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Health Services in response to contract # 1334-91698*



**Forensic Mental Health
Consultant Review
Final Report**

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Prepared by: Groundswell Services, Inc.

W. Neil Gowensmith, Ph.D.

University of Denver

Daniel C. Murrie, Ph.D.

University of Virginia

Ira K. Packer, Ph.D.

University of Massachusetts



Groundswell Services, Inc.

EXECUTIVE SUMMARY

In fulfillment of our contract (*No. 1334-91698*), we performed a thorough review of Washington's forensic mental health system, visiting key sites, interviewing stakeholders, and collecting input via online surveys. Our review revealed that Washington struggles with many of the same challenges other state forensic systems face. In some respects, they have handled these challenges well and have made genuine improvements despite inadequate resources and infrastructure. However, improvements are inevitably limited as long as the system remains constrained by a lack of infrastructure specific to forensic services, a lack of systematic training and oversight for forensic clinicians, and a lack of community-based alternatives to lengthy inpatient hospitalization for incompetent defendants and NGRI acquittees. Our impressions and recommendations are detailed in the following report. Priority recommendations are highlighted here:

- *Establish a centralized Office of Forensic Mental Health Services with adequate authority and data-management capacity:* Current forensic services are often disconnected and embedded in other systems, particularly the state hospitals. Further, there is little meaningful data to shed light on the forensic population or inform decisions. A central office should oversee all forensic evaluation services, assist hospitals and community agencies in implementing best-practice forensic treatment, and liaise across systems to ensure a strategic, integrated approach to the forensic population. The office should have sufficient data-management resources to monitor forensic services, appropriately allocate resources, and otherwise inform decisions.
- *Establish state-wide procedures to facilitate forensic evaluations, train forensic evaluators, and monitor quality in forensic evaluation reports:* Competence evaluations in Washington have involved lengthy delays for a variety of reasons. But a centralized Office of Forensic Mental Health Services could address these delays by fostering collaboration across systems to facilitate evaluations, providing a state-wide mandatory training of evaluators, and monitoring the quality of evaluations. A well-trained, well-staffed, and well-monitored cadre of evaluators is necessary to increase the pace and quality of evaluations.
- *Improve and diversify competence restoration services:* Washington currently relies solely on inpatient hospitalization for *all* incompetent defendants, even though such intensive service is necessary for only some of them. Developing procedures to reduce inappropriate referrals and provide competence restoration services in the community (for select, appropriate defendants) will reduce delays and expenses while better stewarding inpatient resources and better respecting defendants' liberties. Inpatient services that remain should be better standardized across hospitals.

- *Overhaul services for NGRI acquittees:* Compared to other states, Washington is clearly an outlier in terms of prioritizing far longer inpatient hospitalization and far less outpatient conditional release for NGRI acquittees. Such lengthy hospitalization is unnecessarily expensive and restrictive, and it is usually unnecessary for public safety. The goals of public safety, financial stewardship, and patient recovery would *all* be better achieved by inpatient treatment that is briefer but more specialized (emphasizing risk factors for criminal behavior), followed by outpatient conditional release that is more rigorous and well-monitored.

Each of the above recommendations is best achieved by a centralized Office of Forensic Mental Health Services that, in turn, facilitates collaboration among the other service systems involved (e.g., jails, hospitals, community services). Although all of these recommendations may involve some initial expense—and certainly some initial planning and re-organizing—all will likely involve long-term savings to the state overall, in that they will reduce the current over-reliance on lengthy inpatient hospitalization while allowing for easier monitoring of forensic services and costs.

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INTRODUCTION

In keeping with our contract (*No. 1334-91698*), we are submitting the following report to summarize our observations regarding the current forensic mental health service system in Washington and our recommendations for improving the system. Very briefly, the context for this report involves long-standing concerns about the quality and timeliness of mental health services to individuals involved in the criminal justice system.

Washington, like all states, is increasingly faced with the challenge of balancing limited mental health resources, public safety concerns, and burdens placed on the legal system to manage defendants with mental illness. In short, many persons with mental illness have found that accessible mental health services are increasingly transitioning into court-ordered services. This change is often referred to as the “criminalization of the mentally ill,” and it is a nationwide phenomenon. In addressing this broad challenge, Washington has been progressive in many respects, and should be commended for many of their strategies and pilot programs. The Department of Human and Social Services (DHS), along with other agencies, have done an admirable job addressing this issue with limited resources and infrastructure. However, much work remains to be done. Pressing problems include the lengthy delays in court-ordered evaluations and treatment interventions, lack of community services for certain populations, census pressures at both state hospitals, and the lack of a clear vision for rectifying these concerns and integrating services. This has been the context for the contract released by the Department of Human and Social Services, as well as our subsequent role as consultants.

In performing this review, we have relied on the professional and scientific literature describing forensic service delivery systems, our own experiences leading services across several states, and numerous historical reports related to forensic services in Washington (see Appendix 1 for documents reviewed). Perhaps most importantly, we made two visits to Washington, during which we held meetings with a variety of administrators, stakeholders, and consumers of forensic services (see Table 1 for stakeholders interviewed). In addition to the on-site meetings in Washington, we conducted phone interviews and collected data from a much broader group of stakeholders using online survey methodology (see Table 2). Specifically, these included forensic evaluators (42), staff from the jails (68), community mental health providers (84), and the judiciary (54).

**Table 1:
Stakeholders Consulted**

2/17/14

- DSHS Administration

2/18/14

- **Western State Hospital:**
 - Hospital administration
 - Center for Forensic Services
 - Community Program
 - NGRI and CST restoration unit staff
 - Forensic evaluators

2/19/14

Pierce County stakeholders:

- Pierce County Superior Court
- Pierce County District Court
- Pierce County Prosecutor’s Office
- Pierce County Assigned Counsel
- Pierce County Jail Mental Health
- Pierce County Executive Office
- Private Defense Attorneys

King County stakeholders

- King County District Court
- King County Superior Court
- Seattle City Attorney’s Office
- King County Prosecuting Attorney’s Office
- King County Department of Public Defense
- King County Executive Office
- King County Mental Health Court
- King County Crisis and Commitment
- King County District Court Probation
- King County Jail Health Services
- King County Department of Adult and Juvenile Detention
- King County Correctional Facility
- Valley Cities Counseling and Consultation
- Harborview Medical Center

2/20/14

- **Eastern State Hospital:**
 - Hospital administration
 - CST restoration unit staff
 - Forensic evaluators
 - NGRI / Conditional Release unit staff & Risk Review Board personnel

2/21/14

- Western State Hospital North Regional Office unit staff (telephone)
- DSHS Administration
- Judicial Legislative Audit Review Committee

5/13/14

- Public Safety Review Panel members (telephone consultation)

6/2/14

- DSHS Administration
- Regional Support Network administration
- WSH and ESH Administration and staff

6/3/14

- Western State Hospital NGRI and Conditional Release unit staff and consumers

Statewide stakeholders (Olympia state capitol complex)

- DSHS Administration
- Disability Rights Attorney's Office
- State of Washington Senate Corrections and Human Services Committee

Public Safety Review Panel

- State of Washington House of Representatives Appropriations Committee
- Public Defender's Office
- King County Correctional Facility
- King County District Attorney's Office
- Pierce County Jail Mental Health
- Harborview Medical Center
- Southwest Washington Mental Health
- King County Regional Support Network
- Greater Lakes Mental Health

Table 2

Online surveys from the following:	Washington county jails (68 surveys received)
	Washington community mental health providers (84 surveys)
	Washington judiciary (54 surveys)
	Washington state-employed forensic evaluators (42 surveys)

Following these visits, surveys, phone calls, and reviews of all other data sources, we concluded that we had a strong understanding of Washington’s current forensic system, particularly with respect to how Washington has approached problems that are common across most state forensic systems. Based on this process, we have identified several key concerns, or challenges, in Washington’s system as it currently stands. We are also proposing several strategies—or potential remedies—to address these challenges. Of course, these challenges tend to be interrelated. Just as problems are related to one another, proposed remedies for one challenge are relevant to other challenges. Therefore, we address these in what we consider their order of importance, beginning with the broadest and most important issues (the “macro” aspects of the forensic system) and narrowing to include specific forensic services or procedures (the more “micro”). For each, we described the current status—or “challenges”—followed by recommendations for better addressing those challenges.

We begin with what we consider the key weakness in Washington’s forensic system—the lack of a centralized administration with authority specific to forensic services—and we propose an Office of Forensic Mental Health Services to centrally manage many of the services that are now poorly integrated. With such a centralized office, Washington will be in a better position to address the other current challenges, particularly improving forensic evaluation services, addressing delays in competence restoration, and addressing inefficiencies in the hospitalization and conditional release of NGRI acquitees.

CHALLENGE #1:**IMPROVING INFRASTRUCTURE and ORGANIZATION**

Forensic administration is challenging in every state because forensic mental health services, by definition, span two disparate systems—the mental health and the criminal justice—that have two very different cultures and sets of goals. The most successful states have handled this challenge by establishing an administrative office specific to forensic services. In contrast, Washington’s current model has no distinct operational structure or line of command specific to Forensic Services. Rather, forensic services are handled at lower levels within the larger mental health system. In terms of reporting relationships, the two hospital chief executive officers (CEO) report to the Deputy Assistant Secretary for Behavioral Health and Service Integration Administration (BHSIA) who reports directly to the Assistant Secretary. There is also a State Hospital Programming and Legislation Manager who reports to the Deputy and advises on Forensic issues but has no operational line of authority relative to evaluation services. Although no organizational structure is without weaknesses, this particular organizational structure contributes to several fundamental problems (described below), which, in turn, exacerbate many of the more specific problems that have received more attention (e.g., delays in competence evaluations).

The problems with Washington’s forensic infrastructure do not reflect the quality of the current leaders. The feedback we received from almost every source described positively the COOs of Western and Eastern Hospital, as well as Central Office leadership. Indeed, it is a testament to these individuals that the system is not more problematic; they have managed to implement many improvements even within the limitations of inefficient organization and inadequate resources. The improvements these leaders have fostered may give the impression that the current organizational structure is adequate to continue making improvements, but our impression is that they have made improvements *in spite of*, not because of, the current organizational structure. Our perspective is that structural, administrative arrangements should not be designed around specific leaders; even if current leadership is excellent, they may eventually be replaced by leaders who function poorly under the constraints of a sub-optimal infrastructure. Furthermore, excellent leaders will work more efficiently, and achieve more, with efficient infrastructure.

The core, fundamental problems with the current infrastructure include:

- The lack of “macro level” oversight of all forensic services and limited capacity to communicate and collaborate across services,
- Substantial difficulty obtaining accurate data, and therefore
- Difficulty in allocating resources,

- A lack of uniform standards and processes for forensic evaluations, resulting in less opportunity to ensure best practices.

Below, we briefly describe these problems and propose one solution.

Lack of centralized oversight:

Without a centralized locus of responsibility for forensic services, many services are simply embedded in the two inpatient hospitals (Western State Hospital and Eastern State Hospital). Consider *forensic evaluation services* as the primary example: All forensic evaluation services are administered by the hospital system and delivered by hospital staff. The main focus of the hospitals is to provide treatment to individuals who are mentally ill, using a recovery model (the standard in the field). Although there are separate units at the hospitals for forensic patients, their main goal is to provide treatment for those individuals who have either been adjudicated as Incompetent to Stand Trial, or Not Guilty by Reason of Insanity. The hospital administrators need to grapple with a wide variety of issues, including managing a limited number of inpatient psychiatric beds with a steady demand to serve both civil and forensic patients, and managing a complex hospital system within budgetary constraints. In this context, the issues related to forensic *evaluations* are very different from the issues related to hospital management, both in terms of substantive issues as well as fiscal ones. Indeed, many state systems have recognized that the goals of accurate forensic evaluations and optimal hospital census can sometimes be at odds. Optimally, forensic evaluation services are not overseen by the hospitals but by a centralized forensic administration that can prioritize the broader goals of accuracy, prompt service to the court, and integration with other forensic services. Furthermore, forensic evaluation services require substantial training, oversight, and quality assurance procedures that are not currently handled by the hospitals, and could probably never be adequately addressed by the hospitals. Such needs could be better handled by a centralized forensic administration (these issues are further addressed in Section 2).

Limited capacity to liaison and integrate services:

Based on our interviews, reviews of previous reports, and results of our online surveys, it appears that there are significant gaps—in communication and service—among various parts of the mental health system that serve forensic clients, and also between the mental health system and other agencies. These gaps make it difficult to ensure seamless communication and services. Without a centralized forensic administration, there is no “boundary spanner” to facilitate cooperation among the mental health and criminal justice systems. We learned, for instance, that there are sometimes difficulties in obtaining space for forensic evaluators at jails, that courts sometimes do not provide necessary documentation to the hospitals in a timely manner, that some counties overuse the forensic inpatient system for misdemeanor defendants, that there are sometimes delays in competency hearings following discharge from the hospital, and that the hospitals and the PSRP are sometimes not “on the same page” about what kind of information and documentation is needed. Although these individual issues will be addressed in other sections of this report, all serve as illustrations of the broader, overall

problem of no centralized forensic administration to bridge these gaps and ensure better communication and collaboration.

Similarly, there appears to be little connection between the inpatient system serving forensic patients and the community programs. A community mental health service to the public sector is coordinated through local RSN's (Regional Support Networks) that oversee local providers. We spoke with some RSN leaders, who were fairly unfamiliar with Conditional Release for insanity acquittees. This is not surprising, given the low number of such individuals in the community, and is not meant as a criticism of the RSNs. However, it points to the need for a centralized Office of Forensic Mental Health Services to develop regular lines of communication with the community system. In the current organizational system, there is no defined mechanism for such communication. In order to ensure that a seamless system of care is available for individuals with a mental illness who are involved with the criminal justice system, it is essential that good coordination exist between Forensic Services and providers of service, including the RSNs.

