Washington State
Institute for
Public Policy

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COMPETENCY TO STAND TRIAL AND CONDITIONAL RELEASE EVALUATIONS: CURRENT AND POTENTIAL ROLE OF FORENSIC ASSESSMENT INSTRUMENTS

The 2010 Legislature directed the Washington State Institute for Public Policy (Institute), in collaboration with the Department of Social and Health Services (DSHS), to search for validated mental health assessment tools (or combination of tools) to be used by evaluators for:

- Court-ordered competency to stand trial assessments of defendants pursuant to RCW 10.77.
- Recommendations to courts regarding the appropriateness of conditional release from inpatient treatment of criminally insane patients.[1]

This review is to be completed by June 30, 2011. Another assignment directed the Institute to search for assessment instruments related to the Involuntary Treatment Act in the civil system.[2]

This report provides background information on the potential role of assessment instruments in evaluators' reports to the court. We also summarize findings from an October 2010 survey of state evaluators and recommend three options for forensic assessment strategies and instruments.

Summary

In response to a 2010 legislative direction, the Institute and DSHS are investigating options regarding the use of mental health assessment tools for two DSHS reports to the courts:

- ✓ Competency to stand trial assessments of criminal defendants whose competency is in question, and
- ✓ The Secretary's recommendations to the courts concerning the potential conditional release of criminally insane patients from inpatient treatment.

This document summarizes results of an October 2010 survey of state forensic evaluators concerning their use of assessment instruments. Thirty-one (of the 35) mental health experts who conduct forensic evaluations for the three state psychiatric hospitals (Western State, Eastern State, and Child Study and Treatment Center) responded to the online survey; this represents an 89 percent response rate.

We present three options for assessment strategies and instruments, with advantages and disadvantages of each option. A detailed comparison of instruments is included.

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[1] Laws of 2010, ch. 37 § 204 (3) (d)
[2] M. Burley. (2010). *ITA investigations: Can standardized assessment instruments assist in decision making?* Olympia: Washington State Institute for Public Policy, Document Number 11-01-3402.

SECTION I: BACKGROUND

The constitutional right to a fair trial includes several elements. An accused individual has the right to be present at the trial, must be able to understand the adversarial nature of the proceedings, and must be capable of helping present a defense. If the issue of competency is raised with respect to a particular defendant, the court must order a competency evaluation. The court may assign one or two experts to the evaluation and order the evaluation to take place in a jail, state hospital, or in the community. In Washington, the vast majority of these evaluations are conducted by state employees and the interviews occur in a jail.

State statute requires that the evaluator's report include the following:[3]

- A diagnosis of the mental condition of the defendant;
- An opinion as to the defendant's competency, and an opinion regarding insanity if insanity is claimed;
- An opinion as to whether the defendant should be evaluated under the Involuntary Treatment Act (ITA);[4] and
- An opinion as to whether the defendant is a substantial danger to others or presents a substantial likelihood of committing criminal acts endangering public safety.

If, after receiving report(s) of the evaluation, the court finds that the defendant is competent, the case proceeds to trial. If the court concludes that the defendant is incompetent, a period of treatment may be authorized to restore the defendant to competency. If the person is restored to competency, the case proceeds to trial. Research in other states indicates that around 75 percent of incompetent defendants are returned to court as competent within six months.[5]

If the court finds the defendant is unlikely to regain competency, the proceedings are dismissed and the defendant is evaluated for civil commitment proceedings under the Involuntary Treatment Act.

The 1998 Legislature extended the criminal competency restoration process to non-felony defendants, broadened the involuntary civil commitment process to non-felony and felony offenders, and strengthened the information-sharing provisions of the law.[6]

Individuals committed to the custody of the DSHS Secretary after being found Not Guilty by Reason of Insanity (NGRI) are frequently placed in a secure facility, typically in the forensic (criminal) unit of one of the three state psychiatric hospitals—Western State Hospital (WSH), Eastern State Hospital (EWH), and Child Study and Treatment Center (CSTC). The term of commitment may not exceed the maximum sentence for the offense for which the defendant was acquitted by reason of insanity.

Individuals confined under the law can apply to the DSHS Secretary for conditional release; the Secretary can also consider conditional release for individuals who have not made this application.

Decisions about release are made by the court of the county that ordered the person's commitment. The Secretary's recommendation to the court is to consider "reports of experts or professional persons" concerning the application and proposed terms and conditions.[7]

[3] RCW 10.77.060 (3)
[4] The ITA is a civil law to protect persons dangerous to self or others (RCW 71.05).
[5] G. Bennett & G. Kish. (1990). Incompetency to stand trial: Treatment unaffected by demographic variables. *Journal of Forensic Sciences, 35,* 403-412; S. L. Golding, D. Eaves, & A. Kowaz. (1989). The assessment, treatment and community outcome of insanity acquittees: Forensic history and response to treatment. *International Journal of Law and Psychiatry, 12,* 149-179; D. R. Morris, & G. F. Parker. (2008). Jackson's Indiana: State hospital competence restoration in Indiana. *Journal of the American Academy of Psychiatry and Law, 36,* 522-534; R. Nicholson & J. McNulty. (1992). Outcome of hospitalization for defendants found incompetent to stand trial. *Behavioral Sciences and the Law, 10,* 371-383.
[6] P. Phipps. (2004). *Mentally ill misdemeanants: An evaluation of change in public safety policy.* Olympia: Washington State Institute for Public Policy, Document Number 04-01-1901.
[7] RCW 10.77.150 (2)

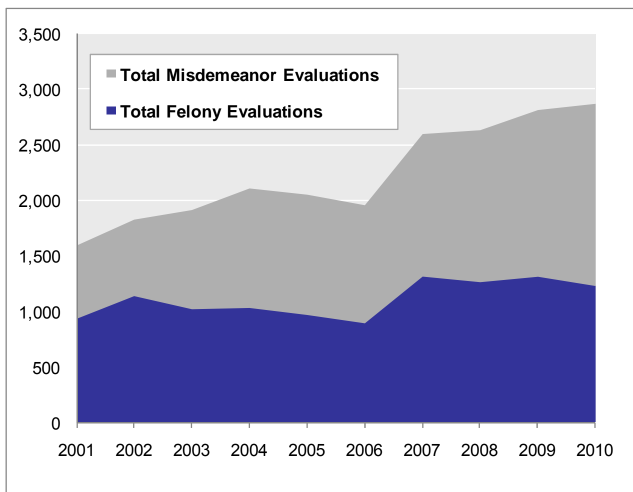
The evaluators' reports to the Secretary for these situations assess the person's history, treatment, and risk management options. The risk assessment portion of these reports is far more significant and complex than the risk assessment portion of a competency to stand trial evaluation.

Washington State Competency Evaluations: 2001 – 2010

Exhibits 1 through 3 display state trends for competency to stand trial evaluations, including the setting (jail or hospital) and whether the charges are for felony or misdemeanor offenses. Two major changes have occurred since 2001:

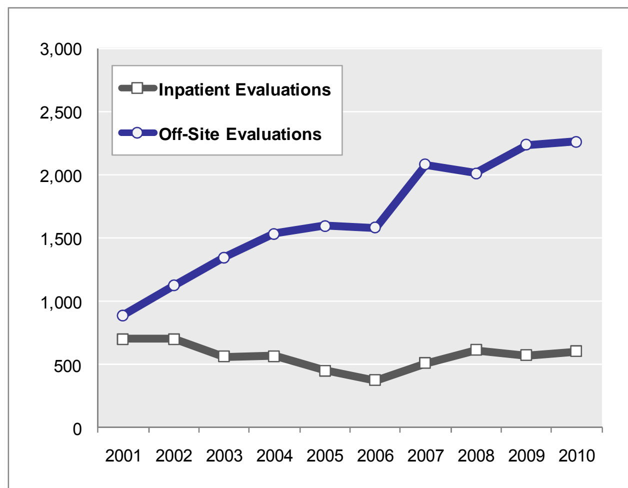
- Misdemeanor evaluations have doubled and are now more common than felony evaluations.
- The growth has been concentrated in off-site evaluations at Western State Hospital.

Exhibit 1
Misdemeanor Competency Evaluations Have Doubled Since 2001



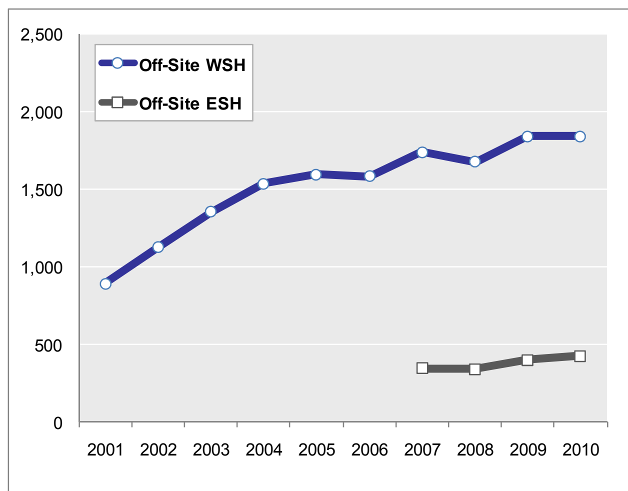
WSIPP, 2011

Exhibit 2
Growth in Competency Evaluations Occurring Off Site



WSIPP, 2011

Exhibit 3
Off-Site Competency Evaluations at WSH Driving Increases



WSIPP, 2011
ESH data not available prior to 2007

Western State Hospital currently has 188 NGRI cases: 107 (57 percent) on inpatient status; 11 (6 percent) on the conditional release in the community program ward; 2 (1 percent) on the conditional release in the civil ward (elderly patients); and 68 (36 percent) on conditional release in the community.

Eastern State Hospital currently has 83 NGRI cases: 69 (83 percent) on inpatient status and 14 (17 percent) on conditional release in the community.

Recent Incidents Related to Institute Assignment

In recent years, two incidents at the state hospitals have been the subject of review. This section will briefly review the events and the consequential policy changes.

2009 Event Leading Up to Statutory Changes in RCW 10.77

In 2009, a long-term forensic patient at Eastern State Hospital eloped from an outing. The individual was captured three days later without incident. In response, DSHS Secretary Dreyfus suspended all off-ward activities for forensic patients at both Eastern and Western State Hospitals. In addition, she convened a State Psychiatric Hospital Safety Review Panel (Dreyfus Panel) to recommend changes to department policy, protocols, and laws related to patients, staff, and the public.

The Dreyfus Panel recommended numerous changes to policies and procedures at the two hospitals, as well as statutory changes. Additionally, they recommended that the management and treatment of insanity acquittees be placed under an independent entity similar to the Oregon Psychiatric Security Review Board.[8]

Following deliberations during the 2010 legislative session, lawmakers created an entity that advises the Secretary and courts with respect to persons found NGRI.[9] The independent Public Safety Review Panel members were appointed by the Governor in December 2010 and began reviewing cases in January 2011. This entity is composed of seven individuals with expertise in mental health, corrections, prosecution, defense, law enforcement, and consumer/family advocacy.[10]

[8] *Final report: State psychiatric hospital safety review panel.* (2009, December 14), prepared for Susan Dreyfus, Secretary, Washington State Department of Social and Health Services. Available from: http://www.dshs.wa.gov/pdf/EA/121509SafetyReview.pdf.
[9] Laws of 2010, Chapter 262, §1
[10] The Panel can be contacted through its coordinator, Keri Waterland, at waterkl@dshs.wa.gov.

The Panel provides advice to the courts regarding all NGRI patients concerning recommendations for:

- Changing commitment status;
- Granting furloughs or temporary leaves accompanied by staff; and
- Permitting movement on the facility grounds, with or without staff accompaniment (RCW 10.77.270).

When the Secretary is considering a recommendation to the court regarding conditional release under RCW 10.77.150, the Panel completes an independent assessment of the public safety risk associated with the proposed recommendation. The Panel indicates whether it agrees with the Secretary's recommendation or whether it would issue an alternative.

In addition to its recommendations regarding management and treatment of NGRI acquittees, the 2009 Dreyfus Panel recommended several policy changes related to the Institute's study assignment:[11]

- The Panel expressed its belief that "the two hospitals should be working collaboratively under the guidance of an executive partnership team that is focused on mutual support and the adoption of uniform practices." (p. 4)
- "The risk management programs and risk assessment tools…at both hospitals appear to be outdated and not evidence-based," and "they should be re-evaluated in the context of contemporary, evidence-based practice." (p. 4)
- "The policies and procedures for assessing patients for competency to stand trial…need to be standardized at the two hospitals" and "reviewed and updated to assure that effective, contemporary, bench-marked, and evidence-based procedures are being employed at both facilities." (p4)
- "A simplified, uniform privilege/level classification should be developed at both hospitals that is linked to formal risk appraisals using evidence-based measures and protocols." (p. 5)

[11] Final report: State psychiatric hospital safety review panel, 2009.

2011 Event Related to Communicating Patient Risk

In March 2011, an involuntarily civilly committed patient left Western State Hospital grounds without permission. He was found the next day and placed in Department of Corrections (DOC) custody.[12] The incident review prepared for DSHS Secretary Dreyfus identified the following issue related to the Institute's assignment:

> "The Department of Corrections and Western State Hospital use different and necessary assessments to assign public safety risk. Department of Corrections assessed the missing patient as 'high risk to commit a non-violent crime,' based on the patient's criminal history and risk behaviors, including a prior threat to harm the Community Corrections officer assigned to the patient's case. Western State Hospital's notification practices to law enforcement are based on a patient's current clinical mental health status and compliance with treatment."[13]

The review indicated that DSHS, DOC, and local law enforcement will "work together to develop a jointly shared understanding of patient risk to the community" and a "mechanism to provide one consistent message to law enforcement and the public."

This review echoes some of the issues of concern identified by the 2009 Dreyfus Panel, in particular the need for standardized communication regarding risk assessments.

The next section will review the role and purpose of forensic assessment instruments related to this study assignment.

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[12] C. Clarridge. (2011, March 9). *Latest escape spurs changes at Western State Hospital*. The Seattle Times. Available from: http://seattletimes.nwsource.com/html/localnews/2014449761_escape10m.html.

[13] State Psychiatric Hospital Safety Review Panel. (2011, March 9). *A review of circumstances surrounding the unauthorized leave of an involuntarily committed civil patient at Western State Hospital on March 4, 2011*, prepared for DSHS Secretary Susan N. Dreyfus.

This section reviews the three categories of forensic assessment instruments that are relevant to this assignment: competency to stand trial, response style/symptom distortion, and likelihood of reoffending We review the purposes of the instruments in each category and identify the instruments most commonly referenced in the research literature.

Appendix D is a matrix summarizing characteristics, psychometric properties, and testing requirements of certain assessment instruments. Testing requirements indicate the average amount of time required to complete the assessment. Timing requirements are particularly relevant for state evaluators who need to complete their evaluations in accordance with hospital policies and court orders.

