Washington State Legal System Guide to

# Forensic Mental Health Services

Behavioral Health Administration

Office of Forensic Mental Health Services
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Washington State Department of Social & Health Services
Transforming lives

**Acknowledgments**

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Office of Forensic Mental Health Services

## INTRODUCTION

Each day in our state and in the nation, many people with mental illness come into contact with the criminal justice system. It is important for courts, attorneys, law enforcement, correctional facilities, administrators and other community partners to understand what services are available to divert, evaluate or treat individuals in the criminal justice system with psychiatric illness. Navigating these services and the processes that are required can seem daunting. The goal of this guidebook is to provide need-to-know information and practical direction to interested parties about forensic mental health services for adults in Washington. This guidebook is for informational purposes only and it is not intended for legal or clinical decision making nor is it a legally binding policy document.

This guidebook will cover the following areas: an overview of the forensic mental health system; background on mental and behavioral health conditions germane to the forensic mental health system; a need-to-know overview of competency evaluation and restoration processes; the civil commitment process including when a defendant's charges are dismissed and a civil commitment is pursued; and finally, an overview of diversion options. This guidebook does not cover specific behavioral health services for violent sex offenders, juveniles, or services in correctional settings. A list of additional resources and contact information is provided.

We appreciate your partnership and assistance to improve services to clients served by our forensic mental health system. We look forward to working with you.

Behavioral Health Administration

- Office of Forensic Mental Health Services

# 1. DEPARTMENT OF SOCIAL AND HEALTH SERVICES

The Department of Social and Health Services (DSHS) is Washington's largest state agency. In any given month, DSHS provides some type of shelter, care, protection and/or support to 2.4 million of our state's 7.1 million people.

Our goal and commitment is to be a national leader in every aspect of client service. Our agency's five priorities consist of preparing for aging Washingtonians; supporting people in our care and custody; serving people in their home community; and increasing organizational efficiency, performance and effectiveness.

**Department of Social and Health Services**
*Cheryl Strange, Secretary*

**Office of the Secretary**
*Don Clintsman, Chief of Staff*
*Dana Phelps, Deputy Chief of Staff*

- Audits
- Communications
- Diversity and Inclusion
- Enterprise Risk Management
- Enterprise Technology
- Human Resources
- Indian Policy
- Information and Governance
- Innovation and Strategy
- Legislation and Constituent Relations
- Policy and Rules
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- Residential Care Services

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- Eastern State Hospital
- Forensic Mental Health Services
- Special Commitment Center
- Western State Hospital

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- Lakeland Village
- Rainier School
- Yakima Valley School

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- Disability Determination Services
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- Contracts, Legal and Background Check Services
- Consolidated Maintenance
- Emergency Management
- Financial Recovery
- Finance Services
- Fraud and Accountability
- Leased Facilities and Warehouse
- Management Services
- Research and Data Analysis

**Division of Vocational Rehabilitation**
*Robert Hines, Senior Director*

- Assessment Services
- Assistive Technology Services
- Independent Living Services
- Job-related Services

## 1.1 Behavioral Health Administration

Behavioral Health Administration (BHA) transforms lives by supporting sustainable recovery, independence and wellness. We do this through funding and supporting effective prevention and intervention services for youth and families, and treatment and recovery support for youth and adults with addiction and mental health conditions (also known as behavioral health). It operates three state psychiatric hospitals: Eastern State Hospital (ESH), located in Medical Lake; Western State Hospital (WSH) and the Child Study and Treatment Center (CSTC), located in Lakewood; the Special Commitment Center (SCC) located on McNeil Island; and oversees the Office of Forensic Mental Health Services (OFMHS). In addition to the state hospitals, two Residential Treatment Facilities in Yakima and Centralia deliver high-quality competency restoration services and the Northern Regional Office in Seattle, as well as outstations located in several counties provide forensic evaluation services.

## 1.2 Office of Forensic Mental Health Services

The DSHS's Office of Forensic Mental Health Services (OFMHS) with headquarters in Lacey is responsible for the leadership and management of the Department's adult forensic mental health care system. The OFMHS provides forensic evaluations, competency restoration, Not Guilty by Reason of Insanity (NGRI) treatment services, and liaison services to effectively coordinate efforts with system partners to meet shared goals.
The OFMHS additionally provides ongoing training and technical assistance to improve quality and timeliness of forensic mental health services, data management and resource allocation, training and certification of evaluators, and quality monitoring and reporting.

The OFMHS works in collaboration with community partners implement robust diversion efforts to prevent individuals with mental illness from entering the criminal justice system.

## 1.3 State Hospitals

**1.3.1 Eastern State Hospital (ESH)** is a 287-bed inpatient psychiatric hospital which is accredited by the Joint Commission and certified by the Centers for Medicare and Medicaid Services (CMS). ESH is located in the city of Medical Lake, approximately 20 miles west of Spokane. ESH is one of two state-owned psychiatric hospitals for adults in the state of Washington and it provides services to individuals in 20 eastern Washington counties. ESH provides evaluation and inpatient treatment for individuals with serious or long-term mental illness that have been referred to the hospital through the Behavioral Health Organizations (BHOs)/Managed Care Organizations (MCOs) when individuals have received a civil court order for involuntary treatment (see RCW 71.05) or through the criminal justice system when individuals have received a forensic court order for involuntary treatment- (see RCW 10.77).