Meaningful data are often unavailable:

In the current system, it is difficult to obtain accurate data regarding the volume, nature, or timeliness of forensic services. For instance, the JLARC auditors found substantial inaccuracies in the data provided on competency to stand trial evaluations (JLARC Competency to Stand Trial, Phase II, April 23, 2014). Likewise, when we requested data regarding evaluations at Eastern State Hospital, we were provided with numbers, but then informed that they may be in error. An inability to access relevant data has tremendous implications for planning. Specifically, although it is clear from all of the sources we obtained (including meetings with evaluators, administrators, court personnel, jail personnel, and our online surveys) that DSHS currently has an insufficient number of evaluators to conduct all the evaluations required (an issue we discuss in Section 2), it is difficult to calculate the specific number of additional evaluators needed. We have been informed that DSHS has requested funding in the new legislative year for three additional evaluators. However, as the JLARC report noted, without reliable data on the total number of evaluations actually conducted, it is not clear if this number is adequate. We endorse JLARC's recommendation that DSHS carefully analyze existing data to determine the actual need. However, a more long-term solution to obtaining essential data is needed. We found data gaps in several other areas, including recidivism and rehospitalization rates of NGRI acquittees, community placements and services for persons on Conditional Release, lengths of time needed to complete various forensic evaluations, and others. Data gaps existed at both state hospitals and in community programs. A more efficient and robust data collection and analysis system, housed in the Forensic Services department, will help gather these important data points.

The *process* by which data are currently collected serves as a correlate challenge to the *types* of missing data listed above. Currently, to provide public data on the number of competency evaluations performed and their timeframes, Eastern State Hospital compiles data from that facility and then passes it on to Western State Hospital. One person at Western State Hospital is tasked with integrating the data from Eastern and data from

Western, and producing a combined report. This is not only inefficient, but results in lack of uniformity of reporting, and inaccuracies. A more efficient model would be to have a centralized Office of Forensic Service develop a uniform reporting structure, and have the capacity to analyze the data. This would involve allocating resources for a data analyst within Central Office to oversee this task. It also would require updating the data programs, as the hospitals appear to use outdated database programs.

Difficulty in Allocating Resources

Decisions about allocating resources require not only access to accurate data, but also a clearly delineated budget. During our discussions with hospital and Central Office administrators, we learned that there is no designated budget for forensic evaluation services. Rather, the funding for these services comes from the overall hospital budget, though in a manner that is apparently not monitored or quantified. Indeed, administrators were unable to identify for us the exact costs for any (or all) forensic services, because there is no separate line item. In other states, there is a separate budget for forensic services, which allows administrators to allocate resources in a rational, strategic manner. Once a Centralized Forensic Service is implemented, it should be accompanied by a specific budget allocation that is sufficient to fund the services it must provide (described below).

Lack of Uniform Standards

There are significant differences in the models that Eastern and Western State Hospitals use to organize forensic evaluation services (see Appendix A of the JLARC final report, April 23, 2014), and even some forensic treatment services. It is not necessarily crucial that the hospitals are uniform in every respect; there may indeed be legitimate reasons for slight procedural differences at each facility. However, in the current system there is no mechanism for higher administration to evaluate the advantages or disadvantages of each model and prescribe best practices. One of the tasks of a centralized Forensic Service would be to carefully analyze the different models, identify best practices, and then implement those. This may require maintaining some differences across sites, but if so it would be based on a careful analysis and not simply a matter of “local custom.”¹

This principle is broader than simply prescribing uniform standards across hospitals. Under the current infrastructure, there is no clear mechanism for higher administration to review, on a statewide basis, key services such as forensic evaluations, community supervision of NGRI acquittees, and competence restoration. Ideally, there would be clear mechanisms to review these services, both quantitatively and qualitatively, and then prescribe best practices. To be clear, we are not advocating uniformity for the sake of uniformity, and we understand that some services will inevitably differ between urban and rural jurisdictions (a challenge common to most state systems). But we emphasize

¹ It is clear that the current leadership has recognized the problem of inconsistencies across hospital sites, and has designated leaders to enhance coordination and uniformity. This is an

that it is difficult to promote best practices state-wide if there is not an infrastructure to review and enforce wide-scale practice.

PROPOSED SOLUTION: Establish an Office of Forensic Mental Health Services

Lessons from other states

The challenge of integrating forensic services is certainly not unique to the State of Washington. But many of the most successful states have responded to this challenge by developing a structure in which forensic services are under the operational control of a *Forensic Director* (or someone with an equivalent title, such as Assistant Commissioner). The exact title, scope of responsibilities, and lines of authority differ across states, but an essential element is a focal point for operational and fiscal oversight of the forensic system. This model allows for consistent standards, uniform training, ability to track data, and ability to make recommendations about system needs based on accurate information.

The nature of Forensic Mental Health Services is that it is a specialty area, requiring not only practitioners with specialized training, but also administrators with knowledge of the criminal justice system, and skills in negotiating two diverse systems (i.e., mental health and legal system). In order to provide services in a coordinated manner, it is crucial to have “boundary spanners” (Steadman, 1992), leaders² who are familiar with the philosophies and needs of both the mental health and criminal justice systems. The tasks involved are diverse, including dealing with misconceptions each system has about the other, troubleshooting problematic cases and system issues, developing standardized court orders, developing standardized report formats, and educating the judiciary about the benefits, as well as limits, of what the mental health system can provide.

Given the need for statewide coordination, authorities recommend that each state designate a higher administrative official to oversee forensic services. The leader charged with overseeing the forensic system must be at a high level within the mental health/behavioral health system (Melton, Petrilla, Poythress, & Slobogin, 2007). Indeed,

“...it is desirable that the position be at the assistant commissioner level, so that the individual who possesses authority clearly has sufficient standing in the bureaucracy to be able to communicate easily with high level administrators in other agencies. Also, because forensic services will cut across levels or types of mental health services (e.g., community services and hospitals), the director of forensic services needs to be at a level commensurate with, rather than subordinate to, the directors of these types of broad services” (p. 114).

² Again, it is our impression that Washington has competent *individuals* who fit this description, but Washington has not developed the administrative *position* with the necessary structure and authority to oversee all forensic services.

In our experience, most states with efficient forensic mental health systems have specifically designated a *Forensic Director* of this sort.

Recommendations:

*Washington must establish a statewide Office of Forensic Mental Health Services*³ to be directed by a skilled administrator with knowledge and experience in both mental health and criminal justice systems. In our view, this single intervention is the first, and most efficient, step towards improvement, and will make all subsequent interventions far more feasible and enduring. The Office must include a Forensic Director, who should be at the level of a Deputy Assistant Secretary, and report directly to the Assistant Secretary for Behavioral Health and Service Integration Administration. This will allow communication and coordination among the Forensic Director and other leaders of the inpatient and community behavioral services program, so that there can be collaboration and synergy among the various services, rather than isolation.

The Table of Organization for this centralized Office of Forensic Service should be determined by DSHS, although we strongly recommend this office serve at least the following functions:

- 1) Operational control of all forensic *evaluation* services (in the hospitals and the community), including specific budget allocation;
- 2) Responsibility for training all forensic evaluators;
- 3) Develop and oversee a system to certify forensic evaluators, and monitor the quality of forensic evaluation reports;
- 4) Liaison to jails to ensure proper flow of information (e.g., from the jails when a forensic evaluation is ordered, and from the hospitals to the jails when an individual is returning after completion of an evaluation or after treatment to restore to competency), as well as to coordinate logistical issues for forensic evaluations at the jails (such as adequate space)
- 5) Liaison with the courts to increase efficiency of the forensic evaluation system (including timely and complete access to records, and expedition of competency hearings), and to solve problems in complex circumstances;
- 6) Coordination with the hospitals regarding all forensic *treatment* services. Standard treatment services for forensic patients (i.e., inpatient hospitalization, psychiatric medication, and general recovery model principles) should remain the hospital's

³ For clarity, we use this lengthy title—Office of Forensic Mental Health Services (OFMHS)—throughout this report, but this need not be the eventual title. The exact label is far less important than the general concept, i.e., a central and adequately staffed office with the adequate authority and resources to oversee and coordinate diverse forensic services.

responsibility. But services that are unique to forensic patients (e.g., education for competence restoration, curricula for NGRI acquittees) should be designed and delivered in close cooperation with the centralized Office of Forensic Services, who will be in the best position to identify and promote best-practices interventions unique to forensic patients, promote congruence across hospital sites, and promote hospital interventions that flow smoothly into community interventions (see #7 below);

- 7) Coordination with the RSNs and/or CMHA's (Community Mental Health Agencies, which are the direct providers of care) regarding community treatment of individuals discharged from hospitals on Conditional Release;
- 8) Coordination with the Department of Corrections, whose Community Corrections Officers are involved in monitoring of insanity acquittees who are on Conditional Release;
- 9) Oversight of the forensic data collection and analysis system statewide, as well as responsibility for disseminating data trends and subsequent recommendations appropriately;
- 10) Oversight over the development, implementation, and maintenance of existing and forthcoming community forensic programs and services. Should the DSHS follow later recommendations in this report regarding the creation of specific community-based forensic programs, the Office of Forensic Services should take the lead in setting standards and maintaining oversight of the fidelity of those programs to expected data outcomes and national trends.

To be clear, this means that the statewide Office of Forensic Mental Health Services would have full budgetary control only over forensic *evaluation* services (including hospital and community-based evaluations for competence to stand trial and criminal responsibility as well as evaluations of risk assessment for insanity acquittees in the hospitals). We are *not* recommending that this office have full budgetary or operational control over the inpatient units or their treatment services. These should continue to be managed by the COO's of the hospitals, because inpatient treatment of forensic patients requires an infrastructure and services so similar to those necessary for civil patients. But where forensic patients require *additional* services and programming, the hospitals should develop and deliver these forensic-specific services with oversight from the new Office of Forensic Mental Health Services. Likewise, the Office of Forensic Mental Health Services would work in close collaboration with the RSNs and/or CMHAs to design and deliver the services that are unique to forensic clients.

Second, *the Office of Forensic Mental Health Services must include a data analyst* and an effective data-management system. This data analyst work with the facilities, community agencies, and forensic evaluators to ensure that there are accurate data available upon which to make policy and resource-allocation decisions. At a minimum, the database in a central forensic office should be able to answer questions such as:

- How many competence and sanity evaluations were performed in a given time period? For what jurisdictions? What were the proportion of incompetence and insanity findings?
- Do incompetence or insanity findings differ appreciably across evaluators or jurisdictions?
- How many defendants are receiving competence restoration services, and where?
- What proportion of defendants is restored to competence, and what are the mean lengths of time until restoration?
- How many individuals are acquitted Not Guilty by Reason of Insanity (NGRI), and what proportion is hospitalized versus released? How long do such individuals spend in the hospital prior to conditional release? What is the duration of supervised conditional release, and what proportion of supervised acquittees discharge their supervision, return to the hospital, or reoffend?
- What types of community forensic programs exist? How many forensic consumers are served by them? What outcomes exist?
- What are the approximate costs of the services described above? Where are the areas with greatest expense and greatest opportunity for savings?

We acknowledge that a data management system, including a dedicated data analyst, involves initial expense and logistical challenges. However, this investment soon “pays for itself” by allowing the forensic director to better identify areas of inefficiency or excessive expense. Just as importantly, good data monitoring can help the director identify areas of inequity and poor services, or provide evidence of equitable and efficient services.

CHALLENGE #2:

IMPROVING FORENSIC EVALUATION SERVICES

In recent history, much of the attention to forensic services in Washington—and perhaps much of the impetus for our consultation—has focused on the concerns regarding evaluations of trial competence, particularly delays in the competence evaluation and reporting process. Clearly, individuals with mental illness who are arrested in Washington, particularly those whose competence to stand trial is questioned, often spend significant time in jail awaiting an initial evaluation. Furthermore, once the evaluation is completed, they have to wait until a bed becomes available in the State Hospital serving their area. Delays in treatment for individuals with severe mental illnesses entail both short-term and long term consequences. They continue to suffer from their symptoms in jails that cannot provide a therapeutic environment, and that often lack resources to identify and offer even initial treatment. This can cause delays in treatment, but also exacerbation of symptoms for the defendant. Delays in assessment and treatment also create problems for the jails, which—as became clear in our survey of jail staff—rarely have adequate resources or ability to manage this population. Finally, the State Hospitals struggle because these individuals then require longer stays once they are admitted, straining the resources of the hospital.

This is a widespread, national problem that is certainly not unique to Washington. But Washington has appeared to struggle more, or at least more openly, with the challenge of timely competence evaluations. This struggle sheds light on many problems with the forensic evaluation system in Washington, which we describe further below.

Before addressing this widely-discussed struggle, we offer two caveats:

First, data reveal clear and significant improvements in Washington's forensic evaluation services during recent history. The most obvious example is the transition from inpatient to outpatient evaluations over the last decade. Consistent with national trends, Washington has shifted from a system in which most evaluations were conducted in the state hospitals (requiring many days of inpatient care for a brief evaluation) to a system in which most evaluations are conducted on an outpatient basis. As noted in the JLARC report, more than 90% of all pre-trial evaluations in Western Washington and almost 80% in Eastern Washington are now conducted in the community. This is the first step in reducing unnecessary hospitalization for forensic patients; this transition has saved state resources and better protected defendants' liberties.

Second, data suggest some improvements in productivity and punctuality of competence evaluations since this issue began receiving increased attention. The limitations in data collection and management leave us reluctant to cite any particular figures, but all accounts suggest some improvement.

Our impression is that *improvements are likely to plateau, however, because competence evaluation services are constrained by some broader, structural problems in Washington's forensic system*. While we acknowledge that there was probably some room for improvement at the level of individual evaluators or worksites, our impression is that the lengthy delays in competence evaluation are generally more attributable to inefficiencies in a system than to inefficiencies in individual evaluators.

