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

Competency to Stand Trial, Phase II:
DSHS Has Not Met Performance Targets – Better Management and Analysis Could Help It Do So

Report 14-1

April 23, 2014

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Committee Action to Distribute Report

On April 23, 2014, this report was approved for distribution by the Joint Legislative Audit and Review Committee.

Action to distribute this report does not imply the Committee agrees or disagrees with Legislative Auditor recommendations.

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STATE OF WASHINGTON

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REPORT SUMMARY

DSHS Provides Services Related to Defendants' Competency to Stand Trial

Federal and state policies are intended to prevent the prosecution of defendants who are not mentally competent to stand trial. If a defendant's competency is raised as an issue in a criminal or civil case, the court suspends the trial so that the defendant's competency can be evaluated.

Competency evaluations are usually performed by psychologists from the Department of Social and Health Service's (DSHS) Western State Hospital or Eastern State Hospital. The initial evaluations can take place in a local jail, at one of the hospitals, or in a community setting such as an attorney's office.

Following this initial evaluation, a court may find that a defendant is not competent to stand trial and may direct that the defendant be admitted to one of the hospitals for competency restoration. Restoration involves services, such as medication management, that attempt to restore the defendant to competency to resume the trial. Once the treatment team believes competency has been restored, the defendant receives a follow-up evaluation.

If the defendant needs to be admitted to one of the hospitals for an evaluation or for competency restoration services, the defendant may have to wait for a hospital bed to become available.

2012 Legislature Set New Targets to Expedite the Competency Evaluation Process

DSHS reports that the number of referrals for competency evaluations has increased over time to approximately 3,000 initial referrals in 2012. This increase has raised concerns about the amount of time defendants spend waiting in jail or in the community for an evaluation.

In 2012, the Legislature passed a bill intended to sustainably improve the timeliness of services related to competency to stand trial (SSB 6492). The Legislature set the following specific targets for the completion of outpatient competency evaluations and admission to the state hospitals:

- In jail setting, completion within 7 days;
- In community setting, completion within 21 days; and
- Defendants' admission to state hospitals within 7 days for an initial evaluation or restoration.

The legislation also directed the Joint Legislative Audit and Review Committee (JLARC) to complete two performance assessments of DSHS's implementation of the bill. JLARC released the Phase One report in December 2012, which addressed DSHS's plans for meeting the requirements in SSB 6492. This report is the second of the two reviews and focuses on results.

DSHS Is Not Meeting the Targets for Competency Services

DSHS is not consistently meeting the performance targets for competency services, as intended by statute. DSHS is also not consistently meeting its assumed evaluator staffing and productivity levels. In response to the 2012 JLARC audit, the agency developed a plan to meet the 2012 legislative requirements, but DSHS has not completed implementation of the plan. The agency has also struggled to provide accurate and timely performance information.

Analysis of Existing Data Can Help DSHS Determine the Best Strategies for Reaching the Targets

DSHS has not completed the basic planning and analysis necessary to identify the best approach to meet the targets. This report identifies the kinds of analyses the agency can undertake to help identify the best path forward. These analyses can identify and address internal capacity and workforce issues, external factors, and strategy effectiveness. In several instances, JLARC staff are providing the initial analysis to aid in the process. One key analysis that needs to be completed is to compare the current service delivery approach to other options.

No Mechanism Ensures a Defendant's Movement through the Competency Process in a Timely Manner

JLARC's December 2012 report pointed out that the competency to stand trial process involves more parties than the state psychiatric hospitals. In Phase Two, JLARC staff reviewed court and hospital data to provide a more complete picture of defendants' experiences. We identified impacts other parties have on the competency process, the varied responses of Washington counties to address their own concerns with the process, actions other states have taken to improve the timeliness of the competency process and recommended best practices from the National Judicial College (NJC).

Legislative Auditor Recommendations

The Legislative Auditor makes five recommendations. Three recommendations are intended to help DSHS meet statutory requirements and accurately assess and effectively manage its resources. Two recommendations are intended to improve coordination and communication among system partners to improve the delivery and efficiency of competency services.

1	Improve performance reporting
2	Develop and implement a service delivery approach and staffing model to meet the targets
3	Address non-compliance with statutory requirements
4	Improve collaboration between key system partners
5	Establish ongoing training

PART ONE: DSHS PROVIDES COMPETENCY EVALUATION AND RESTORATION SERVICES

Competency evaluations are intended to prevent the prosecution of mentally incompetent defendants. The Joint Legislative Audit and Review Committee's (JLARC) Phase One report from December 2012 has more information about competency evaluation requirements in state statute and federal case law.

Nearly Ninety Percent of Competency Orders from 2012 Were for an Outpatient Setting

If a defendant's competency is called into question, the court suspends the trial and orders a competency evaluation. State statute allows county courts to pay for and appoint an evaluator or request an evaluation from the Department of Social and Health Services (DSHS). DSHS does not bill the courts for the competency services, all of which are funded through the General Fund and paid for by DSHS. These services are provided without a contract from DSHS that might include provisions such as penalties for delays or cancelled evaluations. Currently, the courts dictate the terms and conditions of the services.

The court order determines whether the evaluation takes place in an *inpatient* setting (e.g. in one of the hospitals) or an *outpatient* setting. For a defendant in custody, outpatient evaluations are conducted in the county jail where the defendant is 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.

A court may refer a defendant for an inpatient evaluation at one of the hospitals if the court 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 staff. 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.

Nearly 90 percent of the 2,939 competency evaluation orders to DSHS in 2012 were for evaluations in an outpatient setting.

DSHS Evaluators Are Based at the Hospitals and Travel to Outpatient Settings

DSHS's Behavioral Health and Service Integration Administration (the Administration) administers competency services. The Administration is responsible for mental health services in both the community and the three state psychiatric hospitals – Eastern, Western, and the Child Study and Treatment Center.

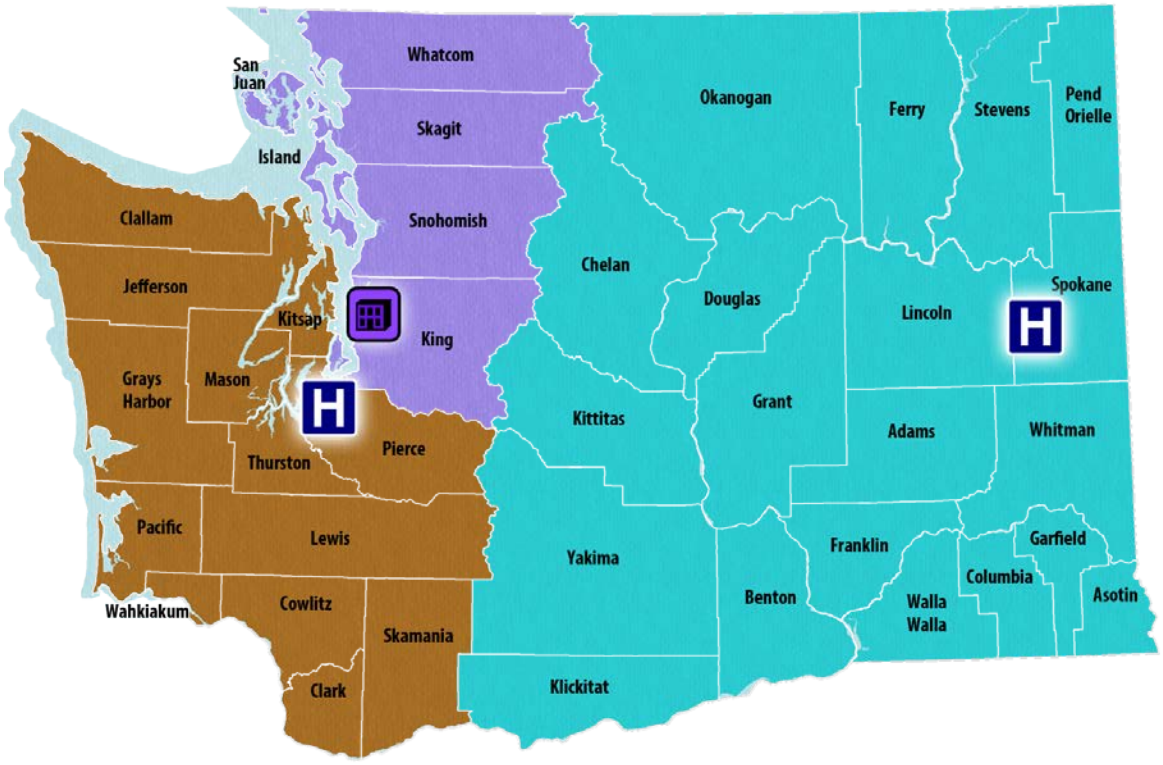
The Administration's evaluators who conduct competency evaluations for adults work at, or are based out of, Western State Hospital (Western) in Lakewood or Eastern State Hospital (Eastern) in Medical Lake, with the exception of some Western evaluators located at a satellite office in King County. According to the Administration, approximately 23 percent ($25.8 million) of Eastern's

budget and 20 percent ($61.7 million) of Western's budget in the 2011-13 Biennium were for the provision of competency services to the courts. These services include inpatient and outpatient evaluations and restoration. Competency restoration involves a team comprised of a psychiatrist, social worker, and nurses who attempt to restore the defendant to competency using approaches such as medication management and education on the judicial process. Once the team believes the defendant is competent or before the defendant's court ordered period of restoration expires, another competency evaluation is conducted.

The Administration's current service delivery model is to base its evaluators out of these three hubs, then have outpatient evaluators drive from these hubs to the county outpatient settings (jail or community). Exhibit 1 shows the counties served by the two hospital hubs and the King County satellite office, with the following exceptions.

Outpatient evaluators based out of Western State Hospital regularly drive to King County and Clark County to evaluate defendants released on their own recognizance or on bail in a community setting. However, similarly categorized defendants located in the other counties west of the Cascades are required to travel to Western for their evaluations. Western's satellite office houses outpatient evaluators who conduct only jail evaluations in King County and counties north.

Exhibit 1 – Current Approach Requires Evaluators to Travel Far Distances



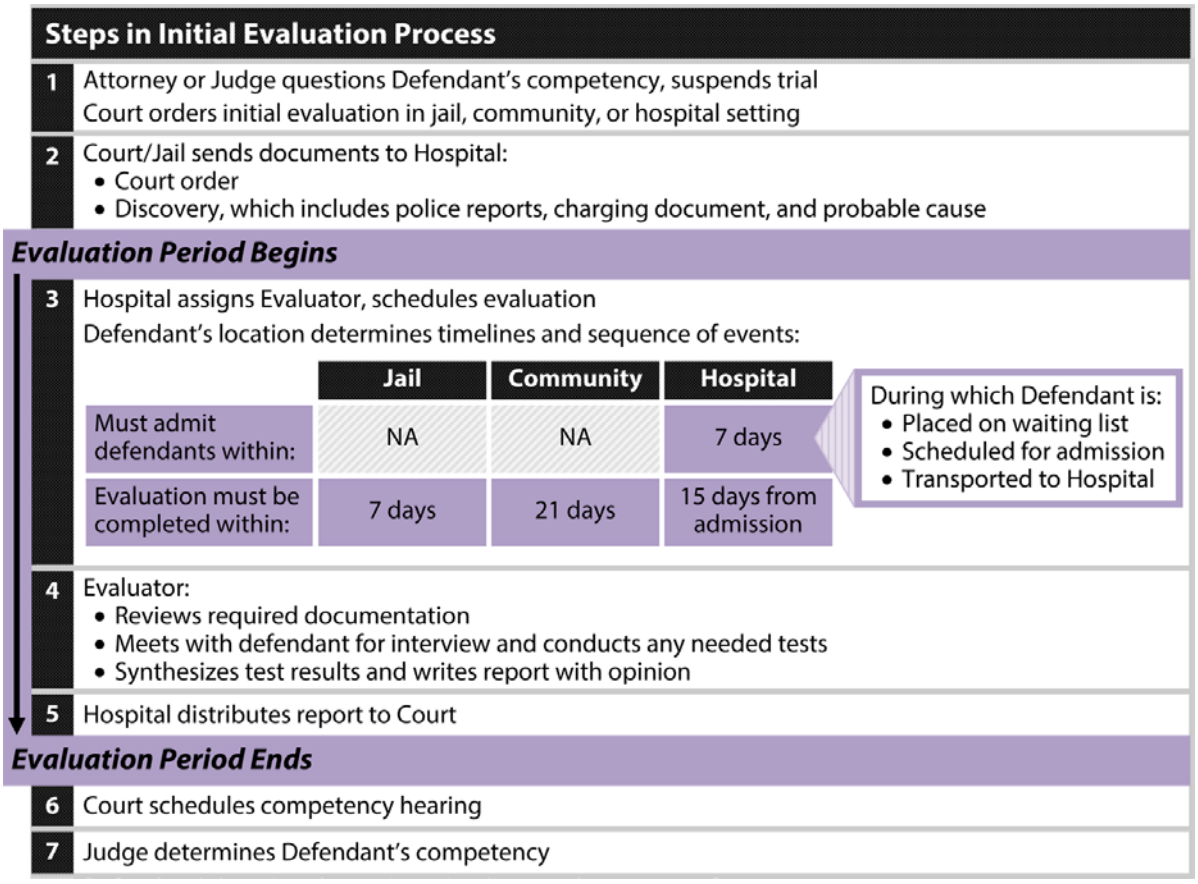
Source: JLARC analysis of DSHS information

Other Parties Can Affect the Timeliness of Competency Evaluations

While DSHS's actions can impact the timeliness of competency evaluations, they are not the only party that can do so. County courts and jails, attorneys, and the defendants themselves all have a role in the timely completion of competency evaluations. However, delays may be necessary, and may benefit the defendant, the court, or DSHS to ensure an accurate evaluation.