The **Forensic Services Unit (FSU)** - FSU is a 95 bed inpatient unit for patients who enter the forensic (legal) unit at ESH through the criminal justice system. Evaluation and treatment services are provided for adults prior to their trial, after they are convicted, or after they are acquitted by reason of insanity.

**1.3.2 Western State Hospital (WSH)** is located in the city of Lakewood and is one of the largest psychiatric hospitals west of the Mississippi with more than 800 beds and 2700 employees. WSH provides evaluation and inpatient treatment services for individuals with serious or long-term mental illness in 20 western Washington counties. Patients are referred to the hospital through a Behavioral Health Organization (BHO)/Managed Care Organization (MCO) when individuals meet the criteria for

involuntary treatment through the civil system (see RCW 71.05) or through the criminal justice system (see RCW 10.77).

The **Center for Forensic Services (CFS)** is located on the WSH campus and serves clients who have been committed to the hospital under criminal proceedings (RCW 10.77). These clients include defendants undergoing inpatient evaluation for competency to stand trial and/or mental state at the time of the criminal offense, as well as clients who have been found Not Guilty by Reason of Insanity (NGRI). The CFS contains five treatment units which primarily house patients that are undergoing forensic evaluation/competency restoration and six treatment units which house NGRI patients. There are presently 330 beds allocated to forensic patients.

In 2016, DSHS established through a collaboration between Correct Care Recovery Solutions two new **Residential Treatment Facilities (RTF)** to provide inpatient competency restoration services for adults. The Maple Lane Competency Restoration Program is a 30 bed facility operated out of the Cascade Cottage on the former Maple Lane School campus in Centralia. The Yakima Competency Restoration Center is a 24 bed facility in Yakima. These RTF's are described in more detail in Section 4.2 of the guidebook.

**1.3.3 The Child Study and Treatment Center (CSTC)**, located in Lakewood, WA, is the only state-operated and funded psychiatric hospital for children and youth (ages 5 to 18) (Washington State Department of Social and Health Services, 2016). Accredited by The Joint Commission, CSTC is a secure campus designed for youth who cannot be served safely in less restrictive community settings. The average length of stay is approximately six months to one year. CSTC has a total capacity of 47 beds divided among three age- and developmentally-based cottages. Camano Cottage serves children ages 6 to 12, Ketron Cottage serves youth up to age 14, and Orcas Cottage serves the older youth up to their 18th birthday. Elementary, middle and high school educational services are provided by the Clover Park School District (CPSD) under an agreement authorized by RCW 28A.190.040. CPSD coordinates educational planning with home school districts prior to admission and upon discharge.

Psychiatric treatment at the CSTC incorporates the most current evidence-based practices including cognitive behavioral therapy (CBT), trauma-focused CBT, Dialectical Behavior Therapy (DBT), skills development, family and recreational therapies. Clinical services include medication management and 24-hour nursing services. The CSTC works with families, guardians and community supports in treatment and discharge planning so that children can successfully transition back to their family home, or community-based foster placement. The CSTC is committed to culturally competent care for children with severe emotional disorders whose needs are often complicated by developmental, medical, social, and legal issues (Washington State Department of Social and Health Services, 2016).

## 1.4 Community Partnerships

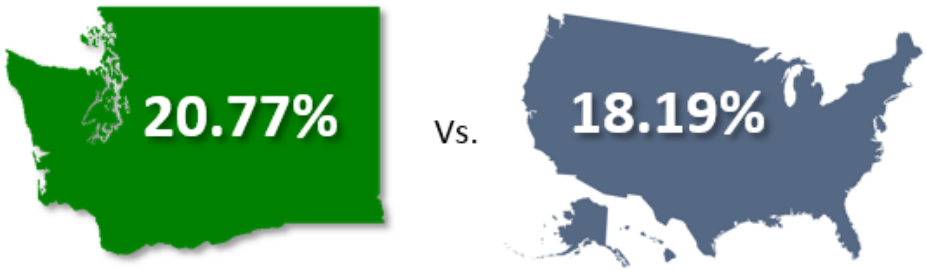
Patients whose medical needs require additional care beyond the hospitals are served in local medical hospitals and clinics. The hospitals works closely with the local courts and the Criminal Justice System to provide forensic evaluations throughout the state. Staff also work with Behavioral Health and Managed Care Organizations in every county to ensure that patients receive adequate outpatient treatments and housing upon their discharge from a state hospital. As of 2019, these services are purchased by regionally operated BHOs through a managed-care structure.

## 2. OVERVIEW OF MENTAL AND BEHAVIORAL HEALTH CONDITIONS

### 2.1 Quick Facts and Trends

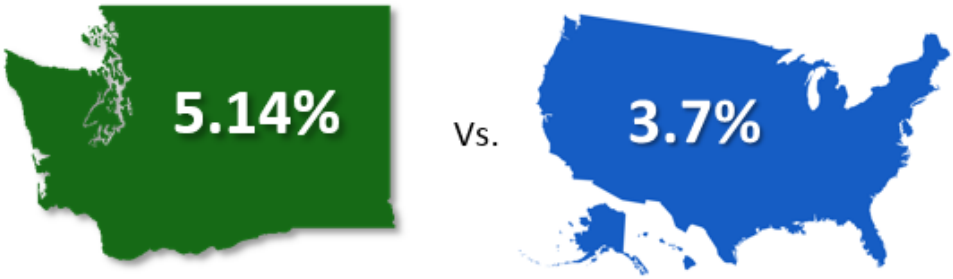
According to data from SAMSHA (Blandford & Osher, 2013), the rate of any mental illness among adults is higher in the state of Washington compared to the National average (See Figure 1.).