Competency to Stand Trial

English common law is the original source for the legal context for competence to stand trial. The U.S. modern day standard was established in *Dusky v. United States* (1960). The court held:

> It is not enough for the district judge to find "the defendant [is] oriented to time and place and [has] some recollection of events," but that the "test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him."[14]

Further clarification from the Supreme Court came in *Drope v. Missouri* (1975), adding the notion that the defendant must be able to "assist in preparing his defense."[15] Case law has defined eight functional abilities necessary for a defendant to be competent:

- That he has mental capacity to appreciate his presence in relation to time, place, and things;
- That his elementary mental processes be such that he apprehends that he is in a Court of Justice charged with a criminal offense;
- That there is a judge on the bench;
- That a prosecutor is present who will try to convict him of a criminal charge;
- That the lawyer will undertake to defend him against that charge;
- That he will be expected to tell his lawyer the circumstances, to the best of his mental ability, the facts surrounding him at the time and place where the law violation is alleged to have been committed;
- That there is, or will be, a jury present to pass upon evidence as to his guilt or innocence of such charge; and
- He has memory sufficient to relate those things in his own personal manner.[16]

As is made clear by this list of functional abilities, this assessment of competency to stand trial can be a complex matter and is not a yes/no determination. The consideration of a defendant's mental state in the context of these abilities requires careful analysis, as noted by Golding and Roesch:

> "Mere presence of severe disturbance (a psychopathological criterion) is only a threshold issue—it must be further demonstrated that such severe disturbance in this defendant, facing these charges, in light of existing evidence, anticipating the substantial effort of a particular attorney with a relationship of known characteristics, results in the defendant being unable to rationally assist the attorney or to comprehend that nature of the proceedings and their likely outcome."[17]

[14] *Dusky v. United States*, 362 U. S. 402 (1960), p. 402.
[15] *Drope v. Missouri*, 420 U. S. 162 (1975), p. 171.
[16] *Wieter v. Settle*, 193 F. Supp. 318 (W. D. Mo. 1961), p. 320.
[17] L. Golding & R. Roesch. (1988). Competency for adjudication: An international analysis. In D. N. Weisstub (Ed.), *Law and mental health: International perspectives,* (Vol. 4, pp. 73-109). New York: Pergamon, p. 79.

For many years, psychologists who evaluated defendants concerning their competency to stand trial relied exclusively on clinical interviews with standard psychological tests. Starting in the 1960s, instruments were developed specifically to assist in answering forensic questions; these instruments are commonly known as “forensic assessment instruments.” A prominent researcher in mental health, Thomas Grisso, noted that in combination with a clinical interview, forensic assessment instruments (FAIs) offer the following benefits to the evaluation of competency:

- Providing structure for the interviewer;
- Potentially improving communication in legal settings; and
- Facilitating empirical research on the association between legally relevant functional abilities and instruments.[18]

Competency assessment instruments are not intended to be used as the sole basis for an evaluator’s opinion regarding competency. Test developers and researchers agree that the information obtained from a competency assessment instrument is to be “used in conjunction with various other sources of information.[19]

Instruments in this field have evolved since the 1960s from checklists and sentence completion tasks, to self-report questionnaires, to interview-based instruments without scoring, and finally to scored interview-based instruments.[20]

The research literature commonly references nine assessment tools for adults that assess competency to stand trial; these instruments can be grouped by the type of instrument.[21]

Checklists, Self-Report Questionnaires, and Sentence Completion Tasks

- CADCOMP—Computer-Assisted Determination of Competency Procedure
- CST—Competency Screening Test

Interview-Based Instruments Without Criterion-Based Scoring

- CAI/RCAI—Competency Assessment Instrument/Revised Competency Assessment Instrument
- CAST-MR—Competence Assessment for Standing Trial for Defendants with Mental Retardation
- FIT-R—Fitness Interview Test-Revised
- GCCT—Georgia Court Competency Test
- IFI—Interdisciplinary Fitness Interview

Interview-Based Instruments With Criterion-Based Scoring

- ECST-R—Evaluation of Competency to Stand Trial-Revised
- MacCAT-CA—MacArthur Competence Assessment Tool-Criminal Adjudication

For children and adolescents, the Juvenile Adjudicative Competence Interview (JACI) is the first instrument published for assessing aspects of normal development and developmental psychopathology that are related to the competence capacities needed in the juvenile justice system. Some instruments developed for criminal (adult) court have developed scores for minors; however, those instruments do not address the differences between child and adult mental health, nor do they account for the differences between juvenile and criminal court.

[18] T. Grisso. (2003). *Evaluating competencies: Forensic assessment and instruments* (2nd ed.). New York: Kluwer Academic/Plenum Publishers, p. 46.
[19] P. Zapf & R. Roesch. (2009). *Evaluation of competence to stand trial*. New York: Oxford University Press, p. 62.
[20] Ibid., p. 60.
[21] P. Zapf & J. Viljoen. (2003). Issues and considerations regarding the use of assessment instruments in the evaluation of competency to stand trial. *Behavioral Sciences and the Law, 21,* 353-369.

Response Style/Symptom Distortion

For competency cases, instruments have also been developed to assist in determining whether the defendant is responding in a way other than "candid, honest or straightforward."[22] Instruments to assess response style or symptom distortion are sometimes known as "malingering" or "feigning" assessments.

The most frequently cited malingering instruments in the literature are the following:

- ECST-R—Evaluation of Competency to Stand Trial-Revised (28 of the items)
- M-FAST—Miller Forensic Assessment of Symptoms Test
- SIMS—Structured Inventory of Malingered Symptomatology
- SIRS-2—Structured Interview of Reported Symptoms (can be used with juveniles)
- TOMM—Test of Memory Malingering

Likelihood of Reoffending

A separate set of assessment instruments appraise the likelihood that individuals with certain characteristics are likely to commit future crimes. This category of instruments started to appear in the 1960s, with significant refinements and advances occurring after the 1980s.[23] Many of these tools are referenced as actuarial instruments: they attach statistical weighting to variables that have been proven to influence recidivism rates of forensic populations.

Significant differences exist between competency assessment instruments (including malingering) and instruments to assess likelihood of reoffending. As described earlier, competency-related instruments systematically assess the functional abilities of a defendant to assist with his/her defense. Instruments to assess response style/symptom distortion help the evaluator understand whether the defendant is feigning or exaggerating mental illness/psychiatric symptomatology or mental impairment/cognitive deficits.

In contrast, instruments that measure risk of future reoffending are significantly based on the defendant's past behavior. As an example, the Historical Clinical Risk Management (HCR-20) instrument includes the following variables: individual acts of violence back to childhood; early maladjustment at home, school, or in the community; any history of victimizing or being a victim, especially during developmental years; interpersonal relationship instability issues; problems in the areas of employment, substance abuse, and prior supervision (corrections or mental health release program).

In addition, the HCR-20 incorporates the score of a separate assessment instrument related to psychopathic personality disorder, one of the versions of the Psychopathy Checklist Revised. A score from this instrument is also included on another risk prediction instrument, the Violence Risk Appraisal Guide (VRAG).

For evaluators to complete an assessment with these types of variables, it is thus critical that he or she access a variety of records from multiple sources. As a result, the time estimates to complete risk prediction instruments are significantly higher than the competency-related assessments.

As described earlier, Washington law requires opinions about a defendant's future dangerousness as part of an RCW 10.77 evaluation for individuals who intend to plead NGRI or if there are reasons to doubt his or her competency. In addition, individuals who are found NGRI are periodically reviewed for potential conditional release, and public safety risks are an important element of the report.

State hospital policies cover the use of risk assessment instruments for NGRI patients. Both adult psychiatric hospitals in Washington State reference risk assessment screening and instruments in their policies regarding privilege

[22] Zapf & Roesch, 2009, p. 123.
[23] V. L. Quinsey, G. T. Harris, M. E. Rice, & C. A. Cormier. (1998). *Violent offenders: Appraising and managing risk.* Washington, D.C.: American Psychological Association.

levels for patients, as well as decisions concerning conditional release.

A 2010 meta-analysis identified several actuarial risk instruments that predict violent behavior, are commonly used, and have been subject to rigorous evaluation.[24]

- HCR-20—Historical Clinical Risk Management
- LSI/LSI-R—Level of Service Inventory/Level of Service Inventory-Revised
- OGRS—Offender Group Reconviction Scale
- PCL—Psychopathy Checklist (various versions)
- VRAG—Violence Risk Appraisal Guide
- VRS-2nd edition—Violence Risk Scale

The Washington State Department of Corrections relies on a static risk assessment tool to assist in supervision-related decisions; the tool is known as the Static Risk Assessment (SRA). This tool was developed and validated on Washington State population.[25]

Western State Hospital

Western State Hospital recently updated their risk assessment/management policies for the Center for Forensics (see Appendix A). Procedures for risk assessment apply to NGRI patients who come to the Center or are living in the community. The assessments are to be completed by a licensed psychologist and meet the following criteria:

- Use the structured interview format available in the Center for Forensic Services' manual.
- Obtain a thorough history.
- May use actuarial instruments, including a review of the patient's history.
- For the risk assessment, use current research and scholarship and include clinical, actuarial situation, and other factors. The Center for Forensic Services utilizes the HCR-20 and VRAG instruments.
- Do not use projective testing.[26]
- Risk assessments will include a summary of dynamic factors, protective factors, and the individual's recent response to treatment.

WSH's policies regarding risk assessment and management include guidelines for decision making tied to a "Defendant Screening Form." The guidelines take into account various combinations of static and dynamic factor scores, risk of sexual aggression, and vulnerability, in the context of ward placement.

The policies indicate that a review for conditional release or final discharge must include completion of the Violence Risk Appraisal Guide and the Psychopathy Checklist-Revised.

Eastern State Hospital

Eastern State Hospital's guidelines direct the use of a risk assessment instrument to assess a patient's potential for self-injury, dangerousness, or elopement when admitted to the Forensic Services Unit and when under consideration for off-ward, off-campus authorized leaves, or less restrictive alternatives. This instrument is completed by a psychiatrist, based on the treatment team's assessment of the patient. The instrument was developed by staff prior to 2009; it has not been validated.

A separate set of policies at Eastern State Hospital govern patients referred to the hospital's Risk Review Board and the Public Safety Review Panel; these have been recently updated (see Appendix B). The template directs the evaluation to include diagnosis, clinical formulation, family/social history,

[24] M. Yang & S. Wong. (2010). The efficacy of violence prediction: A meta-analytic comparison of nine risk assessment tools. *Psychological Bulletin, 136*(5), 740-767. Twenty-eight independent studies are analyzed in this paper. We include the instruments that are for general populations as opposed to sex-offender specific.

[25] E. Drake & R. Barnoski. (2009). New Risk Instrument for Offenders Improves Classification Decisions. Olympia: Washington State Institute for Public Policy, Document Number 09- 03-1201.

[26] A projective test is a type of personality test in which the individual offers responses to ambiguous scenes, words, or images.

mental health, and criminal/ violent behavior. In addition, the evaluation is to "usually" use the VRAG or HCR-20 and identify dynamic/static factors as well as protective factors.

Child Study and Treatment Center

For juveniles, the Child Study and Treatment Center does not have specific policies regarding use of instruments. The Center bases its work on "best practices," and, thus, uses the Juvenile Adjudicative Competence Interview (JACI). This instrument is a structured competency to stand trial interview for juveniles. The youth's responses are evaluated qualitatively and are not scored.

If a youth has unusual circumstances or needs, evaluators may add another competence forensic assessment instrument. They use the Youth Level of Service/Case Management Inventory (YLS/CMI) to structure risk assessment opinions, but consider other factors as well, based on recent research.[27]

Relevant Practices in Other States

We were interested in learning about the forensic assessment policies in other states. We initiated the review by contacting experts in the field and asking about jurisdictions that had considered or adopted policies concerning forensic assessment instruments. We investigated states' instrument policies in three categories: competency to stand trial, response style/symptom distortion, and risk assessment. None of the states we contacted had policies mandating the use of particular competency assessment instruments; some states do require use of specific risk assessment instruments. Exhibit 4 summarizes these interviews.

[27] Personal communication with Fran Lexcen, Ph.D., Acting Director, Child Study and Treatment Center, April 2011.

Exhibit 4
Example States' Approaches to Forensic Assessment Tools

Competency to Stand Trial	
Connecticut	Relies on a standardized protocol of questions. "Competency is an individual decision that takes into account various situations associated with the defendant, his/her crime, and particular legal tasks that the person needs to participate in. Instruments do not add additional value to this determination, if you ask the right questions." The directors of each of the five state clinics meet and discuss cases and examine inter-rater reliability, which has been found to be high.[28]
Maryland	Have a detailed training program for mental health professionals and use evaluation checklists but do not use pretrial assessment instruments.[29]
Missouri	Uses the Dusky standards to guide clinical assessment.[30]
New York	Managers found that there was no uniformity to the competency assessment reports. They created templates to help structure the reports and ensure that the same categories of information are covered in each report.[31]
Response Style/Symptom Distortion	
Georgia	They encourage use of a standardized measure of malingering (SIRS, ILK, etc.).[32]
Risk Assessment	
Connecticut	Does not rely on standardized assessments. "All forensic patients have histories of criminal activity; the key issue is not whether they are in a high risk category; the decision is how to proceed to manage the risk. The risk will not evaporate. One could make an argument for the HCR-20; in the end, however, it is just a mnemonic device that helps one ask about the relevant variables and the score contributes nothing of value." For release recommendations, they have a consulting forensic examiner who independently reviews the staff recommendations and must agree with all decisions for level changes. They also have a quasi-judicial board that makes release decisions and the clinical staff must prove to this board that the person is ready for release.[33]
Georgia and Florida	Require the completion of the HCR-20 and the PCL-R for NGRI acquitees.[34]
Maryland	Uses actuarial risk assessment instruments sparingly. "We never refer to instrument findings in reporting to the court about a patient's commitability; instead, we use them to plan strategies for managing risks."[35]
Missouri	Has used various risk assessment instruments, including the PCL and the HCR-20. "Ideally, the instruments help provide a road map of what needs to be covered in a report to the court, particularly for those new to the practice." The key decisions for their NGRI patients are made by senior clinicians and the instruments help them structure questions and conclusions, and demonstrate that the evaluation has been done with due diligence. The instrument guides are programmed into a template, so when the clinician starts the report, he or she knows what to cover. Scores are not particularly influential; "someone with a score of 20 is not that different from someone with a score of 19."[36]
New York	Assesses NGRI patients using the HCR-20. Some evaluators score the instrument and include this information in their report to the court, others do not.[37]
Ohio	Has developed its own licensed version of the HCR-20 for exclusive use by their Department of Mental Health. It was modified slightly from the original HCR-20. The instrument is used for decisions on conditional release and risk related to the program. There are no norms for the instrument; it requires professional judgment. The instrument is considered valuable, because it organizes information and is based on validated research. The state was subject to lawsuits in the past over their decision making, and this instrument makes it easier to defend their process.[38]
Multiple States	Developed in Canada, the START (Short-Term Assessment of Risk and Treatability) is used by several states, including Oregon and Georgia, with sites in Alabama and Connecticut using the adolescent version.[39]
Multiple Sites and Countries	The HCR-20 is used in multiple locations in the U.S. including Ohio, New York, Georgia, Hawaii, Virginia, Florida, Nevada, and Pennsylvania. It is also used in Canada, Sweden, Norway, the Netherlands, Germany, Belgium, Japan, and Australia, and has been translated into 18 languages. The HCR-20 has approximately 150 dissemination studies.