For these reasons, we believe *the best way to promote timely, high-quality evaluations is to begin with the broad infrastructure changes we proposed in Section #1*. Ultimately, clear, centralized leadership and liaison services can smooth many of the barriers that slow competence evaluation. The administration must also remedy some of the resource shortages that constrain productivity. In the sections below, we further detail current challenges and proposed solutions in four areas:

- Productivity of evaluators (including punctuality and productivity standards)
- Availability of evaluators
- Training of evaluators
- Quality assurance interventions

Increasing the productivity of evaluators (including punctuality standards)

We consistently learned, both from on-site interviews as well as our online surveys, that there are significant delays for defendants awaiting trial in jail, both in obtaining the initial evaluation of competence to stand trial and being admitted to a hospital following a determination of incompetency. The JLARC (Joint Legislative Audit and Review Committee) has studied this issue over the past two years and issued a final report (Competency to Stand Trial, Phase II: April 23, 2014). They identified a number of problems that are consistent with our findings. We will briefly review their findings and recommendations, and then we will offer our comments and recommendations.

First, DSHS is not meeting the timelines for completing competency evaluations. The legislature established a 7-day timeline for completing evaluations for defendants in custody (jail) and 21 days for those in the community. DSHS has not been able to meet these timelines consistently (per the JLARC report, the average time for evaluations in jails was 19 days for Western State Hospital and 33 days for Eastern). Based on our review of the JLARC report, as well as our meetings with the various stakeholders, there are *several reasons for these delays*. Some are logistical and more easily remedied through better coordination across systems, whereas others can only be addressed by provide more resources.

- a. Some delays are a function of the defendant asserting legal rights (for example, delaying an evaluation until an attorney can be present). This is a reasonable basis for a delay, and these cases should not be counted when evaluating compliance with timelines.

- b. Some delays are a function of the evaluators not receiving full documentation in a timely manner (police reports, medical records, etc.). This systematic issue that should be addressed with the courts by the proposed Office of Forensic Mental Health Services. Evaluators cannot conduct an appropriate evaluation without certain documents, and it is not feasible to begin the process until such documentation is received. We recommend that for the purpose of measuring compliance with deadlines, the “clock” should not start until such time as all necessary records have been received. But, ultimately, this problem should be addressed via clear communication with courts, attorneys, and law enforcement; ideally the state will draft and widely disseminate guidelines for prompt provision of records to evaluators.⁴
- c. Some delays are apparently caused by lack of private office space available at some jails. Evaluators reported that they are sometimes told that a room is not available because it is being used for attorney contacts or other reasons. Again, these cross-system challenges should be addressed by coordination between a centralized Forensic Office and the jails, with the goal of establishing *state-wide principles* (e.g., jails protect space for competence evaluations) even if the specifics of these principles must differ by region (e.g., some jails might use attorney-visit rooms, while others may use an office in the medical department).
- d. To a slight extent, delays may be reduced by decreasing the overall volume of competence evaluations where feasible. Washington, as a whole, does not appear to have an inordinate or inappropriate number of competence referrals. Thus, educating the judiciary about appropriate referrals will not solve the state-wide problem of slow evaluations. But, at least one jurisdiction (King County) struggles with a disproportionate number of competence referrals for misdemeanants. Often, this is symptomatic of a resource-strapped system using competence evaluations as a mechanism to secure treatment for indigent patients (which thereby creates other resource problems in the forensic system). In the jurisdictions where this is most problematic, it would be helpful to educate

⁴ Some states go so far as to prescribe this type of record provision in the statutes that guide forensic evaluations. For example, Virginia code § 19.2-169.1 (“Raising question of competency to stand trial or plead; evaluation and determination of competency”) includes the following:

“ Provision of information to evaluators. - The court shall require the attorney for the Commonwealth to provide to the evaluators appointed under subsection A any information relevant to the evaluation, including, but not limited to (i) a copy of the warrant or indictment; (ii) the names and addresses of the attorney for the Commonwealth, the attorney for the defendant, and the judge ordering the evaluation; (iii) information about the alleged crime; and (iv) a summary of the reasons for the evaluation request. The court shall require the attorney for the defendant to provide any available psychiatric records and other information that is deemed relevant. The court shall require that information be provided to the evaluator within 96 hours of the issuance of the court order pursuant to this section.”

the judiciary about which cases are (and are not) appropriate for competence evaluation referrals, and less resource-intensive ways to secure treatment.

- e. A *primary* reason for delay—as documented by JLARC and confirmed in our discussions with forensic evaluators, administrators, and other stakeholders—is that *Washington does not employ enough evaluators to conduct all the evaluations requested*. Although there is some confusion about the expected productivity, we have been informed by DSHS, that the expectation is for each evaluator at WSH to conduct 11 evaluations per month (or 121 per year, taking into account leave time), and 9 evaluations per month (or 99 per year) for each evaluator at ESH. Unfortunately, there are no national “productivity norms” for competence evaluations (these would be largely meaningless because the context and procedures vary widely across jurisdictions). However, based on our interviews with evaluators, as well as review of anonymous surveys, it is our impression that these numbers (121 for Western and 99 for Eastern) are ambitious but *generally* reasonable. But all sources agree: *even with optimal productivity standards, additional evaluators are needed*. We discuss this issue further, below.
- f. Finally, a few of the ostensible “delays” may reveal more about the system of deadlines than the system of evaluators. We concur with DSHS’s legislative request to redefine the 7 and 21 day timelines to exclude weekends and holidays. Generally, it is more reasonable to design expectations based on work days, rather than calendar days. Of course, this is a very minor change that makes expectations on evaluators more reasonable, but does not address the underlying issues.

More significantly, *we encourage extending the 7-day deadline*. There are no national norms for such competence evaluation deadlines (again, such norms would be largely meaningless because the evaluation process works somewhat differently in each state), but it is clear that a 7-day deadline is an outlier. Among the broad range of time frames across states, 7 days is unusually short, and we could find nothing about Washington’s system that suggests evaluations can or should be completed more quickly than in other states. Obviously, extending this 7-day deadline will *not* solve the broader problem of delays, but an unrealistically short deadline does artificially “set evaluators up for failure” and makes it more difficult to isolate and remedy the truly problematic delays.

- g. Other delays occur *after* an adjudication of incompetent to stand trial, and admission to the hospital. These delays appear to be entirely a function of bed capacity within the hospitals’ forensic units, and unrelated to the competence evaluation process. The best solution for this problem is to expedite discharge of patients already in the hospital. Later in this report, we address recommendations for more efficient discharge of the two relevant forensic populations (i.e., patients admitted for competence

restoration, and patients who have been adjudicated Not Guilty by Reason of Insanity), which would leave the hospital with greater capacity for admitted those patients who require competence evaluation on an inpatient basis.

Table 3	
<u>Source of Delay</u>	<u>Proposed Remedy</u>
Defendants assert legal rights	No remedy needed. Should not be counted when evaluating compliance with timelines.
Evaluators awaiting key collateral data	OFMHS disseminate guidelines and mechanisms for prompt provision of records to evaluators.
Evaluators lack interview space in the jail	OFMHS facilitates state-wide policy for jails to protect evaluation space
Occasional frivolous referrals, or unnecessary referrals for misdemeanants	OFMHS educates judiciary about appropriate referrals, particularly in problematic jurisdictions
Insufficient evaluators to conduct the evaluations requested	Additional evaluators must be hired.
Some apparent delays reflect unreasonably ambitious timelines	Extend the 7-day timeline, and ensure all timelines include only workdays

Increasing the availability of evaluators

- a. For evaluations to be punctual, *additional evaluators must be hired*. Virtually all sources agreed on this resource problem. Even in very recent history when evaluators have apparently met productivity standards, these are outpaced by the quantity and frequency of referrals. The necessary number of evaluators needed will be based on a projection of expected evaluations. DSHS has requested, as a starting point, three additional evaluators. We do not have an independent means to assess projected number of evaluations, although we agree with the methodology employed (that is, using the productivity standard established above to determine resource need).
- b. One of the obstacles to recruiting additional evaluators, as well as retaining those already in the system, is low salaries. We do not recommend specific figures because salaries across the country are

influenced by numerous factors (including cost of living, nature of the job, etc.), but it is clear that the existing salary structure does not take into account the specialized skills and training required of forensic psychologists and psychiatrists. A more systematic analysis of comparable positions in both the public and private sector in Washington should be undertaken to determine a more equitable pay scale.

- c. Acknowledging the need for additional, adequately-compensated evaluators, there are *also* additional structural issues that can improve the access to evaluators and the punctuality of evaluations:
 - i. Satellite sites for evaluators: Currently, there is only one satellite site, North Regional Office (NRO) in King County. Evaluators assigned to this site serve King County and other counties in the Northwest part of the state. This model works well and helps to relieve some of the pressure from evaluators at WSH. Given that NRO is in Seattle, which has a large number of evaluations, and access to forensic evaluators who are drawn to that area, this model works for that area. It may be more difficult to replicate this model in other areas, but evaluators and administrators at ESH suggested that it may be feasible to try to site a satellite clinic in Yakima that would serve that county as well as Tri-City. We are not in a position to make such specific recommendations, but do recommend that DSHS fully explore such options. This would likely be especially helpful in the Eastern part of the state, as evaluators currently have to travel many hours to conduct jail evaluations.
 - ii. SSB 5551: This legislation allows counties to hire evaluators independent of the State Hospitals. To date, only Pierce County has taken full advantage of this option. The stakeholders in Pierce County with whom we met reported that this is working well for them. However, they emphasized some of the unique characteristics of Pierce County that may not apply elsewhere. They emphasized that their proximity to WSH allows access to a cadre of evaluators who had previously been trained at WSH. Other counties would not necessarily have such a pool of evaluators. Pierce County stakeholders also emphasized their high volume of cases. As such, evaluators are willing to conduct the evaluation for the \$800 fee established (which is well below market rates), as they have some assurance of a steady referral source. Again, this is unlikely to be applicable in most other jurisdictions. Thus, we recommend that SSB 5551 continue beyond its current expiration date of June 30, 2016, even if it continues to be used by only a very limited number of jurisdictions. All evaluators who conduct evaluations per 5551 should be subject to the same Quality Assurance review process

(and certification, if that is developed statewide) that will be developed for the evaluators employed by the State (see below).

Training evaluators

One straightforward approach to improving evaluator performance and evaluator availability is to formally, systematically train evaluators. Currently, there is *no* statewide training to guide forensic evaluations (such as competence to stand trial, criminal responsibility, violence risk assessment). Furthermore, we learned from evaluators that they do not even receive coordinated training on site. The quality of training provided to newly hired forensic evaluators appears to vary greatly, and depends on the commitment and resources of individual supervisors. Furthermore, there is no mechanism and no allocated funds for updating evaluators on developments in the field. For instance, some evaluators expressed an interest in learning about a recent update to the HCR-20 (a widely used violence risk assessment instrument), and others had requested training on the new DSM-5, but conveyed resources were available.

In any state system, *formal forensic training is essential*. Just as scientists and technicians who work in forensic science labs must receive formalized training and quality assurance checks, forensic mental health professionals (who also provide scientific evidence to the courts) must complete formal training and quality assurance reviews. Different states use different models to provide forensic training and even formal certification (see Frost et al, 2006 for a good overview and Karas, Gowensmith, & Pinals, 2014 for more current data). But since the first wide-scale forensic clinicians in Virginia in the early 1980s, research (e.g., Fitch & Warren, 1989; Melton et al, 1985) and professional consensus has consistently underscored the value of state-sponsored training for forensic clinicians. Nationally, states with better forensic services tend to require more training of evaluators. Massachusetts has had the most rigorous model, requiring a formal certification procedure; Georgia and Oregon have recently developed certification processes as well. There is no single model that will work best for all jurisdictions,⁵ but the guiding principle is that psychologists and psychiatrists who conduct forensic evaluations should have specialized training and should be reviewed for quality assurance. Because formal state-wide certification requirements appear to promote better forensic evaluations (Gowensmith, Sledd, & Sessarego, 2014), *we recommend that Washington begin mandatory training as soon as possible and progress towards a formal certification process*.

A centralized, statewide Office of Forensic Mental Health Services, with its own budget, would identify and prioritize training needs, fund them, and develop a standardized process for new forensic evaluators. Ideally, the office would soon progress towards developing a formal certification process for forensic evaluators.

⁵ We are happy to provide, upon request, much more detailed information about the training programs in the states where we have provided these services (i.e., Massachusetts, Virginia, Hawaii) and can provide summary information about approaches in other states.

Beyond addressing the ethical and professional need to ensure high-quality forensic evaluations, formal training requirements offer several other advantages. For example:

- Some of the trainings required for forensic evaluators would assist other groups as well. For instance, training on violence risk assessment, a core element for forensic evaluators, is also important for other clinicians working with forensic patients and civilly committed patients. Thus, there could be efficiency and cost savings by incorporating other clinicians into the relevant forensic trainings. Furthermore, some of the trainings would also be valuable for attorneys and judges. In addition to helping legal professionals better understand the forensic system, such trainings would enhance interaction and coordination between the mental health and criminal justice system, which may help reduce unnecessary referrals and otherwise increase efficiency.
- *Mandatory training and certification may help rural areas better access good forensic evaluators.* Historically, Washington has lamented that forensic evaluations are unavailable in rural areas, and therefore required extensive travel from the forensic evaluators based near the state hospitals. But some clinicians who are already based in more rural areas could complete the mandatory training, demonstrate competence as forensic evaluators, and then become available to perform evaluations in their own regions (thereby reducing the costs and delays of requiring evaluators to travel from the hospitals). Several states adopt a similar approach because research demonstrates that community clinicians can be trained—through rigorous state-sponsored trainings—to perform adequate forensic evaluations, saving time and money (Melton et al., 1985).

Although high-quality training and certification procedure may involve initial effort and expense, it enhances the availability and quality of evaluators in ways that will ultimately serve the system well.