**Figure 1**. Rate of any mental illness among adults.




The rate of serious mental illness among adults is also higher in Washington compared to the national average (SAMHSA, 2013) (See Figure 2.).

**Figure 2.** Rate of serious mental illness among adults.




In forensic populations, the prevalence of mental illness is even higher. The estimated proportion of adults with mental health, Substance Use, and Co-occurring Disorders in U.S. Population and under Correctional Control and Supervision are shown below in Table 1.

**Table 1.** Estimated proportion of adults with mental health, Substance Use, and Co-occurring Disorders in U.S. Population and under Correctional Control and Supervision.

| | General Public | State Prisons | Jails | Probation and Parole |
|---|---|---|---|---|
| Serious Mental Disorders | 5.4% | 16% | 17% | 7-9% |
| Substance Use Disorders | 16% | 53% | 68% | 35-40% |
| Co-occurring Substance Use Disorder w/Serious Mental Disorder | 25% | 59% | 72% | 49% |
| Co-occurring Serious Mental Disorder w/Substance Use Disorder | 14.4% | 59.7% | 33.3% | 21% |

**Source:** Blandford and Osher (2013).

There are 10 times more individuals with serious mental illness in jails and state prisons than there are in state mental hospitals (Torrey, Zdanowicz, Kennard et al. 2014). Nationally, only one-in-three state prisoners and one-in-six jail inmates report having received mental health treatment since their admission (James and Glaze 2006).

Female inmates have higher rates of mental health problems than male inmates (state prisons: 73% of females and 55% of males; local jails: 75% of females and 63% of males) (James & Glaze, 2006). Also, Jail inmates who had a mental health problem (24%) were three times as likely as jail inmates without (8%) to report being physically or sexually abused in the past (James & Glaze, 2006).

Individuals with mental illness are also at higher risk of re-entering the criminal justice system (Barr, 1999). Approximately 49% percent of federal prisoners with mental illness have three or more prior probations, incarcerations or arrests, compared to 28% without mental illness (Ditton, 1999). Family members report that the average number of arrests for their relative with mental illness is more than three (McFarland, Faulkner, Bloom & Hallaux, 1989).

## 2.2 Types of Mental and Behavioral Health Conditions

Any type of mental or behavioral health disorder found in the general population is found among defendants in the criminal justice system. This section of the manual presents some of the most common conditions, especially those that require consideration when determining the need for competency evaluation.

The assessment and diagnosis of clinical conditions are conducted by licensed health care providers. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association (2013), is the handbook used by health care professionals to classify and diagnose mental health disorders. Mental illness is different than cognitive impairment or developmental disability, although they may both be present. The information presented here is intended to provide a general overview and should not be used for legal or clinical decision making.

## Psychotic Disorders

**Psychotic disorders** are severe mental disorders that can result in abnormal thinking, delusions, and perceptual distortions. People with psychoses can be said to experience an altered reality. Two of the main symptoms are delusions and hallucinations:

**Delusions** are false or erroneous beliefs that usually involve a misinterpretation of perceptions or experiences. A person experiencing delusions may experience:

- Beliefs that someone is plotting against them (persecutory delusions).
- Beliefs that external forces are controlling their thoughts, feelings and behavior.
- Beliefs that trivial remarks, events, objects, or other environmental cues have personal meaning or significance, thinking that the TV is sending them secret messages.
- (ideas or delusions of reference).
- Thinking that they have special powers, are on a special mission, or that they are God.

**Hallucinations** are false perceptions that may occur in any sensory modality (e.g., auditory, olfactory, gustatory, visual, and tactile). For example, a person experiencing hallucinations may experience:

- Voices conducting a running commentary on the person's thoughts or behavior.
- Voices telling the person to commit acts of violence or self-harm.
- Feeling like something is crawling on or under their skin.
- Seeing someone take the shape of something, such as a demon.

In DSM-5, primary psychotic disorders are broadly classified under Schizophrenia Spectrum and Other Psychotic Disorders (45). Schizophrenia is one type of psychotic disorder. Lack of insight into one's mental illness is very common among individuals with Schizophrenia and may include a complete disbelief that they have a disorder. This can create barriers to engaging in treatment and to medication and treatment adherence. Ensuring engagement with treatment often requires external motivators (e.g. housing, financial and emotional support). Examples of other disorders with psychotic features are Schizoaffective Disorder, Delusional Disorder, Schizophreniform Disorder, and Brief Psychotic Disorder.

People with Bipolar Disorder and depression (and transiently in personality disorders) may also present with psychotic symptoms. These can be differentiated from primary psychotic disorders due to their absence of psychosis in the absence of mood symptoms. The use of alcohol and some substances (e.g., marijuana, LSD, amphetamines and other substances) can precipitate psychosis in people who are already vulnerable. Other problems that can cause psychosis include metabolic abnormalities/delirium, dementia, brain tumors, brain infections, and stroke.

Treatment depends on the cause of the psychosis. Medications such as anti-psychotics, antidepressants and mood stabilizers help to control symptoms and individual or group therapy may be recommended. Hospitalization may also be appropriate for serious cases where a person might be dangerous to self or others or gravely disabled.

## Depressive Disorders

Depressive disorders are characterized by sadness severe enough or persistent enough to impair social, occupational or other important areas of functioning. The term depression is often used to refer to any of several depressive disorders. The DSM-5 defines depressive disorders by specific types:

- Major depressive disorder (often called major depression and may be single or recurrent episodes)
- Persistent depressive disorder (also called dysthymia)
- Other specified or unspecified depressive disorder
- Premenstrual Dysphoric Disorder
- Substance/Medication-Induced Depressive Disorder
  Depressive Disorder Due to Another Medical Condition
- Disruptive Mood Dysregulation disorder (in children age 6-18).

