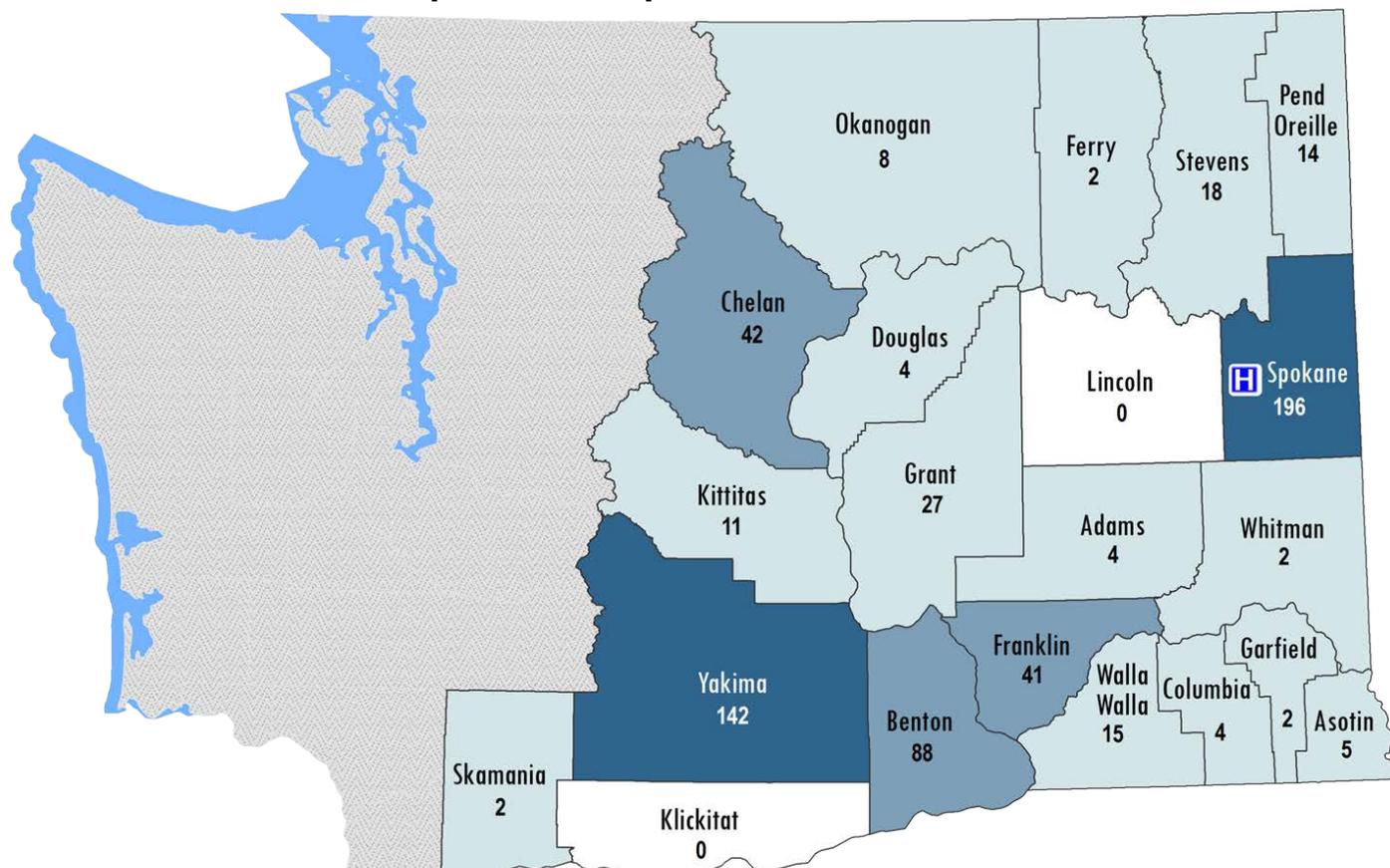


<b>WSH Service Area – Detail of Five Largest Referral Counties</b>							
County	% of Population Compared to % of Referrals		Referrals by Offense Type and Evaluation Setting				Total Referrals
	Population	Referrals	Outpatient		Inpatient		
			Misdemeanor	Felony	Misdemeanor	Felony	
King	37%	44%	760	151	15	95	1,021
Pierce	15%	18%	154	107	4	160	425
Clark	8%	10%	143	71	1	20	235
Snohomish	14%	7%	102	55	0	11	168
Thurston	5%	5%	42	51	1	29	123
All Other	21%	16%	136	159	3	55	353
<b>WSH Total</b>	<b>100%</b>	<b>100%</b>	<b>1,337</b>	<b>594</b>	<b>24</b>	<b>370</b>	<b>2,325</b>

Note: Four referrals are not reflected on this map, as they were sent from counties typically served by Eastern (Ferry, Yakima, Stevens, and Benton). These referrals are included in the total number of referrals.

Source: JLARC analysis of DSHS data and OFM state population data.

**Exhibit 4 – Eastern State Hospital Received a Total of 627 Outpatient and Inpatient Referrals in 2011**



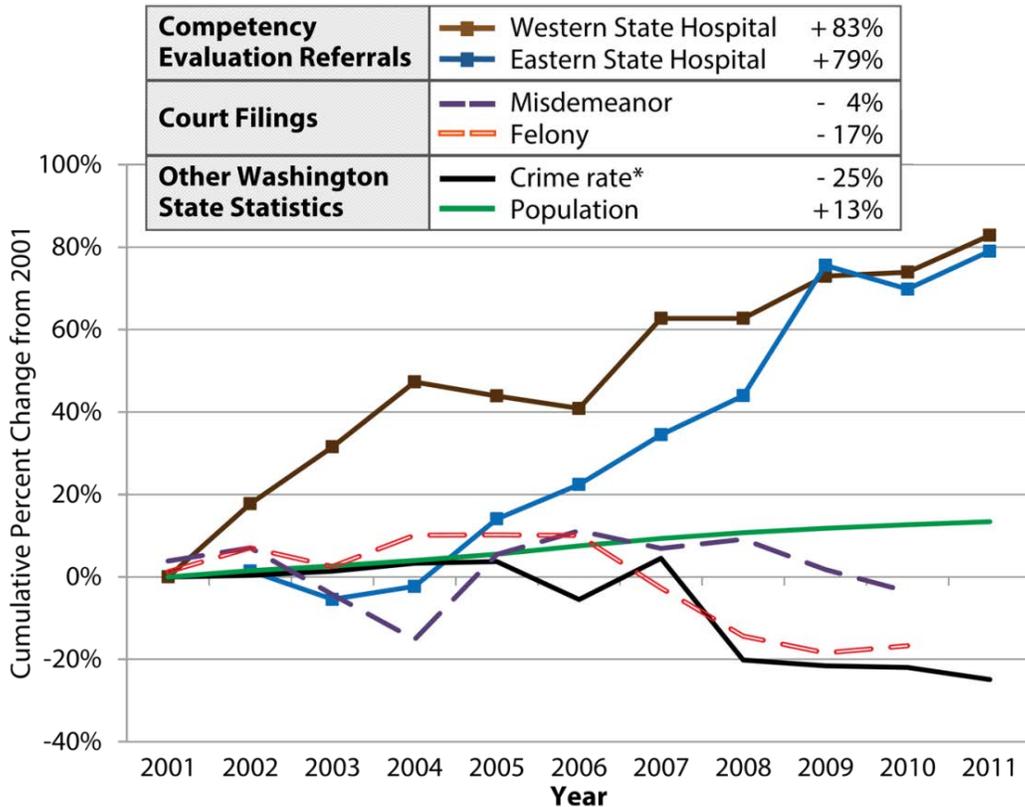
<b>ESH Service Area – Detail of Five Largest Referral Counties</b>							
County	% of Population Compared to % of Referrals		Referrals by Offense Type and Evaluation Setting				Total Referrals
			Outpatient		Inpatient		
	Population	Referrals	Misdemeanor	Felony	Misdemeanor	Felony	
Spokane	31%	31%	70	82	9	35	196
Yakima	16%	23%	81	29	11	21	142
Benton	12%	14%	44	27	1	16	88
Chelan	5%	7%	28	10	1	3	42
Franklin	5%	6%	10	17	2	12	41
All Other	31%	19%	27	42	11	38	118
<b>ESH Total</b>	<b>100%</b>	<b>100%</b>	<b>260</b>	<b>207</b>	<b>35</b>	<b>125</b>	<b>627</b>