[28] Interview with Michael Norko, Director of Forensic Services, Connecticut Dept. of Mental Health & Addiction Services, July 2010.
[29] Interview with W. Lawrence Fitch, J.D., Director of Forensic Services, Maryland Mental Hygiene Administration, July 2010.
[30] Interview with Rick Gowdy, Director, Forensic Services, Missouri Department of Mental Health, July 2010.
[31] Interview with Rich Miraglia, ACSW, Director, New York State Office of Mental Health, Bureau of Forensic Services, September 2010.
[32] Personal communication with Denis L. Zavodny, Ph.D. Office of Forensic Services, Georgia Dept. of Behavioral Health and Developmental Disabilities, October 2010.
[33] Michael Norko interview.
[34] Denis Zavodny interview.
[35] Lawrence Fitch interview.
[36] Rick Gowdy interview.
[37] Rich Miraglia interview.
[38] Interview with Robert N. Baker, Ph.D., Manager, Community Forensic Programs, Office of Forensic Services, Ohio Dept. of Mental Health, Columbus, OH, July 2010.
[39] Interview with Kevin Douglas, Associate Professor, Department of Psychology, Simon Fraser University, Burnaby, BC, Canada, November 2011.

To learn about practices throughout Washington, we surveyed forensic evaluators. As a first step, we met with evaluators from the three state hospitals to discuss the survey objectives and review survey drafts. In October 2010, an online survey was distributed to employees and contractors who conduct relevant examinations for courts in Washington State.

The survey focused on three topics:

- What proportion of forensic evaluators use standardized mental health assessment tools as part of their evaluations for competency to stand trial and recommendations regarding conditional release for persons confined under Not Guilty by Reason of Insanity laws?
- For those who use standardized instruments, which instruments do they use most frequently?
- What do evaluators think is important for legislators to understand about their use of mental health assessment tools in preparing reports regarding competency and conditional release reviews of NGRI patients?

Contacting and Recruiting Evaluators

Hospital administrators supplied work email addresses of forensic evaluators at the state hospitals (Western State, Eastern State, and Child Study and Treatment Center).[40] We provided each evaluator with a summary of the legislative direction for the study, consent procedures, and a request for their participation in an online survey. The respondents were assured that all responses would be kept anonymous; we asked that they complete the survey from a hospital kiosk computer or their home.

Invitations were emailed to 32 state-employed evaluators and three private contractors:

Western State Hospital	23
Eastern State Hospital	7
Child Study and Treatment Center	2
Private Contractors[41]	3
Total	35

Thirty-one survey responses were received, for a response rate of 89 percent (24 surveys were completed in full and 7 were partially completed).

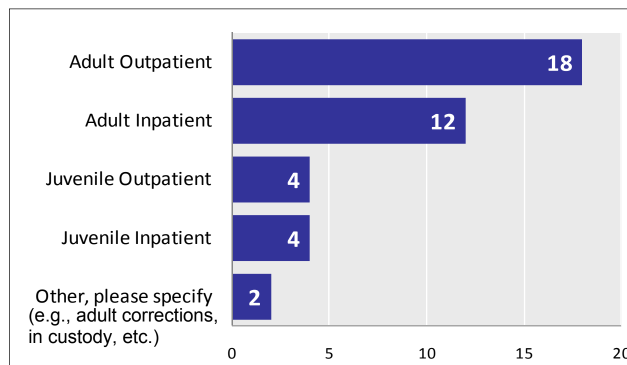
Since all responses were confidential, we do not know the distribution of respondents by work setting.

Background/Experience

Twenty-three of the 24 respondents indicated that they have doctoral degrees in psychology and, as a group, have held their current mental health license for an average of 13.4 years (range from 2 to 36).

Exhibits 5 and 6 describe respondents' work settings and the number of forensic reviews completed in 2010. Most respondents work in adult outpatient or inpatient settings and submitted 50 or more forensic evaluations to the state's courts in 2010.

Exhibit 5
Distribution of Work Settings
N = 22[42]

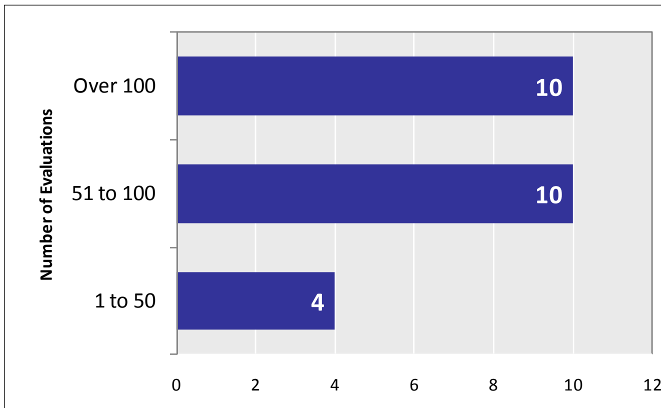


WSIPP, 2011

[40] The Institutional Review Board determined that this survey did not require a formal review, because it represented program evaluation rather than research.

[41] Private contractors perform evaluations for CSTC.
[42] Number of respondents varied, depending on survey question.

Exhibit 6
Number of Forensic Evaluations Submitted to Washington Courts by Respondents in 2010
N = 24



WSIPP, 2011

Current Use of Standardized Instruments

We asked respondents about their use of standardized mental health assessment tools in the two areas of interest to the legislature: competency to stand trial evaluations and, for patients found Not Guilty by Reason of Insanity, assessments regarding potential conditional release decisions.

- 23 respondents currently submit competency to stand trial evaluations to the court.[43]
- 5 respondents have been involved in patient reviews for conditional release recommendations.

Competency to Stand Trial

We asked evaluators whether they used a structured clinical interview or a standardized mental health assessment instrument when they conducted competency to stand trial evaluations. Of the 23 respondents who conduct competency assessments, 18 indicated they have used standardized mental health instruments in the past year.

As can be seen by the responses in Exhibit 7, evaluators relied on a variety of instruments in assessing competency to stand trial.

The instrument used most frequently, the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR) is the only published instrument applicable for individuals with the cognitive deficits of mental retardation.

The revised versions of the Competency Assessment Instrument (CAI) and Evaluation of Competency to Stand Trial (ECST) were also used by several respondents.

Exhibit 7
Use of Interviews and Instruments to Examine Competency to Stand Trial
N = 23

Instrument	Number Using
Structured Clinical Interview	17
CAST-MR–Competence Assessment for Standing Trial for Defendants with Mental Retardation	16
ECST-R–Evaluation of Competency to Stand Trial-Revised	10
CAI/RCAI–Competency Assessment Instrument/Revised Competency Assessment Instrument	9
MacCat-CA–MacArthur Competence Assessment Tool-Criminal Adjudication	5
JACI–Juvenile Adjudicative Competence Interview	4
CST–Competency Screening Test	2
GCCT–Georgia Court Competency Test	1

Some respondents reported using more than one instrument.
WSIPP, 2011

[43] Of the 24 respondents, one no longer submits competency reports.

Response Style/Symptom Distortion

As indicated earlier, assessments related to competency to stand trial can incorporate a formalized review of the defendant's response style to help determine if the defendant is distorting his or her symptoms. Evaluators indicated that they primarily use two instruments for this purpose: The Test of Memory Malingering (TOMM) and the Structured Interview of Reported Symptoms (SIRS) (see Exhibit 8).

Exhibit 8
Use of Instruments to Examine Response Style
N = 22

Instrument	Number Using
TOMM—Test of Memory Malingering	15
SIRS—Structured Interview of Reported Symptoms	13
M-FAST—Miller-Forensic Assessment of Symptoms Test	6
MMPI—Minnesota Multiphasic Personality Inventory	4
VIP—Validity Indicator Profile	4
CAST-MR—Competence Assessment for Standing Trial for Defendants with Mental Retardation	3
ILK—Inventory of Legal Knowledge	2
PAI—Personality Assessment Inventory	2
Rey-15—Rey-15 Item Memory Test	2
SIMS—Structured Inventory of Malingered Symptomatology	2
Word Memory Test	2
B-Test	1
Dot Counting	1
ECST-R—Evaluation of Competency to Stand Trial-Revised	1
WAIS-III—Wechsler Adult Intelligence Scale III	1

WSIPP, 2011
Some respondents reported using more than one instrument.

Level of Risk Assessments Associated With Competency Assessments

The statutory direction for the forensic evaluation of competency to stand trial requires an opinion whether the defendant is a "substantial danger to other persons, or presents a substantial likelihood of committing criminal acts jeopardizing public safety or security, unless kept under further control by the court or other persons or institutions."[44]

This provision is typically referenced as the "future dangerousness" assessment. Numerous assessment instruments address the potential for a defendant's risk of violence in the future. Respondents indicated that the Historical Clinical Risk Management (HCR-20) instrument was used more frequently than other instruments for this assessment of dangerousness (see Exhibit 9).

Exhibit 9
Use of Instruments to Examine Future Dangerousness in Competency to Stand Trial Assessments
N = 23

Instrument	Number Using
HCR-20—Historical Clinical Risk Management	13
Structured clinical interview	5
YLS/CMI—Youth Level of Service/Case Management Inventory	4
PCL-R—Psychopathy Checklist Revised or PCL-R derivatives (e.g., PCL-SV)	1
SAVRY—Structured Assessment of Violence Risk in Youth	1

WSIPP, 2011
Some respondents reported using more than one instrument.

[44] RCW 10.77.060 (3) (f)

Assessing Conditional Release for NGRI Patients

Of the survey respondents, five indicated they were involved in reviewing conditional release decisions in 2010. The various instruments they used are summarized in Exhibit 10.

Exhibit 10
Use of Interviews and Instruments for NGRI Risk Assessments
N = 5

Instrument	Number Using
HCR-20—Historical Clinical Risk Management	3
PCL-R—Psychopathy Checklist Revised or PCL-R derivatives (e.g., PCL-SV)	2
Structured clinical interview	1

WSIPP, 2011
Some respondents reported using more than one instrument.

Other Mental Health Assessment Instruments

Depending on the individual being evaluated and their potential mental health issues, evaluators may choose to utilize a variety of other mental health assessment tools. In addition to the instruments previously identified, 16 respondents listed numerous instruments as having been included as part of their 2010 assessment assignments (see Appendix C).

Responses From Open-Ended Questions in Survey

In the survey, we asked respondents to share their opinions regarding state or hospital policy on the use of standardized assessments in competency to stand trial evaluations and conditional release reports. The comments follow; slight editing was done to protect the confidentiality of respondents and improve readability.

Is there a mental health assessment instrument or instruments that you would like to use when assessing dangerousness in competency to stand trial cases, but do not?

- We don't have time to use anything but a VERY BRIEF assessment tool. If there was unlimited time—VRAG (Violence Risk Appraisal Guide).
- I would like to familiarize myself with some of the instruments mentioned in survey, but again, we are getting pressure from administration to shorten our reports and our evaluations in general, so I do not feel I have the luxury of time.
- Psychopathy Checklist (PCL-R) instruments or VRAG, or domestic violence instruments; however, time and resources are insufficient for a full risk assessment—hence, statute should be changed to not require it in competency to stand trial evaluations.
- I do not use an instrument in assessing dangerousness for routine competency to stand trial evaluations, but I do in more extensive risk assessments for clients seeking conditional release.
- VRAG; PCL-R.
- Not necessary. We have National Crime Information Center criminal history and we have our assessment.
- The VRAG (which includes a PCL-R score) is the gold standard. VRAG assessments are EXTREMELY time-consuming.
- Hare Psychopathy Checklist (PCL-R).

What do you believe is important for legislators to know about validated mental health assessment tools used for competency to stand trial evaluations?

- Use of tools must remain a professional discretionary item, used on cases as clinically warranted. Administrators and legislators should not dictate clinical instrumentation - that is the job of clinical supervisors. Courts are charged with review of assessment methods and weight to give evaluations. Legislators may only indicate that the legislative intent is for professionally sound evaluations - which frankly will expand the scope of evaluations rather than reduce them, as the evaluations now are bare-boned. This is

dramatically so on the issue of risk assessment. Instruments are discretionary adjuncts, not determinants of competence, etc. Slavish use of instruments will likely inflate the number of defendants found incompetent, if only because so many cannot cooperate with testing yet are competent.

- There are no certainties in evaluation. Multiple sources need to be considered, relying more heavily on data, and less so on "clinical judgment." Though clinical interviews (at least semi-structured and structured), can lend to the data being considered.
- The use of a tool or tools does not reduce the need for advanced clinical training/ experience; in fact, it increases it. Most psychological tests require the user to have an advanced degree in psychology (i.e., doctor of psychology) with specific training and experience with psychometrics and test interpretation. The test manuals articulate the required user qualifications. There is great potential for misuse of psychological testing results. Results from validated mental health instruments alone are not sufficient to form conclusions regarding competency or other forensic or clinical conclusions (i.e., test results need to be interpreted by qualified clinicians in light of all other available data). The use of validated psychological testing instruments can be very beneficial to the forensic opinions of qualified professionals. Rather than having a particular tool or tools required for all cases, the qualified clinician should always maintain the responsibility and authority to decide which tool(s) are appropriate for the particular case. There are circumstances in which the use of validated instruments are not indicated or appropriate (e.g., when assessing an individual who is not represented in the standardization sample, or when there is strong evidence of an invalid response style such as malingering).
- Tools are much less important than the data gathering process.
- Different tests need to be administered to different defendants, depending on their presentation.
- They take time to administer and we are currently being pressured by hospital administration to complete a greater number of reports per month than is possible when doing a thorough and ethical evaluation.
- They have not been validated in Washington State populations of criminal defendants. The legislature needs to fund a validation study so that these tools can be most effectively and ethically used.
- Actual data from the evaluation and description of the examiner's reasoning process is what is helpful toward the fact-finder's consideration of the expert's opinion.
- Tests identified for use in competency assessments can be compromised. Defendants seeking a finding of incompetency will sometimes "fake bad." Validity scales are inadequate to identify faking.

What do you believe is important for legislators to know about validated mental health assessment tools when assessing future dangerousness in the context of competency to stand trial evaluations?