Depressive symptoms or disorders may also accompany physical disorders, including Vitamin and B12 deficiency, thyroid/parathyroid and adrenal gland disorders, stroke, traumatic brain injury, seizures, Infections (HIV/AIDS, syphilis, hepatitis C, CJ and Lyme disease, West Nile virus), Parkinson disease, multiple sclerosis and malignancies (paraneoplastic syndromes and pancreatic cancer). Certain medications, such as anti-epileptics, beta-blockers, corticosteroids, Interferon, Accutane, Chantix, Zyban, and reserpine, can also result in depressive disorders.

Treatment may include medications and/or individual or group therapy. Psychiatric hospitalization is sometimes necessary.

**NOTE:** Mood disorders are less frequent than psychotic disorders in criminal forensic evaluations, but may be relevant in competence-to-stand-trial and insanity evaluations. They are more common in civil forensic evaluations, particularly disability evaluations (Parker, 2014).

## Bipolar and Related Disorders

The two main types of bipolar disorders are bipolar I and bipolar II according to the DSM-5. Bipolar I disorder involves episodes of severe mania and often depression. Bipolar II disorder involves a less severe form of mania called hypomania. Mania is defined by a distinct period of abnormally and persistently elevated, expansive, or irritable mood lasting at least a week that is sufficiently severe to cause marked impairment in social/occupational functioning or in usual activities or relationships with others or to require hospitalization to prevent harm to self, others, or there are psychotic features.

An individual experiencing a manic episode may experience elevated self-esteem, have little need for sleep, have increased rate of speech (talking fast), experience flight of ideas or be easily distracted. They also typically have increased energy and interest in goals or activities though they may have difficulty finishing them. They may also engage in risky or reckless behavior, such as risky sexual behavior, spending excessive amounts of money, or making impulsive decisions. During a hypomanic episode, a person may experience similar symptoms but they do not experience psychotic symptoms, it is still noticeable to others but does not cause major functional impairment. Many individuals who experience hypomania associated with bipolar II experience the feeling of increased energy and decreased need for sleep, but typically do not require hospitalization.

Treatment of bipolar I disorder is highly individualized and based on the types and severity of symptoms a person may be experiencing. Mood stabilizers and atypical antipsychotics are typically the core treatment. Behavioral and Cognitive Behavioral Therapy (CBT) may also be helpful.

## Anxiety Disorders

Anxiety disorders are characterized by feelings of anxiety and fear that are severe and persistent enough to interfere with daily activities and functioning. Examples of anxiety disorders include generalized anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), panic disorder, and social anxiety disorder. Any of these conditions may co-occur with other mental health conditions and substance use disorder. Persons with PTSD, for example, may also experience dissociative symptoms (i.e., flashbacks and intrusive thoughts), that must be differentiated from perceptual disturbances that occur in psychotic disorders.

Treatments for anxiety disorders may include psychotherapy, such as Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR) and medications including antidepressants and anti-anxiety agents.

## Personality Disorders

Personality disorders are associated with enduring patterns of inner experience and behavior that markedly deviates from ones culture and causes difficulties with perception, interpersonal interactions, emotional regulation, and impulsivity. These patterns develop early, are inflexible, and are associated with significant distress or disability (APA, 2013).

Personality disorders fall within 10 distinct types: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, antisocial personality disorder, borderline personality disorder, histrionic personality, narcissistic personality disorder, avoidant personality disorder, dependent personality disorder and obsessive-compulsive personality disorder (APA, 2013). Personality disorders may co-occur with other conditions and can influence competency of criminal defendants.

Examples of psychotherapy treatments for some personality disorders include Dialectical Behavioral Therapy (DBT) and Cognitive Therapy (CT). Psychiatric medications may help with various symptoms and co-occurring disorders associated with personality disorders.

## Neurocognitive Disorders

Neurocognitive disorder refers to impaired mental function from a medical condition other than a primary psychiatric disorder. Impaired brain function may be caused by:

- Trauma (bruising of the brain or bleeding into the brain or space around the brain),
- Lack of oxygen (hypoxia, hypercapnia)
- Cardiovascular disorders (e.g., stroke, atherosclerosis)
- Degenerative disorders (e.g., Parkinson's Disease, dementia caused by metabolic disorders)
- Delirium (electrolyte abnormalities, Infections (e.g., Meningitis), substance use, vitamin deficiency, etc.)

**NOTE:** Other conditions, such as Depression, Psychosis, etc. can mimic Neurocognitive Disorders.

## Substance Use Disorders

Substance use disorders occur when the recurrent use of alcohol and/or substances causes clinically or functionally significant distress and often causes impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of increased impaired control, social impairment, risky use, and pharmacological criteria. Substance use disorders are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual.

Substance use disorder in DSM-5 combines the previous DSM-IV categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Each specific substance (other than caffeine, which cannot be diagnosed as a substance use disorder) is

addressed as a separate use disorder (e.g., alcohol use disorder, stimulant use disorder, etc.), but nearly all substances are diagnosed based on the same overarching criteria.