Quality Assurance Procedures for Evaluators

With a formal training and certification process in place, quality assurance procedures become far more feasible. *Currently, Washington appears to have no formal quality assurance procedure for forensic evaluations at any site.* When we inquired of the evaluators, they reported informal mechanisms, such as consulting with each other, and occasionally reading reports completed by their colleagues. We learned that since our initial visit in February, 2014, there has been some movement to begin peer review at Western State Hospital. However, quality assurance should be managed by a centralized Forensic service. This can be accomplished either internally (that is, by hiring excellent local forensic psychologists or psychiatrists to conduct the reviews), or by contracting out these services. At a minimum, a quality assurance process should involve:

- Reviewing a random sample of reports from each evaluator to gauge:
 - o Adherence with ethical standards and best practices such as:

- Properly using collateral sources of information
 - Including data sufficient to address the referral question
 - Omitting irrelevant or prejudicial data
 - Clearly conveying an answer to the referral question, and the rationale underling that answer
- o General rates and patterns of opinions (e.g., are some evaluators finding an unusually high or low percentage of defendants incompetent or insane?)
- Supervising and mentoring evaluators, particularly those who demonstrate weaknesses in the reviews described above
 - Regularly surveying report consumers (i.e., judges and attorneys) regarding the quality and utility of reports. Our online surveys revealed input that was not entirely negative, but did convey concerns about bias, inaccuracy, or hasty work by evaluators.

CHALLENGE #3:**IMPROVING COMPETENCE RESTORATION**

Overall, the current system for competency restoration is limited to inpatient restoration. Western State Hospital (WSH) and Eastern State Hospital (ESH) are the two only locations with formal competency restoration programs. This means any person found incompetent to stand trial will be placed in the most restrictive and most expensive level of care in order to receive competency restoration. This one-size-fits-all approach cannot address, in any individualized way, a defendant's level of clinical need, risk of violence, or likelihood of attaining competency in a reasonable period of time. *Furthermore, limiting all incompetent defendants to inpatient restoration increases hospital census and lengthens delays for restoration services.*

We recommend a more diverse system of restoration services. This system would assess levels of clinical need, risk for violence and recidivism, and restorability prior to, or immediately upon, placement in an inpatient hospital setting. This also includes creating innovative police- and court-based services that assess and treat individuals likely to otherwise be ordered to a competency evaluation. This system would provide less expensive alternatives to inpatient restoration for those individuals that do not need hospital-level care and supervision, while freeing hospital beds for those who need them most.

Historical context

We are not aware of any key events that have shaped Washington's competency restoration practices or system. We understand that legislation was drafted which proposed the creation of a jail-based competency restoration program in 2013; this measure included a budget but ultimately did not advance to a final hearing. We also understand that a similar bill is being considered for introduction at the coming legislative session in 2015.

Current practices*Reducing inappropriate referrals*

A first step in facilitating efficient competence evaluations and restoration involves reducing inappropriate referrals for these services. Currently, Washington has a few practices that may help divert inappropriate referrals (we will recommend additional practices later in this section):

- Few jurisdictions use screens or other clinical measures to divert inappropriate CST evaluations. But King County has several pre-trial diversion programs, including LEAD, the Crisis Solution and Diversion Center, and mental health personnel integrated with crisis mobile teams and specialized law enforcement teams. This array of diversion programs is commendable and certainly serves to steer persons

with serious mental health problems into services rather than into the criminal justice system. However, King County does not seem to have any specific staff or programs dedicated to early identification or intervention with potential CST evaluation cases. Instead, the King County Mental Health Court appears to be responsible for an unusually high number of misdemeanor defendants referred for competency evaluations. Dedicated attorneys are provided to the King County MHC for competency-related issues. It would be ideal for the Seattle Municipal Court and the King County MHC to incorporate an earlier intervention that could discriminate the legitimate cases that need a CST evaluation from those that may not.

- One notable exception exists in the early intervention system. In Pierce County, local jail staff communicate directly and frequently with the court next door regarding clinical issues among defendants making their first appearances in court. Staff report that one benefit of this system is identifying defendants who are the most appropriate candidates for CST evaluation.

Locations for CST restoration

Currently, individuals who are found incompetent to stand trial are ordered to restoration in either WSH or ESH. Although statutes allow for restoration to occur in alternative locations, current practice is to always remand all incompetent defendants to inpatient restoration. Competency restoration appears to begin and end at the two state hospitals.

No formal alternative locations currently exist for competency restoration. Rarely, individuals are allowed to obtain competency restoration in the community; these cases typically involve juveniles or persons with developmental disabilities, and do not average even one case per year statewide, sources report.

Seattle's Municipal Court allows outpatient competency restoration for certain misdemeanor cases. Eligible defendants must be receiving intravenous psychiatric medication, be currently connected with a mental health treatment provider, and cannot be using drugs or alcohol. Staff report that approximately 3-4 persons are released for outpatient restoration per year, though no formal program exists to provide competency restoration interventions; these are apparently crafted on a case-by-case basis.

Current CST restoration approaches

Policies and restoration activities are not uniform between the two hospitals. The Washington State Institute for Public Policy consulted with national competency expert Dr. Patricia Zapf in a 2013 effort to delineate reasonable time frames for restoration and to standardize restoration activities across ESH and WSH. Dr. Zapf noted that the restoration interventions differed significantly between ESH and WSH. Our review of documents and interviews with staff indicate that competency restoration approaches and models continue to differ significantly between the two hospitals. Neither hospital identified a cohesive model or methodology for competency restoration, and each seemed to rely on fairly informal restoration methods, which varied by staff. Staff have "done

much with little,” apparently restoring many defendants to competency within reasonable (i.e., consistent with national trends) time frames. However, both hospitals could improve their restoration interventions considerably and a shared, formalized approach to restoration would help restore competency more efficiently and effectively statewide.

Lessons from National Models and Best Practices

Several alternative models to inpatient competency restoration exist nationwide. These include initial screens, community-based restoration programs, and jail-based restoration programs.

Initial screening programs

Many cities and counties around the country employ some sort of court-based clinic model to screen cases with mental health considerations. These clinics are designed primarily to assess clinical needs of the defendants prior to their first appearances in court, and often serve as a way to divert inappropriate CST evaluations. At times, CST evaluations may be ordered as a “default” mental health evaluation in an attempt to understand the mental health issues at play in the case. However, the CST evaluation should be used only as a test of the defendant’s competence, and not as a default mental health evaluation.

- In Chicago and Philadelphia, for example, courts employ psychologists to conduct in-depth psychological evaluations directly for the courts themselves. The courts operate and staff these programs. This allows recommendations to funnel straight to the court, where specialty mental health court programs are headquartered in partnership with county and state mental health agencies. These evaluations often serve as de facto competency evaluations and can be used to order CST restoration more quickly, as well as to weed out inappropriate cases that may have otherwise been ordered to competency evaluation or later placed into competency restoration.
- In Washington DC, a court clinic operates between the Washington DC district hospital and the court, in which psychologists serve on a rotating basis at the court’s in-house clinic. This clinic is run by the hospital. Psychologists screen defendants in the court cell block at the request of judges or attorneys. Evaluations are again meant to screen out inappropriate evaluations (malingering, drug or alcohol intoxication) and identify bone fide treatment and evaluation needs.
- In Honolulu, two pre-trial clinic programs serve the court. First, a clinic operated by the Department of Health is located in the Honolulu Police Department cell block. When suspects are arrested and held overnight, the clinic staff (staffed by advanced psychiatric nurses) assess clinical needs, obtain current and recent treatment history, administer medication, and provide summary information to the court prior to their first appearances in the morning. This allows persons charged to begin receiving the benefits of psychiatric medication in advance of their first

court hearings. Second, the Department of Health staffs a court-based clinician (psychologist) at the district (misdemeanor) court to conduct screening assessments and advise the court of available community treatment resources. Like Washington DC, psychologists screen defendants in the court cell block at the request of judges or attorneys.

According to mentalcompetency.org, a website and resource of the National Judicial College dedicated to promoting research and best practices regarding competency to stand trial, placing mental health professionals in these types of settings can be effective:

“A mental health nurse practitioner can perform invaluable roles which can help to prevent defendants from decompensating and alleviate further costs. A mental health nurse practitioner may be best suited to: (1) administer medications, assure the defendants are following the proscribed mental health treatment, and encourage them to follow the treatment; (2) alert the treating professional, counsel, and court about adverse effects of the treatment and/or if defendant fails to follow the prescribed mental health treatment; (3) observe the defendant's behavior and alert the treating physician, counsel, and court if it appears the defendant is decompensating.”

Community-based restoration programs

Currently, 39 states (including Washington) have statutory allowances for competency restoration to occur outside of an inpatient hospital setting. Sixteen states currently operate formal outpatient competency restoration programs (OCRPs).⁶ Although each state's program is unique, there are some similarities and patterns among them, according to a recent national survey about OCRPs (Gowensmith, Therson & Speelman, 2014).

All outpatient competency restoration programs are located in designated urban areas; very few OCRPs operate statewide (Virginia and Texas are the largest exceptions, with programs in several locations statewide). OCRPs are typically operated by state departments of mental health rather than by county agencies or courts, though close partnerships with local courts and judges are imperative in starting such programs. OCRPs represent a relatively new phenomenon; 13 of the 16 current programs were created within the past seven years. Most programs start fairly small and expand over time, with most programs serving between 1-30 persons at any one time. Most are focused in a large population center (i.e., New Orleans, Honolulu, Miami, Little Rock).

Regarding demographics, most OCRPs restrict their participants to assuage public safety and mental health concerns. Most programs begin by restricting eligible participants to defendants facing misdemeanor or non-violent felony charges. Also, most programs' initial eligibility criteria include medication adherence, low elopement risk, and clinical stability. Finally, while most OCRPs treat a spectrum of competency-related matters, a

⁶ States with OCRPs: Arkansas, Colorado, Connecticut, Florida, Georgia, Hawaii, Louisiana, Michigan, Nevada, Ohio, Rhode Island, Tennessee, Texas, Virginia, Washington DC, Wisconsin.

handful do not address developmental disabilities or substance-related disorders. In general, OCRP criteria expand over time to accommodate more defendants

While some programs admit participants directly from court, most participants are referred from inpatient hospitals. These hospitals quickly assess the defendant's clinical stability, match them against other eligibility criteria for their outpatient program, and then make referrals accordingly. Courts usually make the ultimate decision on hospital discharge.

OCRPs are typically operated at community mental health centers, though a few are operated out of a day treatment wing of the state hospital. The hospital-based programs are located in cities that house both the state hospital and a large urban population, making day treatment options possible. Six states also have programs operating in local county jails (detailed later in this chapter).

The most significant differences among programs involve a) ancillary services provided to the OCRP, and b) levels of direct government resource allocations. First, some OCRPs restrict their services exclusively to therapeutic restoration activities, typically running competence-education groups and medication management out of a community center or hospital-based day clinic. Others, in contrast, offer varying degrees of ancillary services: housing, substance abuse treatment, peer involvement, and/or intensive case management services. Second, about half of the current OCRPs rely exclusively on the governmental entity (usually the state department of mental health) directly for staffing, space, and other necessary program resources. The other half uses some combination of governmental and contracted agencies to operate the program. Private agencies are typically utilized for ancillary services.

Regardless of the model, the outcomes of OCRPs are fairly uniform and positive. Restoration to competency rates is about the same as those found in corresponding state hospitals (about 77%). The average number of days prior to restoration is higher than the number reported from inpatient units (about 150 days compared to 120 days inpatient); however, the costs savings associated with outpatient programs are substantial. Outpatient programs cost about \$203 per day, as compared to average inpatient hospital costs of \$607 per bed day. Program managers have reported that longer lengths to restoration are welcome given the overall cost savings and the increased civil liberties afforded to the participants. Our survey participants estimated OCRP savings at more than \$60,000 per participant.

Finally, negative outcomes (arrests, elopements, acute decompensation, and serious rule violations) appear rare in OCRPs. No incidences or arrests for serious violence have been reported by any OCRP to date. The average rate of any OCRP negative incident is 16.7% across states, with the majority of those (73.0%) due to acute decompensation or clinical problems requiring a return to an inpatient setting.

According to mentalcompetency.org, outpatient competency restoration is a recognized best practice model:

“It is a best practice for the court to refer a defendant for competency restoration in the least-restrictive setting consistent with public safety and the defendant's treatment needs – whether in a secure psychiatric hospital, federal medical center, state hospital, jail, community mental health center, or mental retardation center or other setting.

In making a determination as to the least-restrictive setting for competency restoration, it is a best practice for the court to weigh both public safety issues and the treatment needs of the defendant. It is also a best practice for the mental health professional to recommend the appropriate treatment setting for the defendant. Whether a defendant is eligible to be released on a personal recognizance is a bond decision that should be made using the same factors as in any other case. The decision about the most appropriate setting for the restoration is a judicial decision based upon medical information provided by the mental health professional.

“It is a best practice for the court to order community restoration for individuals with mental retardation, cognitive disorders or developmental disorders, or major mental illness, if all of the following apply: (a) the community has a program to restore competency that is suitable for the treatment needs of the defendant; (b) the program provides intensive, individualized competency training tailored to the demands of the case and the defendant's particular competency deficits; (c) the defendant has a stable living arrangement with individuals who can assist with compliance with appointments and with treatment; and (d) the defendant is compliant with treatment, and not abusing alcohol or other chemical substances.”

The National Judicial College also lists necessary conditions that should be present if competency restoration is to occur in an inpatient setting:

“It is a best practice for the defendant to be restored in the least-restrictive treatment setting or facility consistent with the public safety and treatment needs of the defendant. It is a best practice to utilize a hospital for competency restoration if any one or more of the following six circumstances are present: (a) the individual presents an imminent risk of danger to self or others due to the mental disorder; (b) the individual is at risk of significant self-neglect; (c) the pathology of the individual is unclear and requires close clinical observation to assess and treat; (d) a thorough evaluation for malingering is required; (e) the individual lacks the capacity to consent to psychotropic medications and is likely to require the involuntary administration of medication for restoration to competency; or (f) emergency mental health or medical services are likely to be needed.