- It takes time to administer these; some (PCL-R) require considerable time.
- What we are currently doing is substandard, as we do not have the time and resources to fully address this issue. We need clarity about what is expected/desired in terms of a dangerousness opinion under RCW 10.77- is it really necessary? What specific issues are they wanting/needing addressed (e.g. civil commitment referral, long range risk, safety to be released)? If the original reason a dangerousness evaluation was requested was for NGRI cases, then we may have morphed into providing these evaluations unnecessarily and now the courts expect it.
- There are no certainties in evaluation. Multiple sources need to be considered, relying more heavily on data, and less so on "clinical judgment." Though clinical interviews (at least semi-structured and structured), can lend to the data being considered.
- Risk assessments must be removed from competency to stand trial evaluations if the scope of evaluations is to be reduced. Risk assessments are currently indefensible.
- The degree of accuracy in predicting future dangerousness needs to be better understood.
- It is not clear how the court(s) use the dangerousness opinions. The only information I

have is that “the prosecutors use it for bail arguments.” They seem more prejudicial than helpful in competency to stand trial evaluations. Forensic examiners are the ones who must testify to our opinions; approximately one time out of every 120 cases.

- This is an extra burden in terms of obtaining further data that might (or might not) be relevant to forming a competence opinion.
- I believe that as an agency, we should be using standardized measures to assess dangerousness to ensure that all appropriate risk factors are considered in forming a dangerousness opinion.
- They are not needed. The court is not asking for detailed examination of a person’s level of dangerousness as part of competency evaluations. The question is whether the defendant presents a higher level of risk than average to the community. We can offer this opinion based on a person's history and known risk factors. We receive the NCIC criminal history, so we know what crimes they've committed in the past, and we ask them about other risk factors as part of their interview. Most of the people we evaluate are dangerous and likely to reoffend based on this information. A person's history is the best predictor of future behavior, and even the best assessment tool for predicting future dangerousness only adds a very small amount of incremental validity to the accuracy of predicting future dangerousness over simply using their history. The amount of time spent administering, scoring, and interpreting the tool is not justified by this very small increase in the accuracy of the prediction. There is a push for us to conduct more and more evaluations and instruments such as the VRAG can take up to a day or more to administer, score, and interpret properly. This would only reduce the efficiency and turnover of our competency evaluations. To my knowledge, no other state or jurisdiction has mandated or recommended that a specific test(s) or tool(s) be used for the assessment of dangerousness.
- It should be kept in mind that RCW 10.77 is being applied to juveniles, and the best instruments to assess dangerousness in adults are inappropriate for use with juveniles.
- This requirement should be eliminated! It is onerous, and dangerousness and is difficult to predict. Only a couple of states require this.
- The vast majority of our pretrial dangerousness assessments are short-term predictions and, as such, are nearly irrelevant, as they would not give any reliable long-term future predictions. Nearly all of the defendants are returned to jail and are not being considered for release to the community.
- They take time to administer and we are currently being pressured by hospital administration to complete a greater number of reports per month.

If you have additional opinions/recommendations related to these topics, please include them here.

- The most important tool is the clinician. I do not believe it will be helpful to mandate one or more instruments for certain types of evaluations.
- Many of our cases are not simple. We are required to give opinions regarding competency to stand trial, diagnosis, prognosis, future dangerousness, and need for RCW 10.77 evaluation. Any validated instruments to cover all that in an hour or less?
- We often use tests other than a competency or dangerousness tool when conducting our evaluations to help with diagnostic clarification or to document a person's level of functioning. These tests include various IQ tests which would be chosen based on the given case. For instance a nonnative English speaker would be given a test that did not involve verbal skills. The tests also include various personality assessments such as the Minnesota Multiphasic Personality Inventory (MMPI) or Personality Assessment Inventory (PAI). We might conduct neuropsychological testing or screening using a plethora of neuropsychological tests such as the Halstead-Reitan battery, the Cognistat Cognitive Assessment, the Mini-Mental Status Examination, the Wisconsin Card Sort Test, etc. As this demonstrates, the decision whether to use a test and which test to use is complex and depends on the case. Therefore, it should be left to the doctoral level examiner who has the responsibility to and liability of providing the opinion to the court. It should not be mandated or even recommended in some general way by the legislators who are not qualified to make this decision.

SECTION IV: OPTIONS FOR FORENSIC ASSESSMENT INSTRUMENT POLICIES

Based on the material and research assembled for this project, we have identified three options regarding the state's potential adoption of assessment tools:

1) Continue the option of allowing each evaluator to make individual choices about instruments for competency assessments.
2) Recommend an assessment methodology for the primary decision points in evaluations.
3) Recommend specific instrument/instruments for primary decision points, and consider adoption of recommendations into hospital policy, administrative code, and/or statute.

The advantages and disadvantages of each approach are listed in Exhibit 11 (see next page). The hospitals could vary the option selected depending on the type of evaluation; for example, having different approaches for competency assessment as compared to conditional release evaluations.

In December 2010, we reviewed these options with a group of evaluators from Eastern and Western State Hospitals. Following this discussion, a Western State evaluator with extensive expertise in psychometrics, Gregg Gagliardi, Ph.D., proposed an approach that takes account of the research findings and practical realities.

This proposal is included as Exhibit 12, "Discussion Proposal: Forensic Assessment Policies and Procedures (see page 21).

Appendix D contains detailed comparisons of relevant forensic assessment instruments, including testing conditions, psychometric properties, and time requirements. Since information on forensic assessment tools is contained in multiple documents, we summarized key factors in a matrix format.

Next Steps

The Institute will consult with Western State Hospital, Eastern State Hospital, and Child Study and Treatment Center to review the options outlined in Exhibit 11.

The authors wish to thank staff from Western State Hospital, Eastern State Hospital, and the Child Study and Treatment Center for their many contributions to this report.

Exhibit 11
State Evaluators' Use of Mental Health Assessment Tools:
Three Options and Potential Advantages/Disadvantages

Option	Pros	Cons
Option One • Continue the policy of allowing each evaluator to make individual choices about instruments	• Maximum discretion and flexibility to evaluators • No additional cost to hospital • No additional training needed • No need to purchase assessments	• No standardization across evaluators/hospitals • No "common language" across evaluators, hospital staff, prosecutors, defense, courts, and law enforcement board • Lack of clarity about which factors influence evaluators' opinions • No change in accuracy of evaluations • No systematic attention to risk prediction levels to aid in outcome research • No standardized data on evaluation
Option Two • Recommend an assessment methodology/procedure for the primary decision points in evaluations	• Increase "common language" in communications among hospital staff, court staff, judiciary, and review board • Increase standardized focus of evaluations • Training can be focused on selected instruments	• Training and supervision may be required • Restricts choice by evaluators • Methodology/procedure may not apply well to individual cases and nuances • May take more time for evaluators to complete
Option Three • Recommend specific instrument/instruments for primary decision points • Consider adoption of recommendations into hospital policy, administrative code, and/or statute	• Increase "common language" in communications among hospital staff, court staff, judiciary, and review board • Increase standardized focus of assessments • Training can be focused on selected instruments • With standardized instruments, research on outcomes more cost-effective	• Restricts choice by evaluators • Training and supervision required • Instruments may not apply well to individual cases, women, and/or juveniles • May take more time for evaluators to complete • As science advances, need to change policies/codes/statutes • May need funds to purchase instruments

WSIPP, 2011

Exhibit 12
Discussion Proposal: Forensic Assessment Policies and Procedures
Gregg Gagliardi, Ph.D.*

A. Competency to Stand Trial

1. We need to help frame the Institute's task as one of selecting an assessment methodology or procedure rather than a single tool. All published competency assessment tool authors and publishers state that no single competency assessment tool is by itself sufficient to complete a competency assessment that typically includes:
   a. Review of police reports
   b. Review of psychiatric records (if and when available)
   c. Review of jail records (if and when available)
   d. Review of criminal history records
   e. Review of 24 hour inpatient records (if and when available)
   f. Clinical interview
2. Pirelli (2010)[45] Nicholson and Kugler (1991)[46] show that (a) the defendant's level of psychosis and (b) performance on a competency assessment tool are the best predictors of an expert's competency determination. Zapf and other researchers have shown that judges only very rarely disagree with the expert's competency opinion[47] so we can pretty safely conclude that these two factors are what determine competency adjudication in the vast majority of cases.
3. There are only a few published competency assessment tools that meet minimal psychometric standards for professional use. They are:
   a. MacCAT-CA
   b. ECST-R
   c. FIT-R
   d. CAST-MR (substandard in my opinion, but the only tool for developmental disabled defendants)

Based on the foregoing considerations, here is a proposed competency assessment protocol:

1. Both examiners (for two-examiner cases) review available records (police, psychiatric, jail, criminal history).
2. Both examiners attempt to conduct a thorough clinical interview that mainly focuses on:
   a. Defendant's current mental status, with special emphasis on the nature and severity of any psychotic symptoms.
   b. A thorough semi-structured interview of the defendant's competency using a published tool or an equivalent unpublished tool or specialized interview.

After completing—or attempting to complete—these two steps, there will usually be enough information to render a competency opinion in most cases, and also enough information to:

1. Support the opinion in court; and
2. In cases of incompetent defendants, to pinpoint the specific barriers to competence for purposes of competency restoration treatment.

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[45] G. Pirelli, W. Gottdiener, & P. Zapf. (2011). A meta-analytic review of competency to stand trial research. *Psychology, Public Policy, and Law, 17*(1), 1-53.
[46] R. Nicholson, & K. Kugler. (1991). Competent and incompetent criminal defendants: A quantitative review of comparative research. *Psychological Bulletin, 109,* 355-370.
[47] M. Cox & P. Zapf. (2004). An investigation of discrepancies between mental health professionals and the courts in decisions about competency. *Law and Psychology Review, 28,* 109-132; N. Poythress & H. Stock. (1980). Competency to stand trial: A historical review and some new data. *Journal of Psychiatry and Law, 8,* 131-146; B. Rosenfeld & K. Ritchie. (1998). Competence to stand trial: Clinical reliability and the role of offense severity. *Journal of Forensic Sciences, 43,* 151-157.

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The remaining small percentage of cases will be those with:

1. Questions regarding malingering or other forms of uncooperative behavior;
2. Complex clinical presentations that a single interview cannot, or does not, capture and which may require further testing (medical as well as psychological) or 24-hour observation on an impatient unit.

B. Standardizing Risk Assessments for RCW 10.77

Considerations for pre-trial risk assessments

1. Existing risk assessment methods fall into three basic categories
   a. Static, i.e., fully actuarial (e.g., VRAG)
   b. Structured Clinical Judgment (e.g., HCR-20)
   c. Mixed (use of risk tool(s) and traditional clinical assessment)
2. Actuarial risk assessment tools require cross validation in the local population of interest in order to yield meaningful quantitative estimates of risk.
3. No risk tool, with the exception of the LSI-R, and the static risk tool developed by the Institute as part of the Department of Correction's (DOC) Risk Classification Level (SRA),[48] has been cross-validated in Washington State, and these tools have only been cross-validated for DOC populations, not pre-trial criminal defendants, civil commitment cases or criminal insanity acquittees.
4. Adopting an actuarial risk tool in Washington State will require either:
   a. A major cross validation study of one or more existing tools in Washington State, or
   b. Development of new tool based on Washington State data. DOC's static risk tool serves as an excellent starting point. It is recommended that the state hospitals immediately begin using it on a provisional basis. In so doing, outcome data will be generated that will allow the tool to be cross-validated or possibly modified for use with populations of mentally ill persons.
5. Any risk tool that is adopted ought to have the following specifications:
   a. High inter-rater reliability
   b. Predictive validity commensurate with "state of the art" risk prediction (i.e., an ROC AUC [Receiver Operating Characteristic, Area Under the Curve] of .75 or better)[49]
   c. Thoroughly cross-validated
   d. Thoroughly investigated in different populations and settings
   e. Requires relatively little specialized training beyond that provided in clinical psychological and psychiatric training programs
   f. Available at a modest cost
   g. Can be completed by a psychologist or psychiatrist following a typical clinical evaluation that entails:
      i. Review of existing mental health records
      ii. Review of social history
      iii. Review of criminal history
      iv. Mental status examination
      v. 24-hour inpatient/jail observations (when available)
      vi. Clinical interview
      vii. Other psychological and medical testing (when testing is indicated)
      viii. Knowledge of common risk and protective factors (social, economic and clinical resources) in the placement environment under consideration (jail, inpatient, community outpatient, full release to the community, etc.) (clinical risk assessments cannot be made without taking the environment into account)
6. An acceptably high level agreement between a pair of examiners as to an examinee's level of risk will necessarily require that both examiners have considered all of the risk assessment data.

[48] R. Barnoski & E. Drake. (2007). *Washington's Offender Accountability Act: Department of Corrections' Static Risk Instrument.* Olympia: Washington State Institute for Public Policy, Document Number 07-03-1201.

[49] 1.0 is a perfect score; .05 represents chance.

APPENDIX A: WESTERN STATE HOSPITAL POLICIES

CENTER FOR FORENSICS RISK ASSESSMENT PROCEDURES

Purpose: To provide a consistent process for conducting Risk Assessments across treatment wards within the Center for Forensics.

Procedure: Risk Assessments are required for patients who are NGRI and receiving a level 6, or being considered for a conditional release or final discharge. Risk Assessments are conducted by the psychologist assigned to the ward. When the psychologist assigned to the ward is not available or has a conflict that prohibits his or her conducting the assessment another Center for Forensics (CFS) psychologist will be assigned. When a patient in the Community Program requires a risk assessment or update, the psychologist assigned to the CFS ward the patient transferred from will conduct the assessment. If that psychologist is not available the CFS psychologists will rotate the assignment.

1. All patients who are Not Guilty by Reason of Insanity and admitted to Western State Hospital Center for Forensics will receive a risk assessment prior to requesting a level 6.
2. Risk Assessments will be reviewed and updated by the ward psychologist every two years or at critical points including:
    a. Within six months of a patient being returned from the Community Program.
    b. Within 6 months prior to a patient being considered for a conditional release or final discharge.
    c. Prior to presenting a case to the RRB.
    d. When there has been a significant change in an individual's risk factors.
    e. When a patient is being considered for a revocation of Conditional Release.
3. The Risk Assessment will be completed by a licensed psychologist and will utilize the structured interview format available in the CFS manual. A thorough history will be obtained.
4. Risk Assessments may include an actuarial and a review of the criminal history of the patient. The Risk Assessment will utilize current research and scholarship, and will include clinical, actuarial, situational and other factors. CFS utilizes the following actuarials:
    a. HCR-20
    b. VRAG

    The Risk Assessment will not include projective testing. Risk Assessments will include the following components:
    - An assessment of prior violence and crime to determine the likely severity of recidivism if it were to occur.
    - As assessment of the individual's history and pattern of violence, crime and victimization that will identify the clinical and situational factors that must be addressed in the treatment plan.
    - As assessment of skill deficits and barriers to skill utilization that make the patient vulnerable to the risk laden situations identified above.
5. Risk Assessments will include a summary of the dynamic factors that led to the patient's criminal behavior and will include the following:
    a. Type of behavior (e.g. violent, sexual, property, etc.)
    b. Victimology (demographic, personality, relationship, etc.)
    c. Contextual-the individual's circumstances around the time of the event.
    d. Situational-associated with the event.

e. Clinical-findings present at the time of the event.

f. Motivation for behavior (reasons, underlying emotion, reality basis, etc.)

g. Outcome of episode.

h. Role or meaning of criminal behavior in the individual's cognitive and emotional life.