Source: JLARC analysis of DSHS data and OFM state population data.

## Competency Evaluation Referrals in Washington Outpaced Other Key Trends

According to DSHS, the number of referrals for competency evaluations has increased by 82 percent since 2001. Exhibit 5 shows that the growth in the number of referrals for competency evaluations in Washington exceeds the growth in court filings, crime, and the state’s population.

**Exhibit 5 – Competency Evaluation Referrals Outpaced Other Key Trends Since 2001**



\*Offenses per 1,000 persons

Source: JLARC analysis of DSHS data, AOC data, WASPC data and OFM state population data.

## Competency Evaluation Referrals Have Increased In Other States As Well

The increase in referrals for competency evaluations is not unique to Washington, and DSHS reports that this is a national trend. During preliminary research, JLARC identified four other states that are also facing an increasing number of competency evaluation referrals and have looked at the issue as well (Colorado, Florida, Texas, and Virginia). JLARC plans to review other states’ experiences with competency evaluations as part of the second study due in December 2013.

JLARC did not find national research that explains the cause of increased referrals for competency evaluations. A national expert on this subject who is working with the Washington State Institute for Public Policy confirmed the lack of definitive research on why referrals are increasing.

**Legislature Passed SSB 6492 to Expedite the Competency Evaluation Process**

The increase in the number of referrals for competency evaluations has raised concerns about the amount of time defendants spend waiting in jails or in the community for an evaluation. In 2012, the Legislature passed Substitute Senate Bill 6492 (SSB 6492), to “substantially improve the timeliness of services related to competency to stand trial” and established performance targets for the timeliness of competency evaluations.

The bill establishes timelines for the completion of outpatient competency evaluations and for the admittance to a state hospital for an inpatient evaluation. The new timelines are as follows:

	Outpatient		Inpatient
	Jail	Community	State Hospital
Must admit defendants within:	NA	NA	7 days
The evaluation must be completed within:	7 days	21 days	15 days from admission
DSHS is required to meet this target by:	November 2012	November 2013	November 2012

The measurement for these targets begin on the date the state hospital receives the court referral and charging documents, discovery, and criminal history information related to the defendant. For additional detail on the timelines and evaluation process, see Exhibit 7 on page 15. JLARC will report in December 2013 on the outcome of DSHS’s efforts to meet timeliness standards.

**DSHS Reports That It Has Plans in Place to Address the New Requirements in Statute**

It was not possible to review outcomes in this first audit given the study’s timeframe. Therefore, JLARC reviewed the steps DSHS is taking, or plans to take, to meet the new requirements. To do so, JLARC asked DSHS to formally respond to eighteen questions related to statutory requirements and to associated challenges that JLARC staff identified. JLARC identified these challenges through interviews with evaluators at Eastern and Western state hospitals, hospital management, and DSHS executives. The categories of challenges and statutory requirements include:

- Forecasting the number and type of referrals, and managing to meet targets;
- Staff recruitment and retention plans;
- Data collection and reporting standards;
- Quality and productivity standards in evaluators’ performance reviews; and
- Processes to monitor defendants’ lengths of stay in state hospitals related to competency evaluation and restoration.

DSHS reported that it has plans in place to meet the new requirements in statute and each of the challenges identified by JLARC. The agency's plan is included in its entirety in Appendix 3. Overall, it appears that DSHS has a number of initiatives underway. The Legislature specifically asked JLARC to review DSHS's plans to 1) establish quality and productivity standards for evaluators and 2) monitor defendants' lengths of stay at state hospitals related to evaluation and competency restoration. Among DSHS's plans are actions to address these two areas. More specifically, DSHS reports the following information:

- 1) **Quality and productivity standards:** DSHS reports that prior to the passage of SSB 6492, it established evaluator productivity standards for inpatient and outpatient evaluators at both hospitals: ten evaluations per evaluator per month at Eastern and 12 per month at Western. These standards were written into evaluators' position description forms as of May 1, 2012, the effective date of the bill. The agency reports that it will manage staff to meet the targets in statute.

DSHS reports that nationally recognized quality standards do not exist for competency evaluations. However, supervisors will review the quality of evaluations on an ongoing basis. Western has recently hired two supervisors that will provide this oversight and quality assurance. Eastern reports that it has existing supervisory staff to provide quality assurance.

- 2) **Monitor length of stay:** If a defendant is found not competent to stand trial, they are sent to one of the state hospitals for a period of competency restoration. A defendant charged with a misdemeanor is eligible for a single period of restoration treatment that can last between 14 to 29 days, depending on the number of days remaining in the evaluation period. This restoration is followed by a new evaluation report. Defendants charged with felonies are eligible for periods of restoration that can last between 45 days to one year. Longer stays to restore competency reduce the number of beds available for new admissions for competency evaluations. DSHS reports they have adopted two policies to monitor and potentially reduce the length of stay:
  - State hospitals adopted a policy to review each inpatient defendant's competency during weekly medication reviews to determine when a patient is restored or if restoration is not possible. This started at Western in August 2011 and at Eastern in August 2012. Prior to the adoption of this policy, there was not a formal schedule for these reviews to occur.
  - For defendants who have been admitted for a longer-term competency restoration, DSHS reports that staff providing competency restoration classes to defendants meet with the defendant's psychiatrist to review the patient's progress twice monthly. Once the attending psychiatrist believes that the patient is competent, he notifies the evaluator, who evaluates the patient to determine if competency has been restored.

