HOUSE BILL REPORT
HB 1218

As Reported by House Committee On:
Civil Rights & Judiciary

Title: An act relating to persons referred for competency evaluation and restoration services within the framework of the forensic mental health care system consistent with the requirements agreed to in the Trueblood settlement agreement.

Brief Description: Concerning persons referred for competency evaluation and restoration services.

Sponsors: Representatives Farivar, Macri, Reed, Simmons, Wylie, Pollet, Street, Ormsby, Scott, Salahuddin, Parshley and Hill; by request of Governor Inslee.

Brief History:
Committee Activity:
Civil Rights & Judiciary: 1/15/25, 2/18/25 [DPS].

Brief Summary of Substitute Bill

- Addresses provisions relating to competency evaluation and restoration services, including appointment and duties of forensic navigators, outpatient competency restoration orders, failure to appear for scheduled admissions, and hearings for involuntary medication determinations.
- Requires the Department of Social and Health Services to establish a growth cap program to manage inpatient competency evaluation and restoration orders, including imposing penalties for counties that exceed a baseline cap of referrals.
- Establishes necessary elements of behavioral health diversion plans.

HOUSE COMMITTEE ON CIVIL RIGHTS & JUDICIARY

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Signed by 8 members: Representatives Taylor, Chair; Farivar, Vice Chair; Entenman, Goodman, Peterson, Salahuddin, Thai and Walen.

Minority Report: Do not pass. Signed by 5 members: Representatives Walsh, Ranking Minority Member; Abell, Assistant Ranking Minority Member; Burnett, Graham and Jacobsen.

Staff: Edie Adams (786-7180).

Background:

Competency to Stand Trial.
A person is incompetent to stand trial if, due to a mental disease or defect, the person lacks the capacity to understand the nature of the proceedings or is unable to assist in his or her own defense. A person who is incompetent to stand trial may not be tried, convicted, or sentenced for a criminal offense as long as the incompetency continues.

Competency Evaluation and Restoration.
When a defendant's competency to stand trial is in question, if there are sufficient facts to form a genuine doubt as to competency, the court must either appoint, or ask the Department of Social and Health Services (DSHS) to designate, a qualified expert to evaluate and report on the defendant's mental condition. If a defendant is found incompetent to stand trial, the court must stay the criminal proceedings and, depending on the charged offense, either order a period of treatment for restoration of competency, or dismiss the charges without prejudice. A court may order a period of competency restoration treatment for a defendant who is charged with a felony or a serious nonfelony offense, but not for a defendant charged with a nonfelony that is not a serious offense.

A defendant may qualify for variable periods of competency restoration treatment depending on the defendant's criminal charges. For defendants charged with a serious nonfelony or certain class C felonies, the court must first consider all available and appropriate alternatives to inpatient competency restoration, and must dismiss charges without prejudice upon agreement of the parties if the forensic navigator has found an appropriate diversion program willing to accept the defendant. Competency restoration is provided in a facility operated or contracted by the DSHS unless the defendant qualifies for an outpatient competency restoration program.

Outpatient Competency Restoration.
A court may commit a person to outpatient competency restoration upon recommendation of a forensic navigator if there is a program available and the defendant is clinically appropriate for outpatient competency restoration. To be eligible, the defendant must be willing to adhere to medications or receive intramuscular medication, abstain from alcohol and prescribed drugs, and comply with urinalysis or breathalyzer monitoring if needed. The DSHS must place the person into approved housing affiliated with a contracted outpatient

competency restoration program. An outpatient competency restoration program may be terminated and the defendant transferred to inpatient restoration if the defendant fails to comply with program requirements or the defendant is no longer clinically appropriate for outpatient competency restoration.

Forensic Navigators.
A forensic navigator is an impartial person employed by the DSHS and appointed as an officer of the court to assist individuals referred for competency evaluation. A forensic navigator assists parties in understanding options available to the person that may allow for diversion from the forensic system or outpatient competency restoration, and to facilitate the person's transition to those options. This includes coordinating access to mental health services and housing, and assisting the person with obtaining prescribed medication and attending appointments and classes. A forensic navigator must be appointed for defendants whose highest charge is for a misdemeanor or certain class C felonies and who have had two or more cases dismissed based on incompetency within the prior 24 months.

