The Honorable MARSHA J. PECHMAN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

Trueblood *et al*. Plaintiffs, v. Washington State Department of Social and Health Services *et al*, Defendants.	NO. 2:14-cv-01178-MJP DECLARATION OF DR. BRIAN WAIBLINGER IN SUPPORT OF DEFENDANTS' RESPONSE TO MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Brian Waiblinger, am over the age of 18 years of age, competent to testify to the matters below, and declare based upon personal knowledge:

1. I am the Medical Director of Western State Hospital (WSH) in Lakewood, Washington. By way of background, I am a 1996 graduate of the University of Washington School of Medicine, where I also completed my residency in psychiatry in 2000. I am Board-Certified in psychiatry and licensed to practice medicine in the state of Washington.

2. Western State Hospital has three centers: the Psychiatric Treatment and Recovery Center (PTRC), the Habilitative Mental Health Unit, and the Center for Forensic Services (CFS). CFS is the WSH unit that admits patients awaiting forensic evaluation,

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restoration and other forensically related matters. I am an authorized representative of the Department of Social and Health Services.

3. As Medical Director, I am familiar with the process concerning admission to WSH for competency evaluation and restoration treatment services. My overall responsibilities include supervising the provision of medical care throughout the hospital, and ensuring that it meets statutory, constitutional, regulatory, and community standards concerning the provision of individualized medical services for the patients at WSH. My responsibilities also currently include reviewing selected competency evaluations, providing supervision of the transportation coordinator, and working with the admitting nursing staff in understanding and implementing the prioritization algorithm that I developed for the admissions waitlist.

4. The Legislature has authorized WSH to staff a finite numbers of beds: 270 forensic beds and 557 non-forensic beds. In addition to the competency-related admissions, the forensic wards also house those adjudicated as not guilty by reason of insanity (NGRI) (including those detained pending revocation of a conditional release and those in the "Community Program" – a conditional release status in which the patients are housed at WSH) and those awaiting civil commitment proceedings after their felony or misdemeanor charges have been dismissed due to incompetency ("felony conversion" cases).

5. The Center for Forensic Services is currently running at near 100% occupancy. All existing space with hardened security is being used. Aside from vacancies created when defendants admitted for competency evaluation or restoration are discharged back to the jail, vacancies for competency-related admissions occur only when there are unexpected cancelations of admissions, when rooms require maintenance, or other exigencies. The current waitlist is approximately 115 defendants. As of October 6, 2014, initial 90 day felony restoration cases are waiting approximately 76 days and initial 45 day felony restoration cases are waiting approximately 66 days. Most inpatient evaluations and misdemeanor restoration

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cases are currently waiting approximately 30 days or less. Approximately 15 patients awaiting restoration treatment are admitted each week. Approximately 12 patients awaiting a competency evaluation are admitted each month.

6. WSH also conducts competency evaluations for individuals in-custody in a county jail. These in-custody evaluation cases are waiting approximately 14 days or less. As of September 26, 2014, 4 in jail felony evaluations and 6 misdemeanor evaluations were waiting more than 7 days.

7. Pre-trial defendants and NGRI patients, those occupying forensic units, require a different level of staffing and security than patients on civil units. While the acuity of civil patients is typically higher than NGRI patients, NGRI patients and pre-trial detainees require specialized levels of staffing and security. In addition, NGRI patients are subject to a criminal order under the statutory framework of RCW 10.77, while civil patients are subject to RCW 71.05.

8. To the extent that admissions are delayed, the delay is due to factors outside of WSH's control, including an average 8% annual increase in court orders to send defendants to WSH for inpatient evaluation or restoration, with a 14% increase in court orders for restoration treatment in the last year, and an increase in the number of those adjudicated as NGRI and committed to WSH. After holding steady near 140 NGRI patients in 2011-2013, the NGRI population has increased by approximately 20 patients in 2014, resulting in fewer forensic beds for competency evaluation or restoration. Today, there are only 113 non-NGRI beds available for pre-trial defendants. An increase in the overall number of NGRI patients has a non-linear impact on competency services because NGRI patients may spend years in the state hospital, essentially freezing those beds for long periods of time.