If none of these conditions are met, the least-restrictive alternatives to hospital-based restoration are appropriate. Coordination with court-based clinicians and cellblock mental health personnel should reduce the need for conditions (c) and (d) to default to an inpatient setting.

Jail-based restoration programs

Six states currently have jail-based competency restoration programs.⁷ Like the outpatient programs, they are each unique though some similarities exist across programs.

Each of the jail-based programs operate as alternatives to hospital-based restoration. However, two main models exist in jails: housing formal restoration programs and offering temporary restoration services. Formal restoration programs (found in California and Colorado, for example) provide an entire jail-based restoration unit dedicated to competency restoration services. Although hospital-level services cannot be replicated in a jail setting for a variety of reasons, the philosophy of these programs is to provide an alternative “hospital-like” unit in the jail. Referrals come from the state hospital; defendants are transferred to a jail for restoration and then returned back to the hospital as necessary. Challenges include limited jail formularies, transportation of defendants, the limited capabilities of correctional facilities to provide adequate mental health care, and perhaps most importantly, significant concerns regarding civil liberties and least restrictive settings for mental health treatment.

The second model, epitomized by Texas, provides restoration services in jail as a temporary stop-gap while the defendant is awaiting placement in a formal restoration program. Incompetent defendants often wait in local jails for a space to open in a state hospital or a community-based OCRP. While these defendants await their transfer, jails provide intensive competency restoration services to jump-start the restoration process.

Unfortunately, no reliable data exists on the viability or the outcomes of the programs. Restoration rates are unknown across programs, though the California program reports lower restoration rates than inpatient facilities (about 45% of defendants are restored to competency, as compared to average inpatient restoration rates of more than 75%).

The mentalcompetency.org resource center does not describe jail-based restoration as an unqualified best practice. Jail-based restoration is recommended only if community-based programs and services are not available, and even then recommendations are tempered by the challenges described above. For example, a recent report from the Hogg Foundation for Mental Health (2013) recommends that Texas pursue outpatient restoration instead of jail-based restoration, and suggests that jail-based restoration only be considered when outpatient restoration programs are not available – and only when mental health staffing is adequate at the facilities. Many stakeholders with whom we spoke also commented that jail-based restoration would essentially lengthen the time that persons with mental illness spend behind bars in a correctional institution, rather receiving access to services at a mental health facility. Given the paucity of data, as well as the significant challenges associated with jail-based mental health services, jail-based competency restoration is not a national best practice model at this time.

⁷ States with jail-based competency restoration programs: Arizona, California, Colorado, Florida, Georgia, and Texas.

Table 4**Examples: Outpatient Competence Restoration in Select States****Arkansas**

Arkansas began their OCRP in 2009 as a day treatment program housed in their state hospital. In April 2012, Arkansas transitioned their hospital-based OCRP program into the community, training eight community mental health centers to provide restoration in their local areas. Participants receive care coordination, drug screenings, family therapy, group psychotherapy, interpretive services, mileage reimbursement, medication evaluations, and psychological evaluations. Benefits from the OCRP in Arkansas include hospital waiting list reductions, lower costs than anticipated, increased understanding of restoration options for individuals, and improved relationships with judges and mental health providers. Barriers to the program include a lack of knowledge about outpatient restoration in many courts as well as courts' hesitancy to keep people in the program even if minor negative events occur. The program continues to expand and has had fewer than 50 individuals participate to date.

Outcomes are good. Restoration rates are similar to those in an inpatient setting (79%) and the amount of time to restore individuals to competency averaged slightly more than three months. Negative events are rare. Cost savings have not been calculated but are believed to be significant.

Hawaii

The OCRP in Hawaii began in 2007 as a partnership between the Hawaii Department of Health and the District (misdemeanor) court in Honolulu. The Department of Health alone manages the program, which is open to all misdemeanants and all non-violent felony defendants. Referrals can come directly from court, but in practice all referrals and participants to date have come from the state hospital. The Department of Health provides case management, psychiatry, and peer support (clubhouse services), all in the community mental health center where the program is headquartered. Housing is provided by a contracted private housing agency, and all participants reside in this group home. The program occasionally provides services to other persons found incompetent and placed in other settings (usually family residences) by including those persons in group therapy and limited case management. Additional services, including substance abuse services, are provided as needed by a privately contracted provider. The Hawaii OCRP is managed by a Department of Health forensic psychologist and utilizes the same restoration materials and processes as the state hospital. The program began in a repurposed, abandoned cottage on the grounds of the state hospital and included security fencing and a security guard to alleviate public safety concerns; however, within two years the guard and fencing were removed as unnecessary. Participants are now housed in a mental health group home in Honolulu with no additional security precautions. Approximately 50 defendants participated in the Hawaii OCRP from 2007-2013.

Outcomes for the program are excellent. Restoration rates (95%) exceed those from

inpatient hospitals, negative outcomes are very rare (no arrests to date), turnover has increased at the state hospitals, and the financial savings have been significant (about \$20,000 per outpatient restoration case compared to about \$75,000 per inpatient case).

Texas

Texas began their outpatient competency restoration programs in 2007. The Department of State Health Services piloted OCRPs in four urban counties. The program has since expanded to 11 sites, with some in rural areas. The program served 182 individuals in 2012. The Texas model is unique in two ways. First, the OCRPs vary significantly from county to county. Austin's OCRP provides extensive ancillary mental health services, the Dallas / Fort Worth OCRP provides housing, and the East Texas program retains high quality by requiring a rigorous selection process for potential participants. In this sense, there is no uniform Texas OCRP. Each county is free to develop an OCRP that fits their needs and resource capacity.

Second, Texas offers informal competency restoration in some county jails. While no counties offer a formal jail-based restoration program (as in California and Colorado), some county jails provide intensive mental health services while a defendant is awaiting transfer to either inpatient or outpatient programs. These services can include prioritization for mental health care, psychiatric medication, more frequent interactions with mental health staff, and placement on special mental health units.

Although results are available from the Texas OCRPs individually, the aggregate results are impressive. Restoration rates are slightly lower than inpatient rates (about 66% are restored or have their charges dismissed after clinical improvement), and the cost differential is about \$38,000 (\$50,000 per inpatient case versus \$12,000 per outpatient case).

Virginia

Virginia has had some OCRP services available for many years, but only recently made them consistently available throughout the state. Statute now requires competence evaluators to opine (if they conclude a defendant is incompetent) whether the defendant is an appropriate candidate for outpatient restoration. This alerts the judge to consider ordering outpatient (rather than inpatient) restoration, which takes place through the Community Service Boards (CSB; state-funded community mental health centers). Each CSB has at least one staff designated to specialize in forensic consumers (e.g., outpatient competence restoration, working with insanity acquittees in the community). These designated forensic clinicians administer the competence restoration services in different locations (the CSB building, jail, or occasionally even the defendant's home) depending on the defendant's circumstances. The state's centralized forensic office (contracting with a university) developed a restoration curricula and tools, including instructional video, for these "restoration counselors" to use, and provided state-wide trainings to foster uniformity in restoration services across the state.

As in other states, OCRP outcomes appear promising, though the full-scale implementation of OCRP is too new for Virginia to have state-wide data. All sources agree there are significant savings, given the cost differential between inpatient and outpatient services.

Wisconsin

Wisconsin law was changed in 2008 to allow an option for community based restoration. The program began in the southeastern corner of the state, an area with a high population density and therefore the most referrals. It has since expanded to 27 other counties, serving more than 200 people since 2008, with 62 defendants in 2013 alone. Due to Wisconsin's rural geography and low population density, they use contract providers.

All defendants ordered for competency evaluation are screened for possible inclusion in the outpatient restoration program. Primary eligibility criteria require that the defendant does not pose a risk to others, is stable enough to participate in outpatient programming, is likely to cooperate with the program, and has a stable living situation. Individuals meeting these criteria receive a more in-depth evaluation from the provider, who recommends outpatient services if appropriate. Individuals participate in competency restoration training sessions (in group or individual formats) several times a week, receive a case manager to ensure continued monitoring and support, receive medication or treatment services as indicated, and participate in periodic evaluations to gauge progress toward restoration. Failure to cooperate with treatment, deterioration in psychiatric stability, behavior that indicates a risk to self or others, or further illegal behavior results in a court hearing and possible transfer to the inpatient program.

Outcomes for the program are excellent. Restoration rates match those from inpatient hospitals, turnover has increased at the state hospitals, and the financial savings have been significant (about \$25,000 for each outpatient restoration case as opposed to about \$63,000 for each inpatient case).

Recommendations

We recommend improvements in three sequential areas: clinical services prior to CST evaluations, uniform competency restoration services for inpatient populations, and outpatient competency restoration programs. Comments regarding jail-based competency restoration and statutory changes will follow.

Pre-evaluation services:

Screening and mental health services and staff should be made available to courts in those jurisdictions that order the most CST evaluations. These services should assess defendants who may be ordered to a CST evaluation at an upcoming court appearance, and they should screen out inappropriate referrals.

King County orders more CST evaluations than any other county and substantially more for misdemeanor defendants. It seems that a large source of these misdemeanor referrals is the King County Mental Health Court. For this reason, these types of pre-evaluation services are critical for King County, and should be integrated closely with the

King County MHC. Pierce and Spokane counties also order many CST evaluations each year and should strongly consider such services. Snohomish, Clark and Thurston counties may not have numbers to necessitate full-time services, but may have large enough numbers to warrant as-needed services.

Services should include the following:

- Develop a police-based cellblock mental health service in King County. This service will screen and assess persons newly arrested and waiting overnight for the first court appearance. Staff should be able to administer psychiatric medication. This program should be operated by DSHS and would have access to RSN and state hospital mental health information, and should be able to transfer information to the court.
- Develop a court-based clinics in King, Pierce, and Spokane County courts. These clinics could operate in various ways, but should employ a psychologist with knowledge of community resources and competency assessment experience. The clinic could operate as a one-person program. The clinic should be “on call” with the judges and attorneys and should be housed in the courthouse in which first appearances routinely occur and in which competency evaluations are most often ordered. The clinic (or clinician) should assess and screen those defendants most likely to be ordered for CST evaluation, and should make recommendations to the court about need for evaluation and community options for evaluation.
- Given the large number of misdemeanor CST evaluations ordered, King County District and/or Municipal courts in particular should house a court-based clinic that is integrated with their Mental Health Court and their Municipal Court. The clinic should be able to perform competency screenings and reduce the overall numbers of CST evaluation referrals to WSH.
- Pierce County Jail and courts should continue their model of communication for mentally ill defendants. This model is unique in the state and seems quite effective. It operates as a de facto court-based clinic. However, it should formalize its procedures and increase its ability to inform the court about community-based options for treatment and competency restoration.
- Require uniform, statewide coding on criminal rap sheets that clearly identify defendants who have been engaged in the competency evaluation and/or restoration process.

Inpatient competency restoration:

Eastern and Western State Hospitals do a reasonable job with competency restoration. Timelines for restoration, and overall restoration rates, are within national norms. Staffing overall seems adequate. It is commendable that the staff responsible for competency restoration programming have done a generally adequate job with limited resources or training. This was reflected in the 2011 report to the State of Washington

from Dr. Patricia Zapf, and continues to be true in 2014. However, standardization of methods within and between the two hospitals should be improved.

- Competency restoration models, programs, modules, resources, and procedures should be largely uniform between Eastern and Western State Hospitals.
- A specific restoration program curricula should be adopted and implemented in both hospitals.
- Specific restoration approaches and resources for special populations (developmentally delayed defendants, primarily) should be adopted and implemented uniformly in both hospitals.
- Uniform procedures for in-house restoration progress review should be adopted by both hospitals.
- A uniform process for requesting a re-evaluation of competency should also be adopted by both hospitals.
- Staff should assess defendants in inpatient restoration programs for their appropriateness for outpatient restoration upon admission and regularly afterward, with every 15 days being optimal.

Outpatient Competency Restoration:

Outpatient restoration programs should be created and implemented in Washington as alternatives to current inpatient restoration programs. Such programs have been clearly effective at increasing hospital bed turnover, saving money, and respecting the civil liberties of defendants without compromising public safety. Formal jail-based restoration programs should not be pursued; however, jails should offer adjunctive services that help make inpatient and outpatient restoration programs more effective. (Jail-based interventions will be discussed in the next section.)

- Outpatient competency restoration programs (OCRPs) should be created and implemented in the King County / Pierce County metropolitan area and in Spokane County. These programs should serve both incompetent misdemeanants and eligible felony defendants from both counties. These programs should be truly outpatient programs, with all services occurring in the community for community residents.
- OCRPs should be operated by DSHS forensic services.
- Creating successful OCRPs will require close communication and partnerships among DSHS, WSH, ESH, RSNs, courts, and jails. An ongoing OCRP development committee, headed by DSHS and with representatives from the above agencies, should be convened. DSHS should consult with other existing OCRPs when developing their programs.

- DSHS will need a legislative appropriation to create, staff and locate these OCRPs.
- OCRPs in Washington should offer, at the minimum, an array of competency restoration services. This should include individual and group education, psychiatric medication, and coordination of competency-related matters (screens of progress on competency restoration, facilitating formal external CST evaluations, coordinating court appearances, etc.).
- OCRPs in Washington should consider, as is appropriate to the specific county in which the OCRP is located, an array of ancillary services to competency restoration. Additional services could include case management, housing, substance abuse treatment, and other related functions. These services can be operated directly by DSHS, ESH or WSH, RSNs and their contracted agencies, or newly-contracted private agencies.
- Competency restoration programming should be identical to hospital-based programming (i.e., if WSH and ESH use a particular model, the outpatient programs should use the same model). Resources and programming can be tailored for community settings and populations.
- Eligibility criteria must be developed to target appropriate persons for outpatient restoration. Initially, this may be restricted to certain persons who are clinically stable, determined to be restorable, and without public safety concerns. OCRPs will be expected to start small.
- WSH and ESH could serve as locations for outpatient treatment if 1) all participants live in the community, and 2) services are operated as a day treatment model. In this model, incompetent defendants living in the community could come to ESH or WSH to receive competency restoration services, and then return to their community placements after programming is completed each day.
- The North Regional Office in Seattle should be considered as a location for day treatment competency restoration services.
- WSH and ESH could utilize existing buildings on hospital grounds or repurpose buildings to provide restoration on an outpatient status. Alternatively, DSHS will need to secure community housing for this population. This population should be prioritized for such housing options.
- A data collection system should be created and run by DSHS to capture program and outcome variables (numbers of referrals, number of participants, restoration rates, program non-completion rates, time to restoration, etc.).