Involuntary Medication.
In *Sell v. United States* the United States Supreme Court held that, under certain circumstances, a mentally ill defendant facing serious criminal charges may be involuntarily medicated in order to restore competency to stand trial. The *Sell* test requires a case-by-case inquiry that weighs the government's interest in prosecution against the individual's rights. Involuntary medication may be ordered only where the proposed medication is medically appropriate and likely to restore competency, and there are no alternative, less intrusive treatments likely to restore competency. Washington has statutorily identified certain offenses that qualify as per se serious offenses for the purposes of ordering competency restoration, and in addition, outlined factors the court must consider in deciding whether a nonlisted offense qualifies as a serious offense in a particular case.

Trueblood Lawsuit and Timelines for Competency Services.
In *Trueblood v. the Department of Social and Health Services*, a federal district court found that Washington was violating the constitutional rights of in-jail defendants for excess wait times for competency evaluation and restoration services. As a result, the DSHS was ordered to provide in-jail competency evaluations within 14 days of a court order and inpatient competency evaluation and restoration services within seven days of a court order. In 2017 the court found the state in contempt for continued noncompliance, and in 2018, the state reached a contempt settlement agreement. The settlement requires the state to take numerous actions to meet the timeframes set forth by the court, and is being implemented in three phases in different parts of Washington. The creation of forensic navigators and outpatient competency restoration programs are components of the settlement agreement and were enacted into law in 2019.

Summary of Substitute Bill:

Competency to Stand Trial Provisions.
Forensic navigators may be appointed for class B and class C felonies and all misdemeanors, and will not be referred for class A felonies unless requested by the court or by a party. Forensic navigator duties include: (a) gathering information regarding the presence of disabilities, injuries, or cognitive disorders to help inform referrals for diversion or services; (b) when able to meet with the individual, gathering accurate contact information from relevant persons to facilitate timely contact if the individual is referred for services; and (c) providing a coordinated transition of an individual found not competent and not restorable due to an intellectual or developmental disability, dementia, traumatic brain injury, or other neurocognitive disorders to appropriate case managers within the DSHS.

To be eligible for outpatient competency restoration, a defendant must be willing to adhere to all rules of the outpatient competency restoration program. The specific requirement that a defendant abstain from alcohol and drugs and comply with urinalysis and breathalyzer monitoring is removed. If a defendant is on personal recognizance waiting for competency services in a county with an outpatient restoration program that has adequate space, the DSHS must provide a recommended services plan to the court. If restoration is still required, the court must order outpatient competency restoration for the defendant.

The DSHS must promptly notify the court and parties when it appears that the condition of a defendant ordered to inpatient competency restoration is such that a transfer to outpatient competency restoration is appropriate. The notice must provide pertinent information concerning the change in condition or the reasons supporting the transfer. The court must schedule a hearing within 10 days of receipt of the notice to review the information, conditions of release of the defendant, and anticipated release date from inpatient treatment. The court must issue appropriate orders if it finds the defendant's condition has so changed that the defendant is suitable for outpatient competency restoration.

If the DSHS is unable to schedule or admit a defendant who is on personal recognizance after two attempts, the DSHS must submit a report to the court and parties and include a date and time for another evaluation at least two weeks later. The court must provide the defendant with notice of the date and time of the admission, and if the defendant fails to appear, the court must recall the order for competency evaluation or restoration and may issue a warrant for failure to appear.

For a defendant ordered to inpatient competency restoration, the DSHS must notify the court and parties when it appears that the defendant's condition and amenability to treatment is such that an involuntary medication order is necessary. The notice must include pertinent information regarding the applicable criteria under *Sell v. United States.* The court must schedule a hearing within 10 days to consider an order for involuntary medication.

In hearings pertaining to involuntary medication, the parties, witnesses, and presiding judicial officer must be present and participate by video, provided that: all parties are able

to see, hear, and speak during the hearing; attorneys are allowed to use exhibits or other materials during the hearing; and respondent's counsel is allowed to be in the same location as the respondent unless otherwise requested by the respondent or respondent's counsel. Witnesses may appear telephonically or through other means according to court rules. The court may require some or all parties and witnesses to participate in person upon its own motion or motion for good cause by any party. In ruling on the motion, the court may consider whether the respondent's behavioral health disorder affects the respondent's ability to perceive or participate in the proceeding by video.

Competency Order Growth Cap Program.
The DSHS must implement a growth cap program to manage inpatient competency orders. The DSHS must establish a baseline cap and incentive cap of referrals for each county. The baseline cap is based on the average number of inpatient competency orders from courts within the county's jurisdiction in fiscal years 2024 and 2025, and the incentive cap is based on the average of such orders in fiscal years 2018 and 2019. For a county with an average of less than two inpatient competency orders, the baseline and incentive caps are set at one.