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 the competency of that individual. JLARC staff summarized this process into seven steps as displayed in Exhibit 2.

Exhibit 2 – Many Parties are Involved in the Defendants' Competency to Stand Trial Process



Note: Chart provides summary overview of competency process. Individual cases may vary.

Source: BHSIA information analyzed by JLARC staff.

If the judge determines that a defendant is competent at the end of the initial competency evaluation process, the trial resumes. If not, the defendant's next steps depend on the charges against the defendant. For a non-serious misdemeanor charge, the judge may dismiss the case or refer the person for an evaluation for civil commitment under the Involuntary Treatment Act. For a serious misdemeanor or felony charge, the judge may order a period of competency restoration at either Eastern or Western. Depending on the charge, a defendant may be eligible for a period of restoration between 14 days and a year. If a defendant's competency is not restored after this time, the judge may refer the person for a civil commitment evaluation.

PART TWO: DSHS IS NOT MEETING THE PERFORMANCE TARGETS FOR COMPETENCY SERVICES

The 2012 legislation established three new performance targets setting a limitation on the amount of time the Behavioral Health and Service Integration Administration (the Administration) should take to complete competency evaluations in jails and in the community and to admit a defendant to a hospital. The Administration is not consistently meeting the performance targets in statute, is not fully meeting its three key assumptions that supported its conclusion that it could meet the targets, and is not fully implementing its plan to reach the targets. We discuss these findings below. Part Three of this report discusses efforts the Administration can undertake to reach the performance targets.

The Administration Is Not Meeting the Statutory Performance Targets

The 2012 legislation called for the Administration to meet performance targets for completing evaluations in jail (7 days) and admitting defendants to the state hospitals (7 days) by November 1, 2012. Based on our review of hospital data from November 1, 2012, through April 30, 2013, neither hospital has consistently met these performance targets as shown in Exhibit 3.

Exhibit 3 – The Administration is Not Consistently Meeting Performance Targets for Hospital Admissions or Completing Jail Evaluations

Hospital Admissions (11/1/12 through 4/30/13)						
	Number of defendants admitted		% of defendants admitted to hospital within 7 days		Average days until admission	
	Evaluation	Restoration	Evaluation	Restoration	Evaluation	Restoration
Western	91	310	14%	30%	29	15
Eastern	28	49	11%	35%	50	17

Jail Evaluations (11/1/12 through 4/30/13)			
	Number of evaluations completed	% of evaluations completed within 7 days	Average days until completion
Western	792	13%	19
Eastern	136	1%	33

Source: JLARC staff analysis of hospital data.

As a reminder, performance targets for completing community evaluations (21 days) did not begin until May 1, 2013. Given our study timeframe, we were not able to analyze data beyond April 30, 2013. Based on JLARC staff analysis of the Department of Social and Health Services (DSHS) data from November 1, 2012 through April 30, 2013, both hospitals met the target less than fifteen percent of the time. The average time to complete a community evaluation was 143 days at Western and 54 days at Eastern.

The 2012 legislation requires DSHS to develop and implement procedures that allow state hospitals to discharge defendants for whom clinical objectives have been achieved and investigate the extent that defendants overstay time periods authorized by statute. During interviews with hospital staff and management, both hospitals reported they had not developed plans to do so.

The Administration Is Not Meeting Its Assumptions for Evaluator Staffing and Productivity and Does Not Know the Rate of Change in Referrals

In its fiscal note for the 2012 legislation, the Administration relied on three key assumptions to support its conclusion that it could reach the targets in the bill. As summarized in Exhibit 4, on the following page, the Administration is not fully meeting two of these key assumptions and does not have accurate information about the third.

Exhibit 4 – Assumptions to Meet Targets Are Not Being Met

DSHS Key Assumption	Actual Outcome	JLARC Staff Observations
Evaluator Staffing Levels (number of FTEs conducting evaluations)		
Western: 24 evaluators	Western: 22 evaluators. Western was unable to confirm what happened to two FTEs, but it is believed that hospital management reallocated these two positions to ward-based psychologists. There has also been high turnover in the group that conducts evaluations in the hospital.	The Administration has not analyzed whether the number of actual or assumed FTEs is appropriate.
Eastern: 6 evaluators	Eastern: 7 evaluators	
Evaluator Productivity (minimum number of completed evaluations by each evaluator per month)		
Western: At least 12 evaluations completed per month	Western: 13 of the 19 evaluators employed for all of January – June 2013 met the DSHS proposed monthly target of 12 completed evaluations.	The Administration cannot determine why assumptions are not being met, such as whether these are impacted by evaluators' other duties, types of cases assigned, and service area. Eastern management reported they were unaware that the Administration assumed its staff would complete 10 evaluations per month.
Eastern: At least 10 evaluations completed per month	Eastern: one of the seven evaluators met the DSHS proposed monthly target of 10 completed evaluations, based on 2012 data.	
Evaluation Referral Rates (number and type of referrals requiring evaluations - misdemeanor and felony)		
The number and type of referrals would continue to grow at an annual rate similar to previous years.	The Administration reports that data on referrals, prior to 2011, is unreliable. Therefore, it is not possible to determine whether the number of referrals has increased since 2011 and, if so, to what extent.	The Administration cannot replicate the data it provided to JLARC staff in 2012 and reports that some data was lost in the transition to a new database at Western. From 11/1/12 through 4/30/13, the Administration reports that counties made 1,247 initial referrals for evaluations.

Source: JLARC staff analysis of DSHS data.

Perhaps more importantly, the Administration does not know why it has been unable to meet the assumptions in the fiscal note. For example, the Administration has not determined whether it is appropriate to assume each evaluator can conduct 10 to 12 evaluations per month or whether other factors have changed to make this assumption impractical.

High Staff Turnover Rate in One Unit at Western Is Likely a Barrier to Meeting Targets

JLARC staff reviewed turnover rates at Eastern and at the three separate units within Western. There was no turnover at Eastern. However, at Western, there was higher turnover in the inpatient unit, as compared to the other units. The evaluators in the inpatient unit conduct competency evaluations for those defendants who have been referred by the courts for an initial evaluation or restoration services at the state hospital. This unit has lost 15 evaluators out of a total of 6.5 allocated FTEs in the past 4.5 years, as shown in Exhibit 5, below. This represents 75 percent of all evaluator resignations from Western in this time period.

Exhibit 5 – High Turnover in Western State Hospital's Inpatient Unit

Competency Evaluation Units at Western State	Allocated FTEs	FTEs that resigned between 1/2009 -7/2013
Inpatient Unit	6.5	15.0
Outpatient Unit: C-18 *Staff cover outpatient evaluations south of King County and out of custody evaluations for all of western Washington*	9.0	3.0
North Regional Office (satellite) *Staff cover jail evaluations in King County and counties north*	6.5	2.0
Total	**22.0**	**20.0**

Source: JLARC staff analysis of DSHS data.

High turnover likely impacts the Administration's ability to meet targets for a number of reasons: newer evaluators may not be able to initially complete as many evaluations as experienced staff, and temporarily unfilled positions result in the unit completing fewer evaluations and admitting fewer defendants into the hospital. According to Western management, the hospital had two vacant full time equivalent (FTE) evaluator positions for the inpatient unit for the first six months of 2013, which resulted in 20 vacant beds each month.

In the short-term, Western hospital management has assigned outpatient evaluators to complete inpatient evaluations on a rotational basis to assist with the high employee turnover. No long-term solution has been implemented to date.

The Administration's plan for addressing turnover, included in JLARC's Phase One report, contained strategies to increase evaluator pay and determine the feasibility of non-PhD evaluators completing forensic evaluations. Since the Phase One report, the Administration updated its plan to specifically address high turnover in the inpatient unit at Western. The updated plan notes that Western will participate in a "Lean project …to determine if a more decentralized staffing model would create more job satisfaction and decrease retention issues." The updated plan notes that "pay is not the sole reason for retention issues" at Western.

The Administration Has Not Completed Its 2012 Plan to Address the New Statutory Requirements

In JLARC's December 2012 report, DSHS formally responded to eighteen questions related to addressing statutory requirements and associated challenges that JLARC staff identified. DSHS reported that it had a plan, consisting of 41 separate actions, in place to meet the new requirements in statute and each of the challenges identified by JLARC staff.

In July 2013, the Administration provided JLARC staff with an update of its 2012 plan. The Administration reports that it has not implemented 19 of 41 actions from its plan. In light of the many actions not completed, the Administration noted that key leadership positions—CEOs at both hospitals—were vacant until August 2013.

Our review also identified a lack of clear communication between the Administration and the staff at the two hospitals about the plan. For example, statute requires the Administration to develop and implement procedures that allow state hospitals to monitor the length of stay in the hospitals and to release defendants as soon as clinically appropriate. One set of actions in the plan that the Administration provided to JLARC was intended to establish such procedures, and was reported as "completed" in its update. However, when we shared the Administration's plan with staff at Eastern, they reported they were unaware of the actions proposed in the plan. Administration staff were not aware that the hospitals had not performed work that was reported as complete in the update it provided to JLARC staff.

Performance Reporting Has Not Been Accurate or Timely

The 2012 legislation called for DSHS to establish "new mechanisms for accountability" which include the following two reports (RCW 10.77.068):

- An **annual report** that includes information on a) the timeliness of competency services, b) the timeliness with which courts provide completed referrals to DSHS, and c) performance by county; and
- A **quarterly report** if either state hospital does not meet the statutory targets. A quarterly report is to include a) the extent of the deviation from the particular target, and b) a description of corrective actions to improve performance.

In the course of our audit, the Administration released two quarterly reports describing Western's and Eastern's performance against the targets. The reports included information that was:

- **Inaccurate**–Totals provided by Eastern in the two quarterly reports cannot be replicated using data the hospital provided to JLARC staff. When asked, Eastern staff were unable to explain discrepancies in data;
- **Inconsistent**–The data reported is not consistent between the hospitals. In its first quarterly report, Western reported two months of data, while Eastern reported three months of data. In addition, the two hospitals are not using the same approach to calculate the time it takes to complete an evaluation; and
- **Delayed**–The Administration released its first quarterly report in September 2013, covering the quarter ending December 2012. The agency released its second quarterly report in October 2013, covering the quarter ending March 30, 2013.

Western is in the process of addressing an issue of concern identified in JLARC's Phase One Report and included improving data quality and data management at Western State Hospital in its 2012 plan. The Administration hired a Forensics Supervisor and a forensic data analyst, both of whom have responded to our data requests and are establishing consistent protocols for data entry at the three units that perform competency evaluations and restoration at Western. Additionally, the analyst has proposed a more complete reporting format. For this revised format to be useful, Western, Eastern, and the Administration must reach clear agreement on the purpose for the reporting and how best to accomplish it.

Recommendation

Legislative Auditor Recommendation 1

Behavioral Health and Service Integration Administration should provide accurate, consistent, and timely reporting on the number of defendants referred for competency evaluations, the number of evaluations completed, the timeliness of completing those evaluations, and timeliness in admitting defendants to the hospitals.

For additional detail concerning the recommendation, see Part Five of this report.

PART THREE: ANALYSIS OF EXISTING DATA CAN HELP DSHS DETERMINE THE BEST WAY TO REACH THE PERFORMANCE TARGETS

The Legislature intended for the Behavioral Health and Service Integration Administration (the Administration) to meet the targets whenever possible and to ***"manage, allocate, and request appropriations for resources in order to meet these targets."*** While the Administration has not met the performance targets, it has also not done the basic planning and analysis necessary to identify the best approach to meet the targets. Part Three provides examples of the kinds of analysis that can help the Administration identify the best approach.

These examples are provided to illustrate the type of analysis that could be performed. They are not meant to be inclusive of all suitable analyses. The Administration could also pursue other approaches.

The Administration Needs Better Information to Develop Strategies to Reach the Targets

The Administration needs to develop strategies linked to the targets in statute. The Office of Financial Management (OFM) provides guidance to agencies in developing such strategies. In its guidance to state agencies on strategic planning, OFM identifies factors to consider in strategy development. We summarized OFM's factors to provide a framework for analyses that can help the Administration. These key factors are: examine existing internal capacity and workforce issues, examine external factors, and analyze strategy effectiveness. Using these three factors as a framework, Exhibit 6, on the following page, provides examples of analyses that can help the Administration determine the best way to reach the performance targets for competency services.