6. A summary of protective factors will also be included. The following list may be used as a guide;

   a. Historical compliance with probation and/or previous conditional release.

   b. Medication compliance.

   c. Degree of commitment to rehabilitation/recovery.

   d. Ability to self monitor symptoms associated with risk.

   e. Degree to which signs of mental illness associated with risk are observable.

   f. Degree that community network supports treatment and recovery.

   g. Adequacy of resources available.

   h. Degree to which patterns associated with past criminal behavior have changed or abated.

   i. Degree to which risk factors can be addressed in aftercare.

7. A summary of the individual's most recent (past 90 days) response to treatment will be included in the report.

8. Completed Risk Assessments will be signed and dated by the Psychologist and placed in the database section of the patient's chart. An electronic copy will be saved to the CFS shared folder for risk assessments.

9. Treatment wards will utilize the information in the Risk Assessment regarding an individual's risk factors to formulate treatment and drive treatment plan goals. The treatment plan will be structured around the Risk Assessment. Court letters will include information about the individual's risk factors and progress in treatment.

CENTER FOR FORENSICS RISK ASSESSMENT AND RISK MANAGEMENT

I. Risk Assessment and Risk Management

Note: Please refer to CFS and WSH policies on Community Notification for timelines of statutory and other notification provisions related to releases, less restrictive placements, etc.

A. Defendants

1. Defendants are placed in accordance with information collected via the CFS Defendant Screening Form. The form may be re-scored when new information becomes available or the clinical presentation changes.
2. CFS Defendant Screening Form – see appendix for copy of form and scoring instructions

   a) The purpose of this assessment is to screen defendants for risk to others and/or potential victimization. The information gathered is used to make decisions about which of the following options is the best placement for a defendant given the information obtained: community, criminal justice custody, CFS high security setting, CFS normal security setting, unisex or mixed sex setting, etc.

   b) Completing the CFS Defendant Screening Form

      (1) The form may be completed by any CFS mental health professional who has received training in its use.

      (2) The form is to be completed on the basis of the best current information gathered by whatever means are feasible given the time limits noted on the form.

      (3) Instructions on completed and scoring the CFS Defendant Screening Form are included on the form. It is important to note that the instrument incorporates static and dynamic risk factors. "Static risk factors" do not change with time but are important indicators of risk, especially long-term risk. "Dynamic risk factors" may change with time (e.g. in response to treatment) and are the primary determinants of short term risk.

   c) **General guidelines for decision-making based on the CFS <u>Defendant Screening Form</u>**

      (1) All those with "high" Static Risk Factor scores should be evaluated in jail if possible. If they are admitted, they should be on an acute ward or ward without vulnerable populations (unless appropriate measures can be taken to ensure the safety of others).

      (2) Those with "high" Dynamic Risk Factor scores but not "high" Static Risk Factor scores may be evaluated inpatient but should be on an acute ward or ward without vulnerable populations (unless appropriate measures can be taken to ensure the safety of others) until their dynamic factors are out of the "high" range. This may require re-scoring of the instrument.

      (3) Those who have "high" Sexual Aggression Risk Factor scores should not be placed with vulnerable males or with females.

      (4) Those males who have a history of sexual deviance towards women (items from Sexual Deviance History involving adult females) or for whom no information about these items is available (regardless of scores or until such information is obtained) should be placed on an all male ward.

      (5) Those males who have a history of sexual deviance towards men (items from Sexual Deviance History involving adult males) or for whom no information about these items is available (regardless of scores or until such information is obtained) should be placed where the possibility of victimizing vulnerable males is lower.

      (6)

      (7) Those with "low" risk in both Dynamic Risk Factors and Static Risk Factors and who are "low" risk in Sexual Aggression Risk Factors and have no sexual deviance directed against men or women can be placed in any setting.

      (8) Those with Special Concerns scores of 2 should be considered vulnerable (and placed in settings where the risk of victimization is lower).

(9) Those with Special Concerns scores of 1 should be considered vulnerable if the one item is history of sexual victimization, history of physical victimization, or frail (and placed where the risk of victimization is lower). Others should be evaluated on a case-by-case basis.

(10) Those with Special Concerns scores of 0 should not be considered vulnerable.

(11) Those with moderate Static Risk Factor scores and moderate Dynamic Risk Factor scores must be treated on a case-by-case basis (paying attention to the special cases noted in 3-8 above).

B. Non-Defendants

1. **No Release of CI Without Court Order**

Pursuant to the Washington Administrative Code (275-59-080), no criminally insane person may be released from CFS without a court order or upon expiration of the maximum sentence. Further, no criminally insane person shall be granted a conditional release, furlough (off grounds without staff or criminal justice escort), or final discharge without a court order (RCW 10.77). Authorized Leave with staff accompaniment does not require a court order.

2. **Procedures at the Time of Transfer to a Less Restrictive Setting**

a) All transfers to a new ward or moves to the community require a physician's order. Some transfers also require RRB and/or court approval as detailed under Risk Review Board (RRB) below.

b) Less restrictive settings include any setting where patients have more ready access to the community. This includes but is not limited to: CFS to APU, GMU or PALS; CFS to the Community Program Ward; the Community Program Ward to any off-campus site.

c) Immediately prior to transfer to a less restrictive setting, an evaluation of the patient's readiness for transfer (for example, evaluation of imminent dangerousness) must be conducted and documented in the patient's chart. If the Treatment Team has reason to believe the patient may be a danger to self or others if transferred, the transfer is postponed until further evaluation indicates that the patient is safe to be transferred. The CFS Forensic Specialist (or designee) will be immediately contacted and will organize further evaluation and make a recommendation to the Risk Review Board. In cases where the Risk Review Board finds the patient still to be potentially dangerous, the patient will continue to be held at Western State Hospital; this will be documented in the patient's chart, and the following will be notified:

(1) Committing Judge

(2) Prosecutor's Office of the committing county

(3) Defense Counsel

(4) Assistant Attorney General for CFS

3. **Risk Review Board (RRB)**

The RRB is the body responsible for overseeing risk assessment and risk management for non-defendants in the CFS. This is accomplished by the implementation of a Risk Assessment/Risk Management Database and by formal evaluation at key risk points in the progression of each patient through the program.

a) Risk Points

The following are the key risk points in the process where the RRB must be directly involved:

(1) Level 6 and within building movement.

(3) Conditional Release

(4) First placement outside secure CFS building

(5) First placement outside a locked setting

(6) First placement off grounds

(7) Patients on CR who have been returned to a more secure setting (including the Community Program ward or other locked setting) under the following conditions:

(a) The patient was placed in the more secure setting due to or following criminal conduct, violence, or escape/UL

(b) The patient has been in the more secure setting for more than 60 days

(8) Revocation of Conditional Release

(9) Transfer to Community Corrections

(10) Final Discharge

(11) Maximum sentence expiration

(12) Failure to progress—no appearance before RRB for more than two years

(13) Other risk related referral from appropriate source

(14) At patient request with 6 month intervals.

b) RRB Membership:

(1) The CFS Unit Manager or designee

(2) The CFS Supervising Psychiatrist

(3) The CFS Nurse Manager or designee

(4) The CFS Forensic Specialist

(5) The CFS Community Program Director

(6) Representatives from the following departments (to be appointed by the CFS Unit Manager): Psychology, Social Work, and Rehabilitative Services.

These representatives will generally be selected according to their clinical knowledge and skills (especially with regard to risk assessment/risk management), their representation of different components of the CFS, and their familiarity with the CFS. In order to train new members, the CFS Unit Manager may assign some members who have little prior experience but have the necessary background to qualify for such an assignment. The NGRI wards will each send a representative who has had orientation training on RRB process and procedure and has participated in observing the RRB for a minimum of 4 meetings. The NGRI ward representatives will participate in discussions but will not be voting members of the RRB.

c) RRB Process

(1) The CFS Supervising Psychiatrist (or designee) will facilitate meetings. He/she will be responsible for scheduling and assuring that cases are presented in a timely manner. The facilitator will also appoint interviewers and coordinate discussion.

(2) A summary of the outcome of RRB will be kept on file.

(3) There must be at least five RRB members present for a case to be presented, one of whom must be a psychiatrist.

(4) Guests will be allowed at the discretion of the RRB. Attorneys may be present in the meeting during the time the patient is present but will be observers only.

(5) All decisions to advance a patient to a higher risk status require a unanimous decision by all members present.

(6) The RRB facilitator will put a note in the chart summarizing the findings and decision.

(7) The RRB will convey their decision directly to the patient when the patient is interviewed unless there are clinical or safety/security contraindications.

For those patients not interviewed, the Primary Therapist will convey the decision of the RRB to the patient.

d) Referral to RRB

(1) Level 6-In building movement

(a) There will be a completed Risk Assessment for the patient prior to consideration of Level 6.

(b) The primary therapist will facilitate completion of the Risk Review Board Level 6 Security Assessment.

(c) The primary therapist and patient will complete the level 6 worksheet.

(d) The primary therapist will submit the level 6 packet consisting on the Security Assessment, Risk Assessment and level 6 worksheet to the CFS Unit Manager or designee one week in advance of the scheduled RRB. Failure to submit the packet may result in delay of the RRB review.

(2) Conditional Release (CR) and Final Discharge

(a) CR on Treatment Team initiative

(i) The Director of the Community Program is notified at least 30 days in advance of the Evaluation and Treatment Conference when a potential CR recommendation is to be discussed and is given a copy of the CR and Final Discharge Risk Assessment Report, most recent treatment plan and psychosocial assessment. This gives the Community Program staff an opportunity to evaluate the patient and participate in an Evaluation and Treatment Conference to provide input and to participate in the decision-making process.

(ii) If the Evaluation and Treatment Conference decision is to recommend a CR, the case is scheduled for RRB for presentation within 30 days.

(b) Final Discharge on Treatment Team Initiative – The Treatment Team decision to recommend final discharge will be made in an Evaluation and Treatment Conference. If the Evaluation and Treatment Conference decision is to recommend a final discharge, the case is scheduled for RRB for presentation within 30 days.

(c) Patient requests CR or Final Discharge

(i) Pursuant to RCW 10.77.150 and 10.77.200, patients may request a CR or final discharge but must wait six months to initiate a new request after being turned down by the court. Patients may make requests even if the Treatment Team is not in favor of CR or final discharge.

(ii) The patient sends a letter (addressed to the Secretary of DSHS) to the WSH Superintendent/CEO requesting CR.

(iii) The WSH Superintendent/CEO's office sends the letter back to the CFS for routing to the responsible Primary Therapist for action.

(iv) A Treatment Team review is held no later than 30 days after receiving the letter from the WSH Superintendent/CEO's office.

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(v) The case is presented to RRB within two weeks of the Treatment Team review for final discharge or if not supported for CR. If CR is recommended, proceed as above for CR on

Treatment Team Initiative.

(d) Court orders hearing for CR or Final Discharge

(i) A Treatment Team review is held no later than 45 days before the scheduled hearing (if possible).

(ii) The case is presented to RRB within two weeks of the Treatment Team review for final discharge or if not supported for CR. If CR is recommended, proceed as above for CR on Treatment Team Initiative.

(3) First Placement Outside Secure CFS Building, First Placement Outside Locked Setting, First Placement Off Grounds – When a CR (or CI) patient is moving to a less restrictive setting for the first time, an RRB review must be done before the move. The Primary Therapist and/or Community Program Therapist present the case to RRB.

(4) Return of CR to Less Restrictive Setting – When a CR patient has been returned to a more restrictive setting (e.g. the Community Program Ward or to a locked setting) for more than 60 days or following criminal conduct, violence or escape/UL, an RRB review must be done before return to a less restrictive setting. The Community Program therapist and, if applicable, the inpatient Primary Therapist present the case to RRB. Note: The Treatment Team may request review by RRB for any return to a less restrictive setting if they feel it is necessary for risk management purposes.

(5) Revocation of CR

(a) The Community Program Treatment Team assesses patients for revocation as needed. For patients not on the Community Program Ward, that ward's Treatment Team will participate in the assessment process.

(b) If the recommendation is to seek revocation, the case is to be presented to RRB within two weeks.

(c) A VRAG must be completed prior to RRB review. An appropriately qualified CFS staff member will be assigned to assist in the completion of a risk assessment. Additional evaluation is to be conducted as necessary.

(d) The case is presented to RRB within two weeks of the formation of the relevant recommendation(s). Presenters include the Community Program therapist and any staff who have conducted elements of the evaluation due to their special qualifications.

(7) Maximum Sentence Expiration

(a) Six months prior to maximum sentence expiration, the following must occur:

(i) For those who are 71.09 qualified and those required to have a sex offender evaluation for risk level, a referral for such evaluation must be made at least 6 months prior to maximum sentence expiration. The case is presented to RRB as soon as the evaluation is completed.

(ii) For those who may not meet civil commitment criteria, the Treatment Team should evaluate for the possibility of a transition CR. If CR is supported, the case is presented to RRB as soon as possible.

(8) Other RRB Referrals – Other issues may require RRB review. If there is any question, consult with the CFS Forensic Specialist. These include (but are not limited to):

(a) CR to Community Corrections

(b) Modification of terms of CR

(c) Resolution of Treatment Team impasses regarding advancement to Level 4 or 5.

(d) Failure to progress – The RRB may be asked by CFS Management to review risk of patients who have not been presented to RRB for an extended period of time.

(e) RRB Presentations

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(1) Materials – The Primary Therapist will provide the relevant Risk Assessment Report (see below) to the RRB designee at least one week prior to the RRB presentation:

For level 6:

(a) RRB Cover Sheet

(b) Risk Assessment

(c) Risk Review Board Level 6 Security Assessment

(d) Level 6 worksheet

All others to include the following if available or indicated:

(i) All elements of the Initial Assessment detailed below are

(ii) Most recent Psychosocial Assessment

(iii) Most recent Psychiatric Assessment

(iv) Most recent Treatment Plan

(v) Initial forensic evaluation(s) and Risk Assessment

(vi) Current NCIC and (if available) WATCH or other criminal history report

(vii) Sex/Kidnapping offender evaluation (when indicated)

(viii) Sexual predator evaluation (when indicated)

(ix) Other documents or tests important to the case may be included or requested

(g) For revocation of CR, CR, moves to the community, returns to the Community Program Ward, and Final Discharge - placement and follow-up plans and proposed terms of CR (if applicable) must address both static and dynamic risk factors.

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(h) Maximum Sentence Expiration Report - Complete CFS Maximum Sentence Checklist (see appendix) — responsibility of Primary Therapist Community Program Therapist

(2) Case Presentation

(a) The Primary Therapist will present the case and the recommendations of the Treatment Team.