## Co-occurring Disorders

A diagnosis of co-occurring mental illness and substance uses disorder or "co-occurring disorder" (previously referred to as "dual diagnosis") describes the presence of both a mental disorder and a substance use disorder. National research suggests that as many as three out of every four criminal defendants in major cities test positive for illegal substances at the time of arrest (National Institute of Justice, 1998). People with substance use disorders are more likely to develop mental illness and people with mental illness are more likely to develop a substance use disorder (Peters & Hills, 1997; Massaro & Pepper, 1994).

People with co-occurring disorders are at higher risk for homelessness, human immunodeficiency virus (HIV), Hepatitis C, violent behavior, trauma (e.g., Post-Traumatic Stress Disorder), unemployment, and social and family relationships problems (Peters & Hills, 1997; Broner, et al., 2000). The presence of co-occurring conditions may complicate the assessment and restoration of competency to stand trial.

## Factitious Disorders

A person with a factitious disorder intentionally (consciously) produces, feigns or exaggerates the symptoms of a disease, illness or psychological condition with the aim of assuming the patient role. The motive varies but may include a desire to seek comfort and attention, attempt to gain access to medications, or a fascination with the medical field.

The DSM-5 criteria for factitious disorder (previously, when severe, was called Munchausen syndrome) include:

- Falsification of physical or psychological signs or symptoms or causing injury or disease with the deliberate intention to deceive
- Pretending to be sick or injured or to be impaired
- Continuing with the deception, even without receiving any visible benefit or reward
- Behavior is not better explained by another mental disorder, such as a delusional disorder or another psychotic disorder

The DSM- 5 categorizes Factitious Disorder into two types: Factitious disorder imposed on self and factious disorder imposed on another. This later condition is when a person deliberately produces, feigns, or exaggerates the symptoms of someone in his or her care.

## Conversion Disorder

A person with a conversion disorder may have a personality disorder and/or unresolved issues from childhood, such as emotional or physical abuse, or early detachment. These motives differ from those of malingering in which one feigns symptoms for external gain (see Malingering description below).

## Malingering

The DSM-5 describes malingering as the intentional production of false or grossly exaggerated physical or psychological problems (APA, 2013). Malingering is not considered a mental illness although it may be assessed and coded in a forensic evaluation (it is given a "V" code in DSM-5, V65.2). Malingered

conditions may include dissociative identity disorder, mood disorders/suicidality, psychosis (e.g., hallucinations), PTSD, amnesia, cognitive deficits, and dementia.

Motivation for malingering is usually external (e.g., avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs) (APA, 2013). The clinical interview is key in the assessment of malingering, and when malingering is suspected, forensic evaluators may use malingering tests to assess for it.

### Intellectual and Developmental Disability

In DSM-5, intellectual and developmental disorders are classified under Neurodevelopmental Disorders. Intellectual Disability (intellectual developmental disorder) as a DSM-5 diagnostic term replaces "mental retardation" used in previous editions of the manuals. Intellectual disability involves impairments of general mental abilities that impact adaptive functioning in three domains, or areas. The diagnostic criteria, as defined by the DSM-5 are:

- Deficits in **intellectual functioning** such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning (ability to learn in school via traditional teaching methods), and experiential learning (the ability to learn through experience, trial and error, and observation).
- Deficits or impairments in **adaptive functioning** (skills are needed for daily living) such as communication, social skills, personal independence at home or in community settings, and social or work functioning.
- These limitations must occur during the developmental period (were evident during childhood or adolescence). If the problems began after the developmental period, the correct diagnosis might be neurocognitive disorder.

**NOTE:** Mental abilities are measured by standardized intelligence quotient (IQ) tests administered by professionals.

In Washington state, RCW 71A.10.020 defines "Developmental disability" as "a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological or other condition of an individual found by the secretary to be closely related to an intellectual disability or to require treatment similar to that required for individuals with intellectual disabilities, which disability originates before the individual attains age eighteen, which has continued or can be expected to continue indefinitely, and which constitutes a substantial limitation to the individual." (RCW 71A.10.020)

## 2.3 Cultural Considerations

Lack of knowledge of certain cultural beliefs or practices can result in erroneous conclusions, whether during a forensic competency evaluation or in the courtroom. For example, visual or auditory hallucinations with a religious content, such as hearing God's voice, may be viewed as a normal part of religious experience (Tseng, Elwyn, & Matthews, 2004). It is essential to be responsive to ethno-cultural differences in etiological and causal models of health and disorder, patterns of disorder, standards of normality, and treatment alternatives.

As part of ethical standards, mental health providers in the forensic system strive to maintain cultural competence as it relates to their practice. Cultural competence is the application of knowledge, skills,

experience, and personal attributes to respond respectfully and effectively to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, and values the cultural differences and similarities of individuals, families, and communities. For more information relevant to culture and forensic mental health, see the Resources section of this manual.

# 3. COMPETENCY TO STAND TRIAL

## 3.1 Background

Competency to stand trial, or adjudicative competence, is the legal construct that refers to a criminal defendant's ability to participate in legal proceedings related to an alleged offense (Mossman et al., 2007). The U.S Supreme Court established the current legal standard for determining competency to stand trial in *Dusky v. United States* (1960). The standard of competence is whether a defendant lacks the "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." (*Dusky v US*; 362 U.S. 402; 1960). In Washington, 'Incompetency' means a person lacks the capacity to understand the nature of the proceedings against him or her or to assist in his or her own defense as a result of mental disease or defect (RCW 10.77.010). Incompetence may occur during any stage of legal proceedings and "no incompetent person shall be tried, convicted, or sentenced for the commission of an offense so long as such incapacity continues." (RCW 10.77.050). The Competency to Stand Trial Process is shown in Figure 3.