The DSHS must notify relevant county agencies and courts on a quarterly basis of the total number of inpatient competency orders for the current fiscal year compared to the baseline for that county.

Beginning in fiscal year 2027, a county must pay a penalty for inpatient competency orders that exceed the baseline number. The penalty is calculated based on the per day individual rate for state hospital treatment for individuals referred for inpatient competency services and applies as follows:

- In fiscal year 2027, each county must make penalty payments equal to 25 percent of the rate for the third and fourth inpatient competency orders over the baseline; 50 percent of the rate for the fifth through seventh inpatient competency orders over the baseline; 75 percent of the rate for the eighth and ninth inpatient orders over the baseline; and 100 percent of the rate for the tenth and all inpatient competency orders over the baseline.
- Beginning in fiscal year 2028 and each fiscal year thereafter, each county must make penalty payments equal to 150 percent of the rate for the third and subsequent inpatient competency orders over the baseline.

Penalty payments must be deposited into a newly created Behavioral Health Diversion Fund (Diversion Fund), which is subject to appropriation and to be used only for services designed to keep persons with behavioral health needs out of the criminal justice system. A county that reduces total annual inpatient competency referrals below the incentive cap or reduces its overall orders for any competency services by at least 40 percent for a given fiscal year may request an appropriation from the Diversion Fund. Any amounts the county receives must be used toward services or supports that prevent individuals with behavioral health needs from entering the criminal justice system or that divert them from the criminal justice system once incarcerated.

The DSHS and the Health Care Authority must convene a taskforce to develop rules, policies, and protocols for implementation of the growth cap program for inpatient competency services, including rules for determining county of origin. The taskforce must also address eligibility requirements on the necessary elements of behavioral health diversion plans. The taskforce must include partners from local government, the criminal justice system, behavioral health providers, tribes, people with lived experience, and Disability Rights Washington or a designee. The taskforce must report to the Governor and Legislature by June 1, 2026.

"Behavioral health diversion plan" is defined to mean a plan or strategy to ensure the availability and utilization of community-based treatment and support services designed to reduce or eliminate the amount of time persons with behavioral health needs spend in a jail facility. The plan must include:

- specific measures to reduce the number of individuals with behavioral health needs whose highest charge is up to a class C felony from entering or remaining in the criminal justice system, or to divert them away from the competency system;
- specific measures to identify individuals who have had multiple prior findings of nonrestorability, and strategies to prevent future competency orders and use diversion options for these individuals;
- strategies to reduce recidivism for individuals with behavioral health needs who are likely to be referred for a competency service within the next six months;
- a strategic plan to create programming, services, and supports along each intercept in the sequential intercept model for the county; and
- a communication and collaboration plan that incorporates key stakeholders in the development of diversion plans.

Substitute Bill Compared to Original Bill:

The substitute bill makes the following changes:

- allows a party to request a forensic navigator referral for a person charged with a class A felony and adds additional duties for forensic navigators;
- requires a court hearing on whether a person should be transferred from inpatient to outpatient restoration to occur within 10 days of notice from the DSHS;
- requires a court to set an involuntary medication hearing within 10 days of receiving notice from the DSHS that a defendant's condition and amenability to treatment are such that an order for involuntary medication is necessary, and allows involuntary medication hearings to be conducted by video if specified standards are met;
- specifies necessary components of behavioral health diversion plans;
- delays implementation of the growth cap penalty provisions until fiscal year 2027; and
- disconnects the growth cap penalty amounts from whether or not the county has established a behavioral health diversion plan, and provides instead that commencing in fiscal year 2028, each county is subject to a penalty of 150 percent of the rate for

the third and subsequent individual orders over the baseline.

Appropriation: None.

Fiscal Note: Requested on January 9, 2025.

Effective Date of Substitute Bill: The bill contains multiple effective dates. Please see the bill.

Staff Summary of Public Testimony:

(In support) The *Trueblood* case has been going on for 11 years now. Tremendous progress has been made in coming into compliance with the court order as a result of significant investments in both bed capacity and community-based services. However, the volume of competency referrals continues to grow exponentially. In the last 10 years there has been an 89 percent increase in felony referrals and a 165 percent increase in misdemeanor referrals, and the latest projections are for an annual growth rate of 8 to 9 percent. As a result, the state is likely to soon run out of beds and once again be out of compliance with the court order. Dismissal rates are also high across the state, with 45 percent of misdemeanor cases being dismissed, resulting in no accountability and no treatment.