9. One reason for the spike in restoration referrals in the past year is due to the success of RCW 10.77.073, which allows counties to contract with private evaluators. Reducing the waitlist for individuals awaiting competency evaluations by increasing the

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number of evaluations in a short period of time, would only further burden the restoration list. As of September 26, 2014, 29 individuals are awaiting in-custody evaluations. Of those, 9 are felony evaluations and of those only 4 were waiting more than 7 days.

10. National standards recommend state psychiatric hospitals should ideally operate at less than full capacity. The forensic and civil sides of WSH consistently operate at essentially 100% capacity. With a legislative limitation on funded beds, shifting forensic patients to civil wards, even those forensic patients whose mental health is comparatively stable, would have consequences and potentially negative impacts on those who have been adjudicated as gravely disabled or a danger to self or others as a result of a mental disorder and in need of longer-term civil treatment. An order dictating that patients be transferred into non-secure civil areas of the hospital negatively impacts those patients already receiving treatment on civil wards and those awaiting placement to civil mental health beds, many of whom are in community hospitals not fully equipped to handle these patients. Civil waitlists would increase with such an influx, and the current treatment of the civil patients will be seriously and negatively impacted with the redirection of patients and resources. In addition, because the civil wards do not meet the security requirements of forensic wards, they would require upgrades and retrofitting to make them hardened and secure.

11. Generally, individuals charged with Class A & serious Class B and non-serious Class B & Class C felonies awaiting admission to begin their initial competency restoration periods are admitted in the order in which the court orders are filed. On occasion, however, WSH will admit a defendant who presents with severe psychiatric symptoms resulting in psychiatrically related medical issues that justify admitting that person out of order, e.g. skin infections, significant weight loss, etc. WSH does not ultimately refuse admission to anyone referred, unless a medical condition exceeds that for which WSH could appropriately care.

12. WSH has made, and will continue to make, good faith efforts to admit all defendants awaiting competency services at the earliest date possible. As the wait list numbers

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surged earlier in 2014, we reinstituted the use of my prioritization algorithm for the admissions waitlist. This algorithm has reduced the wait times for the inpatient competency evaluation cases, the misdemeanor restoration cases and has prevented as great a rise in the 45-day restoration cases despite increased referral and reduction in available beds due to increased NGRI referral. Those numbers will continue to reduce in the coming months. Since August 8, 2014, inpatient felony evaluation wait times have dropped from 42 days to 31 days and (2 cases are waiting longer but this is related to complicated cases with large amounts of discovery), misdemeanor restoration wait times have dropped from 42 days to 31 days. Inpatient misdemeanor evaluation wait times are currently waiting 24 days.

13. The bed allocation algorithm takes advantage of the differential lengths of stay for the various types of admissions to most efficiently use available bed space. Our current referral rate is approximately 1100 cases representing approximately 115 hospital beds for non-NGRI cases per year. We currently have 157 individuals in NGRI beds occupied so we either meet or exceed our current capacity of 270 beds allocated by the Legislature, just through referrals. There is no additional bed space at WSH to reduce these numbers. However, in order to more efficiently use beds, WSH has assigned a certain portion of beds based on their rapid turnover. For example, felony evaluations use on average 12.4 bed days. Misdemeanor evaluations use on average 11 bed days. Misdemeanor restorations use, on average, 21.4 bed days. While 45 day restorations, on average, use 34.9 bed days. And 90 day restorations use, on average, 69.9 bed days. Therefore, WSH uses two "wheels" with the short term beds turning over 3-6 times as fast as the longer term felony restoration cases.