**NOTE:** Some defendants may be aware that they have a mental illness, but they may not have insight into its influence on their judgment. This may persist even when psychiatric symptoms are in remission.

## 3.2 Competency Evaluation and Restoration Treatment Court Orders

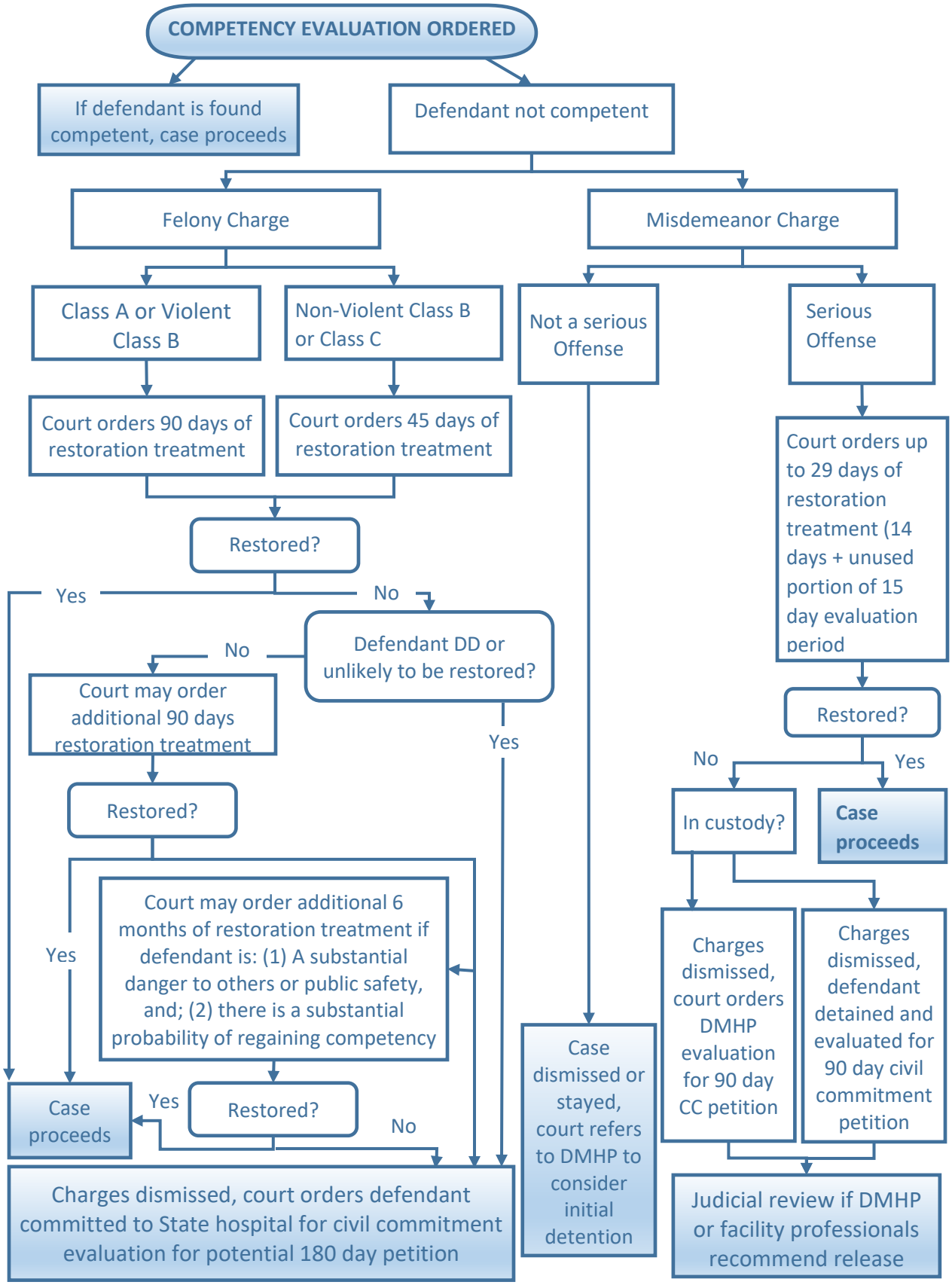
Evaluations of competency to stand trial are the most common source of referrals to forensic mental health treatment providers nationally and in Washington (Gowensmith, Murrie, & Packer, 2014). DSHS is mandated to provide forensic evaluation and treatment services when court ordered. Evaluations are conducted only under valid court order and after counsel has been appointed, unless waived pursuant to state law (see RCW 10.77.020).

The Administrative Office of the Courts released standardized forms for RCW 10.77. Forms for court orders are available at https://www.courts.wa.gov/forms/. By checking the box for "Department Facility" on court orders for competency services, you can allow DSHS to place an individual for restoration services in a state hospital or one of the three DSHS residential treatment facilities (see **Section 4.2**) depending on the individual needs of the defendant.

## 3.3 Competency Referral Screening Assessment

Some counties, such as Snohomish County, conduct in-jail screening of inmates who may be candidates for pretrial forensic mental health evaluation under RCW 10.77.060. The screening is conducted by trained jail staff or other designee and entails a brief review of mental health history, current mental status, assessment of psychiatric impairments to understanding legal proceedings and ability to assist in their own defense. The screening assessment is not a competency evaluation, but a screening process to help identify and recommend to the court appropriate referrals for competency assessments.