Jail-based restoration

Jail-based competency restoration is not a viable option for Washington at this time. Resistance from most stakeholders, as well as limitations on locations, prevent formal

jail-based restoration programs from occurring. Some of the strongest and most consistent feedback we received from stakeholders was resistance to jail-based restoration, mostly due to concerns about civil liberties and the inadequacy of mental health care in jails. Additionally, data is equivocal regarding the effectiveness of such programs. Truly outpatient competency restoration programs should be pursued instead. However, jails still serve an important role in the competency-restoration process of incompetent defendants.

- An information sharing system between DSHS, county jails, and courts should be created. Primarily, this system should identify those defendants in local jails ordered to receive a formal CST evaluation.
- Upon receiving the information that an inmate is scheduled for an upcoming CST evaluation, the jail should prioritize the inmate for mental health assessment and services. The jail should coordinate with a court-based clinician to mutually share clinical information about the defendant.
- Anyone waiting in local jails for placement in either inpatient or outpatient restoration programs should receive priority for mental health services in the jail.

Statutory changes

Washington should consider changing the current statutory allotment of 14 days for competency restoration for serious non-felony (misdemeanor) defendants (RCS10.77.088). The current statute sets a timeline for restoration that is clinically unrealistic, and therefore results in finding many defendants unrestorable and converted to civil commitments. The statute should be changed to accomplish two goals: 1) significantly increasing the numbers of misdemeanant defendants referred to outpatient competency restoration, and 2) developing more realistic timeframes for restoration.

The following are *potential* statutory changes that could be considered. Without further study we cannot recommend these changes outright; however, we believe the spirit of these statutory changes should be strongly considered if the current competency restoration system in Washington is to see significant change:

- First, all misdemeanants (regardless of the “seriousness” of the offense) could be ordered to outpatient competency restoration as the default placement, with inpatient admission only available if civil commitment criteria are met. Non-violent felony defendants could also be subject to this change. This change would restrict hospital-level care for lower-level criminal defendants to only those who meet hospital-level criteria, while still mandating defendants with more significant public safety concerns be initially placed in a secure hospital setting.
- Second, all incompetent defendants facing serious non-felony (misdemeanor) charges could have a maximum of 90 days to attain competency restoration. This is an increase from 14 days. Based on national norms, 90 days is a realistic time frame in which most defendants will be restored to competency. Because most

misdemeanant defendants will be ordered to outpatient restoration, additional time for restoration should not be a significant concern. No changes should be made to timeframes for felony defendants.

- Defendants found incompetent are currently allowed to be released to the community for outpatient restoration under RCW 10.77.086 and RCW 10.77.088. This is referred to as a “conditional release” in RCW 10.77.088. However, “conditional release” is a term most often used in other Washington statutes to refer to a person found not guilty by reason of insanity and subsequently released to the community. It is unclear if other statutes governing conditional release are meant to apply to those individuals who are incompetent to proceed and released to the community for outpatient restoration. Persons who are incompetent to proceed should not have their community placements restricted by currently existing statutes related to the conditional release of insanity acquittees (i.e., the Public Safety Review Panel, etc.). Changing the statutory terminology for these two very different populations (i.e., “pre-trial conditional release” or “restoration release”) would alleviate potential confusion.

These types of recommendations are meant to form a package of changes. Individual or piecemeal changes will be far less effective. If statutes are changed to place non-violent, low-level incompetent defendants in the community, a system of outpatient restoration must be ready to serve them. However, a robust system cannot exist without the types of statutory changes described above. Pre-evaluation services will play an important role in diverting defendants away from the CST evaluation process as needed, while jumpstarting the CST restoration process in appropriate cases. Uniform inpatient hospital approaches and ancillary efforts from local jails will combine to make the restoration process more efficient overall. We strongly recommend that changes in each of these areas be pursued if Washington is to see positive changes in its large inpatient population of incompetent to proceed.

Throughout interviews and surveys, both inpatient and outpatient staff – as well as DSHS administration, jail, and court staff – conveyed their willingness to implement the types of changes discussed above. However, they also emphasized they have not received the resources, staffing, or training to implement these types of changes.

CHALLENGE #4:**HOSPITALIZATION AND CONDITIONAL RELEASE for NGRI ACQUITTEES**

Any state with insanity defense laws faces some challenges in treating defendants who have been acquitted not guilty by reason of insanity (NGRI) and then helping them transition back to the community, usually via conditional release (CR). By definition, these acquittees have serious mental illness and a history of at least one criminal offense, which raises reasonable concerns about public safety and requires cooperation among the criminal justice and mental health systems.

However, Washington has appeared to struggle with this population more than other states, and has settled upon a system of practices that are much more restrictive and expensive than other states. Put frankly, the current system for treating persons acquitted as NGRI and preparing them for CR appears far more lengthy and laborious than necessary, diverting disproportionate resources for a relatively small and manageable population. In our view, inpatient facilities should begin preparing persons acquitted as NGRI for CR as soon as they are admitted into their facilities, rather than defaulting to long-term hospitalizations. Inpatient units, forensic evaluators, review panels and boards, courts, and community providers should all be trained to recognize and understand risk factors for the NGRI/CR population, and should use the same risk factors and risk management approaches consistently across all levels and legal statuses for this population. Community providers, in particular, must provide better services for this population in order to transition NGRI/CR patients from inpatient to outpatient services. Although improving this NGRI/CR system to prioritize community supervision over lengthy hospitalization may *appear* to involve new expenses up front, it is ultimately far *less* expensive than a system that provides expensive inpatient care for years longer than necessary. Done correctly, improvements would not compromise public safety, but they would far better respect patients rights related to the “least restrictive” treatment.

Historical context

In September 2009, an NGRI acquittee committed to Eastern State Hospital left without authorization from a sanctioned outing to a state fair. The man had been acquitted by insanity after committing homicide, so news of his elopement spread quickly and generated substantial media attention. The acquittee was apprehended three days later without significant incident. However, this high profile event prompted significant changes to the NGRI and CR processes statewide. These included more conservative approaches to risk assessment, increased restrictions on off-grounds privileges for insanity acquittees, increasingly restrictive state statutes governing the NGRI and CR process, and the creation of the PSRP in reviewing applications for CR.

Current practices in Washington

Practices in Washington seem to vary significantly between Eastern State Hospital (ESH) and Western State Hospital (WSH). We will discuss the practices relevant to the NGRI

acquittee committed to a hospital, and then discuss practices relevant to the CR population.

NGRI commitments

NGRI acquttees are placed on specialized units in both WSH and ESH. WSH has four units dedicated to this population, housing approximately 135 of patients in March 2014. In comparison, ESH has two units dedicated to this population, housing approximately 70 of patients in the same time period. Both hospitals use a treatment mall approach with NGRI acquttees. In discussions with staff and in review of materials, it appears that acquttees receive a standard constellation of mental health services found in most long-term inpatient mental health units. These include individual and group therapies, medication management, occupational and recreational therapies, and milieu therapy. The HCR-20 appears to be a foundation of risk and relapse plans, and therapies use a combination of interpersonal, psychodynamic, and cognitive interventions. These approaches are fairly typical. However, we could find no explicit focus on criminogenic needs, treating risk factors, or social learning—all treatment components that are also typical in other states.

In WSH, NGRI patients progress through a seven-level system by passing certain benchmarks. Upon reaching level 7, they may be transferred to the Community Program (a transition unit). At this point, generally with the treatment team's sanction, the patient may be evaluated for CR readiness by the hospital's internal Risk Review Board. This requires forensic evaluators complete a risk assessment in the hospital. If the evaluation is favorable, it will be reviewed by hospital administration. If this review is favorable, it will be sent to the PSRP for additional review. Again, if favorable, it will be sent to the DSHS secretary for review. If each of these parties recommends the person for CR, the case will be sent to court and reviewed there (and potentially by additional evaluators). If granted, the person will be placed on CR and will either remain on the unit or move to the Community Program unit. On this unit, the acquttee granted CR must prepare for placement in the community by progressing through a five-level system. Levels 1-3 provide a successive on-grounds privileges, while levels 4 and 5 provide increasing off-grounds privileges. On this unit the person learns activities of daily living, stress management, and begins transitioning to the community on increased privileges. Off-grounds privileges are typically limited to very few options – the street just beyond the hospital border, a nearby strip mall, or other areas close to the hospital. Acquiring level 5 privileges typically takes about two years before leaving the hospital, and each successive level apparently requires the same laborious process (evaluations and reviews by the parties named above). After approximately two years, the person *may* be discharged from WSH on CR (but with continued supervision by WSH personnel as described below).

- WSH staff commented with consistency that additional locations for off-grounds privileges should be available to help the person prepare for realistic community experiences and to build a clearer record of progress and community readiness.
- Many WSH staff commented that the process for NGRI acquttees, including the multiple level system and the lengthy status on the community transition unit, is

too slow. Perhaps not surprisingly, insanity acquittees committed to the Community Program unit echoed this concern. Indeed, it seems that it could take a potentially ready CR applicant several years to be discharged, even after an initial hospital evaluation recommends them for CR.

- Staff from both hospitals reported that options for day outings and off-grounds privileges have been unnecessarily rescinded due to the high-profile elopement of an ESH insanity acquittee several years ago. For example, WSH staff commented that courts require 50 days advance notice before changes to day outings will be considered.
- Unfortunately, there was no evidence of treatment modalities or content specifically focused on the NGRI population, and little programming designed to specifically foster readiness for CR. There was no mention or documentation of integrating current, evidence-based practices focused on the NGRI or CR population at WSH. These include addressing criminogenic factors, utilizing the Risk-Need-Responsivity model, using current assessment instruments to help determine progress or readiness for CR, cognitive-behavioral modalities addressing criminogenic potential, utilizing social learning, or specific interventions targeting how mental health needs impact criminogenic factors and potential.

In ESH, the procedures and programming are somewhat different. NGRI acquittees progress through an eight-level inpatient system, at which point they are referred for evaluation. Similar to WSH, after a positive evaluation, the case is referred sequentially to the ESH Risk Review Board, the PSRP, and DSHS administration for approval. If approval is garnered, the case goes to court and a “partial conditional release” may be ordered. These “partial CRs” initially allow for the acquittee on-grounds privileges. In this way, ESH seems to have a slightly quicker process for physically moving patients granted CR out of the hospital units than those in WSH. Additional privileges, ultimately including off-grounds privileges and hospital discharge, are again reviewed by the hospital evaluators, RRB, PSRP, DSHS administration and the courts. Despite these changes in procedures, ESH staff voiced the same the three concerns (listed above) as did WSH staff.

Evaluations of CR readiness

Evaluations to determine readiness for CR are completed by the forensic services evaluators at both WSH and ESH. WSH described a very thorough process for these evaluations, including using the HCR-20, VRAG, and PCL-R (all commonly-used, empirically supported instruments), structured interview, and history to inform recommendations. The WSH policies and procedures governing these evaluations were quite clear and specific, and seemed sound. It is unclear how closely these policies and procedures are followed in practice, however.

The process at ESH is less formalized. Evaluators use a non-validated structured assessment matrix to determine risk, and may supplement this assessment matrix with the HCR-20 as needed. An interview and history are also part of the ESH assessment. The

policies and procedures for these evaluations at ESH were less clear and specific. Interestingly, the PSRP and ESH both reported a higher rate of successful CR petitions for ESH patients than for WSH patients, despite their less formalized process.

CRs in the community

Whether from WSH or ESH, acquirtees on CR are assigned to a local Community Mental Health Association (CMHA) in their home court county. CMHAs are typically contracted by state-funded Regional Support Networks (RSNs). These agencies employ mental health professionals and services to treat the mental health needs of the person on CR. They also employ a Designated Mental Health Professional (DMHP) who has the authority to intervene in a crisis situation and rehospitalize the person on CR if deemed necessary. It is unclear how much forensic training the DMHPs have. One problem reported by the CMHAs and RSNs is that persons on CR fairly easily reach a clinical level that exceeds eligibility criteria for service, *so acquirtees are sometimes discharged from community services for being "too stable."*

Also, regardless of which county the person on CR returns to, very little is in place in the Community Support Network mental health centers to address their specific needs. No specific CR groups or interventions were described or documented in the materials we reviewed or in the 84 anonymous survey responses we obtained from community providers. Community staff members reported nearly unanimously that they have received little training on how to work with the CR population, what assessments or interventions are most effective, and that little forensic expertise or resources exist on hand. ESH staff were particularly vocal about the lack of community transition resources available to acquirtees who may be conditionally released. Indeed, even DSHS's RSN administrators admitted little working knowledge of the CR process or specific treatment modalities for the outpatient CR population. This is not an indictment of their knowledge base, but rather a reflection of the somewhat cursory attention paid to the outpatient CR population from all sectors. Fortunately, community providers also expressed a confidence in working with forensic populations if given time and resources for training and interventions, and most expressed an interest in doing so.

At ESH, persons on CR are routinely assigned a community corrections officer (CCO) in addition to mental health supervision. These CCOs have contact with the person on CR about 2-4 times monthly, including drug screens, face-to-face visits, polygraph testing, and other supervisory tasks. Staff from the hospital do not routinely visit their caseloads face-to-face given the large geographical area from which their CR population is drawn. ESH reported a recidivism rate of three arrests in the past 10 years, with approximately 35 persons on conditional release and 10 persons on partial CR at any point in time.