JLARC will review DSHS's implementation of these plans as part of the second study due in December 2013.

## Two Issues of Concern in DSHS's Early Implementation

Based on a review of three months of self-reported data from the state hospitals, JLARC observed two issues of concern that may prevent DSHS from meeting the targets in statute and from providing quarterly reports required by SSB 6492.

<b>Issue 1</b>	<b><i>Early Estimates Indicate Assumed Staffing and Productivity Standards in the First Three Months of Implementation Were Not Likely Met</i></b>
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### Meeting the Targets in Statute Depends on Three Key Drivers:

The ability for DSHS to meet the evaluation timelines is based on three assumptions:

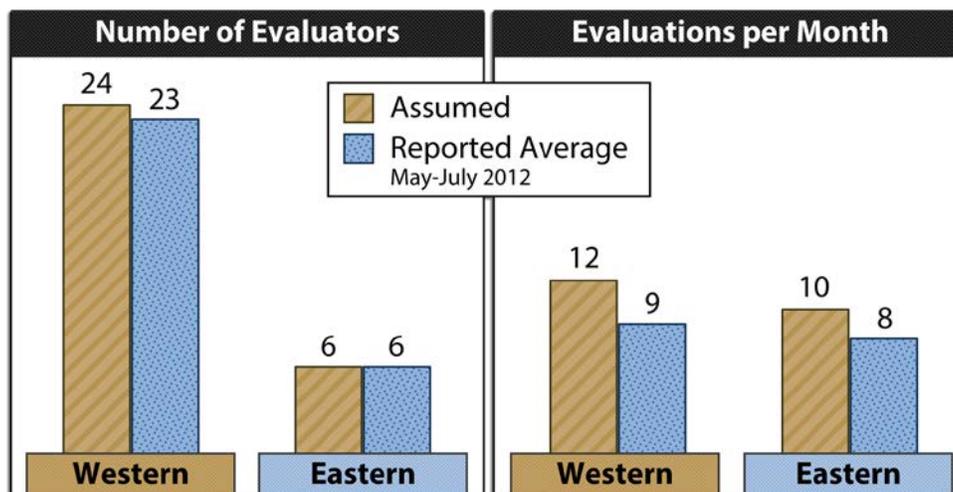
1. The number and types (misdemeanor and felony) of individuals requiring evaluations continues to grow at a rate similar to previous years;
2. Western will employ 24 full-time evaluators and Eastern will employ six;
3. Each evaluator will consistently complete a certain number of evaluations per month:
  - Eastern: a minimum of ten evaluations per month, and
  - Western: a minimum of 12 evaluations per month.

While the number and types of individuals requiring evaluations is outside of DSHS's control, DSHS is responsible for hospital staffing and evaluator productivity (#2 and #3 above). Additionally, statute requires DSHS to "manage, allocate, and request appropriations for resources to meet these targets."

These three assumptions were included in the bill's fiscal note on SSB 6492. In the fiscal note, DSHS described the expectations for increased productivity as the new "base targets" for evaluators, and the agency reported that, if the hospitals retained experienced staff and the referral rates remained consistent, it could meet the December 2012 inpatient and jail timelines.

To compare the assumptions in the fiscal note with the actual early implementation of the bill, JLARC requested information on the number of competency evaluations completed at each of the two hospitals during the first three months of the bill's implementation (May – July 2012). Exhibit 6 shows the results of this comparison, using the best data the hospitals were able to provide. As described on the following page, concerns with data reliability made it difficult for JLARC to determine evaluators' actual productivity. While the two hospitals reported at or close to the assumed number of evaluators, both fell short in meeting the assumed productivity standard for the number of monthly evaluations per evaluator.

**Exhibit 6 – Based on Early Implementation Results,  
Productivity Assumptions Not Likely Met**



Source: Fiscal Note, DSHS.

**DSHS Has Prepared a Plan in Case Staffing and Productivity Assumptions Are Not Met**

Both Eastern and Western have reported challenges with recruiting and retaining evaluators and psychiatrists. In the course of this study, Western reported filling three vacancies for forensic psychologists and hiring two supervisory positions for the forensic services unit. However, over half of the psychologists and psychiatrists at both hospitals are eligible for retirement in the next ten years. Given the importance of experienced staff to meet the targets in statute, JLARC asked DSHS about its plans to address recruitment and retention challenges.

DSHS provided JLARC with a plan that includes options for addressing the recruitment and retention challenges, such as evaluating the need for pay increases and working to create a separate forensic psychologist job classification. DSHS has also drafted a “Forensic Work Plan” that includes additional approaches for completing evaluations beyond the use of full-time state psychologists if the staffing assumptions are not met. These approaches include hiring Master’s level social workers to complete evaluations, recruiting private psychologists to complete evaluations in jails and serve as on-call employees, or using Advanced Registered Nurse Practitioners to perform psychiatric duties if the hospital is unable to hire a psychiatrist.

Additionally, DSHS reports that it will track the number of evaluations performed by each evaluator, and may reassess the resources it needs to meet the targets.

**Issue 2** ***JLARC's Request for Data on Early Implementation Revealed Data Reliability Issues***

**Data Challenges May Impact the Agency's Ability to Provide Reliable Reports**

Statute requires DSHS to report annually on: 1) its performance providing competency evaluations; and 2) the timeliness in which court referrals, accompanied by charging documents, discovery, and criminal history, are provided to the hospitals relative to the signature date of the court order. Additionally, DSHS must report in any quarter that a state hospital does not meet one or more of its timelines, and any planned corrective actions.

JLARC requested information on the number of evaluations completed by evaluators at both Eastern and Western during the first three months of the bill's implementation (May –July 2012). While Eastern was able to provide this data, Western provided data with several anomalies and apparent outliers in the numbers of evaluations. DSHS was unable to provide an explanation as to how JLARC should interpret the anomalies and outliers. DSHS has not been able to provide JLARC with reliable information regarding controls for who can enter data, what data is entered, or the quality of that data. **If DSHS does not address its data reliability issues, it will impact the agency's ability to report on its progress and JLARC's ability to complete its second study in 2013.** JLARC will conduct a more thorough review of both hospitals' data for the second study.

**DSHS Recognizes That the Hospitals Need to Improve Data Quality and Better Utilize Data to Inform Decision Making**

DSHS's implementation plan recognizes the need to improve data collection and analysis, and the agency outlines a plan for doing so. This includes hiring a supervisor for the three forensic units at Western State Hospital and a data analyst tasked with handling all required SSB 6492 reporting and tracking reasons for why evaluations are delayed. The supervisor will need to assure that consistent data controls are in place, and the data analyst should provide a single point of accountability for data needs. Additionally, DSHS reports that hospital research and budget staff will analyze trends in the number and types of evaluations requested to forecast future needs. JLARC will monitor the implementation of these efforts and report on the results in December 2013.