Exhibit 6 – Analysis Required for Strategic Planning Could Help the Administration Develop Data-Driven Strategies to Meet Targets

OFM Strategic Planning Factor	Analyses to Help Identify the Best Approach to Meet the Competency Services Performance Targets
Examine existing internal capacity and workforce issues	♦ Assemble a detailed profile of the work the evaluators are currently accomplishing ♦ Assess the quality and consistency of evaluator reviews ♦ Review differences in how the staffs at Western and Eastern provide competency services ♦ Review communication challenges between headquarters and hospitals
Examine external factors	♦ Examine trends in the setting where the competency evaluations take place (hospital, jail, or community) ♦ Review referral trends by county ♦ Analyze the impacts of repeat referrals (courts referring the same defendant for multiple evaluations) ♦ Review the early use of new county authority to appoint third party experts to conduct competency evaluations
Analyze strategy effectiveness	♦ Develop budget information on the cost of providing competency services ♦ Compare the current service delivery approach to other options ♦ Analyze whether differences in practices and trends align with the differences in the timeliness and quality of evaluations

Source: JLARC staff analysis of OFM's Strategic Plan Guidelines and DSHS data.

OFM Guidance: Examine Internal Capacity and Workforce Issues

Assemble a Detailed Profile of the Work the Evaluators Perform

To determine the best approach to deliver competency services and meet the targets, the Administration has to understand and analyze the work that evaluators are currently performing and determine how long it takes to complete that work. Lacking this type of analysis, it is not possible to determine the extent to which the Administration can meet the targets with existing resources.

Among other items, this profile could include:

- **Data collection and management** such as historical data, types of cases, number of evaluations conducted, evaluator experience levels, and time spent on specific tasks or processes;
- Evaluator **service area** and the amount of time in travel;
- **Alternate approaches** to completing the work such as housing the evaluators at locations other than the two state hospitals and the use of other forensic resources within DSHS such as evaluators at the Special Commitment Center;
- Necessary **administrative support**; and
- **Accountability measures** for individual competency evaluators, such as an analysis of production targets.

JLARC staff interviewed 13 evaluators (six from Eastern and seven from Western), representing approximately 46 percent of all evaluators, to ask questions about their experiences as competency evaluators since the passage of SSB 6492 and to understand their perspectives on what is and is not working with the service delivery process. We found differences between the hospitals in the work required of evaluators. There are at least 17 different required tasks to complete an initial competency evaluation from referral to report sent to the court. Of these tasks, 53 percent are handled differently between the two hospitals and some equate to additional administrative requirements for evaluators at Western. For example, evaluators at Western are required to schedule the interviews and request additional supplementary information when needed. Evaluators identified several issues that directly affect their work and productivity, such as the time it takes to obtain medical records and the availability of interpreter service at Western. Appendix 4 provides additional details of the evaluators' experiences.

Assess the Quality and Consistency of Evaluator Reviews

In meeting the targets, the Legislature made clear that it did not want the quality of evaluations to diminish. We identified opportunities for the Administration to improve its delivery of competency services in two areas: quality and consistency.

Although there is not a single national standard for quality, practices of other states offer examples. One indicator of quality used by other states is evaluator consistency, comparing the percentage of defendants found competent and incompetent between evaluators and regions. We reviewed evaluation outcomes among Washington's evaluators and found variation between the two hospitals, within hospitals, and between evaluators working in the same unit. This information is not routinely reviewed by the Administration or hospital management.

In addition to monitoring rates of competency, other states reported alternative approaches to ensure consistency and monitor quality:

- Ohio has a peer review process to examine the quality of evaluations. A sample of reports from each of its ten community forensic psychiatry centers are exchanged between the directors for their review.
- Oregon requires evaluators to be state-certified. To maintain certification, evaluators must send three reports to a statewide commission each year and must be recertified every two years, which includes on-going training.

Washington's evaluators also report that they conduct *informal* peer reviews of one another's work and noted that they measure their own quality by the feedback, when provided; from the courts, who request the evaluations; and from mental health professionals in the community who reference the reports.

Establishing a measure of competency evaluation quality is critical for ensuring state dollars are spent effectively, especially in light of legislation enacted in 2013 that allows private evaluators to conduct evaluations in certain circumstances (SSB 5551).

Review Differences in How the Hospitals Provide Competency Services

There are differences in how the two hospitals operate their competency evaluation and restoration services. These differences could have an impact on service delivery, staff productivity, and data reporting. Identifying and addressing differences between the hospitals, if needed, provides at least three benefits. The Administration can:

- Assess whether a practice at one hospital should be adopted by the other;
- Provide accurate performance reporting; and
- Treat defendants in different areas of the state consistently.

One example of differences between the hospitals is seen with administrative staff duties. At Eastern, administrative staff handle duties like scheduling interviews and obtaining additional information such as medical records, rather than the evaluators. At Western, the evaluators perform these administrative tasks themselves. Appendix 3 provides additional examples of differences we observed and the types of questions Administration management might consider.

Review Communication Challenges Between Headquarters and Hospitals

Some of the problems we observed in Part Two of this report are likely the result of communication challenges between the hospitals and headquarters staff. This was also likely a factor in completing actions from the Administration's 2012 plan and providing accurate performance information. For example, information in the plan that hospitals reported as "completed" had not been implemented. Analyzing the communication and coordination between the hospitals and headquarters may encourage the Administration to develop clear lines of authority and improve the clarity of roles and responsibilities.

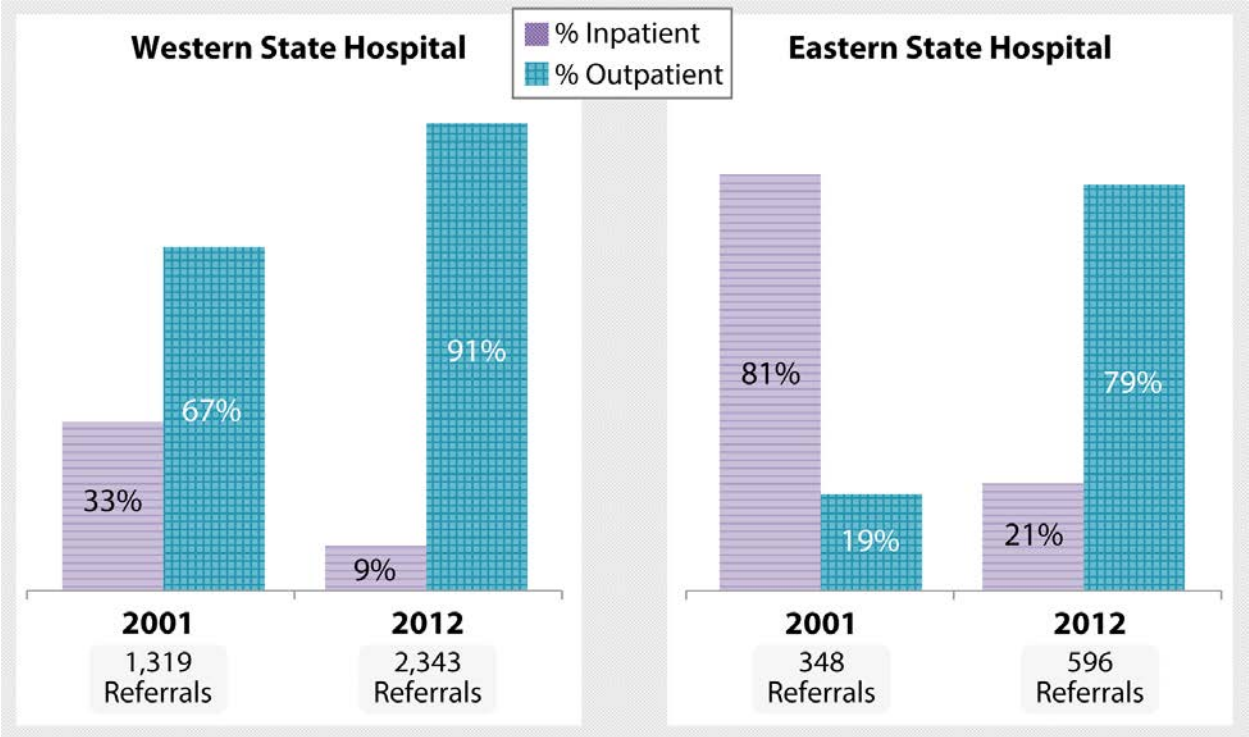
OFM Guidance: Examine External Factors that Affect the Ability to Achieve Goals and Performance Targets

Examine Trends in the Setting Where the Competency Evaluations Take Place

A court order determines the location of where the competency evaluation will take place. However, if the court orders an outpatient evaluation, the evaluator can determine that an inpatient evaluation is necessary.

Most referrals for competency evaluations in 2012 were for outside of a hospital setting (91 percent at Western and 79 percent for Eastern). The percentage of evaluations referred for jails or the community has increased at both Eastern and Western since 2001, as seen in Exhibit 7. Absent information on the evaluators' time spent in transit, it is not possible to determine the efficiency of the current approach. There is no requirement for the evaluators to be stationed in the hospitals.

Exhibit 7 – Evaluations Increasingly Referred Outside of Hospitals



Source: JLARC analysis of DSHS data.

Review Referral Trends by County

The Administration could review referral trends by county to help management focus limited resources, communicate with counties, and identify possible opportunities for training.

Other states use referral data, by jurisdiction, to communicate with counties to understand why referrals are increasing and provide training or discuss diversion options, if necessary. We estimated changes to referrals by county, using hospital data. Benton County experienced a 37 percent increase and Snohomish County experienced a 30 percent increase in referrals between 2011 and 2012. This information could provide management with an opportunity to focus communication with specific counties, understand the reasons for an increase, and determine whether training might be needed.

Analyze Impacts of Repeat Referrals

The Administration could review the impact of defendants referred for multiple evaluations to help management work with counties to identify diversion opportunities, if appropriate.

Courts that refer defendants for multiple evaluations can have a significant impact on some counties' referral totals, which directly impact county and state resources. Using hospital data, we estimated that in King County, 29 percent of the people referred for misdemeanor evaluations account for 51 percent of misdemeanor referrals for the county since 2011. For illustrative purposes, if each of the 359 individuals referred for multiple evaluations only had one evaluation over that time period, King County's referral totals would decline by 572 referrals, which is roughly equivalent to the output of two full-time evaluators over two years' time.

Review Early Use of County's Appointment of Experts to Do Evaluations

The Legislature passed a bill in 2013 (SSB 5551) that allows counties to seek reimbursement from DSHS for the cost of appointing a private evaluator to complete a competency evaluation for a defendant in jail. The county can seek reimbursement if DSHS does not meet its seven-day performance target for at least 50 percent of defendants in the county during the most recent quarter. Reviewing the results of early implementation could be helpful in reviewing other service delivery approaches; specifically, to determine whether a market exists for contract evaluators to assist with spikes in referrals, and whether the quality and timeliness of contract evaluations is sufficient to meet the needs of courts and the state.

OFM Guidance: Analyze Strategy Effectiveness

Develop Budget Information on the Actual Cost of Providing Competency Services

For the Administration to accurately determine the cost and efficiency of its current approach and to identify the best way to deliver competency services and meet the targets, it needs sound fiscal information it can analyze and provide to others.

Both hospitals have civil and forensic units. The forensic units serve individuals who are not guilty by reason of insanity as well as defendants who receive competency evaluations and restoration. The Administration cannot readily provide detailed fiscal information on competency services which include outpatient and inpatient evaluations and restoration because it does not budget competency services separately. Therefore, it estimates that in the 2011-13 Biennium, the forensic services budget for the two hospitals was $137.7 million, representing 33 percent of the hospitals' budgets. The Administration further estimates that $87.5 million, or 63 percent, of the forensic services budget is for competency services ($25.8 million for Eastern and $61.7 million for Western).

These estimates are problematic for determining the efficiency of the current approach and for conducting a comparative analysis with other approaches. For example, the Administration based its estimate of forensic and competency services on the percentage of beds dedicated to the various forensic patients. However, this is not an accurate representation of all competency services. The method does not account for management and support staff costs that are dedicated solely to competency services such as the supervisor, data analyst, and administrative and clerical staff.

While this approach may work for other hospital services, it does not align with the work conducted by competency evaluators. Using this method to estimate fiscal information for competency services, the Administration cannot accurately determine the cost and efficiency of its current approach or compare it to other approaches.

Compare the Current Service Delivery Approach to Other Options

For the Administration to determine the best approach to meet the targets, it should reassess its current approach to conducting evaluations across the state which includes housing its evaluators in three locations: Eastern, Western, and Seattle (satellite office). There is no requirement for the Administration to house evaluators at state hospitals.

The identification of alternative options and the comparison would need to take into account information such as:

- What the Administration learned about external factors, such as the shift to outpatient evaluations;
- Referral trends in individual counties, and
- Internal capacity and workforce issues, including the detailed profile of evaluators' work and the differences in how the staffs at the two hospitals provide services.

Housing evaluators somewhere other than at the hospitals may improve retention and may reduce evaluators' time spent travelling to evaluation sites. Due to a lack of data and analysis, neither the hospitals nor the Administration can report whether the current approach is the best approach.

Analyze Whether Differences in Practices and Trends Align with the Differences in the Timeliness and Quality of Evaluations

We observed several differences between the two hospitals and how they deliver competency evaluation services. These differences may impact the hospitals' ability to meet the targets and the quality of the evaluations. Examples of differences include whether key activities are performed by evaluators or hospital administrative staff, varying methods to calculate evaluator productivity, and differing approaches to data collection and reporting. Additional examples of our observations are provided in Appendix 3. Reviewing the impact of these differences may identify efficiencies that the Administration can implement to improve service delivery.