At WSH, persons on CR have not routinely been assigned a community corrections supervisor, although this practice does appear to be increasing. Supervision instead comes from the WSH staff of the Community Program. These individuals travel many miles by car to have face-to-face contact visits with the people on CR on their caseload, often transporting the person on CR in their car. Staff described no specific risk assessment tools or decision-making rubric for determining if a person on CR was in

need of revocation or rehospitalization. However, they did state that they remain conservative and have an extremely low recidivism rate (less than 1%) for their CR population. The CR population in the community who were discharged from WSH totals approximately 75 individuals.

Finally, *the proportion of acquittees granted CR versus remaining at both state hospitals is significantly askew*. ESH reported that of the 70 NGRI acquittees in the hospital, about one per year is released on CR. ESH staff commented that they only present the best cases to evaluators and to the RRB, as the PSRP and courts have a very conservative and cautious nature that will not allow less certain cases to be granted CR. WSH reported an approximate turnover of 12 beds per year in the NGRI / Community Program units; however, most of these patients are transferred to a geriatric inpatient ward or die prior to true discharge on CR. WSH has had fewer than five annual outpatient CR discharges since 2009, with some years resulting in only one or two outpatient CR discharges.

Summary of Current Problems with NGRI Treatment and CR

The approach appears unnecessarily slow and punitive:

The lengths of time that Washington NGRI acquittees spend hospitalized before conditional release is striking, both relative to their clinical needs and national norms. NGRI/CR statistics from both hospitals, as well as anecdotal evidence from those acquitted NGRI, illustrate an approach to this population that is far more restrictive than other states. Among the many acquittees currently hospitalized in WSH or ESH, only a handful has been released on CR in the past several years. Currently, a person acquitted by insanity in Washington is more likely to be discharged to a civil geriatric hospital unit or to the coroner's office than to be discharged on conditional release. In WSH, several acquittees have apparently waited for more than one year to have a routine risk assessment completed (a task that requires less than a month in most hospitals), which is required prior to being considered for CR. No clinical reasons were associated with those delays. In addition, many patients are assigned apparently arbitrary time periods that they must complete prior to moving up the NGRI and CR level systems. Again, these time periods do not appear to reflect any clinical task or progress, but simply arbitrary prescriptions of wait times. Indeed, some currently inpatient acquittees are not prescribed psychiatric medication, suggesting they may be clinically stable enough to function in the community.

Anecdotally, we spoke with several NGRI acquittees who have remained in the inpatient NGRI unit for *years* after seemingly small violations of their CR occurred – years longer than they would have served in a civil unit for the same behaviors. One patient was required to spend an extra month on her current CR level after she was given the wrong identification badge, though this was due to staff error, according to all accounts. Another was required to re-start the NGRI/CR process from the beginning after returning to the hospital voluntarily for clinical reasons; she has remained in the hospital for more than three years after previously spending more than 10 years in the community on CR. These examples are two of many that illustrate a systemic approach that appears much more punitive and restrictive (and therefore expensive) than most.

The programs lack interventions specific to patients with a criminal history.

On the one hand, the system seems over-focused on the criminal history of NGRI acquittees, as reflected in severe restrictions in the name of public safety. But on the other hand, the system seems to under-focus on the criminal history of NGRI acquittees by using only traditional, clinical treatment models that neglect most risk factors for criminal reoffending. State-of-the-art treatment for NGRI acquittees address what are often referred to as an acquittee's "criminogenic needs," the risk factors and behaviors that should be addressed in order to reduce recidivism (e.g., substance abuse, criminal thinking errors, etc.). Likewise, state-of-the-art conditional release procedures employ strategies from the criminal justice system, and mandate mental health treatment, rather than relying on traditional mental health rules of service. Thus, an irony in Washington's approach to NGRI acquittees is that it both *too much* treats them like criminals (by excessive deprivation of liberty, and restricted access to the community) and *too little* treats them like criminals (by neglecting to provide interventions for criminogenic needs, and ongoing supervision in the community).

Lessons from National Models and Best Practices

While there are no identified "model" systems of care for persons on CR, several jurisdictions nationwide provide promising practices and many have clear empirical support.

Evaluation of CR readiness

No formal assessment measures or protocols exist for the assessment of an NGRI acquittee's readiness for conditional release. Recent research suggests that evaluators are often confused about how to evaluate readiness for CR – what questions to ask, which factors to prioritize, what methodologies to use, what time frames to define, what definitions of success / failure to use, and even the purpose of the evaluation itself (Bryant, Gowensmith, & Vitacco, 2014). Evaluators also show very low rates of inter-rater reliability when making independent recommendations for CR readiness of the same acquittee (McNichols, Gowensmith, & Jul, 2011). Lack of formal assessment measures, vague statutes, and evaluator confusion make these evaluations especially challenging, so *formal state-sponsored training of evaluators is crucial.*

Evaluators and judges agree that the most important factor when evaluating an NGRI acquittee's readiness for CR is their potential risk for violence (Bryant, Gowensmith, & Vitacco, 2014; Jul & Gowensmith, 2014). Accordingly, when using formal risk assessment instruments in their CR readiness evaluations, evaluators more accurately predict future rehospitalization (McNichols, Gowensmith, & Jul, 2011; Manguno-Mire et al., 2007). Risk for violence should therefore be a primary consideration in CR readiness evaluations. Given the unique parameters of this population, these evaluations should go beyond standard risk assessment and also assess mental health stability, criminogenic risks, and responses to supervision. Evaluators should also carefully consider factors that have been associated with success and failure on CR, detailed in the next section. These assessment protocols should include a structured professional judgment measure to assess

risk for violence, but should also include other formal measures and semi-structured interviews to assess for additional elements. Collateral records and sources, such as hospital records and probable community treatment / housing / employment resources, should be consulted. Evaluators should also delineate the time frames for which they are evaluating success / failure post-discharge. *Perhaps most importantly, the factors that evaluators prioritize should be the same ones that inpatient and outpatient treatment teams emphasize, and the same ones that decision-makers in the PSRP and courtrooms emphasize.*

Factors associated with success and/or failure on CR

First, it is important to consider base rates for recidivism and rehospitalization in the CR population. As a general rule, *persons on CR do well when released to the community.* Arrest and recidivism rates range from 2% – 11%, with the highest percentages found among misdemeanants (Fitch, 2009; McNichols, Jul, & Gowensmith, 2010; Vitacco et al., 2011). Rates of violence in the CR population are extremely low, ranging from 0% - 0.5% (McNichols, Jul, & Gowensmith, 2010). *These rates are lower than violence rates in the general population.* Rates for rehospitalization are also fairly low, ranging from 13% - 35% over several years (Bertman-Pate et al., 2004; Parker, 2004; Vitacco et al., 2011). In other words, over the course of 2-5 years post-discharge, about 65-87% of persons released on CR retained their tenure in the community. Overall, this population has a good track record of successfully maintaining their CRs. Data provided by WSH and ESH show extremely low recidivism rates of their persons released on CR; however, rates for rehospitalization seem relatively high.

Several factors have been identified as important when predicting success or failure of the CR population. In most studies, failure is defined as a revocation of CR, necessitating a forced return to a forensic hospital. Voluntary or clinically-based readmissions (i.e., short-term civil commitments for suicidal ideation or acute clinical decompensation) are not considered a failure.

Factors that have been associated with successful tenure on CR include intensive mental health treatment, a strong continuity of care among hospital and community agencies, intensive substance-abuse services, and an agile mental health team that can address the earliest signs of trouble (Vitacco et al., 2011). Dialectical-Behavior Treatment is especially effective with females on CR (Vitacco et al., 2011). A combination of mental health and law enforcement / judicial supervision yields the best outcomes (Vitacco et al., 2008), and the same researchers encouraged service providers to adhere to the tenets of the Risk-Need-Responsivity model when assessing and providing services to the CR population.

Factors associated with poor tenure on CR include a history of previous CR revocations, substance abuse, and acute psychotic episodes (Vitacco et al., 2008; 2011). High levels of psychopathy and longer criminal histories also predict lower rates of success for CR populations (Manguno-Mire, 2007; Monson et al., 2001). It is clear that an absence of adequate mental health services and law enforcement supervision lowers the success rates for CR populations substantially.

Table 5

Examples: Conditional Release of Insanity Acquittees in Select States

Hawaii:

Hawaii has the largest per-capita CR population in the nation, with more than 400 people on CR currently. This is due in part to the practice of placing misdemeanants on CR, with many acquittees placed on CR immediately upon being found NGRI. A risk assessment and community readiness evaluation is completed concurrently with the criminal responsibility evaluation, allowing for CR to be ordered immediately upon an acquittal. If committed, the acquittee will be reviewed and recommended by treatment staff for evaluation for conditional release by an independent forensic psychologist. There are no timetables for review, and no hospital or external review board is convened to review these applications. Once granted CR, persons on CR in Hawaii have dual commitments: they are assigned a probation officer and assigned a mental health team in a state-operated community mental health center (CMHC). Those CMHCs each have a forensic psychologist on staff to manage each CR case assigned to that center. That psychologist coordinates and liaisons treatment and court-ordered requirements ad infinitum, whether the person moves from their local county, is rehospitalized, etc. This allows for continuity of care and a consistent repository for knowledge of the acquittee's mental health and criminogenic needs. Persons on CR are mandated to treatment in the community by court order, and the CMHCs are mandated to prioritize them for service by departmental policy. All CHMC staff receive training and resources annually on how to work effectively with the CR population. Specialized Hawaii probation officers with mental health training have been more effective with their CR population than traditional probation officers, in that the acquittees spend fewer days hospitalized (Gowensmith, Skeem & McNichols, 2013). Average rehospitalization lengths of stay span days to months, and the violent recidivism (0.5%) and rehospitalization rates (13.5%) are low.

Oregon:

Oregon also has a large CR program; 385 people, or approximately 69% of their Guilty Except for Insanity (GEI) population (comparable to NGRI acquittees), are in the community on CR. Like Hawaii and Wisconsin, Oregon law also allows both felons and misdemeanants to be found GEI and placed on CR. Also, like Hawaii and Wisconsin, persons found GEI may be immediately placed on CR from court. Ordinarily, however, persons are committed to the state hospital upon a finding of GEI. At 60 days post-commitment, a review is completed to determine if the person should be discharged on CR. If they remain in the hospital, a formal risk assessment (utilizing the START assessment instrument) is conducted every three months. Upon recommendation from the treatment team, a hospital psychologist conducts a risk assessment for each applicant to CR (as opposed to an independent forensic evaluator). Unlike Hawaii and Wisconsin, Oregon utilizes an independent review board on potential CR cases; this board is called the Psychiatric Security Review Board (PSRB). The applications for CR, as well as hearings for changes in inpatient privileges, are reviewed by the PSRB. A court hearing is held if the PSRB supports the application. The PSRB retains some oversight of the CR once released to the community, and has authority to delineate treatment settings, requirements, etc.

Community clinical services are overseen by a county mental health representative and are mandated to occur at state- and county-funded community mental health centers. These community providers cannot refuse or withdraw treatment. A county representative also serves in a community corrections supervision role. Recidivism for the CR population is approximately 2%, rehospitalization rates average about 12% per year, and rehospitalizations are typically short-term (one month) in nature.

Wisconsin:

Wisconsin has a robust CR program, with 424 persons on CR in 2013. It is a centralized system housed within the Department of Health Service's Community Forensic Program, and it is divided into four geographic regions. Insanity acquittees may be placed on CR directly from court upon a finding of NGRI, though most are committed to the Mendota Mental Health Institute first. If the person is committed, a review of their readiness for release occurs every six months, led by an objective forensic evaluator. No hospital review board or external review panel are utilized; like Hawaii, treatment teams recommend a person for evaluation by an external forensic evaluator and that evaluation is later discussed at a formal court hearing to determine if the CR will be granted. Upon release to the community, the person on CR is placed in their county of referral and provided a case manager and a parole agent. The case manager oversees treatment and determines the level of clinical service provided to the acquittee. Services are provided by community mental health centers. These centers cannot refuse services to the person on CR. The CR population in Wisconsin is comprised of both felony and misdemeanor acquittees, though the commitments are limited to the time they would have otherwise served in jail or prison for the same charge(s). Recidivism rates (.5% for non-violent crime, 0% for violent crime) and CR revocation rates (9.9%) are low.

Table 6

	Hawaii	Wisconsin	Oregon	Washington
Number of persons on CR in community	432	424	385	110
Percentage of NGRI acquittees on CR	78%	75%	69%	35%
Direct release from court to CR used often?	Yes	Yes	Yes	No
Routine assessment of CR readiness?	No	Yes	Yes	No
Hospital review board?	No	No	Yes	Yes
Public safety review panel?	No	No	Yes	Yes
Length of time to successful granting of CR?	Weeks to months	Weeks to months	Weeks to months	Years
Dual commitment to mental health and public safety?	Yes	Yes	Yes	at times
Can community providers refuse or withdraw service to persons on CR?	No	No	No	Yes
Is person on CR automatically eligible for community mental health services?	Yes	Yes	Yes	No
Rates of violent recidivism	.5%	.5%	<2%	.5%
Rates of rehospitalization	15% per year	9.9% per year	12% per year	<10%
Lengths of rehospitalization	Days to months	Weeks to months	Days to weeks	Months to years

Recommendations

Following are recommendations in three sequential areas: clinical services to the NGRI populations within hospitals (pre-release), evaluation of CR readiness (assessment of release), and CR service and supervision in the community (post-release).