(b) The Psychiatrist will review biological therapies and any other relevant material

(c) A representative of the Community Program (if involved) will discuss the patient's placement readiness.

(d) Other presentations (e.g. by a psychologist, CCO, or other person involved in evaluation or treatment) may be included as necessary.

(3) Patient Interview - A patient interview is conducted in all cases except level 6 , modification of terms of CR, move to the community, and return to less restrictive setting of CR who has been back for more than 60 days (those returned following criminal conduct will be interviewed). In rare cases, an interview may be necessary for these cases as well.

e) Transition Program

(1) Patients on locked CFS wards who have been approved for CR by the RRB and are waiting for a CR hearing may enter the Transition Program unless the RRB finds that this is not indicated.

(2) Patients will be escorted by CFS staff to and from all Transition Program activities outside the locked setting as per movement requirements in the Security Section. Exceptions may be granted by the Unit Manager.

4. Court Letters, Court Hearings, and Re-Review

a) All RRB decisions will be communicated in a letter to the court (exceptions: level changes and placement changes not requiring court approval need no letter) by the Primary Therapist, co-signed by the psychiatrist, and the Unit Manager. A draft should be completed and distributed to signatories within seven working days and the letter must be sent to the CEO within 14 calendar days. This letter in many cases must include recommendations, e.g. regarding specific conditions of release. Attach a copy of the patient's letter of request (if applicable).

b) If a hearing is to be held but has not occurred within three months or there is a significant change in the patient's condition, it is necessary to return to the RRB to discuss any changes in the patient's condition and to ensure that recommendations are consistent with current conditions.

c) At court hearings, the Primary Therapist is expected to convey the opinion of the RRB though must answer questions about other issues subject to court rules and procedures. Others may testify if needed or required.

C. Elements of the Risk Assessment/Risk Management Database

1. The elements of the database are determined by CFS Management Committee with input from the RRB, CFS Forensic Specialist, and other qualified staff. It is updated periodically to reflect changes in the science of risk assessment as reflected in the literature.
2. The content of each risk assessment is based on the type of risk related to the issue at hand

3. The CFS Forensic Specialist is responsible for training regarding any changes in the assessment process.
4. As permitted by resources, the relationship of outcome to the risk assessment process will be statistically monitored.

D. Initial Assessment for Extended Treatment

1. Risk to others is generally a salient feature of those committed to CFS for extended treatment. As such, treatment must focus on risk assessment, risk reduction, and risk management. In order to accomplish this, a thorough assessment of static and dynamic risk factors must be done early in the treatment process. In order to gather the data for the assessment, the Treatment Team must collect relevant records as indicated and available (hospital records, school records, military records, criminal history, etc.). The specific elements are enumerated below.
2. Elements of the Initial Assessment for Extended Treatment
    a) **Violence Risk Appraisal Guide (VRAG)** – an actuarial instrument based on historical and clinical data of a generally static nature that has been shown to be highly associated with long-term risk. The VRAG is designed to assess risk more than to guide treatment.
    b) **HCR-20**
    c) **Interview of Patient** – a semi-structured interview designed to gather static and dynamic risk factors and to assist in collecting elements necessary for completing the PCL-R and VRAG. It also seeks to identify patterns of risk-related behavior to be addressed in the Treatment Plan.
    d) Other tests and instruments as indicated
3. Completing the Initial Assessment for extended treatment
    a) The VRAG can each be completed by any CFS mental health professional that has received training in their use.
        (1) historical information can be collected prior to this times) but no later than six months following commitment as criminally insane.
        (2) The VRAG and PCL-R must be completed prior to review for CR or final discharge. It is recommended that they are completed at the outset of treatment as the management of static risk is an important element of risk reduction (e.g. in discharge planning).
        (3) The Ward Psychologist is responsible for seeing that the VRAG, PCL-R, are completed by properly trained personnel.

EASTERN STATE HOSPITAL
MEDICAL RECORD MANUAL
GUIDELINES FOR THE APU/GPU RISK ASSESSMENT

FORM #: EFFECTIVE DATE 10.30.09
Revised: 2.7.2011

I. PURPOSE
To establish a tool to assess patient's potential for self-injury, dangerousness, or elopement.

II. SCOPE
Psychiatrists and all patients being considered for escorted or unescorted off campus or unescorted off ward activities, authorized leaves (AL) or less restrictive release/discharge (civil patients) or transfer to another ward if requested.

III. POLICY
It is the policy of Eastern State Hospital to allow patients to have access to community outings and activities, both with and without staff escort as they progress through the recovery model of care. In order to ensure that the patient's potential risks for self-injury, dangerousness, elopement, or other risk is appropriately assessed prior to allowing off ward activities, a risk assessment is completed. For civil patients on the Forensic Services Unit and all forensic patients on APU or GPU, the FSU Risk Assessment is utilized.

IV. PROCEDURE
A. The psychiatrist completes the APU/GPU Risk Assessment form based on the treatment team's assessment of the patient.
B. An assessment is completed any time the patient is being considered for a-e. Each of these steps requires separate approval.
   - Unescorted off ward or campus activities (requires CEO approval)
   - Escorted off campus activities (requires CEO approval)
   - Authorized leaves (AL)
   - Less restrictive alternative release or discharge (civil patients) for patients who are a felony flip, those patients who are affected by ESH Policy 1.41, or patients who have a Tarasoff.
   - When being transferred to another ward if requested by the receiving psychiatrist
C. The psychiatrist signs/dates the APU/GPU Risk Assessment form.
D. The Risk Assessment is filed as the first document in the current treatment plan section of the patient record.
E. A risk assessment must be completed within one month of the consideration listed in 2 above or whenever the patient experiences a significant deterioration of functioning.
F. For forensic patients on APU or GPU, and for civil patients on FSU, the FSU Risk Assessment form is utilized.
G. Once the Risk Assessment is completed, it must be forwarded to the CEO/Medical Director for consideration. Only the CEO may approve the actions identified for either escorted off campus activities or unescorted off ward or off campus activities.

Instructions: Complete this risk assessment by marking the appropriate rating whenever a civil patient on the Adult Psychiatric Unit or Geropsychiatric Unit is being considered for:

- *Escorted off campus activities (requires CEO approval)*
- *Unescorted off ward or off campus activities (requires CEO approval)*
- *Authorized Leave (AL)*
- *Less restrictive alternative release (civil patients)*
- *At the request of the receiving attending psychiatrist when patient is being transferred to another ward*

Risk assessment must have been completed within one month when considering the above options or whenever there are behavioral changes. For civil patients on the Forensic Services Unit or forensic patients on APU or GPU, the FSU risk assessment must be completed.

RISK FACTOR	RATING SCORES 1 No known risk	2 Low risk	3 Moderate risk	4 High risk	5 Extreme risk
Assault/Violence 1 ☐ ☐ ☐ ☐ 2 ☐ ☐ ☐ ☐ 3 ☐ ☐ ☐ ☐ 4 ☐ ☐ ☐ ☐ 5 ☐ ☐ ☐ ☐ Date:	No history of violent behavior or ideation.	History shows one or two incidents of minor assaults and/or threats or verbal aggression. Current mental status shows no paranoia or tendency toward violence.	History shows one or two incidents of minor assaults or threats or verbal aggression. Current mental status shows some mild paranoia or tendency towards violence. May have episodes of property damage or destruction or possession of a weapon more than 2 years previously.	History shows at least one serious assault or violent incident resulting in personal injury, a pattern of paranoid or threatening behavior, verbal aggression or current violent ideation. There is a current on past Tarasoff requirement. May have had episodes of property damage or destruction or possession of a weapon within the past year.	History shows at least one violent incident resulting in death or serious bodily injury or a pattern of violent behavior or verbal threats. Current mental status shows very active current paranoia, violent ideations or overt threats or a pattern of serious violent behaviors. Recent assaultive episodes towards other patients or peers. Admitted as a DMIO commitment. Requires a discharge review per 71.05.232 Has had property damage or arson or had a weapon at the time of evaluation for admission. Has a jail hold. Continues on next page

RATING SCORES					
RISK FACTOR	**1** **No known risk**	**2** **Low risk**	**3** **Moderate risk**	**4** **High risk**	**5** **Extreme risk**
Escape/unauthorized leave 1 ☐ ☐ ☐ ☐ 2 ☐ ☐ ☐ ☐ 3 ☐ ☐ ☐ ☐ 4 ☐ ☐ ☐ ☐ 5 ☐ ☐ ☐ ☐ Date:	No history of attempted elopement; no current thinking or behaviors suggestive of an elopement.	One prior elopement or attempt to elope or failure to return from temporary visit more than two years previously. Or no history of attempt/ elopement but current behavior suggests a mild possibility.	Prior history shows at least one elopement from a secure facility more than two years previously. Current behavior or circumstances suggest this is a possible intention.	Prior history shows at least one prior elopement or attempt from a secure facility within the last six months. Current circumstances or behavior show a likely intention to elope.	Prior history of multiple elopements or attempts from a secure facility within the past year. Current behavior shows an active intention to attempt elopement.
Mental illness 1 ☐ ☐ ☐ ☐ 2 ☐ ☐ ☐ ☐ 3 ☐ ☐ ☐ ☐ 4 ☐ ☐ ☐ ☐ 5 ☐ ☐ ☐ ☐ Date:	No history of mental illness.	History of mental illness but shows nearly complete recovery and good stability.	History of mental illness with current partial remission.	Current function shows active mood or thinking disturbance.	Actively psychotic, manic or depressed with paranoia or dangerous behavior. Patient may be victimized.
Sexual deviancy 1 ☐ ☐ ☐ ☐ 2 ☐ ☐ ☐ ☐ 3 ☐ ☐ ☐ ☐ 4 ☐ ☐ ☐ ☐ 5 ☐ ☐ ☐ ☐ Date:	No history of sexually deviant behavior or ideation.	History shows one prior non-violent victim. No active ideation.	Several prior victims. No use of force or weapon.	Several prior non-violent incidents. One incident involving force or weapons. Continuing active ideation. Has a level 1 or 2 sex offender designation.	Long history of severe acting out involving predatory behavior. Use of force or weapon. Continuing inappropriate sexual ideation. Has a level 3 sex offender designation.

Continues on next page

RATING SCORES					
RISK FACTOR	1 No known risk	2 Low risk	3 Moderate risk	4 High risk	5 Extreme risk
Substance abuse 1 ☐ ☐ ☐ ☐ 2 ☐ ☐ ☐ ☐ 3 ☐ ☐ ☐ ☐ 4 ☐ ☐ ☐ ☐ 5 ☐ ☐ ☐ ☐ Date:	History shows minimal or no use of drugs or alcohol.	History of past experimentation with drugs or alcohol or sharing prescribed medications.	Prior periods of alcohol or substance abuse with current sobriety and hx of tx within past six months. Has shared or obtained others prescription medication.	Long history of heavy substance abuse or dependence. Sobriety prior to admission. Has shared or obtained others prescription medication.	Active substance dependency or polysubstance abuse. Has shared or obtained others prescription medication.
Suicide self-injury 1 ☐ ☐ ☐ ☐ 2 ☐ ☐ ☐ ☐ 3 ☐ ☐ ☐ ☐ 4 ☐ ☐ ☐ ☐ 5 ☐ ☐ ☐ ☐ Date:	No known history of suicidal ideation or self-injury.	History shows prior suicidal ideation or minor attempts at self-injury. Current mental status shows no self-injurious ideations or behaviors suggesting current self-injury intent.	History shows a pattern of self-injurious behavior under circumstances similar to present situation. Current mental status shows some suicidal ideation without active planning or preparation for self-injury.	Current suicidal ideation with a prior history of self-injury. Current mental status shows self-injurious ideation and some planning or preparatory behavior.	History shows a pattern of serious self-injury or suicide attempts. Current mental status shows active suicidal ideation with active planning or overt attempts at self-injury.
Treatment non-compliance 1 ☐ ☐ ☐ ☐ 2 ☐ ☐ ☐ ☐ 3 ☐ ☐ ☐ ☐ 4 ☐ ☐ ☐ ☐ 5 ☐ ☐ ☐ ☐ Date:	Patient has a well established history of participating appropriately in treatment provided even when not supervised.	Patient generally follows through with recommended treatment.	Patient is generally compliant with recommended treatment if supervised.	Patient is not compliant at times even when closely supervised.	Patient rejects need for treatment and actively opposes it. Continues on next page

RISK FACTOR	1 No known risk	2 Low risk	3 Moderate risk	4 High risk	5 Extreme risk
	RATING SCORES				
Falls/Medical problems 1 ☐ ☐ ☐ ☐ 2 ☐ ☐ ☐ ☐ 3 ☐ ☐ ☐ ☐ 4 ☐ ☐ ☐ ☐ 5 ☐ ☐ ☐ ☐ Date:	Patient has no history of unexplained falls. Has good balance. There's no medical concern.	Patient has had some unexplained falls in the past six months but no injury. Medical conditions are well controlled.	Patient has had unexplained falls in the last two months with or without injury. Medical conditions require some supervision.	Patient has had falls in the last week. Medical condition requires nursing care supervision.	Patient is not able to ambulate without support. Patient requires major nursing care for a medical condition.

Based on this patient's individual risk assessment, history, current mental status and discharge criteria, the treatment team approves:

	Date:	**Date:**	**Date:**	**Date:**
Escorted off campus activities (requires CEO approval	☐	☐	☐	☐
Unescorted off ward privileges (requires CEO approval)	☐	☐	☐	☐
Unescorted off campus privileges (requires CEO approval)	☐	☐	☐	☐
Authorized Leaves (AL	☐	☐	☐	☐
Less restrictive alternative release (civil patients)	☐	☐	☐	☐
Transfer to another ward	☐	☐	☐	☐

Comments:____

____

____
Psychiatrist Signature Date/Time Assessment Completed

____
Signature of CEO/Designee Date/Time

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Psychiatrist Signature Date/Time Assessment Completed

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Signature of CEO/Designee Date/Time

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Psychiatrist Signature Date/Time Assessment Completed

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Signature of CEO/Designee Date/Time

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Psychiatrist Signature Date/Time Assessment Completed

____
Signature of CEO/Designee Date/Time

Distribution: This document is placed in the front of the current treatment plan section. The attending psychiatrist notifies the clinical director of any patient whose assessment results in the majority scores of 4 or 5.

FSU INITIAL RISK ASSESSMENT

FORM #: EFFECTIVE DATE 1.11

I. PURPOSE

To establish a historical baseline for a patient's potential for self-injury, dangerousness, or elopement upon admission to the Forensic Services Unit.

II. SCOPE

The risk assessment will be completed for

- all patients admitted to the Forensic Services Unit, regardless of legal authority
- all patients committed under RCW 10.77, regardless of which unit the patient is admitted to (e.g. GPU or HMH)

III. POLICY

It is the policy of Eastern State Hospital to allow patients to have access to activities, both with and without staff escort, as they progress through the recovery model of care in order to ensure the patient's historical risk factors are accurately assessed upon admission, and to derive a baseline for self-injury, dangerousness, elopement, or other risk.