# PART THREE

## COMPETENCY EVALUATIONS INVOLVE MORE THAN THE STATE HOSPITALS, AND THESE PARTIES' ACTIONS CAN DELAY EVALUATIONS

This is a third issue for the Legislature to be aware of as DSHS moves forward with implementation of the 2012 legislation to expedite competency evaluations. State hospitals, county courts and jails, attorneys, and the defendants themselves all have a role in the timely completion of competency evaluations. The cooperation and availability of each of these parties are needed for DSHS to meet the statutory timelines. Actions by these parties, while outside of the control of DSHS, can nonetheless prevent an evaluation from being completed on time.

The initial competency evaluation process for a defendant begins with the court referring the individual for a competency evaluation and ends with the court determining competency of that individual. JLARC summarized this process into seven steps as displayed in Exhibit 7.

### Exhibit 7– Other Parties Can Impact the Hospitals' Ability to Complete Competency Evaluations

Steps in Evaluation Process				
1	Attorney or Judge questions Defendant's competency, suspends trial. Court sends Defendant to Jail or releases to Community.			
2	Court/Jail sends four documents to Hospital: <ul style="list-style-type: none"> <li style="display: inline-block; width: 45%;">• Referral</li> <li style="display: inline-block; width: 45%;">• Discovery</li> <li style="display: inline-block; width: 45%;">• Charging</li> <li style="display: inline-block; width: 45%;">• Criminal History</li> </ul>			
Evaluation Period Begins				
3	Hospital assigns Evaluator, schedules evaluation Defendant's location determines timelines and sequence of events:			
		Jail	Community	Hospital
	Must admit defendants within:	NA	NA	7 days
	Evaluation must be completed within:	7 days	21 days	15 days from admission
	<div style="border: 1px solid black; padding: 5px; display: inline-block;">           During which Defendant is:           <ul style="list-style-type: none"> <li>• Placed on waiting list</li> <li>• Scheduled for admission</li> <li>• Transported to Hospital</li> </ul> </div>			
4	Evaluator: <ul style="list-style-type: none"> <li>• Reviews required documentation</li> <li>• Meets with defendant for interview and conducts any needed tests</li> <li>• Synthesizes test results and writes report with opinion</li> </ul>			
5	Hospital distributes report to Court			
Evaluation Period Ends				
6	Court schedules competency hearing			
7	Judge determines Defendant's competency			

Notes: Information pertains to the first competency evaluation. Information represents summarized examples and should not be considered all-inclusive.

Source: ADSA information analyzed by JLARC staff.

## **Possible Causes of Delay Outside of DSHS's Control**

Statute recognizes that there can be causes of delay in meeting timelines that are beyond DSHS's control and identifies four such causes:

1. DSHS has not received medical clearance information regarding the defendant's current medical status for admission to a state hospital;
2. A third party has medical history information that is needed to complete an evaluation and cannot be obtained immediately;
3. Counsel, jail, court personnel, or defendant not available or participating in referral; or
4. An unusual spike in evaluation referrals or in the number of defendants requiring restoration services, causing temporary delays until the unexpected excess demand has been met.

Statute acknowledges that there could be other acceptable reasons for delays.

The hospitals have already identified multiple possible causes of delay, from the county courts, jails, or defendant themselves, that may prevent the hospitals from meeting the required timelines. Examples of these possible delays are listed below.

### **County Courts:**

- Courts may not provide required documents (referral, charging, discovery or criminal history) to the hospital in a timely manner.
- A court, concerned that defendant has not been admitted to a state hospital or evaluated, may request a "show cause" hearing. This requires state hospital staff to travel to the court in order to testify and explain the reason for the delay.
- An attorney may be unresponsive to an evaluator's requests to schedule a meeting with the defendant.
- A defendant may request his attorney's presence at an evaluation, and the attorney has ongoing scheduling conflicts.

### **Jails:**

- A jail may not provide required documents to a state hospital in a timely manner.
- Medical clearance may not have been completed: In order for a state hospital to admit a defendant, the defendant must have a medical evaluation to assure that he does not have any communicable diseases. Jail medical staff perform these evaluations for defendants in custody.
- Room in a jail for outpatient evaluations may not be readily available.
- Transportation of a defendant to or from the hospital by jail staff may not be readily available. Some counties only transport defendants to a state hospital once or twice a week.

### **Defendant:**

- A defendant has the right to have his attorney present during his competency evaluation. While the defendant may not want his attorney present when the evaluation is scheduled, a defendant may change his mind once the evaluation is underway. If so, the hospital must schedule a new evaluation with the attorney present.
- For outpatient evaluations in the community, the evaluator may not be able to locate the defendant. DSHS reports that it is not uncommon for a defendant released on personal recognizance to be homeless or without permanent housing.
- The defendant may be uncooperative with the evaluator.
- An evaluator may begin an evaluation but determine that it cannot be completed in an outpatient setting and requires additional observation in an inpatient setting.

While DSHS has identified these possible causes of delay in completing competency evaluations, the agency acknowledges that it has not been tracking the frequency of these occurrences. DSHS reports it will begin tracking these additional causes of delay to report on its performance in meeting the new statutory timelines.

### **Recap of Issues and JLARC Next Steps**

This first JLARC report identifies three issues for legislators to be aware of at this early stage of implementation of the 2012 legislation on competency to stand trial:

- It appears that the two state hospitals likely did not meet the assumed staffing and productivity standards in the first three months of implementation of the legislation. Meeting these assumptions is key to DSHS meeting the statutory timelines for completion of competency evaluations. DSHS has prepared a plan intended to address staffing and productivity;
- JLARC's request for data on early implementation revealed data reliability issues. If DSHS does not address these data reliability issues, it will impact the agency's ability to report on its progress and JLARC's ability to complete its second study. DSHS recognizes that the hospitals need to improve data quality and has identified plans for this; and
- Competency evaluations involve more than just the state hospitals, and actions by these parties can delay evaluations. These potential causes of delay are beyond DSHS's control. DSHS reports it plans to track causes of delay in the completion of competency evaluations.

JLARC has a second assignment from the Legislature to report on DSHS's timeliness in completing competency evaluations. In early 2013, JLARC will present a Scope and Objectives for the second study. What we learned in this report and in DSHS's implementation plan in Appendix 3 will inform this second study, due in December 2013.