**Figure 3.** Competency to Stand Trial Process.



## 3.4 Competency Evaluation Process

Forensic evaluations may be conducted in inpatient facilities, jails, or in community settings. In Washington, the majority of forensic evaluations are conducted by DSHS employees and the interviews occur in a jail. State statute requires that the evaluator's report include the following (as pursuant to RCW 10.77.060):

- A description of the nature of the evaluation;
- A diagnosis of the mental status of the defendant;
- An opinion as to the defendant's competency, and an opinion regarding insanity if insanity is claimed, and an evaluation and report by an expert or professional person has been provided that meets statutory criteria (RCW 10.77.060(3)(d));
- An opinion as to whether the defendant should be evaluated by a designated mental health professional under the Involuntary Treatment Act (ITA).

The evaluation is then submitted to the court, and if 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.

**NOTE:** The role of forensic evaluators differs from that of treatment providers. Professionals who take on the role of forensic evaluators evaluate issues including, but not limited to, defendants' competence to stand trial, their mental state at the time of the offense (i.e., insanity), and their risk for future violent behavior. Treatment providers are responsible for psychological intervention or treatment of individuals in both criminal and civil cases who require (e.g., competency restoration or civil commitment) or who request these services.

## 3.5 Sell Orders

A Sell Order is an authorization to administer medications involuntarily. In Sell v. United States, (539 U.S. 166 (2003)) the United States Supreme Court held that the Constitution allows the government to administer antipsychotic medications involuntarily to a mentally ill criminal detainee in order to render that defendant competent to stand trial for serious, but nonviolent crimes. (539 U.S. 169 (2003).

In the State of Washington, it is the responsibility of the Treating Psychiatrist to initiate Sell Hearing proceedings. The process is typically as follows:

1. If the defendant 1) refuses medications, or 2) has a pattern of inadequate medication compliance lasting at least a week, and it is the opinion of the treating psychiatrist that the defendant cannot be restored without medication, then the treating psychiatrist will send a letter to the court requesting a Sell Hearing (unless the Court has indicated that a hearing has already been scheduled).
2. If the defendant returns from the Sell Hearing (a) without an order for the forced administration of medication, and (b) the defendant continues to refuse to take medication, and (c) it is the opinion of the evaluators that the defendant will not be restored without medication compliance, a report will be submitted to the court indicating the clinically relevant information and rendering an opinion on the defendant's current capacities to stand trial.

# 4. COMPETENCY RESTORATION SERVICES

## 4.1 Overview

While the majority of defendants evaluated for competency to stand trial are viewed as competent to proceed, those found incompetent to stand trial may be referred to treatment and specialized training to enable them to proceed to trial. This process is typically referred to as *competency restoration*. These persons constitute the largest group referred for inpatient mental health treatment within the criminal justice system (Cutler, 2008).

Most incompetent adult defendants are sent to Western State Hospital (WSH) or Eastern State Hospital (ESH) for competency restoration. Alternate restoration facilities are also in use, and are described in the following section.

NOTE: Jails and prisons also have a constitutional obligation to provide treatment to inmates with serious medical and psychiatric conditions (Veysey, Bichler-Robertson, 2002). Types of treatments in these settings may include medication, counselling (e.g., individual or group therapy), and rehabilitation (e.g., involvement in a program directed at enabling people to live safely within the community).

## 4.2 Residential Treatment Facilities (RTF) Overview

In 2016, DSHS established through a collaboration between Correct Care Recovery Solutions two new residential treatment facilities where pretrial adult defendants can receive competency restoration services. The Maple Lane Competency Restoration Program (shown in Figure 4) consists of a 30-bed facility located at 20311 Old Highway 9 SW, Centralia.

**Figure 4.** Maple Lane Competency Restoration Program

The Yakima Competency Restoration Program (shown in Figure 5) consists of a 24-bed facility and is located at 1500 Pacific Avenue, Yakima.

**Figure 5.** Yakima Competency Restoration Program

The Fort Steilacoom Competency Restoration Program (shown in Figure 6), opening in 2019, consists of a 30-bed facility and is on the Western State Hospital Campus in Lakewood, WA.

**Figure 6.** Fort Steilacoom Competency Restoration Program

All three facilities serve patients who are assessed to be relatively low in their risk to harm themselves or others. Candidates for admission are screened by clinical staff to determine their appropriateness for the program. Both WSH and ESH continue to be options for screened and selected patients. Defendants ordered into competency restoration services are assessed through a centralized screening process to determine which of the five locations best matches their needs. State law gives the Secretary of DSHS the discretion for placement for competency restoration. (*See* RCW 10.77.084(1)(b), 10.77.086(1)(a)(i) and 10.77.088(1)(a).)

### 4.2.1 Transportation of Defendants to/from Residential Treatment Facilities

Transportation for patients coming from jails are arranged by the sending county. Patients coming to the alternate site from a state psychiatric hospital are transported by DSHS.

RCW 10.77.078 states that jails must transport a defendant to competency restoration sites within one day of an offer of admission and must provide a defendant's medical clearance to the state hospital admissions staff. In order to make efficient use of the new facilities, and place defendants in the most appropriate facility, DSHS requests that jails provide available information to DSHS admissions staff who screen individuals for placement. This would include information about the patient's behavior within the jail, the patient's willingness to take prescribed medications, and other relevant information.

### 4.2.2 Medication and Personal Belongings at Residential Treatment Facilities

Unlike the hospitals, the alternate sites do not have an on-site pharmacy and must coordinate medication orders through local community pharmacies. DSHS works with jails to ensure that 5 days of medications are sent with incoming patients and sent out with patients. This 5-day supply bridges the medication gap until it is ordered and received by the RTF site.