Inpatient NGRI units:

Hospitals should begin preparing NGRI acquittees for discharge immediately upon the judicial NGRI disposition and subsequent admission to their units. This includes the following:

- Using the Risk-Need-Responsivity model as the foundational model for all assessment and clinical services to inpatient NGRI populations.
- Developing and implementing evidence-based risk assessments and risk management planning. This should include formal risk assessment instruments or protocols.
- In accordance with the RNR, risk for recidivism and for violence should be assessed immediately by a validated risk assessment protocol (such as the LS/RNR, HCR-20 v3, etc.).
- This assessment should be supplemented as needed by other assessments relevant to the individual acquittee (i.e., trauma, substance-related problems, etc.).
- Acquittes should be placed into corresponding treatment regimens based on assessed risk levels (high risk individuals receive a higher treatment “dosage” of interventions, low risk individuals receive lower dosages).
- Evidence-based factors associated with success on CR should be incorporated across all treatment modalities. These factors should be explicitly known to staff and acquittes, and should match those that will be later reviewed and evaluated by the forensic evaluators, hospital Risk Review Boards, and the Public Safety Review Panel.
- Cognitive-behavioral models should underlie all treatment modalities. This includes pro-social modeling, incentivizing change and successes, social learning, developing wellness recovery action plans, and emphasizing changes in criminal thinking. Current focuses on psychodynamic-like approaches (lengthy autobiographies, lengthy relapse prevention plans) should be tailored to fit these modalities.
- Experiential learning is crucial. Off-grounds privileges and opportunities must be greatly increased in order to prepare acquittes for life outside of the hospital. Inpatient units should have increased opportunities to develop vocational and life skills.
- Criminogenic interventions should be prioritized just as highly as mental health interventions. The mental health treatment needs of NGRI acquittes are critical but likely lifelong; acquittes will continue require ongoing assertive, intensive mental health treatment once released on CR. Inpatient treatment should just as assertively target the criminogenic treatment needs (e.g., substance abuse, criminal thinking) as mental health needs, thereby reducing further the risk of re-offense.

- Substance-related treatment services are only inconsistently available, but should be consistently available to the inpatient NGRI population. This includes recognized treatment for substance-related issues beyond a 12-step support group.
- Step-down units should be considered once the CR is granted. This could include currently vacant structures on hospital grounds if they exist, or could include modular buildings created as housing options. Off-grounds units should also be considered. These could be operated by the hospital or by DSHS forensic services. They would serve as additional options for safely managing and housing the CR population while they receive treatment at either community or hospital day treatment agencies, and would also allow for acquittees to build a “track record” of success that would aid them in securing an earlier CR.
- A uniform level system for NGRI acquittees should be developed and implemented in both ESH and WSH. Although the processes are somewhat similar currently, significant differences also exist. ESH utilizes fewer levels in their level system, exercises a partial conditional release option, and routinely includes Community Corrections Officers as part of their discharge plans. We recommend that these approaches be implemented at WSH as well. The two hospitals should have equivalent processes and expectations for progressing through the NGRI and CR systems.
- A definite “max date” for termination of the NGRI commitment needs to be more reliably communicated with the treatment teams at ESH and WSH.

Evaluation of CR readiness:

CR evaluators should review and evaluate CR readiness using the same factors utilized by the inpatient treatment teams, review boards and panels, courts, and community providers. Given the lack of an extant formal CR readiness assessment instrument, these factors should prioritize those substantiated by extant CR research, criminogenic factors, and mental health factors:

- Readiness for CR should be assessed by NGRI unit staff on a fixed schedule, at 30 days post-admission and at every 2-3 months afterward being optimal. Formal evaluations by a forensic services evaluator will be triggered by this assessment.
- Methodologies for CR readiness evaluations should be standardized. This should include the factors prioritized, formal instruments used, and the parameters defined in the evaluations (lengths of time to consider post-release, which risk assessment protocols to use, definitions of success and failure on CR, etc.).
- Evaluators should have access to community treatment plans and the transition plan from hospital to community, and they should review these carefully as part of the readiness evaluation. Hospital NGRI units should have this information ready for the evaluator’s review at the time of the assessment.

- Evaluations of CR readiness should be conducted by psychiatrists or psychologists.
- Predictions and risk management recommendations for violence risk should be developed through the use of formal and validated risk assessment protocol (such as the LS/RNR, HCR-20 v3, etc.).
- Evaluators should prioritize criminogenic factors, mental health predictive factors, and factors supported by the CR research literature. Evaluators should also review and consider protective factors and strengths in these evaluations.
- Evaluator disagreement is a powerful predictor of the rehospitalization of persons on CR. Therefore, multiple, independent, and concurrent evaluations should be considered for CR readiness evaluations. When three evaluators were asked to independently make recommendations on CR readiness for the same defendant (routine practice in Hawaii), they disagreed in more than 50% of cases (McNichols, Gowensmith, & Jul, 2011). Of those acquittees that were nonetheless released on CR, 71.4% were rehospitalized within three years (significantly more than the 34.5% three-year rehospitalization rate in cases in which evaluators agreed unanimously on acquittees' readiness for CR). Single, point-in-time evaluations will not be able to capture this predictive power without a very large improvement in the training of evaluators and the standardization of evaluations.
- Again, a uniform system for evaluating NGRI acquittees' readiness for conditional release should be developed and implemented in both ESH and WSH. WSH has more formalized procedures and describes a more consistent inclusion of formalized risk assessment instruments. We recommend that these approaches be implemented at ESH as well. The two hospitals should have equivalent processes and expectations for evaluating readiness for CR in NGRI acquittees.
- We agree with the Washington State Institute for Public Policy's 2011 document and staff from both hospitals that neither evaluation processes or the instruments used therein should be codified in statute.

CR community supervision and treatment:

Community providers and agencies should substantially increase their capacity to manage and treat persons released on CR.

- RSN and CMHA staff and personnel should be trained to understand forensic issues and the forensic populations which they serve (or could serve).
- CMHAs should hire one forensically-trained psychologist to serve as a forensic specialist for that CMHA. Smaller CMHAs may consider sharing a forensic specialist, or utilizing an expert on retainer as needed.

- RSNs and CMHAs must improve their data collection and analysis. At a minimum, RSNs and DSHS administration must know how many individuals are on CR status in the community (and their names, contact information, address, and treatment providers). Beyond this, RSNs and CMHAs should know community tenure rates, lengths of time on CR, recidivism rates, and rehospitalization rates.
- Every person acquitted of insanity should be assigned a community corrections officer (CCO) from the Department of Corrections. This officer should be responsible for law enforcement job duties, such as mandating urine drug analyses, ensuring public safety, and authorizing rehospitalization as necessary.
- WSH should stop sending case managers to monitor and evaluate persons on CR. These functions should come from CMHA forensic staff.
- Administrators should expect that about 10% of persons on CR will commit a new crime within three years after release, with less than 2% being violent in nature, and that about 35% will be rehospitalized within the same time frame. Crimes and violations are likely to be low-level, quality of life transgressions.
- Given the literature on CR success, CRs in the community should receive intensive treatment services, substance-related services, excellent continuity of care from inpatient to outpatient services, and a nimble team of providers that can immediately attend to mental health and criminogenic needs as they arise. Females on CR should receive dialectical behavior therapy unless contraindicated.
- A community-based three-step model for persons on CR should be considered. This would include an initial set of group sessions designed to assist new persons on CR to the legal system, the CR, their commitments to mental health and corrections, and other orientation issues. The second (and longest) set of sessions would focus on the maintenance of CR: criminogenic factors, illness and symptom awareness, wellness recovery action plans, crisis plans, vocational skill-building, and other issues to maintain stability and recovery. The final set of sessions would focus on readiness for the legal discharge off of CR and into a voluntary legal status.
- Forensic staff in the community should have oversight and supervision by both the CMHA / RSN structure as well as the forensic mental health department. This staff would be responsible for many forensic issues in the RSNs and CMHAs, including knowing who is on CR, knowing the legal statuses (probation, parole, incompetence to stand trial, etc.) of all persons served at that CMHA, liaison duties with courts and hospitals, providing trainings to other CMHA staff on forensic issues, and others.
- Persons on CR should receive automatic eligibility for RSN / CMHA services by virtue of their legal status. This service eligibility cannot be removed or adjusted due to clinical stability (or instability).

- Persons on CR *must* be served clinically by the RSN / CMHA system.

Current administrative rules found in WAC 388-875-0090 are broad and do not cover many of the essential procedures and processes used for NGRI and CR cases. DSHS should create a more detailed, written description of the procedures, policies and processes that oversee the NGRI and CR populations as delineated in this report. This may require changes to WAC 388-875-0900 and/or internal policies and procedures.

It was noted in both interviews and surveys that both inpatient and outpatient staff are ready and willing to implement the types of changes listed above, and they verbalized an interest in speeding up the acquittal to CR process overall. However, as of yet they have not received the resources, staffing, or training to implement these types of changes. Such resources are *essential* and are ultimately cost-saving, to the extent that they reduce lengthy and unnecessary inpatient hospitalizations for acquittees who do not require such intensive services.

CONCLUSIONS

We recognize that any consultation report—at least one that identifies significant problems and proposes meaningful solutions—reads as a daunting “to do” list. Solutions may appear expensive, or at least logistically challenging, if they require changes to current practice. Without minimizing the challenges involved in significant change, we emphasize the following:

First, Washington has already made significant systemic changes in recent history (i.e., the transition from inpatient to primarily outpatient models, the progress towards competence evaluation timelines), even without an efficient forensic infrastructure, designated director, or adequate funding. In short, leaders have done well, despite limited resources. Adequate resources and infrastructure should allow for far more striking improvements

Second, developing a designated Office of Forensic Mental Health Services, led by a director with sufficient authority, will make all other recommended changes far easier to achieve. To be clear, much of the coordination and collaboration we have recommended will remain difficult without centralized leadership and data management. But developing such leadership and infrastructure makes subsequent improvements far more feasible and efficient.

Third, in implementing our other recommendations, Washington rarely needs to reinvent the wheel. For most of our recommendations, we have tried to briefly describe models from other states or illustrative programs. We remain happy to provide additional examples, and points of contact if needed. Few of the challenges Washington faces are unique, so solutions rarely need to be unique. Washington can replicate established, empirically-supported programs from other states, and even expand some of the promising programs operating in their own state.

Fourth, almost any of the recommended changes will require resources, at least in the form of initial meetings and organizational time. Some may even appear financially expensive at the start. But almost all of the recommendations we suggest will lead to *significant long-term savings for the state overall*, to the extent they reduce the current over-reliance on lengthy inpatient hospitalizations as a default intervention. Of course, identifying and stewarding these savings will require the type of forensic-specific data management we described earlier.

In short, Washington faces significant challenges, but these are challenges are common to many other states, and promising solutions are available. Washington also appears to have a competent work force, who clearly recognize these challenges, and appear motivated to approach them constructively. With changes in infrastructure and

monitoring, and a willingness to alter some of the traditional default approaches, we are optimistic that Washington can continue to improve their forensic mental health system in ways that are more efficient, more congruent with best practices, and (ultimately) more affordable.

APPENDIX 1:

Washington-specific materials reviewed for consultation

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APPENDIX 2:

Related issues beyond the scope of consultation.

1. Consider interventions along the *Sequential Intercept Model*

Our survey of jail personnel, as well as our meetings with relevant stakeholders, revealed that Washington, like all other states, struggles greatly with the problem of persons with mental illness entering the criminal justice system disproportionately, creating challenges for courts and jails. This broad problem is often labeled “the criminalization of the mentally ill.” We address this problem in our discussions and recommendations throughout this report. But the problem is even broader than the focus of our consultation, and it requires a variety of interventions that go beyond the scope of our consultation. One nationally-popular intervention approach is the “sequential intercept model” (Munetz & Griffin, 2006), through which resources are allocated at *all points in the criminal justice process* (e.g., working with police to divert mentally ill individuals prior to arrest, diversion at the point of arrest, diversion from jail, pre-trial diversion, as well as services post-arraignment and post-trial). Proponents of the model emphasize that the greatest systematic impact occurs at the beginning of model – from community providers, law enforcement, corrections, and the judiciary.

Washington already offers several pilot programs that are consistent with the Sequential Intercept Model, whether or not they are formally identified as such. These include: mental health courts, jail diversion programs, police-led diversion teams, and so on. LEAD, Harborview, FISH housing, FACT teams, and the use of treatment and evaluation centers all represent good examples of creatively, efficiently and sensibly interventions with mentally ill individuals in the criminal justice system.

However, these innovative approaches currently occur primarily at the local (rather than state) level, and they remain piecemeal across the state. Washington has much room to expand these types of programs across the state. Such interventions and programs could include Crisis Intervention Training for more police departments, increasing the numbers of pre-booking jail diversion programs, increasing the numbers of specialty courts, and increasing the numbers of Forensic Assertive Community Treatment teams. Specialized forensic housing is also far below necessary levels and should be increased.

If Washington were to adopt our recommendation for a centralized Office of Forensic Mental Health Service, this office could oversee broader implementation of promising pilot programs, and make available much broader training and guidance to local providers. In Massachusetts, Hawaii, and Virginia, for example, the state’s forensic office, through Federal Block grants, provides trainings to community providers on issues related to treatment of mentally ill individuals who have criminal justice involvement. These trainings include workshops on relevant clinical issues, training for law enforcement who encounter mentally ill individuals, working with probation and parole, models for diversion, and workshops on helping clients transition from correctional facilities to the community.

2. Address “forensic flips” and competence examinees eligible for civil commitment

Though not directly related to the focus of this consultation, our interviews elicited many comments about “forensic flips,” i.e., the population of patients who are found *unrestorable* to competence and therefore transferred to an inpatient civil commitment unit at WSH or ESH. Because a primary focus of our consultation was to optimize the competency evaluation and restoration systems, we anticipate that our recommendations in that regard should ultimately reduce the number of these “forensic flips.” Further recommendations on this issue are beyond the scope of this consultation. However, we would like to mention two programs that are approaching this issue with success:

- In King County, the Harborview program places a screener, trained in mental health, in the local jails to determine civil commitment criteria for those found non-restorable, rather than waiting until the person is referred for evaluation at the center or hospital. This provides appropriate services faster to individuals who meet civil commitment criteria.
- Pierce County uses a local Treatment and Evaluation Center to commit violent misdemeanor defendants, rather than committing them to the state hospital. This process is reportedly more efficient and results in shorter lengths of stays.

We recommend that other jurisdictions consult with the above agencies and programs to determine whether similar approaches can be utilized in their jurisdictions.

APPENDIX 3:

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