IV. PROCEDURE

A. The patient's assigned Forensic Therapist/Social Worker is designated to document the treatment team's assessment of the patient on the risk assessment tool.
B. The treatment team will complete an assessment by the time of the master treatment plan (7 days).
C. The assessment by the treatment team is documented on the risk assessment tool by the Forensic Therapist/Social Worker who signs the form.
D. The attending Psychiatrist signs the risk assessment form.
E. The risk assessment is filed as the first document in the current treatment plan section of the patient record.

RISK FACTORS	RISK LEVEL				
	NONE	LOW	MODERATE	HIGH	EXTREME
ASSAULT/VIOLENCE	1	2	3	4	5
ESCAPE/UL	1	2	3	4	5
MENTAL ILLNESS	1	2	3	4	5
SEXUAL DEVIANCY	1	2	3	4	5
SUBSTANCE ABUSE	1	2	3	4	5
SUICIDE/SELF HARM	1	2	3	4	5
TREATMENT NON-COMPLIANCE	1	2	3	4	5

SUMMARY OF KEY RISK FACTORS (LEVEL 3 OR ABOVE)

Assaultive/Violence: ____________________

Escape/UL: ____________________

Mental Illness: ____________________

Sexual Deviancy: ____________________

Substance Abuse: ____________________

Suicide/Self Harm: ____________________

Treatment Non-Compliance: ____________________

____

Attending Psychiatrist Date

EASTERN STATE HOSPITAL
MEDICAL RECORD MANUAL
FSU PCR/CR RISK ASSESSMENT

FORM #: EFFECTIVE DATE 1.11

I. PURPOSE

To establish a tool to assess a patient's potential for self-injury, dangerousness, elopement, and insight into mental illness and crime.

II. SCOPE

The risk assessment will be completed for

- all patients admitted to the Forensic Services Unit, regardless of legal authority
- all patients committed under RCW 10.77, regardless of which unit the patient is admitted to (e.g. GPU or HMH)

III. POLICY

It is the policy of Eastern State Hospital to allow patients to have access to activities, both with and without staff escort, as they progress through the recovery model of care. In order to ensure that the patient's potential risks for self-injury, dangerousness, elopement, or other risk is appropriately assessed prior to allowing off ward activities, a risk assessment will be completed.

IV. PROCEDURE

A. The patient's assigned Forensic Therapist/Social Worker is designated to document the treatment team's assessment of the patient on the risk assessment tool.
B. The treatment team will complete an assessment by the time of the master treatment plan (7 days) and any time the patient is being considered for:
   - Recovery step A
   - off ward activities
   - off campus activities
   - authorized leaves
   - partial conditional release
   - conditional release
   - final discharge
   - quarterly at treatment plan
   - any critical incident
   - and any major behavior change
C. The assessment by the treatment team is documented on the risk assessment tool by the Forensic Therapist/Social Worker who signs the form.
D. The attending Psychiatrist signs the risk assessment form.
E. The risk assessment is filed as the first document in the current treatment plan section of the patient record.
F. A risk assessment must be completed within one month of the consideration listed in B above or contemporaneous to a patient's critical incident or major behavior change.
G. A patient may meet one or all guidelines of each risk rating to qualify for the rating.

TABLE ONE ______ + TABLE TWO ________= TOTAL NUMBER OF POINTS: ________
(Optimal range to proceed with PCR/CR Request = 24-34)

CRITERIA FOR INITIAL PCR/CR APPROVAL	YES	NO
This patient has met the conditions needed for discharge as stated on the patient's Treatment Plan.		
This patient's score from the Risk Assessment is within the acceptable range of scores.		
A majority of the Program's Core Team has recommended that a □PCR □Modified PCR □CR □Modified CR □Temporary Visit □Grounds Privileges be granted to this patient.		

If *all* of the above questions have been answered YES, the patient will be referred to the Forensic Services Unit's Risk Review Board for further review.

CORE TEAM MEMBERS	APPROVE	DENY
Psychiatrist:		
Forensic Therapist/Social Worker:		
Forensic Therapist/Social Worker:		
Forensic Therapist/Social Worker:		
Day Shift RN3:		
Afternoon Shift RN3:		
Rehab CTRS:		
Other:		
Other:		

Comments:

RISK FACTORS	READINESS FOR PCR/CR PRIVILEGES					
	RISK BY HISTORY	BY MENTAL STATUS AND BEHAVIOR				
CURRENT RATING		1	2	3	4	5
ASSAULT/VIOLENCE	1,2	1	2	3	4	5
	3-5	2	4	6	8	10
ESCAPE/UL	1,2	1	2	3	4	5
	3-5	2	4	6	8	10
MENTAL ILLNESS STATUS		2	4	6	8	10
SUBSTANCE ABUSE		1	2	3	4	5
SUM OF COLUMNS						

RISK FACTORS	READINESS FOR PCR/CR PRIVILEGES						
	RISK BY HISTORY	BY MENTAL STATUS AND BEHAVIOR					
CURRENT RATING		0 N/A	1	2	3	4	5
SUICIDE/SELF HARM							
SEXUAL DEVIANCY							
WARD BEHAVIOR							
PROGRAM RULES COMPLIANCE							
TREATMENT ATTENDANCE							
SELF REGULATORY BEHAVIOR							
MEDICATION COMPLIANCE							
UNDERSTANDING OF SIGNS/SYMPTOMS OF MI							
SELF AWARENESS							
LIFE STYLE ADJUSTMENT							
CONCERN ABOUT BECOMING ILL							
PLAN FOR RE-EMERGENCE OF ILLNESS							
ACCEPTS RESPONSIBILITY FOR CRIME							
RELATIONSHIP OF ILLNESS TO CRIME							
NEED TO CONTINUE TREATMENT							
FUTURE PLANS							
ACCEPTS CR/PCR RESTRICTIONS							
SUM OF COLUMNS							

Instructions: Complete this risk assessment by marking the appropriate rating for all admissions or whenever a patient on the Forensic Services Unit is being considered for off ward activities with or without escort. This form must be completed whenever behavior changes, at quarterly treatment plans and within one month of a new consideration for off ward activities.

Signature of person completing the risk assessment — Date Assessment Completed

Signature of Attending Psychiatrist — Date

Distribution: This document is placed in the front of the current treatment plan section. The attending psychiatrist notifies the Clinical Director of any patient whose assessment results in the majority scores of 4 or 5.

EASTERN STATE HOSPITAL
FORENSIC SERVICES UNIT
FORENSIC RISK ASSESSMENT

Patient Name: ESH Number:

DOB: Age:

Alias:

Sources of Information:

Risk Assessment Evaluator:

II.

Location: Eastern State Hospital, Forensic Services Unit, Ward:

DSM-IV:
- Axis I:
- Axis II:
- Axis III:

CLINICAL FORMULATION:
Identifying data and reason for admission:

HISTORY:
- Family/Social Background

III. Mental Health:

Criminal/Violent Behavior:
List criminal history (WATCH/NCIC), as well as patient self report

RISK ASSESSMENT:

Actuarial: Usually uses the HCR-20

Dynamic/Static factors:

Protective factors:

SUMMARY/CONCLUSION:

SIGNATURE/DATE

____

Signature of Person Completing the Risk Assessment Date

APPENDIX C: OTHER STANDARDIZED INSTRUMENTS

Other Standardized Instruments Used by Evaluators
N = 16

Instrument	Number Using
MMPI-2—Minnesota Multiphasic Personality Inventory-2	3
VIP—Validity Indicator Profile	3
WAIS—Wechsler Adult Intelligence Scale [total includes editions III and IV]	3
McGarry Criteria (case law criteria)	2
MMSE—Mini-Mental State Examination	2
PAI—Personality Assessment Inventory	2
RBANS—Repeatable Battery for the Assessment of Neuropsychological Status	2
WASI—Wechsler Abbreviated Scale of Intelligence	2
WIAT-II—Wechsler Individual Achievement Test-II	2
WISC-IV—Wechsler Intelligence Scale for Children, 4th edition	2
WRAT-4—Wide Range Achievement Test, 4th edition	2
Word Memory Test	2
BASC-2—Behavioral Assessment System for Children, 2nd edition	1
B-test	1

Instrument	Number Using
Dot Counting Test	1
GAMA—General Ability Measure for Adults	1
AVLT—Hopkins Auditory Verbal Learning Test	1
KBIT—Kaufman Brief Intelligence Test	1
Leiter-R	1
OWLS—Oral and Written Language Scales	1
PDD—Psychophysiological Detection of Deception Examination	1
Ravens Progressive Matrices	1
Rorschach—Rorschach Inkblot Test	1
Social Communication Questionnaire	1
Vineland Adaptive Behavior Scales	1
WMSR—Wechsler's Memory Scale-Revised	1
WMS—Wechsler's Memory Scales	1

WSIPP, 2011
Some respondents reported using more than one instrument.

Appendix D: Forensic Assessment Tool Review

This section summarizes key features of three categories of forensic assessment tools:

page

I. Competency to Stand Trial ... 43

II. Response Style/Symptom Distortion ... 50

III. Likelihood of Reoffending ... 54

Important caution: These summaries were prepared by staff without psychometric training; agencies should consult with experts in the field before taking action related to forensic assessments.

I. Competency to Stand Trial

Instrument Overview

Assessment Instrument	Description	Additional Details	Issues Identified in Literature
Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR)	Structured interview with 50 questions organized into 3 sections: basic legal concept skills to assist defense; understanding case events; and asks questions about the roles, meanings of words and concepts, and functions. Multiple choice responses, with 1 point for each correct answer. Total score from 0 to 50. Authors indicate it should be used as only one component of an overall assessment.	Multiple choice questions allow defendants with limited linguistic ability to respond. Vocabulary and syntax are simple.	Multiple choice answers do not mimic what is often required in a courtroom setting. Evaluator's assessment of quality of case events in Part III can be subjective.
Competence Assessment Instrument (CAI)	Instrument was developed to deliver clinical opinion to the court; purpose was to standardize, objectify, and quantify relevant criteria. Developed by an inter-disciplinary group at Harvard. Semi-structured interview covers 15 competency domains. Each domain is to be rated on 5-point scale. Describes 13 functions related to defendant's ability to cope with the trial process in an adequately self-protective fashion. There are two or three questions for each item. Clinicians are urged to conduct the interview with appropriate clinical flexibility. Scores are not summed or weighted. Few instructions for administration.	Developed as a companion tool for the Competency Screening Test (CST). Scoring criteria considered vague and must be extrapolated from case examples. Limited coverage of competency screening construct.	Best viewed as brief tool to identify areas of further inquiry.

Assessment Instrument	Description	Additional Details	Issues Identified in Literature
Competency Screening Test (CST)	Designed as a brief, psychometric instrument to determine if more extensive assessment is needed. Intended as a screening tool by identifying those competent to stand trial. Consists of 22 items, each is the beginning of an incomplete sentence. Sentence completions are scored according to the definitions and examples in the manual. Scores are 0, 1, and 2. Total score below 20 is a signal to raise the question of incompetence. Intended to be used as a companion to the CAI.	Based on three legal concepts: potential for constructive relationship between client and lawyer; client's understanding of the legal process; and ability to deal emotionally with the criminal process. Some people believe the concepts do not conform with the Dusky standard, as someone could have a good relationship with a poor lawyer.	Not appropriate for use with individuals with developmental disabilities.
Evaluation of Competency to Stand Trial-Revised (ECST-R)	Semi-structured interview format with 18 items. Closely tracks legal standards. Covers four aspects of competency: ✓ Consult with counsel ✓ Factual understanding of courtroom proceedings ✓ Rational understanding of courtroom proceedings ✓ Overall rational ability	Also covers atypical presentation (related to potential feigning).	Not normed on individuals with tested IQs less than 60. Only for defendants with requisite language skills. Interpreters possible. Does not produce an overall numerical score; intended for combination with case-specific information.

Assessment Instrument	Description	Additional Details	Issues Identified in Literature
Fitness Interview Test-Revised (FIT-R)	Originally based on the Competence Assessment Interview; was extensively revised in the 1990s. A semi-structured clinical assessment instrument to guide evaluators through a set of defined criteria. There are 4 background questions and 70 questions grouped according to 16 items that are clustered in 3 sections. Examiners rate each item (0, 1, 2) with consideration of response to all questions associated with that item. Examiners are urged to rate according to opinions about examinee's abilities, not specific words used in the answers. Ratings are 0 for little or no impairment of ability, or 1 (moderate), or 2 (severe). There are no formulas. Demonstrated utility as a screening instrument when paired with instrument to assess mental disorder. Has been tested with juveniles.	Originally constructed to be compatible with Canadian law; most concepts are relevant for the U.S.; manual includes review of U.S. law and procedure. Some researchers assert it should only be used in Canada.[50] The test focuses on the defendant's own circumstances, includes a diverse set of questions to explore the defendant's abilities. Assessment procedure based on two components: (1) assessment of the defendant's mental state and determination whether he/she has a mental disorder; (2) assessment of the psycholegal abilities required by the defendant and determination whether there is any impairment on any of these. Those found incompetent to stand trial must have a mental disorder and the mental disorder must cause impairment on one or more these necessary psychological abilities.	Evaluators should ask all questions in instrument; evaluators are free to tailor questions to specific individuals and personalize the interview. The evaluators can probe and query as necessary and use own clinical judgment to assess the defendant's knowledge and abilities. Questions are asked in a standardized sequence, probing answers is at examiner's discretion. Ratings are done in a narrative format, without specific scores.
Georgia Court Competence Test-Mississippi State Hospital (GCCT-MSH)	Revision of the original Georgia Court Competence Test (GCCT). Considered a screening device. 21 questions grouped into 6 categories. Maximum possible points of 50, multiplied by 2 to obtain a score between 0 and 100. Cutoff for incompetence is 69.	Tests knowledge of the charge, knowledge of the possible penalties, some understanding of courtroom procedures, and ability to communicate rationally with the attorney to prepare the case.	Focuses on foundational competencies and ignores more important decisional competencies.

[50] J. Skeem, S. Golding, & P. Emke-Francis. (2004). Assessing adjudicative competency: Using legal and empirical principles to inform practice. In W. O'Donohue & E. Levensky (Eds.), *Forensic psychology: A handbook for mental health and legal professionals* (pp.175-211). New York: Academic Press.

Assessment Instrument	Description	Additional Details	Issues Identified in Literature
Interdisciplinary Fitness Interview-Revised (IFI-R)	Semi-structured interview assesses 6 relevant symptoms (rated as present/absent) and psycholegal abilities along 4 domains. 20 items. Format requires evaluators to consider both legal and mental health issues, neither in isolation. No summed scores or normed data.	Addresses both legal and psychopathological aspects of competency.	Designed to be administered jointly by an evaluator and an attorney; can be administered by evaluator alone.
MacArthur Competence Assessment Tool: Criminal Adjudication (MacCAT-CA)	Structured, highly standardized interview with 22 items organized in three parts: understanding, reasoning, and appreciation. Uses hypothetical vignettes about a character charged with assault along with structured interview to assess defendant's ability to appreciate his/her circumstances and situation. Responses are scored as 0, 1, or 2. Considered a tool, not a "test." Does not systematically assess all relevant factors.	Tests adjudicative competence: competence to assist counsel and decisional competence using vignettes.	Not normed on populations with mental retardation.