Recommendations

As noted, DSHS has not yet completed the work to identify the best strategy to meet the targets. Given that, we make the following recommendations:

Legislative Auditor Recommendation 2

After collecting and analyzing descriptive data about its current operations, the Department of Social and Health Services should hire an independent, external consultant to develop 1) a service delivery approach that enables the Administration to meet the statutory targets, and 2) a staffing model to implement the new approach.

The consultant should use the following information, at a minimum, to inform development of the staffing model:

Information about evaluators' work:

- Basic elements about the work being done by evaluators including, but not limited to the number of referrals, service area, type of case, other assigned tasks, and experience of individual staff
- Time from evaluator assignment to completed evaluation and reasons for delays
- Number of hours evaluators spend completing competency evaluations (including review of information, interview, analysis, and report writing), travel time, and time spent completing administrative work

- Points of comparison, historical workload, variations and trends by location, costs per staff, and travel costs
- Availability of other DSHS resources, such as evaluators employed at the Special Commitment Center

Factors beyond the competency evaluation:

- Administrative support and duties
- Time from receipt of court order to completed referral and reasons for delays
- Time from completed referral to evaluator assignment and reasons for delays

Costs per full time employee (FTE):

- Salary, benefits, support services, and travel costs
- Evaluation of the feasibility of, and any benefits that may accrue through, shared services between the hospitals such as fiscal, data analysis, and information technology
- Number of hours spent completing competency evaluations compared to time spent travelling to counties and time completing administrative work such as scheduling evaluations with courts

Parts Two and Three of this report identified additional requirements in statute that the Administration has not addressed, such as ensuring that the quality of evaluations does not diminish and that the Administration manage, allocate, and request appropriations for resources to meet the targets. Given our findings we offer the following recommendation:

Legislative Auditor Recommendation 3

Behavioral Health and Service Integration Administration should take actions to comply with additional statutory requirements from SSB 6492.

For additional detail concerning these recommendations, see Part Five of this report.

PART FOUR: NO MECHANISM ENSURES A DEFENDANT'S TIMELY MOVEMENT THROUGH THE COMPETENCY REFERRAL, EVALUATION, AND RESTORATION PROCESS

JLARC's December 2012 report highlighted that the competency to stand trial process involves more parties than the state psychiatric hospitals. In Phase Two, JLARC staff reviewed other parties' impacts on the competency process, actions taken by Washington counties, practices from other states, and recommendations from the National Judicial College (NJC) for best practices related to competency to stand trial services.

Even though there is no mechanism to ensure a defendant's timely movement through the competency process, available data provides insight into defendants' experiences and there are promising practices from Washington's counties and other states that may provide alternative service delivery options. The recommendations from the NJC may provide ideas for additional collaboration between the parties involved in the competency process.

Review of Court and Hospital Data Provides a More Complete Picture of Defendants' Experiences

To provide a more comprehensive perspective of defendants' experiences in the competency process, JLARC staff matched a sample of client data from the state hospitals with court data. Appendix 6 includes details on the approach we used to obtain the sample. The work to align defendant data from hospital and court sources may be the first effort to quantify defendants' experiences before and after an evaluation is referred to and completed by DSHS. The sample data begins with the date the court orders a competency evaluation (i.e. referral) and ends with the court's determination of competency. Appendix 5 provides a graphic display of this process, from referral to initial competency hearing for outpatient referrals. This chart also represents the steps in the process we discuss in Part Three, highlighting the differences between the hospitals' outpatient competency processes.

Using the sample data, we performed two analyses: review of selected case studies and analysis of a statistical sample of aggregated data. These analyses led to three key findings:

1	The complexity of the competency process highlights the importance of all parties' cooperation and coordination in order for a defendant to move through the system in a timely manner.
2	Analyzing data on the defendants' experiences can help identify where delays occur and common case characteristics, and provides the opportunity to develop strategies for an efficient service delivery approach.
3	While our effort to align court and hospital data provides insight into defendants' experiences, there are additional questions we could not address in this study that may merit further review, but require additional data.

Case Studies Highlight the Complexity of the Competency Process

JLARC staff reviewed, in detail, five individual cases to better understand defendants' experiences in the competency process, where delays occur, and what causes them. Our case studies sought information related to the entire process in addition to the part of the process that is tracked—statutory timelines for DSHS. The complexity of the competency process highlights the importance of all parties' cooperation and coordination in order for a defendant to move through the system in a timely manner.

Delays can occur at any point in the competency process from the initial court referrals through the competency hearing and beyond. However, delays may be necessary and may benefit the defendant, the court, or DSHS to ensure an accurate evaluation. Because delays do occur, it is helpful to understand why they occur, as there may be opportunities for the parties involved to identify process improvements or share best practices to circumvent some of the delays.

Five cases illustrate the impact key parties can have in the competency process. These cases are not meant to be representative, but they do highlight how delays can arise due to:

- Time involved with evaluator travel to conduct interviews in county jails and community settings;
- Court processes related to receiving and recording completed evaluation reports and scheduling of competency hearings;
- Consistent and timely communication and coordination between the parties involved (jail, attorney, and hospital);
- Attorneys' schedules and preferences for the assignment of certain evaluators or a delay in the evaluation; and
- Defendants' preferences for attorney's presence at the interview.

Details on the case studies are included in Appendix 6.

Sample Data Provides Insight into Defendants' Experiences in the Competency to Stand Trial Process

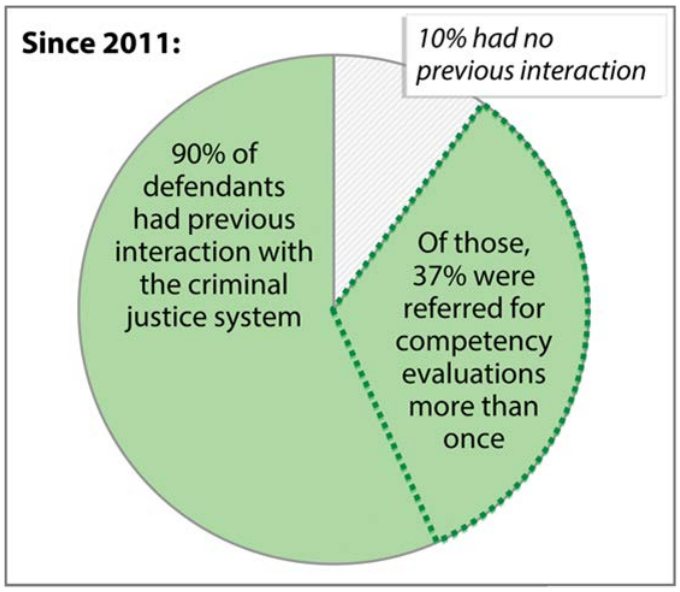
Analyzing data on the defendants' experiences can help identify common case characteristics that contribute to delays, and provides the opportunity to develop strategies for an efficient service delivery approach. The Administration and other parties may want to search for answers to questions this type of information raises such as: Are there opportunities to divert some of these defendants that are known to the courts? Are there opportunities for collaboration, communication, and education between the parties involved? We discuss additional promising practices beginning on page 27.

Based on our sample of available data, we can report on six aspects of defendants' experiences:

1. Most defendants referred for evaluations have prior experience with the criminal justice system. Ninety percent of the defendants had prior interaction with the criminal justice system. Thirty seven percent have been referred for a competency evaluation more than once since 2011.

As Part III describes, defendants referred for multiple evaluations can significantly impact counties' referral totals, which directly impact county and state resources. Some counties that we interviewed

described diversion programs as an alternative for defendants who have been seen by a court on multiple occasions. Reviewing counties' policies on alternative approaches may identify best practices that could be replicated in other counties. Reviewing that and other differences between counties, such as the number of cases dismissed, length of time defendants spend waiting for a competency hearing, or the length of time defendants spend waiting for a county to assemble necessary information for a completed referral may provide educational opportunities for counties, and foster the sharing of best practices.



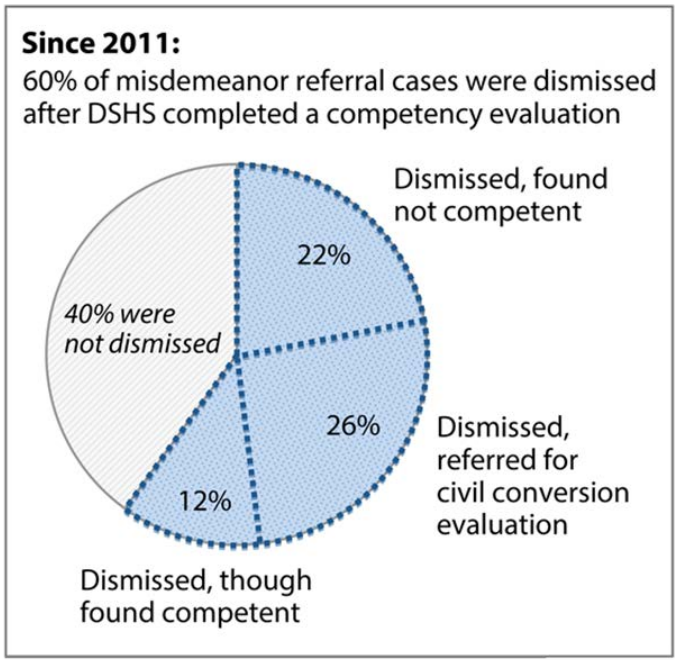
Source: JLARC Analysis of AOC and DSHS Data.

2. Competency is most often questioned within 30 days of the defendant's first court appearance. Although it can be raised at any point in the trial, including after the defendant has been sentenced and placed on probation, competency was questioned within 30 days of the defendant's first court appearance for 65 percent of our sample. Of that group, 69 percent had competency raised within 10 days of the first court appearance.

3. Courts are quick in providing referral information to hospitals. In 77 percent of the cases courts took five days or less, after the judge signed the court order, to send the hospitals a completed referral package.

4. The majority of misdemeanor cases referred for an evaluation were ultimately dismissed by the court. Sixty percent of misdemeanor referral cases—the fastest growing referral population according to DSHS—were dismissed after DSHS completed a competency evaluation. Of the cases dismissed, the court found the defendant competent in 12 percent of the cases. Of those found not competent, at least 26 percent were referred for a civil commitment evaluation.

There is currently no data that explains what happens to defendants who are found not competent and have their charges dismissed. Such data could answer whether defendants in this situation are being connected to community mental health services.



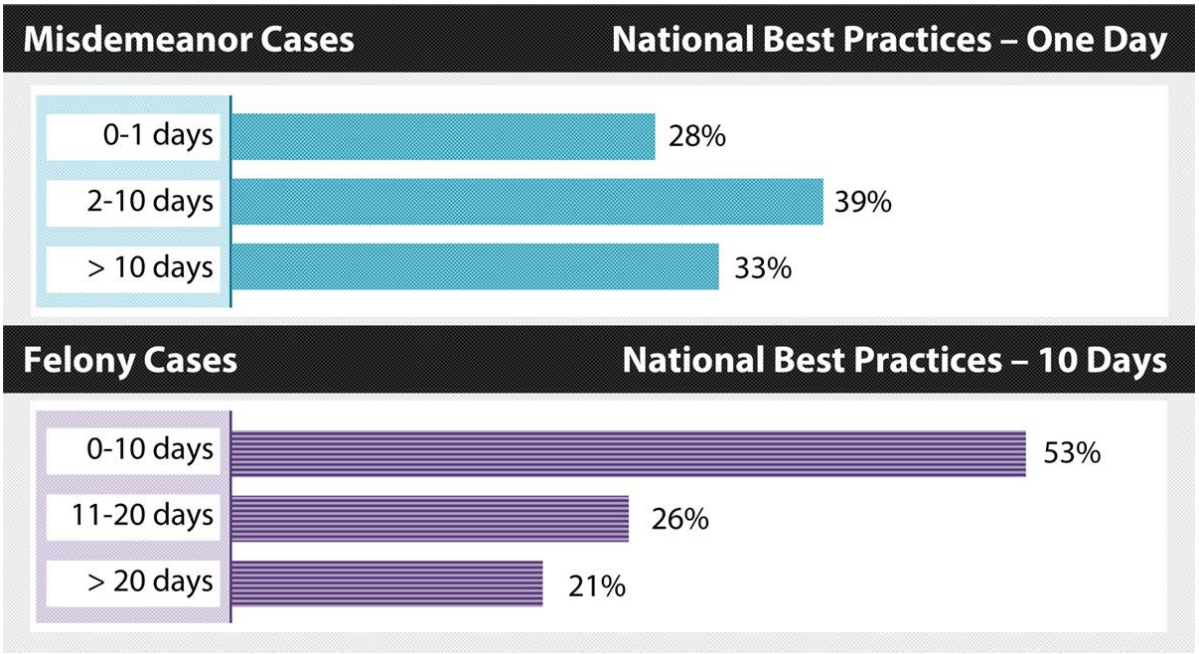
Source: JLARC Analysis of AOC and DSHS Data.

5. Courts may not believe that restoration time is sufficient for misdemeanants found not competent. Defendants charged with non-serious misdemeanors are not eligible for restoration, and defendants charged with serious misdemeanors are eligible for 14 days of restoration plus any unused evaluation time (15 days). One public defender noted that the allowable restoration time for misdemeanors was often too short to be effective, and judges may dismiss cases rather than refer the defendant for restoration. This was an issue highlighted by the Washington State Institute for Public Policy in its report, *Standardizing Protocols for Treatment to Restore Competency to Stand Trial*.