## COMPETENCY TO STAND TRIAL – AUDIT 1 OF 2

### SCOPE AND OBJECTIVES

JULY 18, 2012



STATE OF WASHINGTON  
JOINT LEGISLATIVE AUDIT  
AND REVIEW COMMITTEE

#### STUDY TEAM

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Elisabeth Donner

#### PROJECT SUPERVISOR

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## APPENDIX 1 – SCOPE AND OBJECTIVES

### What Is an Evaluation for Competency to Stand Trial?

The U.S. Supreme Court has held that a criminal defendant is incompetent to stand trial if the defendant does not have the capacity to understand the proceedings against him or her or does not have sufficient ability to assist in his or her own defense (*Dusky v. United States*, 362 U.S. 402 (1960)). Washington state statute also prohibits an incompetent person from being “tried, convicted, or sentenced for the commission of an offense so long as such incapacity continues” (RCW 10.77.050).

If the defendant’s competency is raised as an issue in a criminal or civil case, the court is required to suspend the trial so that staff from the Department of Social and Health Services (DSHS) can evaluate the defendant’s competency to stand trial. These evaluations may be performed in one of the state’s two mental hospitals operated by DSHS, in county jails, or in the community for out-of-custody defendants. Based on the evaluation, the court may determine either that the defendant is incompetent to stand trial and order a period for competency restoration, or that the defendant is competent and resume the trial.

### Why a JLARC Study of the Timeliness in Completing Competency Evaluations?

According to a report prepared by Senate Human Services Committee staff, the number of court referrals for competency evaluations increased 82 percent between 2000 and 2011. By 2011, DSHS received a combined 3,035 court referrals for initial competency evaluations for adult defendants. The report found that the increase in referrals has been accompanied by an increase in the amount of time defendants spend awaiting evaluation in state hospitals, jails, and in the community.

In 2012, the Legislature passed Substitute Senate Bill 6492, which is intended to “substantially improve the timeliness of services related to competency to stand trial” and establishes performance targets for the timeliness of competency evaluations. This bill also directs JLARC to complete two performance assessments, six and eighteen months after the bill’s effective date, of the agency’s timeliness in completing competency evaluations.

### Legislature Directs DSHS to Improve Timeliness

The Legislature requires three key tasks of the Department of Social and Health Services:

- 1) **Report progress meeting timelines established in the bill for completing competency evaluations:** The bill establishes targets for the completion of competency evaluations in jails, state hospitals, and in the community and provides exceptions for why targets may not be met.

DSHS must provide annual performance reports. In any quarter in which DSHS fails to meet a performance target, the agency must report on the extent of the deviation and the corrective action the agency is taking;

- 2) **Establish productivity standards for DSHS staff that perform competency evaluations;** and
- 3) **Monitor defendants’ time in state hospitals and reduce the length of stay related to evaluation and competency restoration:** DSHS is to monitor whether defendants’ clinical objectives have been met so they can be discharged before their commitment period expires. Additionally, DSHS is to assess the extent to which patients overstay statutory limits in state hospitals and to take steps to limit commitment times.

### Study Scope

This is the first of two JLARC audits of DSHS’ timeliness in completing competency evaluations. This first audit will review what steps DSHS is taking to meet the performance targets and deliver the information required in statute. This work will inform the objectives for JLARC’s second audit due in December 2013.

### Study Objective

The study will report on the steps DSHS is planning to take to accomplish the three tasks identified above. Specifically, JLARC will review how DSHS has or plans to:

- 1) Meet timelines established in statute for completing competency evaluations and reporting the agency’s performance;
- 2) Establish quality and productivity standards for DSHS staff who perform competency evaluations and determine how these standards will be used; and
- 3) Monitor defendants’ lengths of stay in state hospitals related to evaluation and competency restoration and facilitate their discharge in a timely manner.

### Timeframe for the Study

Staff will present this report at the JLARC meeting in December 2012. This will be followed by a more detailed Scope and Objectives for the second phase of this study due in December 2013.

### JLARC Staff Contact for the Study

Eric Thomas (360) 786-5182 eric.thomas@leg.wa.gov  
 Elisabeth Donner (360) 786-5190 elisabeth.donner@leg.wa.gov



### Criteria for Establishing JLARC Work Program Priorities

- Is study consistent with JLARC mission? Is it mandated?
- Is this an area of significant fiscal or program impact, a major policy issue facing the state, or otherwise of compelling public interest?
- Will there likely be substantive findings and recommendations?
- Is this the best use of JLARC resources? For example:
  - Is JLARC the most appropriate agency to perform the work?
  - Would the study be nonduplicating?
  - Would this study be cost-effective compared to other projects (e.g., larger, more substantive studies take longer and cost more, but might also yield more useful results)?
- Is funding available to carry out the project?

## APPENDIX 2 – AGENCY RESPONSES

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- Department of Social and Health Services





**STATE OF WASHINGTON**  
**DEPARTMENT OF SOCIAL AND HEALTH SERVICES**  
**Aging and Disability Services Administration**  
PO Box 45050, Olympia, WA 98504-5050

November 19, 2012

Keenan Konopaski  
1300 Quince Street South East  
PO Box 40910  
Olympia, Washington 98504-0910

Mr. Konopaski,

Thank you for the opportunity to offer a response to the findings in the “Competency to Stand Trial, Phase One” report. We appreciate your identification of two key issues that could potentially impact the successful implementation of changes in RCW 10.77 resulting from SB 6492.

The first issue identified “that early estimates indicate assumed staffing and productivity standards in the first three months of implementation were not likely met.” This is something that we agree with. As noted in your report, we have developed plans that we feel will address our ability to meet new evaluation timelines.

The second issue identified that “JLARC’s request for data on early implementation revealed data and reliability issues.” Again, we agree with this identified issue and are taking steps toward rectifying our data collection and analysis issues. It is our hope that we have solid and reliable data, not only for use in JLARC’s second study and future reports to the Legislature, but to improve the care we provide to our patients.

We believe that there is a third issue that may contribute to our success in meeting the new evaluation timelines. The issues surrounding the admissions of misdemeanor conversion civil commitment patients and evaluation patients referred to inpatient because “the court finds that it is more likely than not that an evaluation in the jail will be inadequate to complete an accurate evaluation; or the court finds that an evaluation outside the jail setting is necessary for the health, safety, or welfare of the defendant” (RCW 10.77.060(1)(d)(ii) and (iii)) are of note. These types of referrals come directly from the court with minimal input regarding the appropriateness of the referral or necessity of inpatient level of care. If the referral is inappropriate, it impacts waitlist placement and admission timeliness for patients who truly require this level of service.

Finally, we appreciate your consideration and addition of these responses and many of our technical comments. Your staff provided a thorough and evenhanded review, and we have

Keenan Konopaski  
November 19, 2012  
Page 2

learned from their analysis of our work plans thus far. We want to express our thanks to you and your staff, and we look forward to working with you on the second phase of this report.