Psychometric Properties

Assessment Instrument	Test/Retest Reliability	Validation Studies	Issues/Comments
Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR)	Inter-rater reliability established.	Two validation studies have been conducted. Good validity reported.	Multiple choice answers do not mimic what is often required in a courtroom setting. Evaluator's assessment of quality of case events in Part III can be subjective.
Competence Assessment Instrument (CAI)	Few studies reporting reliability.	Limited coverage of competency construct. Few studies of validity.	Most classification errors are false positives (rates as high as 53 percent). Prone to false positives for "gray area" patients; not recommended for these cases.
Competency Screening Test (CST)	Acceptable inter-scorer reliability. Acceptable internal consistency.	Construct validity questioned in research literature.	Low score can be produced because of deficits in only some areas of the test, or with moderate deficits across all areas. Instrument makes no attempt to examine the defendant's knowledge/ ability in relation to his/her specific trial circumstances. High false positive rate.
Fitness Interview Test-Revised (FIT-R)	Good inter-rater reliability and internal consistency. Average correlation for the overall judgment of fitness found to be high; some rating categories are problematic.	Construct validity yet to be tested.	May have use as a screening instrument. Can be used to assess a juvenile's functional legal capacities. Some experts believe this instrument should only be used In Canada.
Georgia Court Competence Test-Mississippi State Hospital (GCCT-MSH)	Two studies of inter-rater reliability for original version; no retest for new version. Internal consistency demonstrated in two studies. Some difficulties found in interpreting research on the instruments. Sensitivity rate in one study was only 71 percent.	Construct validity has been questioned in research literature.	No assessment of trial situation facing the examinee nor responses in light of specific demands and circumstances of examinee's future legal situation. High rate of false positives (up to 68 percent).
Interdisciplinary Fitness Interview-Revised			Scoring criteria discriminate against defendants who express doubt in judicial fairness or disagreement with attorney advice.

Assessment Instrument	Test/Retest Reliability	Validation Studies	Issues/Comments
MacArthur Competence Assessment Tool: Criminal Adjudication (MacCAT-CA)	Large development sample. Inter-rater reliability established.		Because it tests responses to a hypothetical cases that does not assess the individual's understanding and reasoning in connection to that person's own case. For some patients, the hypothetical scenario allows a less threatening mechanism to assess defendants with strong paranoia about their own case. Tool cannot be sole basis for competency assessment. Must be accompanied by assessment of psycopathology. Tool does not include detailed questions about consulting with counsel. Terms used (simple and aggravated assault) may not match all jurisdictions. Not normed on persons with IQs lower than 60. Only available for English-speaking and normed on English speaking. Unclear if it applies to women. Few test items related to ability of defendant to communicate well with lawyer. Scoring can be difficult.

Practical Considerations

Assessment Instrument	Qualifications/ Training for Use	Time to Complete*	Cost
Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR)	Could not find any requirements	30 to 45 minutes	Introductory kit with manual and 20 interview booklets: $198.
Competence Assessment Instrument (CAI)	Could not find any requirements	Less than one hour	Unknown.
Competency Screening Test (CST)	Could not find any requirements	Less than 25 minutes	No cost.
Evaluation of Competency to Stand Trial-Revised (ESCT-R)	Forensic experts qualified to provide conclusory opinions to court.		Initial cost $430; additional record forms @$4.50 each.
Fitness Interview Test-Revised (FIT-R)	Mental health professionals, including social workers.	30 to 45 minutes	$50.00 CD-ROM included in the package provides all necessary forms; there is no per-use fee. A training video is available.
Georgia Court Competence Test-Mississippi State Hospital (GCCT-MSH)	Could not find any requirements	10 to 15 minutes	No cost.
MacArthur Competence Assessment Tool: Criminal Adjudication (MacCAT-CA)	BA in psychology, psychiatry, counseling, social work, or related field and relevant training.	25 to 55 minutes	Introductory kit with professional manual and 20 interview booklets is $125.

*Note: Estimates are for time to complete the assessment instrument, not time needed for an evaluation and report preparation.

II. Response Style/Symptom Distortion

Instrument Overview

Assessment Instrument	Description	Additional Details	Issues Identified in Literature
Evaluation of Competency to Stand Trial-Revised (ECST-R)	28 items on the instrument can screen for feigned incompetency.		
Miller-Forensic Assessment of Symptoms Test (M-FAST)	The M-FAST is a brief 25-item screening interview that provides preliminary information regarding the probability that a client is feigning psychiatric illness. The 7 M-FAST scales operationalize response styles and interview strategies that have been demonstrated to successfully identify individuals who are attempting to feign psychological deficits.		
Structured Inventory of Malingered Symptomatology (SIMS)	75-item self-administered true/false screening measure for malingered psychopathology and neuropsychological symptoms. Intended for adults aged 18 and over. Requires 5th grade reading level for written version. Software available for self-administration by clients with reading difficulties.	Diagnosis of malingering should not be based on instrument findings alone. Users should continue with more extensive evaluation if SIMS results suggest malingering. Significant cognitive incapacity and gross psychotic presentation may preclude test administration.	
Structured Interview of Reported Symptoms (SIRS-2)	16-page interview booklet has 172 items. For individuals aged 16 and over. Spanish version available as well as an abbreviated version of 69 items.	Authors strongly recommend one or more structured measures be administered before the SIRS-2 to discourage long answers that would be difficult to score. Not valid for defendants with mental retardation or adolescents.	Abbreviated version had elevated false positive rates. Considered by many to be best means to test whether someone is faking psychotic symptoms

Assessment Instrument	Description	Additional Details	Issues Identified in Literature
Test of Memory Malingering (TOMM)	A 50-item visual recognition test designed to help distinguish malingering from genuine memory impairments in individuals ages 16 and older. Relies on the forced choice principle. Consists of two learning trials and an optional retention trial, and provides two cutoff scores: ✓ Below chance ✓ Criteria based on head injured and cognitively impaired patients	Insensitive to wide range of neurological impairments, aiding in detection of exaggerated deliberately faked memory impairment.	
Validity Indicator Profile (VIP)	A self-administered forced-choice validity indicator for individuals over 18. Test helps assess the relationship between the individual's intention and their effort in completing the test. The report categorizes the individual's style as: compliant, inconsistent, irrelevant, or suppressed. Can be used as a screening tool. Intended to be administered concurrently with a battery of cognitive tests.	Contains verbal and non-verbal subtests which can be administered independently. Not intended for individuals known to have mental retardation or are illiterate.	

Psychometric Properties

Assessment Instrument	Test/Retest Reliability	Validation Studies	Issues/Comments
Evaluation of Competency to Stand Trial-Revised (ECST-R)	See information on competency to stand trial.	Amalgamation of instrument samples used to demonstrate validity.	
Miller-Forensic Assessment of Symptoms Test (M-FAST)	Established in clinical/nonclinical samples.	Tested using simulation designs.	
Structured Inventory of Malingered Symptomatology (SIMS)	Limited testing.	Limited studies.	
Structured Interview of Reported Symptoms (SIRS)	High inter-rater reliability.	Multiple validation studies by numerous authors show moderately strong validity.	Considered by many to be best objective test of malingering. Tested in inpatient, forensic, and correctional populations.
Test of Memory Malingering (TOMM)	Did not locate reliability data.	Manual includes validity data using intact individuals and clinical samples.	Questions raised about sensitivity.
Validity Indicator Profile (VIP)	Did not locate reliability data.	Cross-validated using independent sample of 312 cases with 5 criterion groups: traumatic brain injured patients; suspected malingerers; normal subjects; a “faking bad group” and a group of random responders.	

Practical Considerations

Assessment Instrument	Qualifications/Training for Use	Time to Complete*	Cost
Evaluation of Competency to Stand Trial-Revised (ECST-R)	Forensic experts qualified to provide conclusory opinions to courts.	60 to 90 minutes	Professional manual, binder with interview booklet, 25 forms, and 25 profile/summary forms: $260.
Miller-Forensic Assessment of Symptoms Test (M-FAST)	A university degree plus completion of substantial graduate or post-graduate coursework in test interpretation, psychometrics, measurement theory, educational statistics.	5 minutes	Instruction manual and 25 interview forms: $375.
Structured Inventory of Malingered Symptomatology (SIMS)	Mental health providers with formal training in case assessment where malingering is suspected. Score interpretation requires graduate training in related field.	10 to 15 minutes	Professional manual and 25 response sheets: $140. Software: $615.
Structured Interview of Reported Symptoms (SIRS-2)	A university degree plus completion of substantial graduate or post-graduate coursework in test interpretation, psychometrics, measurement theory, educational statistics.	30 to 40 minutes	Professional manual, 25 interview booklets, and set of 2 security templates: $479.
Test of Memory Malingering (TOMM)	Licensure to practice in field related to test or doctoral degree in psychology, education, or related field.	15 to 20 minutes for two trials, additional 5 to 10 minutes for optional trial.	Professional manual, 1 set of stimulus booklets, and 25 record forms: $206.
Validity Indicator Profile (VIP)	Licensure to practice in field related to test or doctoral degree in psychology, education, or related field.	Verbal subtest: 20 minutes (78 items). Nonverbal subtest: 30 minutes (100 items).	Professional manual, 1 test booklet and 3 answer sheets: $135

*Note: Estimates are for time to complete the assessment instrument, not time needed for an evaluation and report preparation.

III. Likelihood of Reoffending

Instrument Overview

Assessment Instrument	Description	Additional Details	Issues Identified in Literature
Historical Clinical Risk Management (HCR-20)	The instrument is a structured professional judgment checklist of risk factors for violent behavior; it consists of 20 items, organized around 10 past factors, 5 present variables, and 5 future issues. Historical factors are weighted as heavily as the combined present and future risk management variables. Three risk categories: low, medium, high.	Requires a thorough review of all available records, including reports by clinicians, social workers, police, prosecutors, and nurses. Detailed interviews with clients recommended. Should be re-administered as individual's circumstances change. Incorporates scores from the Psychopathy Checklist.	
Level of Service Inventory/Level of Service Inventory-Revised (LSI/LSI-R)	54-item survey of indicators of risk/need distributed across 10 subcomponents. Total score is sum of checked items. Based on Risk/Need/Responsivity model.	Most widely used offender need/risk assessment tool: used by 23 states, 13 Canadian jurisdictions, and multiple other countries. Available in French and Spanish. Computer-based assessment available.	
Offender Group Reconviction Scale 3 (OGRS-3)	Developed in the UK. Predicts reconviction within two years after release. Covers both custody and community populations.	Commonly used by probation staff in the UK.	Can be used with juveniles.
Psychopathy Checklist Revised (PCL-R) or PCL-R derivatives (e.g., PCL-SV, YV)	PCL-R is a 20-item construct rating scale to assess psychopathy in adults. Standard administration is a semi-structured psychosocial interview and file/collateral data review.	Includes a screening device and youth version.	
Static Risk Assessment (Washington)	Developed using Washington State data on 56,000 adult offenders using risk levels related to Washington State supervision practices.	Some modifications to the instrument were recommended by the developer and are in the process of being adopted.	
Violence Risk Appraisal Guide (VRAG)	Actuarial scale widely used to predict risk of violence following release. Score is a sum of 20 statistically weighted variables. Relies on the clinical record; incorporates a score of the Psychopathy Checklist.		
Violence Risk Scale-2nd edition (VRS-2)	Includes 6 static and 20 dynamic factors rated on a 4-point scale. Screening version available (VRS-SV).	Items and theoretical underpinnings derived from Andrews and Bonta's Risk, Need, Responsivity Model.	

Psychometric Properties

Assessment Instrument	Test/Retest Reliability	Validation Studies	Issues/Comments
Historical Clinical Risk Management (HCR-20)	Multiple studies: good to excellent reliability found.	Multiple studies: moderate effect sizes.	Has been tested in correctional as well as forensic and civil psychiatric settings. Has been tested on female populations.
Level of Service Inventory/Level of Service Inventory-Revised (LSI/LSI-R)	Tested in a variety of settings. Test-retest properties more difficult to assess with this instrument because it is designed to score changes in the same offender over time.	Extensive research related to predictive ability.	
Offender Group Reconviction Scale 3 (OGRS-3)	Version 3 based on extensive consultations with user groups.	Version 3 substantially improves prediction powers.	
Psychopathy Checklist Revised (PCL-R) or PCL-R derivatives (e.g., PCL-SV)	Numerous research studies report high levels of rater agreement	Prediction of validity of instrument examined in several populations; well-established ability to predict general and violent recidivism in the community.	
Static Risk Assessment (Washington)		Validation study indicated that some factors needed adjustment.	
Violence Risk Appraisal Guide (VRAG)	Met high standards for reliability.	Replication studies affirm validity.	
Violence Risk Scale-2nd edition (VRS-2)		Validated on Canadian adult male offenders, medium secured forensic psychiatry patients in the UK.	

Practical Considerations

Assessment Instrument	Qualifications/Training for Use	Time to Complete*	Cost
Historical Clinical Risk Management (HCR-20)	Requires expertise in conduct of individual assessments and in the study of violence. For clinical purposes, users should have high level of expertise (graduate level university course and requisite professional credentials).	Dependent on quality/ quantity of records.	Manual and 50 coding sheets: $140
Level of Service Inventory/Level of Service Inventory-Revised (LSI/LSI-R)	Can be administered by correctional workers, jail staff, etc. Professional with advanced training in psychological assessment must assume responsibility for use, interpretation, and communication.	30 to 45 minute interview	Manual and 25 interview forms: $130.
Offender Group Reconviction Scale (OGRS)	Developed for use by correctional and probation staff.	25 to 30 minutes	In the public domain.
Psychopathy Checklist Revised (PCL-R) or PCL-R derivatives (e.g., PCL-SV)	Requires a high level of expertise in test interpretation.	90 to 120 minutes for interview section; approximately 60 minutes for collateral review (depending on record quality).	PCL-R: 2nd Edition Kit includes manual, one rating booklet, 25 scoring forms, and 25 interview guides.
Static Risk Assessment (Washington)	Not specified.	Average of 45 minutes for centralized Washington State DOC team; likely to take longer for those less familiar with records.	In the public domain.
Violence Risk Appraisal Guide (VRAG)	Requires clinical expertise.	Average of 2.5 days (depending on record quality).	In the public domain.
Violence Risk Scale-2nd edition (VRS-2)	Not specified.	Requires careful review of file material.	In the public domain.

*Note: Estimates are for time to complete the assessment instrument, not time needed for an evaluation and report preparation.

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