6. Twenty-eight percent of the misdemeanor cases and 53 percent of the felony cases meet best practices for court scheduled initial competency hearings. Although statute does not clearly establish a timeframe for courts to schedule an initial competency hearing, the NJC established best practices for maximum number of days a court should take to hold an initial competency hearing after it receives an evaluation from the hospital. Best practices recommend advancing the date for the competency hearing to the day after the competency report is filed for a misdemeanor charge and to within 10 days for a felony charge. Exhibit 8 displays the percent of our sample cases that meet and exceed the best practices.

The NJC cites the need for this timeline for several reasons: a defendant's competency status can change, it protects the defendant's constitutional rights, it prevents the defendant from reverting to their pre-restoration state of not being competent, and it decreases the amount of time a person with a mental illness spends in jail. Staff from several counties explained that courts attempt to advance the competency hearing date once state hospitals send the competency report. However, county staff indicated one example that would explain a delayed hearing—an attorney may request a second competency evaluation by an outside expert.

Exhibit 8 – Time From Faxed Report to First Competency Hearing



Source: JLARC Staff analysis of BHSIA and court data.

There is currently no available data that explains why defendants are waiting longer than national best practices for competency hearings. A defendant's competency status can change. If a court waits too long to schedule a competency hearing, the evaluation provided by the Administration may no longer be relevant.

Promising Practices From Counties, Other States, and the National Judicial College

To learn of promising practices to improve the delivery of competency services, JLARC staff interviewed county staff from the top eight referral counties based on 2011 data from DSHS, surveyed other states, and reviewed best practices from the NJC. This analysis led to three findings:

1. All of the parties involved in the competency process could benefit from sharing promising practices;
2. Other states have taken actions to improve the timeliness of the process, reorganize certain functions to improve efficiency, and ensure that evaluations referred by courts are appropriate. These practices are not in place in Washington, and may be useful as the Administration reconsiders the competency service delivery approach; and
3. The NJC drafted best practices for competency evaluations and strongly focused on the need for collaboration and training.

This information may also assist other groups who are examining the behavioral health system.

Agreements with Hospitals and Resources Available to Counties Vary

Counties' actions vary based on their relationship with the hospital, and range from collaborative approaches, such as expediting certain types of hearings, to more antagonistic actions, such as requesting "show cause" hearings and ordering a hospital evaluator to appear in court. Some of these approaches may be beneficial to other counties. However, DSHS has not implemented these promising practices across counties, nor is there a forum in which staff from the Administration, the hospitals, and the county participants in the competency judicial system can routinely share beneficial practices.

The resources available to counties vary. In 2005, the Legislature allowed counties and cities to impose a sales and use tax in the amount of 1/10th of one percent for chemical dependency and mental health programs and services. Five of the top eight competency referral counties impose this sales and use tax. In 2012, these five counties (Clark, King, Snohomish, Spokane, and Thurston) collected a total of $76.4 million in revenues and spent approximately $26.6 million for services focused on mental health programs. These programs include activities such as mental health courts, housing, community services (e.g. mental health crisis next day appointments and screening), and psychiatric services in jail. Counties could benefit from sharing promising practices and information about effective programs with one another.

Examples of Other States' Actions to Improve the Competency Process

In Parts Two and Three of this report, we describe the need for an assessment of the current approach to delivering competency services. We learned of practices in other states that the Administration may wish to consider. Examples include:

- **Actions to improve timeliness:** Missouri created "Competency Restoration Specialist" positions at each state hospital to coordinate with local jurisdictions and ensure individual defendants move throughout the system in a timely manner. A few states have created programs to restore a defendant's competency in a community or jail setting to free up hospital beds for other patients.
- **Actions to centralize or decentralize services for efficiency:** Wisconsin contracts with a pool of private evaluators throughout the state for outpatient evaluations. Georgia centralized its referral process to ensure evaluations are processed in a timely manner and provide courts with a single point of contact when an evaluation is requested.
- **Ensure that competency evaluations are appropriate:** In response to a growing number of misdemeanor referrals for competency evaluations, Tennessee now requires local jurisdictions to pay for misdemeanor evaluation. Baltimore City District Court pre-screens defendants prior to referring them for a full competency evaluation. In 2011, the court reports that it diverted 30 percent of the defendants from moving forward through a full evaluation unnecessarily.

National Judicial College Notes Importance of Collaboration and Training

The NJC assembled a panel of experts—judges, lawyers, policy makers, court managers, psychiatrists and psychologists—to develop a best practices model for mental competency to provide "*a body of practices deemed to be most effective and efficient for handling mental incompetency issues in the criminal justice and mental health systems*."

The best practices model emphasizes the need for collaboration and training. Two types of training are described as best practices: profession-specific competency training and cross training for other parties involved in the process. The NJC states that training should be held on an ongoing basis as state laws and case law are not static, and understanding changes is important to correctly interpret standards. In speaking with counties, several reported that training and education on the competency to stand trial process would be helpful, and welcomed, if offered.

Recommendations

Given our findings regarding the need for collaboration and training, we offer the following recommendations.

Legislative Auditor Recommendation 4

Behavioral Health and Service Integration Administration, its primary judicial system partners, including the Administrative Office of the Courts, and other stakeholders should meet to develop an approach to assure collaboration and communication among the partners.

Legislative Auditor Recommendation 5

Behavioral Health and Service Integration Administration should work with its judicial system partners, including the Administrative Office of the Courts and other stakeholders, to develop training specific to their professions, as well as training material appropriate for cross training.

For additional detail concerning these recommendations, see Part Five of this report.

PART FIVE: LEGISLATIVE AUDITOR RECOMMENDATIONS

This report offers five recommendations. Three are intended to help the Department of Social and Health Services (DSHS) and its Behavioral Health and Service Integration Administration (the Administration) determine the best strategy for meeting the competency services targets and improving management and oversight of these services. The final two recommendations recognize that many different parties affect the timeliness of competency services. These two recommendations encourage the Administration and its judicial system partners to improve collaboration and training.

Improve Performance Reporting

The 2012 legislation called for DSHS to establish "new mechanisms for accountability" which include the following two reports (RCW 10.77.068):

- An **annual report** that includes information on (a) the timeliness of competency services, (b) the timeliness with which courts provide completed referrals to DSHS, and (c) performance by county.
- A **quarterly report** if either state hospital does not meet the statutory targets. A quarterly report is to include (a) the extent of the deviation from the particular target, and (b) a description of corrective actions to improve performance.

In the course of our audit, the Administration released two quarterly reports describing Western's and Eastern's performance against the targets. The reports included information that was inaccurate, inconsistent, and delayed.

Legislative Auditor Recommendation 1

The Behavioral Health and Service Integration Administration (the Administration) should provide accurate, consistent, and timely reporting on the number of defendants referred for competency evaluations, the number of evaluations completed, the timeliness of completing those evaluations, and timeliness in admitting defendants to the hospitals.

Legislation Required:	None
Fiscal Impact:	JLARC staff assume this can be completed within existing resources
Implementation Date:	June 30, 2014

Develop and Implement a Service Delivery Approach and Staffing Model to Meet the Targets

The Legislature intended for DSHS to "manage, allocate, and request appropriations for resources in order to meet these targets whenever possible" and to enact "reforms to ensure that forensic resources are expended in an efficient and clinically appropriate manner" for competency evaluation and restoration services (RCW 10.77.068).

As discussed in this report, DSHS is not meeting the targets the Legislature set in 2012 to expedite competency evaluations. The Department has also not addressed the monitoring of and improvements to competency restoration services.

DSHS has not yet completed the work to identify the best strategy to meet the targets. JLARC staff have conducted initial analysis, as discussed in Part Three. Given the Department's difficulties, DSHS may need some independent, outside assistance to complete one key component.

The Administration's current service delivery approach is to base its evaluators at the hospitals, and have them drive to the various counties to provide outpatient evaluations. Almost 90 percent of the evaluations in 2012 were conducted in outpatient settings, either in the jails or in the community. As noted in Part Three, a key analysis that needs to be completed is to compare the current service delivery approach to alternatives. There is no requirement for the evaluators to be based at the hospitals.

Legislative Auditor Recommendation 2

After collecting and analyzing descriptive data about its current operations, the Department of Social and Health Services (DSHS) should hire an independent, external consultant to develop 1) a service delivery approach that enables the Behavioral Health and Service Integration Administration (the Administration) to meet the statutory targets, and 2) a staffing model to implement the new approach.

Legislation Required:	None
Fiscal Impact:	Based on discussions with consultants, JLARC staff estimate that DSHS will need up to $200,000 for the analysis
Implementation Date:	DSHS implementation report due by December 30, 2015

The consultant's analysis should independently consider the most efficient approach to provide DSHS's competency evaluation and restoration services and the resources needed to meet the targets. Before engaging a consultant, the Administration should collect and analyze descriptive data about its current operations. This includes:

- Detailed profile of what the evaluators do;
- Differences in how the hospitals provide services; and
- Trends in where the evaluations take place.

1. Service Delivery Approach

The Administration, in consultation with the Office of Financial Management, should engage a consultant to identify the best service delivery approach to use to reach the targets. The consultant's analysis should consider internal capacity and workforce issues (such as the detailed profile of the work the evaluators do and the differences in the ways the hospitals provide services) and external factors, a key one being the location where the evaluations need to be conducted. The analysis should consider issues such as the costs of providing competency services. The analysis should also consider how other states provide competency services as well as approaches used by DSHS in other service areas. The consultant should consider providing options if there is more than one approach that could meet the statutory targets in an efficient and clinically appropriate manner.

2. Staffing Model

The consultant should identify the number, workplace location, and responsibilities of staff needed to implement the service delivery approach chosen by the Administration to meet the targets. The staffing model should include the evaluators, support staff, staff for performance data collection and reporting, and staff for management and oversight. The model could also take into account the availability of other DSHS staff resources such as evaluators employed at the Special Commitment Center.

DSHS should report to the appropriate committees of the Legislature on its implementation of the service delivery approach and the staffing model, including any barriers or resource needs, by December 2015.

Address Non-Compliance with Additional Statutory Requirements

The 2012 legislation assigned specific requirements to the Administration in delivering competency services. As noted in this report, the Administration has not addressed these requirements:

- Ensure that the quality of competency evaluations does not diminish;
- Develop, document, and implement monitoring of defendants' length of stay to ensure release when clinically appropriate and within statutory time limits;
- Ensure that forensic competency resources are expended in an efficient and clinically appropriate manner; and
- Manage, allocate, and request appropriations for resources in order to meet these targets whenever possible.

Legislative Auditor Recommendation 3

The Behavioral Health and Service Integration Administration (the Administration) should take actions to comply with additional statutory requirements from SSB 6492.

Legislation Required:	None
Fiscal Impact:	JLARC staff assume this can be completed within existing resources
Implementation Date:	Before the 2015 Legislative Session

The Administration should report to the appropriate committees of the Legislature before the 2015 Legislative Session on actions it has taken to address non-compliance with requirements from SSB 6492. If additional resources or changes to legislation are needed, DSHS should submit a request in the 2015-17 agency budget request.

Improve Collaboration Between Key System Partners

The National Judicial College (NJC) states that "*The importance of collaboration cannot be overstated. It is a best practice for the stakeholders on the state, regional, and local levels to collaborate. On the state level, it is a best practice for all of the stakeholders statewide to meet regularly – depending upon the initial or subsequent needs – to collaborate on the best practices for the state in handling all facets of managing mental competency issues.*"

JLARC staff's review of the competency evaluation process found that the system is fragmented – counties have different ad hoc agreements and there is no consistent or coordinated approach. For example, different counties have different ad hoc agreements with the state hospitals as noted in Part Four.

Staff from several of the counties JLARC staff interviewed cited a lack of transparency from the hospitals as a concern, and stated that a better understanding of the reasons for delays in evaluations would be helpful. Some county staff reported using "show cause" hearings as a means of receiving information concerning an evaluation. County staff we interviewed said that it is not always clear who they should be working with at the hospitals, and also reported that hospitals may not send information to the most appropriate contact at the courts.

Legislative Auditor Recommendation 4

The Behavioral Health and Service Integration Administration (the Administration), its primary judicial system partners, including the Administrative Office of the Courts, and other stakeholders should meet to develop an approach to assure collaboration and communication among the partners.

Legislation Required:	None
Fiscal Impact:	JLARC staff assume this can be completed within existing resources
Implementation Date:	Develop and implement an approach by December 30, 2014

Judicial system partners include judges, attorneys, court social workers, and court clerks. Such meetings could improve transparency in hospital operations, establish regular, identifiable points of contact for all parties, and allow counties the opportunity to share promising practices.

Establish Ongoing Training

The National Judicial Court (NJC) describes two types of training as best practices: profession-specific competency training and cross training for other parties involved in the process. The NJC states that training should be held on an ongoing basis. A national researcher on competency issues JLARC staff interviewed reiterated this point, noting that state laws and case law are not static, and understanding changes is important to correctly interpret standards.

The NJC recommends cross discipline education. They note that when professions understand what information other parties need and why, it can have a positive impact on how competency cases are handled.

Many of the county court personnel JLARC staff interviewed stated that training on competency issues would be welcomed. To be valuable, this training must be timely and accurate. In reviewing material the Administrative Office of the Courts provided to the state Judicial College in 2013, the material does not incorporate the requirements from the 2012 legislation, such as a change in law that removed a requirement for two evaluators.