14. 17 beds have been allotted for fast turnover beds: 1 for misdemeanor evaluation cases, 10 for misdemeanor restoration cases and 6 for felony evaluation cases. These numbers were based on the rate of referral multiplied by the average length of stay over the last year with the current waitlist numbers as of the end of June. This assumes a constant referral rate. The allocations were increased to anticipate a reduction in the wait times for these classes

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to 7 days or less in approximately 3 months once all 17 beds were allocated to this population. By October 10, all 17 beds allocated for rapid turnover cases will be filled with rapid turnover patients. The wait times have come down and the target of 7 days or less to admission is expected to be reached sometime in December.

15. 45 day restoration cases also turnover at about twice the rate of 90 day cases. Therefore, 34 beds have been allocated to reduce these numbers to less than 7 days in approximately 6 months once all 34 beds are allocated to this population.

16. Without additional beds, meaning secure space and appropriate staffing levels, the felony restoration cases will remain at their current wait times or rise given the 8-10% rise in referrals per year (14% recently). The addition of approximately 15-20 beds are needed as we are currently operating at full capacity. Once the high turnover beds are down to 7 days or less, 4-5 beds can be returned to felony competency restoration beds (anticipated in December) which will help meet the demand for that group.

17. Additionally, we have changed our practice concerning the patients committed under RCW 71.05.280(3) (patients whose felony charges have been dismissed due to incompetency) by moving them over to the PTRC sooner. Previously the forensic units housed between 18-20 felony conversion patients. As of October 6, 2014, the forensic unit is housing 5, all of whom are awaiting their civil commitment hearings pursuant to RCW 71.05.280(3).

18. We have conducted meetings with the judges, prosecutors, defense counsel and other stakeholders in King, Pierce and Snohomish Counties to discuss ways to address these issues. In the past, these meetings have resulted in changes in practices, increased efficiencies and proposed legislative changes that have resulted in shorter waiting times.

19. Further, DSHS, on behalf of WSH, has submitted a decision package requesting 30 additional forensic beds. Because we are already short 15-20 beds for the planned reduction times using the priority algorithms, current demand for forensic beds cannot be met within the existing bed capacity. Introducing operating efficiencies have reduced the impact of the

growing forensic population in Washington, but more must be done to keep pace with the national trend of increasing forensic referrals of the mentally ill swept into the criminal justice system.

20. WSH currently appears in show cause hearing, regarding forensic wait times, in counties throughout Western Washington. I routinely make recommendations to the other stakeholders in this system (prosecutors, defenders, jail health) for alternative solutions, particularly where immediate transport is ordered or requested. Jails could involuntarily medicate those waiting with the proper resources, staff, and court orders. While not a perfect solution, psychiatric medications are the single most important component in the vast majority of competency restoration cases, in all but a few exceptions. Counties can exchange patients of higher acuity who are lower on the waitlist with another patient higher on the waitlist within the same county. In addition, the criminal parties can agree, and request from the court, a temporary release from jail while awaiting placement at the state hospital, either to the civil system or to a supportive family member. Only rarely have these options been utilized.

21. More specifically, concerning plaintiffs' requests for relief, WSH has already taken many of the steps requested, and those steps not already implemented carry with them inherent difficulties, impossibilities, or cannot be implemented in the short-term.

22. Plaintiffs' request that WSH contract with private evaluators is impractical, difficult to implement, and will likely increase current restoration wait times. The pool of forensic evaluators is small and finite. Even if ordered to do so, the dearth of available evaluators makes it incredibly unlikely WSH will have anyone with whom to contract. Pierce County has been able to utilize RCW 10.77.073 to positive effect in large part due to the high number of retired WSH evaluators living within the Pierce County area. This is not true for the other counties in Western Washington.

23. For WSH, competency evaluations are not the primary, or even secondary, source of the wait times. In-custody evaluations already move at a relatively good pace, on

average only waiting 13.75 days. Inpatient evaluations are only a minor population utilizing forensic beds, due in large part to WSH's efforts encouraging courts to utilize the in-custody option for evaluations. Many counties have shifted most competency evaluations to in-custody rather than inpatient.