Sincerely,



Jane Beyer  
Interim Assistant Secretary

cc: Bill Moss, Deputy Assistant Secretary, ADSA

# APPENDIX 3 – DSHS'S PLAN TO IMPLEMENT SSB 6492



**STATE OF WASHINGTON**  
**DEPARTMENT OF SOCIAL AND HEALTH SERVICES**  
**Aging and Disability Services Administration**  
PO Box 45050, Olympia, WA 98504-5050

August 27, 2012

TO: Keenan Konopaski, Legislative Auditor

FROM: Keri Waterland, Operations Manager Aging and Disability Services  
Administration *KW*

RE: Formal Response to JLARC Questions for Competency to Stand Trial  
Performance Audit

As requested in your correspondence dated August 15, 2012, the Aging and Disability Services Administration (ADSA) has provided responses to your questions regarding the implementation plan for SSB 6492 (2012).

Should you have any questions or concerns, please contact me by telephone at 360-725-2265 or via email at [keri.waterland@dshs.wa.gov](mailto:keri.waterland@dshs.wa.gov).

Thank you for allowing us to provide responses to your questions.

Attachments

cc: Kevin Krueger  
Alan Siegel

**Objective #1: Meet timelines established in statute for completing competency evaluations and reporting the agency’s performance.**

**Forecasting and managing to performance targets**

Statute requires ADSA to “*manage, allocate, and request appropriations for resources,*” including staff and facilities, needed to address growing competency evaluation caseload. What is ADSA’s plan to:

- **Forecast and communicate its resource needs?**
  - Currently all data is being entered at both Eastern State Hospital (ESH) and Western State Hospital (WSH).
  - WSH has a newly allocated position (CFS Management Analyst) to enter data required by SSB 6492. The position will assure all data is entered timely and accurately into the hospital information system. This position, along with the Forensic Psychology Services Supervisor and Forensic Admissions Coordinator will generate reports for the hospital executive staff.
  - ESH is looking at the feasibility of creating and funding a similar position which would gather data required by SSB 6492, enter the data in the established database and generate reports for the forensic services clinical director and hospital executive staff.
  - Further analysis of forensic data at ESH and WSH will be done by hospital research and budget staff. This information will be used to analyze trends in the numbers and types of evaluations requested, and to forecast future needs and trends (i.e. FTE’s, location of evaluators, satellite offices).
  - Analysis will further clarify factors that may have an impact on compliance with time frames identified in SSB 6492.
  - Analysis of the forensic data will compare the waitlist (and waitlist projected growth) to the productivity of the evaluators and the expected productivity targets.
    - If the state hospitals, through the DSHS budget process, determine a need for additional evaluators (or other resources) to keep up with the waitlist, a decision package (DP) will be submitted.
- **Assure that beds are used efficiently to meet timelines established in statute?**
  - The state hospitals review each court order for inpatient competency evaluation or restoration to ensure that they meet the new requirements the statute as updated by 6492. If not, the attorneys are contacted to discuss SSB 6492 and clinically appropriate admission criteria as needed.
  - The state hospitals have implemented a review of each patient during weekly medication reviews to determine when a patient is restored or if a determination made that restoration is not possible. By returning these patients to the jail or the community for adjudication, more beds open up for new admissions. This started at WSH in August 2011 and at ESH in August 2012.

- The number of individuals on the waitlist and the average rate of referral were initially analyzed in November/December of 2011 and current bed allocations were established based on this data. Patients were admitted using these ratios and the waitlist drastically and predictably dropped until a significant shortage of forensic evaluators occurred. Now that these positions have been filled, it is anticipated that the waitlist will again decrease.
- WSH hired a Forensic Admissions Coordinator who will review each court order for accuracy and monitor the waitlist to assure that beds are used efficiently. The Forensic Admissions Coordinator will continue to fill and admit from the waitlist using the current ratios and admissions procedures.
- ESH admits patients based on the date the order was received. ESH has one ward that provides services for patients committed for both competency evaluation and competency restoration. Bed utilization is managed to ensure that patients committed for competency restoration are admitted within seven days of receipt of the order.

**Potential difficulties in meeting statutory timelines:**

- There is currently a waiting list for WSH and ESH patients awaiting forensic admission. This increase is tied to the shortage of inpatient forensic evaluators and psychiatrists.
  - Many states require competency evaluations be completed by a psychologist while the person remains in jail and do not offer admissions to state hospitals for evaluation purposes.
  - Once admitted, all required hospital admission services must be provided, including a full admission assessment by the attending psychiatrist. By mandating that all evaluations occur in jail, psychiatry time spent on patients who frequently return to jail within 15 days would be significantly reduced. This would allow more psychiatric services for those patients who are committed for forensic treatment. Unfortunately, SSB 6492 did not give full discretion over admissions to the state hospitals.
  - The state hospitals continue to admit patients who may not clinically require inpatient hospitalization because the statute does not support the hospitals clinical decision over the Court’s order.
- The number of civil commitment (commonly referred to as “forensic flips”) referrals has increased since the implementation of SSB 6492. Because changes in the bill, misdemeanor civil commitment referrals to forensics must now be admitted within 72 hours and felony referrals within seven days, and all must be filed within 72 hours. This impacts the waitlist numbers for evaluation and restoration admissions.
  - The inpatient forensic waitlists would decrease if civil commitment cases were not referred to and admitted directly to the state hospital forensic units for civil commitment evaluation purposes.
  - The Department consulted with the Attorney General’s office and feels that civil cases (resulting from dismissed forensic charges) should be either evaluated in the jail or admitted to Evaluation and Treatment facilities (E&T’s).

- ADSA is planning a discussion with legislative staff, stakeholders, community providers and Regional Support Networks (RSN) for October/November 2012 to explore the reasoning for the increase in civil commitment referrals.

### **Recruitment and Retention**

Eastern State Hospital (ESH) and Western State Hospital (WSH) both described recruiting and retaining psychologists and psychiatrists as a key barrier to meeting the timelines in statute.

- What is ADSA’s plan to address recruiting and retention challenges?
- Are there other strategies that could be used to help meet the performance targets?

Both hospitals have a core cohort of psychiatrists and psychologists nearing retirement eligibility.

- What is ADSA’s plan to deal with these pending retirements?