The Administration staff that JLARC staff interviewed stated that evaluators do not receive training after their first year of work, and noted that the lack of ongoing training may contribute to evaluators' inconsistency in findings of competent/not competent.

Legislative Auditor Recommendation 5

The Behavioral Health and Service Integration Administration (the Administration) should work with its judicial system partners, including the Administrative Office of the Courts and other stakeholders, to develop training specific to their professions, as well as training material appropriate for cross training.

Legislation Required:	None
Fiscal Impact:	JLARC staff assume this can be completed within existing resources.
Implementation Date:	Develop training by December 30, 2014.

APPENDIX 1 – SCOPE AND OBJECTIVES

COMPETENCY TO STAND TRIAL – PHASE II

SCOPE AND OBJECTIVES

MARCH 5, 2013

STATE OF WASHINGTON
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What Does Competency Mean for Civil and Criminal Defendants?

Washington state statute 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). A defendant is incompetent if the person 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.

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

In 2012, the Legislature passed Substitute Senate Bill 6492, with the intent 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 admittance to state hospitals. This bill directed Joint Legislative Audit and Review Committee (JLARC) auditors to complete two performance assessments of the Department of Social and Health Services' (DSHS) timeliness in completing competency evaluations. JLARC auditors completed Phase I in December 2012 (Competency to Stand Trial, Phase I). The second study is due in December 2013.

Phase I Identified Three Issues of Concern

During Phase I, JLARC auditors identified three issues of concern that could prevent DSHS from meeting its targets:

1) **Staffing and Productivity Standards:** In the first three months (May – July 2012) of implementation, it appears that DSHS did not meet assumed evaluator staffing and productivity standards. Meeting these assumptions is key to DSHS meeting its statutory timeliness;
2) **Data Reliability:** Data requests to DSHS revealed reliability issues. If DSHS does not resolve problems with data management, it will impact the agency's ability to report progress in meeting the legislative timeliness mandates and the extent to which JLARC auditors can assess DSHS's progress and compliance with statute;
3) **Other Parties' Actions:** Competency evaluations involve more parties than just the state hospitals. The actions of county courts and jails, attorneys, and the defendants themselves can impact the timing of evaluations. Some of these causes of delay are beyond DSHS's control.

DSHS agreed with the audit findings and reports that it has a plan in place to address these issues.

Study Scope

This study will assess DSHS's success in meeting the statutory performance targets and in reducing the length of stay in state hospitals. Additionally, this study will examine other parties' experiences with the competency to stand trial process and the experiences of other states.

Study Objectives

This study will report on the activities DSHS has taken to improve the competency to stand trial process and the agency's success in doing so. To provide credible information for decision makers and to allow JLARC auditors to thoroughly answer the first three objectives, DSHS must develop and maintain accurate data. Phase II will address the following questions:

1) Is DSHS meeting the statutory targets for completing competency evaluations and admittance to Eastern and Western state hospitals for services related to competency?
2) To what extent has DSHS addressed two key concerns identified in Phase I: meeting assumed staffing and productivity standards and improving the quality and completeness of data?
3) Has DSHS implemented new procedures to monitor defendants' length of stay at the state hospitals, and if so, how have those procedures affected the length of stay for competency services?
4) Phase I of this study identified that actions by other parties, such as jails and courts, can have an effect on DSHS's ability to meet its targets. What information can these parties provide that helps explain whether their actions impact the timeliness of evaluations, such as caseload referral data, wait times, and causes of delays?
5) During Phase I, JLARC staff found that other states have also experienced a growth in competency evaluation referrals. What are some examples of how other states have responded to this growth?

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?

Timeframe for the Study

Staff will present its preliminary report at the JLARC meeting in December 2013.

JLARC Staff Contacts for the Study

Eric Thomas	(360) 786-5182	eric.thomas@leg.wa.gov
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APPENDIX 2 – AGENCY RESPONSES

- Department of Social and Health Services

Note: JLARC also requested a response from the Office of Financial Management (OFM). OFM responded that they did not have comments on this report.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Behavioral Health and Service Integration Administration
PO Box 45050, Olympia, WA 98504-5050

March 31, 2014

Keenan Konopaski
1300 Quince Street South East
P.O. Box 40910
Olympia, WA 98504-0910

Mr. Konopaski,

As requested in your correspondence dated March 18, 2014, the Behavioral Health and Service Integration Administration (BHSIA) respectfully submits our formal response to JLARC's "*Competency to Stand Trial, Phase II: DSHS Has Not Met Performance Targets – Better Management and Analysis Could Help It Do So*" report. We appreciate your identification of five recommendations that could potentially improve implementation of changes in RCW 10.77 that resulted from passage of SB 6492.

The forensic evaluators face ever-increasing referrals for pre-trial evaluation services. As noted in your report, there is a general trend of increasing demands for competency evaluation and competency restoration services. We want to take this opportunity to voice our appreciation to these staff. The forensic evaluators have, as a group, continued to show their professionalism and dedication to providing forensic evaluation services. They continue, despite demands on their time, to produce high quality work. We want to commend them for these efforts, and thank them for their commitment to transforming the lives of the people we serve. In addition, each of the state hospitals has a new CEO – Ron Adler at Western State Hospital (WSH) and Dorothy Sawyer at Eastern State Hospital (ESH), who are engaged in extensive efforts to improve the safety of patients and staff, as well as the quality of care provided in both the civil and forensic wards at the hospitals.

We are all fully committed to the goal of reducing the amount of time that individuals spend in jail awaiting competency evaluation or restoration services. In regards to the five recommendations, you will see that we concur or partially concur on all, and are amenable to implementing the recommendations in the report. We remain dedicated to using the correct mix and expertise of staff to make the system more efficient, recognizing additional resources will be needed to meet JLARC's and the legislature's expectations. We offer the following information, which contextualizes our need for additional funding to accomplish the recommendations:

- During the period of state fiscal challenges between 2008-2012, both state hospitals lost many systemic supports such as forensic specific center and clinical director positions and various administrative staff, who, together assured the system functioned well. Lack

of coordination and control at the center/unit level in the last few years has led to delays in a number of support functions, including scheduling for forensic evaluators, psychological test scoring, test materials acquisition and assignment, and related clinical oversight functions.

- We completed a Lean Value Stream Mapping workshop at WSH focused on streamlining the admissions process for the Center for Forensic Services. This produced promising results, and we are anticipating this to decrease the time it takes to admit a patient by nearly 70 percent.

- We are committed to continuing to explore opportunities to improve efficiency, such as the example above, but our referral and waitlist data indicate that we need two additional forensic wards (one at ESH and one at WSH), with a third ward as a possibility.
    - The state hospital forensic bed capacity has remained largely unchanged over the past ten years. Competing bed demands for competency restoration patients, inpatient competency evaluation and not guilty by reason of insanity (NGRI) patients have led to wait lists for admission to the state hospital.
        - While roughly 90 percent of competency evaluation orders call for in-jail or in-community evaluations, between 30 – 40 percent of all competency evaluations result in the need for in-hospital competency restoration treatment.
        - With the state hospitals currently being to only location for competency restoration services, even after we have proper evaluator staffing levels to complete the initial competency evaluation, we will not have a complete solution to the waiting list. When the initial competency evaluation wait list is reduced, this in turn increases the wait list for admission to the state hospitals for competency restoration treatment.
        - We continue to have discussions with stakeholders on development of an outpatient competency restoration pilot program. This pilot would create alternative locations for these services.

- We are currently working with a forensic consulting group who will be issuing a report to DSHS in July 2014, with a final report due to the legislature on August 1, 2014. The consultants will provide DSHS with recommendations on how to improve the delivery and effectiveness of Washington State's forensic mental health system. The report will specifically include recommendations on the following:
    - Forensic mental health system redesign;
    - Increasing collaboration between DSHS, the judicial system, local law enforcement, the Department of Corrections, and community mental health;
    - Community resources for forensic mental health services;
    - Best practices for the delivery of forensic mental health services;
    - Timeframes for the delivery of forensic mental health services;
    - Forensic evaluation services (including but not limited to the referral process from the courts for competency, sanity and diminished capacity evaluations, and the methods for completing forensic evaluations);

- Alternative locations to the current State Hospital system;
- Evidence based competency restoration treatment programs; and
- The appropriateness of creation of a statewide Office of Forensic Mental Health Services.

We will be evaluating the consultants' recommendations and taking steps towards implementing recommendations that can be accomplished within current resources; nevertheless, these recommendations could potentially result in requested statutory or policy changes by the legislature in 2015.

We appreciate the work your staff have done throughout this audit and their ongoing willingness to work closely with us in preparation of the report. Thank you, as well, for your clear recognition from the beginning, that the forensic behavioral health system requires attention and resources to operate efficiently. If you have any questions or concerns, please contact Keri Waterland by telephone at 360-725-2265 or via email at keri.waterland@dshs.wa.gov.

Sincerely,

Jane Beyer
Assistant Secretary

cc: Valerie Whitener, Audit Coordinator, JLARC
Eric Thomas, Research Analyst, JLARC
Zane Potter, Research Analyst, JLARC
Kevin W. Quigley, Secretary, DSHS
Victoria Roberts, Deputy Assistant Secretary, BHSIA
Keri L. Waterland, State Hospital Policy, Programming and Legislation, BHSIA
Alan Siegel, External Audit Compliance Manager, DSHS

RECOMMENDATION	AGENCY POSITION	COMMENTS
Recommendation Number 1 The Behavioral Health and Service Integration Administration (BHSIA) should provide accurate, consistent, and timely reporting on the number of defendants referred for competency evaluations, the number of evaluations completed, the timeliness of completing those evaluations, and timeliness in admitting defendants to the hospitals.	Partially Concur	While we concur with the overall recommendation, we do not believe that the implementation date of June 30, 2014 is feasible. We further do not agree that this recommendation can be accomplished within current resources, and offer the following: DSHS will need 2.0 FTEs to implement this recommendation. One position will be an Information Technology Specialist 6 (ITS6), and the other will be a WMS Band 2. Both will be based out of BHSIA headquarters (HQ). We believe that by siting these resources at HQ, we can ensure that the observed differences noted in Appendix 3 are addressed. We also believe that these positions will support efforts aimed at rectifying the inconsistent practices outlined in Exhibit 10. Each state hospitals data collections system is antiquated. Neither possesses the ability to communicate data in one uniform manner, nor are they able to share data between ESH and WSH. Without the benefit of a sophisticated data analysis system, the staff who are dedicated to collecting data have done wonders. However, the type of reporting both the hospital staff, DSHS and JLARC would like to see will require both the development of a more sophisticated data system and dedicated staffing. • The ITS6 position (Range 70, Step H) will be focused on collecting and analyzing data from all three state hospitals so that it can be presented in a uniform manner. This position will ensure consistency between the state hospitals' data collection and analysis. This position will be accountable for the consistency and accuracy of all data for legislative reports, legislative requests, and will create uniform databases specific to required forensic data collection. • The WMS 2 position will be focused on creating and reviewing policies and procedures from all state hospitals to ensure forensic specific policies and practices are uniform, including forensic evaluation and competency restoration. This position also will be involved in creating and implementing consistent peer review processes for forensic evaluations. **The annual cost of the ITS6, including salary benefits is $123,359 total funds; $78,900 GF-S.** **The annual cost of the WMS 2, including salary benefits is $116,611 total funds; $75,797 GF-S.**

RECOMMENDATION	AGENCY POSITION	COMMENTS
Recommendation Number 2 After collecting and analyzing descriptive data about its current operations, the Department of Social and Health Services (DSHS) should hire an independent, external consultant to develop 1) a service delivery approach that enables the Behavioral Health and Service Integration Administration (BHSIA) to meet the statutory targets, and 2) a staffing model to implement the new approach.	Concur	While we concur with the recommendation, we estimate the cost to be less than JLARC's original estimate. During the 2013 legislative session, in 2SSB 5732, the legislature focused on improving the delivery of mental health services in Washington State. Funding for a forensic consultant was provided to develop recommendations as to how the state's forensic mental health system should be modified and improved. DSHS is currently working with a contracted forensic consultant group, who is reviewing the current delivery system of forensic mental health services in Washington state, and will be providing recommendations as to whether and how the state's forensic mental health system should be modified. On August 1, 2014, DSHS must submit a report regarding the recommendations of the independent consultant to the governor and the relevant fiscal and policy committees of the legislature. We anticipate that the second consultation included in the JLARC recommendations can build upon the recommendations of the forensic consulting group and will focus on providing detailed service delivery approaches and staffing models needed for implementation of the recommendations. **It is estimated that the cost of the consultant could range from $100,000 to $120,000 total funds; $65,000 to $78,000 GF-S.**