24. WSH already staffs and uses all existing space with hardened security for forensic services. All hardened space is at essentially 100% capacity. Hardened security space at WSH means it has specialized ingress and egress with secure escape-proof fencing (rather than the traditional fire doors), secure sally-ports, escape-proof windows, break-proof fixtures, modified ceilings that removes access to ceiling panels, additional cameras, break-proof glass at the nursing stations, modified furniture to prevent creation of weapons, etc. Comparatively, civil units are not secured in the same manner because they house different populations that don't typically require the same level of security.

25. The immediate transfer of patients without consideration of individualized treatment determinations puts staff and patients at risk. Further, the state hospitals daily makes individualized determinations for patients in regard to the appropriate placement within the hospital, as required by law and best practices. Plaintiffs' request for the immediate transfers of these broad groups of patients is not feasible because:

a. WSH has changed its practices to reduce the number of civil patients on the forensic wards to only those whose legal posture or psychiatric acuity warrant continued stays on the forensic units. The only wards for those individuals who have not already had some treatment in the community are located in the forensic unit. Moving patients prematurely to the civil unit before minimal stabilization has (by recent prior experience) placed other patients on the civil unit at increased risk, particularly for physical and sexual aggression.

b. Patients determined Not Guilty by Reason of Insanity (NGRIs) require staffing with different levels of training and certification than patients on civil wards. Patients cannot be mixed in therapeutic milieus without the appropriate staff and treatment available

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because patients can have varying acuity levels, may require specialized treatment or care, or may be physically or sexually aggressive towards certain categories of peers. Staff cannot simply interchange between different clinical populations without the appropriate training and licensure. Many forensic staffing classifications require training in forensics and additional schooling or certifications (e.g. mental health technicians, who work on civil units, require less education and experience than psychiatric security assistants, the equivalent position in the forensic units).

c. In spite of some of these logistical difficulties, WSH is already reviewing options to move NGRI patients in the community program, medically fragile NGRI patients, or high level NGRI patients to other parts of the hospitals outside of those areas used for competency related services. However, none of these movements can happen in bulk without consideration for individualized treatment needs of all patients to be moved, both forensic and civil. Determining the individual treatment needs of the forensic patients alone, as plaintiffs request, ignores the individualized treatment needs of civil patients that may share space with these forensic transfers. In addition, transferring patients within the state hospitals is a dynamic and complicated process, governed by nuanced decisions. Plaintiffs' request to "immediately transfer" broad and generic groups of patients with no consideration for their individuals rights and treatment needs, or the treatment rights and needs of civil patients, except through review by the court, is not only irresponsible and short-sighted, but potentially detrimental and dangerous to any patients and staff in the path of this massive shuffle.

d. Patient movement varies daily at WSH, from none to a dozen or more depending on admissions, discharges and transfers. These decisions are made on a daily basis. Subjecting transfers of certain patients to court oversight, and the often slow processes and procedures of the judicial system, would unnecessarily burden the hospital, parties, and courts. Requiring judicial intervention in each of these cases to determine whether transfer is or is not appropriate, at every moment where transfer might be warranted under rapidly changing

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circumstances, would cause the normal functioning of the entire hospital to cease and would likely increase both civil and forensic wait times and result in unused beds and decreased overall efficiency.

e. Transfer of NGRI patients to civil units has adverse impacts on the civil population of the hospitals. Civil patients, by their nature, move in and out the hospital at much faster rates than NGRIs, many of whom stay for years. Placement of NGRI patients on the civil units decreases bed availability for an already taxed civil commitment system.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

Executed this 6TH day of October 2014, at Lakewood, Washington.

BRIAN WAIBLINGER, M.D.
Medical Director, Western State Hospital

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CERTIFICATE OF SERVICE

Beverly Cox, states and declares as follows:

I am a citizen of the United States of America and over the age of 18 years and I am competent to testify to the matters set forth herein. I hereby certify that on this 6 day of October 2014, I electronically filed the foregoing document with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the following:

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I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Dated this 6 day of October 2014, at Olympia, Washington.

Beverly Cox

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