The state must meet constitutional obligations under *Trueblood*, but the current system does not have checks on when and how individuals are referred for competency services. If the goal is to increase resources for community-based services, the state must address the rate of referrals and reduce the pressure to continually build very expensive forensic beds, which cost around $1.5 million per bed. It is not possible to build out of this problem because a bed built is a bed filled. It is time for everyone to recognize the role they play and the stake they have in the system, and come together to solve this issue.

The system is not demonstrating meaningful accountability, rehabilitation, or treatment to help folks move forward in their lives. Data shows that people are repeatedly cycling through the system. The assumption that people can access treatment through arrest, prosecution, and competency restoration is factually inaccurate. Restoration is not treatment and is not working to stabilize people and interrupt recidivism. What works are programs with housing supports and low barrier services. There are community-based services in many places, and diversion providers that want to serve this population. The bill focuses on investing in these community services instead of taking the path of least resistance.

This legislation is about presenting a better solution. Past efforts to incentivize diversion and create presumptions against inpatient restoration have not been enough. The bill proposes a good model that asks cities and counties to think carefully about who they are sending to the competency system, but there are other ways to address the issue. The

method is less important than the outcome that everyone wants, which is greater investment in diversion, prevention, and community behavioral health, so that people can receive the care that they need where it is most appropriate outside of the criminal justice system.

(Opposed) Not all communities have providers who will take cases with a mix of behavioral health issues and criminal behavior. Many victims are family members who are frustrated with not being able to get help in the community, and the only available option is competency restoration. There is significant opposition to the cap and penalty provision as well as other concerns. The bill requires a court to order someone to outpatient treatment if available, and that is not appropriate in some cases. It is also not appropriate to require a court to withdraw a competency order just because someone failed to appear for admission.

The state continues to prioritize bringing online the far more expensive state hospital beds at the expense of investments in the community behavioral health system, which should be the focus in order to stem this tide. The bill shifts part of the state's responsibility to counties without providing funding. It does not define "county," leaving ambiguity about whether it is a geographic area or county government. County governments lack authority over municipal misdemeanor cases, but will be penalized if a city refers too many defendants. To ensure appropriate referrals, data should be collected on case types and volumes by jurisdiction, not just geography, to help identify the right solutions.

The bill is not the best way to go about solving the challenges in the competency system. Cities and counties cannot control the number of people coming into the criminal justice system that have mental health challenges. The bill will pit jurisdictions within a county against each other in a race to fill limited competency spots, and it will lead to more cases being dismissed which will not benefit anybody. More investment in the behavioral health care system is needed so that folks can access services before they reach the point of engaging in criminal behavior.

(Other) Individuals with mental illness are 10 times more likely to be incarcerated than hospitalized. It makes no sense to penalize counties because individuals need hospital level care. Requiring a pre-*Sell* hearing is not workable and will lead to equal protection violations. Forensic navigators should be available in all cases. Outpatient competency restoration is significantly helpful and should be available in every community, and providing for more diversion of individuals is a good idea. The Legislature needs to create a work group to comprehensively evaluate the competency laws and do something proactive, not continually make piecemeal changes.

It seems like the forest has been lost through the trees with this bill. Reducing wait times by kicking people out of the line is not solving the problem. People get into the competency system because they need help and some kind of harm has happened in the community. The central driver behind the bill should be how to provide help to people who need it and how to prevent harm to the community.

The five-day deadline for a hearing on transfer of a patient to outpatient restoration is too short and should be extended to at least 10 days. There should be more clarity on who participates in the hearing and how it should take place. A court authorizing involuntary medication should apply the order to any location the person will be, not just the state hospitals, so that the person does not decompensate upon return to jail.

Persons Testifying: (In support) Representative Darya Farivar, prime sponsor; Amber Leaders, Office of Governor Jay Inslee; Kimberly Mosolf, Counsel for Plaintiffs in AB v DSHS (Trueblood); Chloe Merino, Disability Rights WA; Plaintiff Counsel A.B. v. DSHS (Trueblood); Kevin Bovenkamp, DSHS Behavioral Health Administration; and Thomas Kinlen, DSHS Behavioral Health Administration.

(Opposed) Russell Brown, WA Association of Prosecuting Attorneys; Candice Bock, Association of Washington Cities; Brad Banks, Washington State Association of Counties (WSAC); and Michael White, King, Pierce, and Snohomish Counties.

(Other) Marc Stern; Kari Reardon, WACDL/WDA; Melissa Johnson, District & Municipal Court Judges' Association; and James McMahan, WA Assoc Sheriffs & Police Chiefs.

Persons Signed In To Testify But Not Testifying: Asenith M Herbert Hill; and Loni Simone.