RECOMMENDATION	AGENCY POSITION	COMMENTS
Recommendation Number 3 The Behavioral Health and Service Integration Administration (BHSIA) should take actions to comply with additional statutory requirements from SSB 6492.	Partially Concur	While we concur with the overall recommendation, we do not believe that the implementation date prior to the 2015 legislative session is feasible, We do not agree that this recommendation can be done within current resources, and offer the following: Given current waitlist numbers and increasing referral trends, DSHS will need funding to create 3.0 additional FTE forensic evaluator positions (Range 67, Step M). We are evaluating current forensic psychologist recruitment and retention challenges in the context of upcoming collective bargaining for the 2015-17 biennium. Our discussions with the Washington Federation of State Employees will begin in April. We have identified sufficient referral patterns that may support out-stationing state forensic evaluators in regions (e.g. southwest, central) in addition the two adult state hospitals. Out-stationing may decrease time spent on non- direct client care activities. Factors such as office space, supervision and organizational structure will need to be considered when evaluating out-stationing. • **WSH** - Assuming that one evaluator will complete 11 evaluations per month, with approximately 4 weeks of vacation, sick leave, testimony etc. being taken into account, each FTE can produce approximately 121 evaluations per year. In order to meet waitlist demands and statutory requirements, WSH should have 2.0 additional FTE forensic evaluators to support efforts in meeting statutory timeframes. • **ESH** - Given the increase in travel demands on the eastside of the state, we assume that one evaluator will complete 9 evaluations per month. With approximately 4 weeks of vacation, sick leave, testimony etc. being taken into account, each FTE can produce approximately 99 evaluations per year. Given that there is one (1) vacancy, and ESH is currently staffed at a level that lends itself to increases in the waitlist, ESH should enhance recruitment efforts for this vacant position and should have an additional 1.0 FTE forensic evaluator to support efforts in meeting statutory timeframes. **The annual cost of three additional forensic evaluators including salary benefits will be $415,287GF-S.**

RECOMMENDATION	AGENCY POSITION	COMMENTS
Recommendation Number 4 The Behavioral Health and Service Integration Administration (BHSIA), its primary judicial system partners, including the Administrative Office of the Courts, and other stakeholders should meet to develop an approach to assure collaboration and communication among the partners. *AND* **Recommendation Number 5** The Behavioral Health and Service Integration Administration (BHSIA) should work with its judicial system partners, including the Administrative Office of the Courts and other stakeholders, to develop training specific to their professions, as well as training material appropriate for cross training.	Partially Concur	While we concur with the overall recommendations, we do not believe that recommendations 4 or 5 are feasible by December 30, 2014. We currently have only one position at HQ that is devoted to all forensic- specific issues. While some of these duties are currently being performed by this position, further outreach and training is not realistic without additional funding for this purpose. Our new state hospital CEO's have engaged in extensive community outreach in their first year on the job. They are dedicated to meeting with the Regional Support Networks and community treatment providers, and have been doing a great deal of outreach to the outlying communities and media regarding behavioral health. We are currently engaged in outreach, training, and stakeholder discussions, and will continue to do this within existing resources. We have several meetings beginning in April focused on discussion with county and municipal courts related to the current process for in-jail evaluations and reviewing how court orders can be improved. We have interim meetings set up to discuss potential request legislation for an alternative location pilot for competency restoration services. Finally, we have focused dedicated resources to support our state hospitals at the HQ level. We realize that there is still work to do, and believe that dedicated stakeholder outreach efforts will improve patient care greatly. Therefore, we offer the following: A WMS Band 2 position should be created to focus on the tasks associated with recommendations 4 and 5. This position will facilitate meetings and develop ongoing collaborative approaches specific to the forensic operations of the three state hospitals. This position will also be tasked with developing and providing internal and external training specific to forensics. **The annual cost of the WMS 2, including salary and benefits is $129,977 total funds; $84,485 GF-S.**

APPENDIX 2A – AUDITOR'S COMMENT

Auditor's Response to Department's Comments on JLARC Recommendations

We are pleased that the Department concurs or partially concurs with the audit's five recommendations. We are further encouraged that, consistent with RCW 10.77.068, the Department has begun considering that it may need additional resources to meet the statutory targets.

The Department notes in its response that it needs three additional forensic evaluators to address workload. However, as noted in our report, a workload study is first needed to clearly identify staffing needs. The Legislative Auditor urges the Legislature and DSHS to ensure this workload study is completed first, and then to use the results as the basis for finalizing decisions on the resources needed to meet targets.

Additionally, as it relates to Recommendation #3, we agree that it may require additional resources to fully comply with other statutory requirements in SSB 6492 (2012). To clarify, we recommend the Department report to the Legislature before the 2015 session on the status of actions it has planned or taken to address the following statutory requirements:

- Ensure that the quality of competency evaluations does not diminish;
- Develop, document, and implement monitoring of defendants' length of stay to ensure release when clinically appropriate and within statutory time limits;
- Ensure that forensic competency resources are expended in an efficient and clinically appropriate manner; and
- Manage, allocate, and request appropriations for resources in order to meet these targets whenever possible.

If additional resources or changes to legislation are needed beyond these actions in order to fully accomplish these statutory requirements, DSHS should submit a request in the 2015-17 agency budget request.

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APPENDIX 3 – EXAMPLES OF OBSERVED DIFFERENCES BETWEEN EASTERN AND WESTERN

	Western State Hospital	Eastern State Hospital	Questions for Administration Management to Consider
Differences in Evaluators' work and how productivity targets are defined			
Forensic policies for competency services	Yes they have them, although outdated.	No, they do not have them.	Are controls in place to assure that evaluations and approaches are consistent between hospitals?
Administrative support	Evaluators obtain medical and other records. Outpatient evaluators schedule evaluations themselves.	Administrative staff perform these functions.	Are evaluators at Western required to perform additional tasks to complete an evaluation? How much of evaluators' time is spent on administrative tasks? Can evaluators' productivity at the two hospitals be accurately compared?
Adherence to productivity targets	Yes. No evaluation of target feasibility.	No, Eastern reduced agency-reported standards for productivity by one per month. No evaluation of target feasibility.	Are the standards for evaluators working at the two hospitals the same? What factors should be considered in developing realistic targets?
Reporting evaluator productivity	Includes referrals withdrawn by a court, "no show" evaluations, and completed evaluations.	Only includes completed evaluations.	Do the differences in the definitions of "completed evaluations" preclude a comparison of productivity between the hospitals?
Policy differences that impact courts and defendants			
Personal recognizance evaluations	Defendant required to go to the hospital for the evaluation in most cases; only "Competency Fests" (see p. 47) are conducted in the defendants' county.	Conducted in defendants' county.	What is the impact of different requirements for defendants in different parts of the state?

	Western State Hospital	Eastern State Hospital	Questions for Administration Management to Consider
Court notification for "lack of cooperation" from defendants	Schedules a personal recognizance evaluation once. If the defendant doesn't show, Western is done with order.	Multiple attempts before notifying the court that the defendant is uncooperative and they are done with the order.	What is the impact of having different allowances for completing personal recognizance evaluations in different parts of the state?
Required documents	Requires courts to provide a declaration of probable cause as part of the Discovery file.	Does not require declaration of probable cause.	What is the impact on evaluation quality and timeliness on the hospitals requiring different documents?
Criminal history check	Runs defendant's criminal history in Washington. If requested, staff will run a national criminal history via national database.	Runs a national criminal history via national database.	What is the impact of hospitals using different background checks?
Differences in data collection and reporting			
Length of stay	Tracks the length of the restoration assigned by a court (e.g. 45, 90 days).	Does not track length of stay information against the restoration assigned by a court.	How can the Administration monitor whether or not defendants are being discharged early, on time, or staying beyond the court mandated restoration period at Eastern?
Start of "clock" in statute	Criminal history is run prior to receipt of Discovery file.	Criminal history is often run 2-4 days after receipt of the court order and police report, which comprise "Discovery" according to Eastern.	How will the Administration address differences to provide accurate performance reporting?
IT system	Cache.	MILO.	How will the differences in data definitions and fields between the two hospitals impact the Administration's ability to run system wide reports, and how will it verify hospitals' data?

Source: JLARC interviews of Administration and review of materials

APPENDIX 4 – EASTERN AND WESTERN STATE HOSPITALS' COMPETENCY EVALUATOR EXPERIENCES

JLARC staff interviewed 13 evaluators (six from Eastern and seven from Western), representing approximately 46 percent of all evaluators, to ask questions about their experiences as competency evaluators since the passage of 2012 legislation (SSB 6492) and to understand their perspectives on what is and is not working with providing competency evaluations for the courts under the new requirements.

The following discussion summarizes the information gathered during the interviews as they relate to common comments among the evaluators and issues raised. The two main topics are:

- Differences between hospitals in the work required of evaluators; and
- Several issues that directly affect the evaluators' work.

There are Differences between the Hospitals in the Work Required of Evaluators

The evaluators we spoke with described their responsibilities, and we noted that these responsibilities are different between Eastern and Western. For example, at Western, the evaluators noted that they are required to obtain their own clients medical records and schedule the interviews. However, at Eastern, the administrative staff are responsible for these activities. Exhibit 10, on the following page, summarizes the tasks required of evaluators to complete competency evaluations and indicates whether the requirements are the same or different between the two hospitals. The order of the tasks is not necessarily the same for each case.

Exhibit 10 – Work Required of Evaluators is Different between Eastern and Western

Required Tasks to Complete Competency Evaluations	Eastern State Hospital Evaluators	Western State Hospital Evaluators	Are Requirements Same or Different?
Case Assignment (After the completed referral is received by hospital administrative staff.)	Administrative staff assigns the evaluator his/her case.	*Outpatient Unit*: Evaluator selects case from list. *Inpatient Unit:* Management assigns the evaluator his/her case.	**Different**
Documentation Review (Part of the referral for initial evaluations and previous documentation for evaluations conducted during a period of restoration.)	Evaluator reviews available information to prepare for interview.	Evaluator reviews available information to prepare for interview. *Inpatient Evaluations:* Sometimes it is difficult for administrative staff to locate previous hospital medical records.	**Same**
Communication with Attorney (If requested on the court referral order.)	Administrative staff schedules the interview, in coordination with the attorney's availability, if the attorney wants to be present.	Evaluator schedules the interview, in coordination with the attorney's availability, if the attorney wants to be present.	**Different**
Communication with Additional Parties (If determined that their presence is needed at the interview such as spouse, social worker, translator, etc.)	Administrative staff schedules the interview, in coordination with the additional party's availability.	Evaluator schedules the interview, in coordination with the additional party's availability. Administrative staff schedules the translator service; however, there have been issues with the reliability of this service.	**Different**
Schedule the Interview	Administrative staff schedules the interview.	Evaluator schedules the interview.	**Different**

Required Tasks to Complete Competency Evaluations	Eastern State Hospital Evaluators	Western State Hospital Evaluators	Are Requirements Same or Different?
Travel to Jail or Community Location for Defendant Interview (for outpatient evaluations)	*Defendants in jail:* Travel to the jail. *Defendants released to the community:* Travel to a location in the community to meet with an individual defendant.	*Defendants in jail:* Travel to the jail. *Defendants released to the community:* Travel to a location in the community for "Competency Fests" at which evaluators meet with several defendants (typically eight) in one location at the same time.	**Different**
Conduct Defendant Interview	Evaluator Sometimes more than one interview is required.	Evaluator Sometimes more than one interview is required.	**Same**
Reschedule Interview (If defendant does not show up, if jail space is not available or is on "lock down", if attorney was no longer available, etc.)	Administrative staff reschedules the interview as needed. If a defendant who has been released does not show up for a community evaluation the administrative staff will attempt to reschedule the interview. Sometimes the evaluator can reschedule while at the location.	Evaluator reschedules the jail interviews as needed. If a defendant who has been released does not show up for a community evaluation, the evaluator sends the court a progress report but does not reschedule.	**Different**
No Show Report (If a defendant released to the community does not show up for the interview.)	Evaluators were unaware of a status report. Administrative staff are often able to reschedule the interview as needed.	Evaluator writes a summary progress report to the court describing what occurred and notifying the court that it can send a new referral if it wants to pursue an evaluation again.	**Different**
Request Additional Information (e.g. medical records) (If determined necessary by the evaluator.)	Administrative staff submit the request for additional information to institutions such as medical facilities, doctors' offices, etc.	Evaluator submits the request for additional information to institutions such as medical facilities, doctors' offices, etc.	**Different**
Review Additional Information	Evaluator reviews available information.	Evaluator reviews available information.	**Same**

Required Tasks to Complete Competency Evaluations	Eastern State Hospital Evaluators	Western State Hospital Evaluators	Are Requirements Same or Different?
Conduct Interview(s) of Additional Parties (e.g. spouse, family, social worker) (If determined necessary by the evaluator.)	Administrative staff schedules the interview.	Evaluator schedules the interview.	**Different**
Review All Information	Evaluator reviews all information to prepare for writing the report and developing an opinion as to competency.	Evaluator reviews all information to prepare for writing the report and developing an opinion as to competency.	**Same**
Peer Consultation (this can occur at any point in the process) (If desired by evaluator or as required for new evaluators.)	Evaluator determines the necessity of a peer review. Requirements for new evaluators include peer reviews of work.	Evaluator determines the necessity of a peer review. Requirements for new evaluators include peer reviews of work.	**Same**
Dictate or Write Report	Evaluator may choose to write his/her own report or dictate it for the transcriptionist. *Administrative staff (transcriptionist):* Two are available.	Evaluator may choose to write his/her own report or dictate it for the transcriptionist. *Administrative staff (transcriptionist):* One is available.	**Same**
Sign Final Report	Evaluator	Evaluator	**Same**
Submit Completed Evaluation to Appropriate Parties	Administrative staff submit the final documents.	Administrative staff submit the final documents.	**Same**

Source: JLARC staff summary of information provided by forensic evaluators who conduct competency evaluations at Eastern and Western State Hospitals, interviews with administrative staff at both hospitals, and hospital information.