### **Recruitment and retention plans:**

- If recruitment and retention difficulties are around pay, submit DP’s for pay increases if deemed necessary by the Department.
- Continue to work toward a forensic psychologist job classification, as the specific duties of a forensic psychologist are different than those of a clinical psychologist. Often times, these employees have additional education and training which should be acknowledged and compensated.
- Continue aggressive recruitment efforts to fill vacancies.
  - Since July 29, 2010 there have been over 1,200 hits on Psychiatrist 4 postings on careers.wa.gov.
  - \$34,267.06 has been used for targeted advertising with medical associations and other medical publications.
  - Increased involvement in career fairs will continue.
  - WSH sent recruitment postings to Tom Rawlings, the State Veterans Outreach Recruiter at the State Department of Personnel (DOP), and Employment Security WorkSource services.
- ESH and WSH worked with the Human Resources Division (HRD) of the Department to ensure recruitment announcements were kept open continuously for psychiatrist and psychologist vacancies.
- ESH and WSH also continue to post recruitment ads in local and statewide newspapers and professional journals.
- Over half of the psychiatrists and psychologists are retiring from the state hospitals in the next ten years. The hospitals plan to use the current recruitment strategies in the forensic work-plan (attached) to fill these vacancies.
- Currently WSH has no vacant Psychologist positions, ESH has one.
- ESH had a Psychiatrist 4 position on the forensic unit that they were not able to fill until a psychiatrist on the adult psychiatric unit was transferred, leaving the vacancy on the Adult Psychiatric Unit (APU).
- During the past four years WSH has not had full staffing of its Psychiatrist 4 positions. Recently they have made two appointments for eight vacant positions out of 42.4 positions. See chart below for summary of psychiatrist vacancies at WSH:

Year	Vacancies
2008	4
2009	3
2010	7
2011	9
2012	8

**Mitigation steps taken during psychiatrist shortage:**

- For a period of time the leadership team at WSH had been reducing admissions systematically and maintaining a lower census to address the staffing shortage. Several wards that serve exceptionally acute patients purposefully have been maintained at a lower census to address patient safety concerns.
- Two wards each having a lower census were combined into one physical location.
- Internal psychiatrists have been redeployed to optimize psychiatric coverage for patient care.
- The hospital’s medical staff included full-time psychiatrists who worked in a satellite office solely to complete Competency Evaluations in community jails. The Medical Director moved those psychiatrists into hospital positions.
  - The hospital receives sanctions from the Court for this program change, specifically show cause hearings.
- Since April 2011, the CEO and members of the Executive Leadership Team composed a letter with supporting data for the Departments Secretary to delineate the severity of the problem. A similar letter was submitted to OFM, the department responsible for approving pay increases. The hospital asked for a 10% pay increase to be approved immediately in order to retain two psychiatrists who were planning to leave otherwise.
- The Secretary understood the severity of the problem and directed the CEO to do what was needed to ensure a safe hospital. In August 2011 she recommended this issue be submitted as a Governor’s Alert.
- Pharmacy staff agreed to complete Medication Reconciliation at admission to relieve some burden for Psychiatrists.
- Concurrent with these initiatives, the Secretary assisted in building collaboration with the DOP to improve and increase the recruitment strategies for psychiatrists.
- During this last Collective Bargaining Session, the hospital agreed to increases in paid time off for Continuing Medical Education (CME) to provide additional benefits to psychiatrists.

**Data collection and public reporting**

Reporting progress and performance on implementing SSB 6492 requires reliable and accurate data. What is ADSA’s plan to assure that:

- Consistent data definitions and data collection approaches are established and used by ESH and WSH?
- Data systems can be expanded for new requirements and adapted for changing needs?

Accurately reporting performance information will require both state hospitals to use consistent definitions for the exemptions in Section 2(c) of SSB 6492. These exemptions, such as “merely supplementary” or “timely request,” could be subject to interpretation. What is ADSA’s plan to:

- Define these exemptions, and make them available publicly?
- Assure that ESH and WSH are using the same definitions?
  - ESH Compliance Officer, ESH IT staff, WSH IT staff, WSH research staff, and hospital forensic staff met to develop data dictionary and standard definitions for data collection through the established databases. The data dictionary is now in use.
    - They identified the most common reasons why evaluations are not completed within the identified time frames. These exemptions, known as “reason codes” are defined in the updated database and dictionary.
    - ESH and WSH agreed to utilize the same codes and include the reason codes in the databases with a description of each code. Both databases capture and report the same elements.
  - The staff that use the database and dictionary helped in development, consultation and identification of the reason codes and the frequency of each, so are aware of the data elements and the definitions. This was a way to ensure reported elements are the same for both hospitals.
  - At ESH and WSH, the eight staff that currently use the databases were trained in the use of the databases and dictionary and reminded of the need for accurate and timely data collection.
    - As new administrative staff are hired, they will be trained on how to data enter in the database and the meaning of the data dictionary.

Statute requires DSHS to publicly report any quarter in which one of the performance targets are not met.

What are ESH and WSH’s plans to:

- Monitor performance and progress on meeting the timelines on an ongoing basis?
- The databases currently being used by ESH and WSH have been updated to include a “reason code” identifying why a defendant is not admitted for inpatient competency evaluation within seven days.
  - The “reason codes” will be used to assist in data collection and identifying the reason an evaluation did not occur within the time frames identified in the statute. The hospitals will also begin to collect data on those orders for which the Court declined to amend the order reflecting the new language.
- A code has been added to the database to label court orders that are not valid (per SSB 6492 updates and changes) and what the requested change will be.
  - The state hospitals continue to send clarifications on what orders are in compliance with the updated statute, yet ultimately, the Court has discretion to send individuals inpatient.
  - Changes stemming from SSB 6492 did not regulate the Courts with regard to inappropriate inpatient commitments because the categories outlined in the statute are broad.
  - The hospitals will begin to collect data on the number of orders that are not valid and the amount of time it takes to receive a valid court order.

- ESH and WSH report waitlist statistics weekly to each hospital's CEO and to the office of the Assistant Secretary of ADSA. The weekly report currently reflects the numbers of evaluations on the waitlist.
- The pre and post SSB 6492 implementation (May 1, 2012) waitlists are being reviewed in order to integrate the orders received after the implementation of SSB 6492 into the schedule and not extend the time frames for the orders received prior to implementation of SSB 6492.
- Regular performance and progress review meetings between supervisors and evaluators will occur.
  - WSH’s new Forensic Psychology Services Supervisor starts on September 17, 2012. The frequency of this meeting will be established after that start date.
  - ESH evaluators have bi-monthly meetings with their supervisor.
- Each discipline (psychology and psychiatry) meets regularly (at least bi-monthly) with their supervisor to review performance goals/expectations and any new issues/concerns.
- The forensic evaluators at ESH meet twice per month with the clinical director to review the status of each evaluator’s caseload, discuss developing issues and address any concerns/issues expressed by court personnel or evaluators as to procedures or newly identified trends.
  - The frequency of this meeting at WSH will be established once the new supervisor starts on September 17, 2012.
- Report this information to ADSA management?
  - Routine reporting to the Assistant Secretary of ADSA is planned as a standing agenda item at ESH/WSH quarterly Governing Body meetings (Assistant Secretary, CEO’s, and Medical Directors).
  - The frequency of these reports will be modified if necessary.
- What is ADSA’s plan to report this information to the Legislature and the public?
  - A report will be distributed through the Department’s Office of Policy and External Relations (OPER) to the State Office of Financial Management (OFM) and the Legislature.
  - ADSA will follow the Department’s procedure for reports to the Legislature and the public.
    - Each hospital will determine the contact person for the reports detailed in SSB 6492. These staff will create a unified report that will be submitted to the Assistant Secretary of ADSA for review.
    - Approximately ten weeks before the report is due to the legislature, the state hospitals will submit the draft of the report to the Assistant Secretary of ADSA for review. This review takes approximately two weeks and is then submitted to OPER for review. OPER has approximately eight weeks to review and submit the report to the legislature.
    -