Several Issues, Raised by Evaluators, Directly Affect Their Work

There are several issues that multiple evaluators raised during the interviews that directly affect their ability to perform their work in a timely manner. Exhibit 11 highlights these issues.

Exhibit 11 – Issues Raised by Evaluators Directly Affect Their Work

Issue Topic	Evaluator Comments
Evaluators no longer have time to wait for medical records and to conduct collateral interviews.	Evaluators no longer have time to wait for additional records from third parties. There is too much pressure for quickly finishing the evaluations. Some evaluators will only consider taking the time to wait for these records with complex cases. There is no longer time to wait for collateral interviews. Some will only consider taking the time for complex cases.
Western has contracted with an unreliable translator service.	The translator service is unreliable. This has caused complications with scheduling interviews and the need to reschedule interviews at the hospital with defendants who have been released to the community, further delaying the process.
Court orders can be unclear about the type of involvement the attorney would like to have.	The Pierce County court orders can be unclear as to whether the attorney wants to be notified of the interview or wants to attend the interview. This lack of clarity can cause delays in the process while the Western evaluator attempts to get in touch with the attorney before scheduling the interview.
Evaluator salaries are not competitive.	Evaluators noted that the salaries are not competitive.
Quality reviews occur informally, most often.	There is little feedback provided by management. However, the evaluators noted that quality reviews take place between evaluators as questions or problems arise. Evaluators noted that they would like more time for peer reviews, but the pressure to get the evaluations done faster makes this difficult. Evaluators noted that they are less likely to get called in to testify if the report has enough information for the attorneys and judge to understand how the evaluator reached his/her opinion.
Difficulty obtaining hospital records from Western.	Administrative staff have a difficult time finding hospital records that the evaluators need for reference. There is a need for additional administrative staff, according to the evaluators.

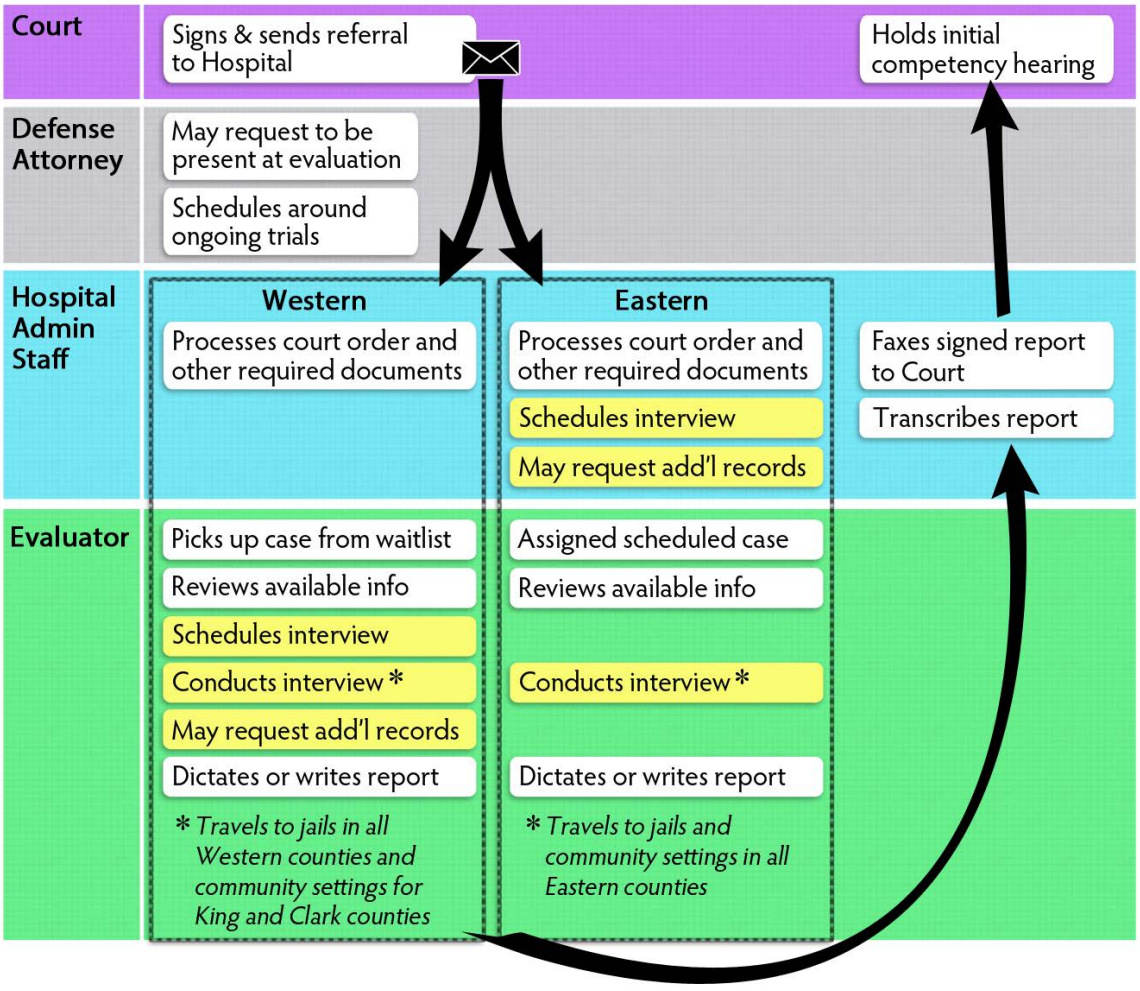
Issue Topic	Evaluator Comments
Not being able to schedule interview times in county jails delays the process.	Western evaluators noted that Clark County does not allow them to reserve a room for the interviews. This means that the evaluator must schedule travel time around the least crowded days and times further complicating the competency evaluation process and resulting in the potential for additional delays. The jail should allow for prescheduled interview times according to the evaluators.
There are aspects of evaluations that should be, but are not, taken into consideration when managing the evaluator productivity and calculating completion rates.	Summary of evaluator examples of what should be taken into consideration: • Complexity of the cases • No show rates • Travel time • Jail scheduling • Annual and sick leave • Time for professional development • Time for peer reviews • Delays with scheduling • Translator service issues/delays at Western
Evaluator recommendations for helping the Administration meet the performance targets.	Evaluator examples of recommendations to help meet performance targets: • Monthly cap of referrals • Consider working with courts to implement the immunity agreements that the Seattle Municipal Mental Health Court has in place • Eastern: a new ward, more administrative staff, and more evaluators • Western: more administrative staff, more evaluators, and overtime pay
Evaluator concerns about the hospitals' ability to meet the performance targets, maintaining quality, and accuracy of information.	Summary of evaluator comments: • The Office of Financial Management salary survey was based on flawed and misleading information • Morale is terrible at Western, but they all love their work • Management does not seem to understand the evaluators' work, what is required of them, and the impact of how the new statutory requirements are being implemented • The faster evaluations are completed, the more it will create a bottleneck with admissions for restoration • Concerns about what will happen when there is a difference of opinion between the state and private evaluators who have conducted evaluations per SSSB 5551 (2013). Will there be more contested hearings? What are the protocols around accessing records? There is a general concern with the quality of the private evaluations. What standards are they required to follow and who is monitoring the quality?

Source: JLARC staff summary of information provided by forensic evaluators who conduct competency evaluations at Eastern and Western State Hospitals.

APPENDIX 5 – EASTERN AND WESTERN STATE HOSPITALS' OUTPATIENT COMPETENCY PROCESSES

The following chart, Exhibit 12, displays the steps necessary for outpatient competency evaluations at Eastern and Western, beginning with the court referral and ending with the initial competency hearing. The required steps for outpatient competency evaluations differ slightly between Eastern and Western State Hospitals. For example, hospital administrative staff at Eastern schedule the evaluation interviews whereas this is the responsibility of Western evaluators. Another example of a difference has to do with the outpatient evaluation interview settings. Evaluators at Eastern will travel to the county in which the defendant is located for interviews at both the jail and in the community. At Western, evaluators will travel to the county in which the defendant is located for jail interviews and for regularly scheduled "Competency Fests" in two counties, Clark and King. For "Competency Fests," several evaluators will travel to one location in the community to meet with several defendants, typically eight. Otherwise, defendants who are not waiting in jail must travel to Western State Hospital for the interviews.

Exhibit 12 – Outpatient Competency Referral to Initial Competency Hearing Process



Source: JLARC staff analysis of BHSIA information and statute, and summary of information provided by forensic evaluators who conduct competency evaluations at Eastern and Western State Hospitals.

APPENDIX 6 – TECHNICAL APPENDIX FOR CASE STUDIES

This appendix details the approached used by JLARC staff to obtain the sample defendant data and information on the five case studies highlighting how delays can arise.

Approach for Selecting Sample Data

JLARC staff drew the sample of defendants from the eight counties that referred the most defendants for evaluations in 2011 (81 percent), according to DSHS data. We then took a stratified sample of referrals, selecting from blocks based on county and type of referral—misdemeanor or felony case—using a 95 percent confidence level. This sampled included 300 defendants in 453 cases, which represents 17 percent of the individuals referred from the top eight counties during the first 11 months after the 2012 legislation took effect. We did not independently verify court data; this data is recorded by county court staff, and it represents the best court data available.

Details of the Five Case Studies That Highlight the Complexity of the Competency Process

The following information illustrates the impact key parties can have in the competency process by highlighting how delays can arise. These examples illustrate the challenges of communicating and coordinating between the involved parties (courts, attorneys, jails, hospitals, and evaluators), evaluators' travel time, efficiency of courts' and hospitals' internal processes, attorneys' schedules and preferences, and defendants' preferences.

Case One: Highlights Two Types of Delays Related to Evaluator Travel and Court Processes

Delay in completing the report: Administrative staff at Eastern assign multiple cases at one time to limit the number of times the evaluator must travel to the same county by grouping referrals for the same county in one trip. While this approach of assigning multiple cases at one time for a single county may maximize evaluators' time conducting evaluations by decreasing the required travel time, it also contributes to delays in completing the written evaluation for the court. If the evaluator is conducting multiple interviews over one or more days in a single location, he/she cannot begin working on each evaluation report immediately after the series of interviews. In this case, the evaluator decided to prioritize misdemeanor evaluations over the felony evaluation which resulted in 21 days between the interview and the report faxed to the court.

Delay in scheduling the competency hearing: The court acknowledged receiving the evaluation report from the hospital 11 days after the hospital faxed it. The defendant waited a total of 26 days from the day the hospital faxed the completed evaluation report to the court to the court-scheduled competency hearing.

Case Two: Highlights One Type of Delay Related to Communication and Coordination Between Involved Parties

Delay in completing the interview: Consistent and timely communication and coordination is required from the jail, attorney (if present at the evaluation), and the hospital to complete an

evaluation. All three parties must be able to quickly respond to ensure an expedited evaluation process. In this case, the attorney wanted to be present for the interview. The evaluator coordinated with the attorney and the jail to schedule the interview. However, delays occurred requiring the evaluator to reschedule the interview multiple times due to the attorney's busy schedule, lack of available room space at the jail, and the attorney not showing up for the scheduled interview. These situations resulted in a total of 39 days from the evaluator receiving the case to the evaluator being able to complete the interview.

Case Three: Highlights One Type of Delay Related to Hospital Processes

Delay in completing the report: The evaluator scheduled an interview with an inpatient defendant, attorney, and interpreter prior to leaving on vacation. It was a complicated case and the evaluator needed behavioral notes from the entire inpatient stay. Upon returning from vacation the evaluator had been assigned a heavy caseload and completed the review of defendant information and the report as quickly as possible, resulting in a 30-day delay from the defendant's release to the report faxed to the court.

Case Four: Highlights Two Types of Delays Related to Attorney's Schedule and Preference, Defendant's Preference, and Court Processes

Delay in scheduling the interview: Decisions made by attorneys, clients, and the court can impact the timeliness of evaluations. In this case, the county refused the evaluator initially assigned, so the defendant had to wait until another evaluator was available, contributing to a delay of 35 days. The defendant's decision to have his/her attorney present necessitated a rescheduled interview, contributing to a nine day delay.

Delay in scheduling the competency hearing: The court acknowledged receiving the evaluation report from the hospital six days after the hospital faxed it. The defendant waited a total of 20 days from the day the hospital faxed the completed evaluation report to the court to the court-scheduled competency hearing.

Case Five: Highlights One Type of Delay Related to Attorney's Preference

Delay in completing the report: Evaluators' work is subject to pressures from other parties. In this example, there was an additional ten-day delay due to a request from the attorney. After hearing that the evaluator believed the defendant to be competent, the attorney requested that the evaluator wait for seven to ten days in case the defendant's condition worsened while waiting in jail. The attorney was concerned that the defendant would not be able to maintain the apparent progress and make it through a trial since three weeks prior to the interview the defendant was in a different state according to the attorney. The evaluator waited ten days, reviewed jail records regarding the defendant's behavior, and completed the evaluation. The Administration has not established guidance to share with all of the parties involved describing the parameters around which it will provide the competency evaluation services to the courts. Absent these guidelines, the evaluators are left to make a decision when responding to such a request while trying to maintain good and collaborative working relationships with attorneys and others.