**Objective #2: Establish quality and productivity standards for DSHS staff who perform competency evaluations and determine how these standards will be used.**

Statute requires ADSA to “*establish written standards for the productivity of forensic evaluators and utilize these standards to internally review the performance of forensic evaluators.*”

- What is ADSA’s plan to establish productivity standards for evaluators?
  - Productivity standards were established prior to the passage of SSB 6492 by means of using a time study and discussions with evaluators.
  - Evaluators are aware of productivity standards as they are all incorporated into their Position Description Forms (PDF).
  - PDF’s were revised and updated to include this requirement effective May 1, 2012.
    - All evaluators reviewed and signed the updated PDF.
  - The expected productivity for the evaluations and risk assessments is nine to 10 per month at ESH, and 10 per month for newly hired evaluators (training) and 12 per month for senior evaluators at WSH.
    - These productivity measures are subject to prorating for approved leave, long commutes to jails for evaluations, extensive court testimony and the preparation required for a specific case, or other assignments of a time sensitive nature.
- How will ESH and WSH incorporate these productivity standards into evaluators’ performance evaluations?
  - Supervisors will take necessary action to assure productivity targets are met. Staff will be managed with the intent of meeting targets. Data will be analyzed routinely to make sure the targets are reasonable.
  - The supervisors routinely monitor staff to ensure that productivity expectations are met and will take appropriate action to address identified issues.
  - Supervisors will specifically address productivity standards in the Performance Development Plan (PDP). The PDF contains a detailed list of essential job functions, including performance expectations. The PDP contains a detailed list of individualized work expectations for each employee, including the expectations for completion of competency evaluations. PDFs were revised in July for all ESH psychologists providing forensic evaluation services to include the productivity standards. PDPs will be completed for all hospital staff in October 2012, and will include the number of assessments/reports completed monthly for each evaluator. If a particular forensic evaluator does not meet performance expectations as outlined in his/her PDF, the supervisor will work with that employee to develop an individualized plan of correction, determine ways to reduce barriers to productivity, and implement. If the employee is unable to follow through on the individualized plan of correction, the supervisor will follow steps of discipline as appropriate and consistent with the Collective Bargaining Agreement.

Statute requires that efforts to meet the timelines do not “*diminish the quality of competency services.*” What is ADSA’s plan to:

- Define a quality competency evaluation?
- Determine the current quality of competency evaluations to establish a baseline?
- Assure that the quality of competency evaluations is maintained?
  - At this time there are no national standards of what constitutes a quality report; however, there are ethical standards that each evaluator will be expected to follow.
  - ADSA feels that at this time it is premature to define a quality competency evaluation, but will review appropriate research as it becomes available.
    - Currently, the University of Massachusetts Medical School is conducting both a meta-analysis and a review of each state’s competency evaluation practices with the goal of determining if it is possible or necessary to establish national standards.
    - ADSA has been in contact with the researchers of this study, and they anticipate that their results will be available by January 2013.
  - Specific report content areas are included in statute. In addition to that content, each evaluator holds a professional license and uses their professional judgment when determining what additional information is needed.
    - Identified trends for additional information requested in the evaluations will be discussed during supervision meetings.
    - The evaluators at ESH and WSH are committed to producing quality reports to maintain their integrity and standing with the Courts as expert witnesses.
  - ESH and WSH evaluators rely on their submitted report when testifying. Data will be captured, maintained and analyzed to see if evaluators are called to testify more often or spend longer time testifying.
    - This will be discussed in the regularly scheduled meetings with the evaluators and their supervisor.
  - The state hospitals will continue discussions with referral sources regarding their opinions as to the quality of reports.
  - The supervisors and senior evaluators will review all newly hired evaluators’ reports for quality.
  - Forensic evaluator supervisors also review a subset of all (new hires and established staff) forensic reports on an ongoing basis to maintain quality assurance and provide corrective action if reports are not meeting acceptable standards of practice.
  - Senior evaluators at WSH and ESH provide training on report writing, quality reports, professional standards, and testifying to new hires. This occurs on a weekly basis at WSH and as needed at ESH.
  - Prior to new evaluators conducting independent evaluations they spend time with current evaluators conducting evaluations, gathering/reviewing data and completing reports. The evaluations are reviewed by the mentor before submission to the Court. Meetings with the supervisor occur as needed to clarify issues and provide feedback on performance goals and targets.
  - The hospitals will continue to rely on customer’s feedback (the Court, attorneys, etc.) by attending already established meetings with referral sources.

- A baseline is established by the supervisor who will review individual reports on a continual basis.

**Objective #3: Monitor defendants’ lengths of stay in state hospitals related to evaluation and competency restoration and facilitate their discharge in a timely manner.**

Statute requires DSHS to “develop, document, and implement procedures to monitor the clinical status of defendants” to discharge defendants for whom clinical objectives have been achieved “before expiration of the commitment period.” The [agency’s fiscal note](#) stated that “there may be some reduction in the average length of stay for evaluation and restoration patients once documented procedures are solidified.” What is ADSA’s plan to:

- Monitor defendants’ length of stay?
- Assure that defendants leave as soon as is clinically possible?
  - ESH and WSH forensic services administrative staff schedule discharge and transport by jail personnel at the time of admission for competency evaluations. If less than 15 days is needed, transportation back to the jail is rescheduled for an earlier date.
  - For patients on competency restoration status, a new process has been implemented to review the patient’s progress in the restoration program twice monthly. This discussion is between the clinical staff providing competency restoration classes and the attending psychiatrist. The opinions are documented and data entered into a database by forensic services administration staff. Once the attending psychiatrist has determined the patient has become competent, the evaluator is notified and evaluates the patient to determine if competency has in fact been restored. Once restoration is complete, the forensic services administrative staff schedule discharge and the evaluator completes and submits a report to the Court.
  - Data in the future will be used to see if there have been decreased lengths of stays due to 45 day vs. 90 day initial competency restoration periods for some patients (SSB 6492). Data will be collected and will show median and average lengths of stay. Once sufficient information has been gathered the Compliance Officer (ESH) and CFS Management Analyst, Admissions Coordinator and Forensic Psychology Supervisor (WSH) will review monthly and report to the CEO. These reports can be used for staffing, caseload forecasting, bed capacity forecasting, etc.

This is how the hospitals may be able to determine if there has been some reduction in the average length of stay for evaluation and restoration patients.