Storage space is limited at the new facilities. DSHS requests that incoming patients come only with the clothes worn for transport, the requested medications and, if they require it, their own copies of their court documents.

### 4.2.3 Visitation at the Residential Treatment Facilities

Just like the state hospitals, attorneys and approved family members are able to visit patients at the RTFs or communicate by telephone.

### 4.2.3 Triage Consultation and Expedited Admission (TCEA)

The Office of Forensic Mental Health Services operates a triage consultation and expedited admission (TCEA) system to facilitate the expedited admission of persons who meet certain criteria that would justify prioritizing the person's admission to a state psychiatric hospital for evaluation for competency to stand trial or competency restoration services. The triage consultation and expedited admission system is not appropriate for people in need of emergency medical services, as those individuals should be referred for immediate medical attention. For more information about the process, visit the OFMHS TCEA website:
https://www.dshs.wa.gov/bha/triage-consultation-and-expedited-admission-tcea

## 4.3 Competency Restoration Treatment

Treatment programs for the restoration of competence typically target mental disorder/cognitive impairment and competence-related abilities. Improvement in the underlying mental disorder or cognitive impairment often results in improvement in competence-related deficits. The most common form of treatment for restoration of competence involves the administration of psychiatric medication.

Competency Restoration treatment may consist of:

- Administration of psychiatric medications. Medication is the most frequent form of treatment. Medication such as antidepressants, antipsychotics and other medications control some of the symptoms of mental illnesses or mental disorders.
- Group and individual psychotherapy that addresses social skills for working with court staff, managing mental illness, and other therapies that assist the patient with overcoming their barriers to competency to stand trial.
- Educational treatment programs designed to increase a defendant's understanding of the legal process or individualized treatment programs that confront the problems that hinder a defendant's ability to participate in his or her defense (competency-related deficits).
- Recreational and psychosocial group activities.
- Medical treatment if necessary.

Training is also often a component of competency restoration. Training may consist of:

- Competency education
- Understanding the legal system

Competency restoration treatment also recognizes the possible presence of trauma symptoms and the role that histories of trauma and exposure to violence may play in an individual's life. Traumatic events can include a history of physical and sexual abuse or assault, domestic violence, neglect, bullying, community-based violence (e.g., exposure to gang violence, police and citizen altercations), disaster, terrorism, and the experience of war (SAMSHA, 2014). Involvement with the criminal justice system can further exacerbate trauma for individuals with histories of trauma experiences (SAMSHA, 2016). Trauma-informed care is an approach used to engage people with histories of trauma. For more information on Trauma-informed care, see http://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf.

In Washington, the length of the competency restoration treatment period depends upon the type of criminal charge. Defendants charged with misdemeanor offenses qualify for an initial 14 to 29 days of restoration treatment. Defendants charged with Class C or non-violent Class B felony offenses qualify for an initial treatment period of 45 days. Defendants charged with violent Class B and Class A felonies are committed for an initial treatment period of up to 90 days (see RCW 10.77).

Most felony defendants treated for restoration to competency in Washington are restored to competency within 90 days. Evidence from the research literatures suggests that defendants that take the longest to restore to competence are those with developmental disabilities and those with longstanding psychotic disorders that have resulted in lengthy periods of hospitalization (Warren et al. 2013). Factors that have been found to be associated with nonrestorability (Colwell & Gianesini, 2011; Morris & Parker, 2009; Mossman, 2007; Warren et al. 2013) include:

- Age over age 65 (even when accounting for dementia)
- Individual with chronic psychotic illness (particularly schizophrenia or schizoaffective disorder), a history of lengthy hospitalizations, and severe impairment in daily living
- Irremediable cognitive disorder such as intellectual disorder or dementia
- Men were more likely than women to be nonrestorable
- Lower level charges (Misdemeanors)

# 5. NOT GUILTY BY REASON OF INSANITY (NGRI)

## 5.1 Background

When defendants plead not guilty by reason of insanity, they are admitting that they committed a crime, but seek to excuse their behavior by reason of mental illness that satisfies the definition of legal insanity. A "criminally insane" person means any person who has been acquitted of a crime charged by reason of insanity, and thereupon found to be a substantial danger to other persons or to present 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 (RCW 10.77.010). The process for civil commitment and NGRI is shown in **Figure 6**. For more information on Maximum term of commitment or treatment, see RCW 10.77.025.

## 5.2 Mental Health Treatment following NGRI

Individuals who have been found NGRI require attention for clinical and legal needs as a result of their connection to both the mental health and criminal justice systems. Some NGRI acquittees may be discharged into community treatment programs.

## 5.3 Public Safety Review Panel

The Washington State Legislature established the Public Safety Review Panel (PSRP) in 2010 (Chapter 263, Laws of 2010), to independently assess and provide advice to the Secretary of the DSHS and to the courts, regarding potential risk to public safety related to the proposed Conditional Release or Final Discharge of patients found Not Guilty by Reason of Insanity (NGRI) committed to Western State Hospital or Eastern State Hospital.

In 2013, the Washington State Legislature expanded the jurisdiction of the PSRP, Chapter 289, Laws of 2013, to include patients civilly committed to WSH or ESH after the court found the criminal defendant not competent to stand trial for a violent offense (RCW 9.94A.030).

# 6. CIVIL COMITTMENT

## 6.1 Background

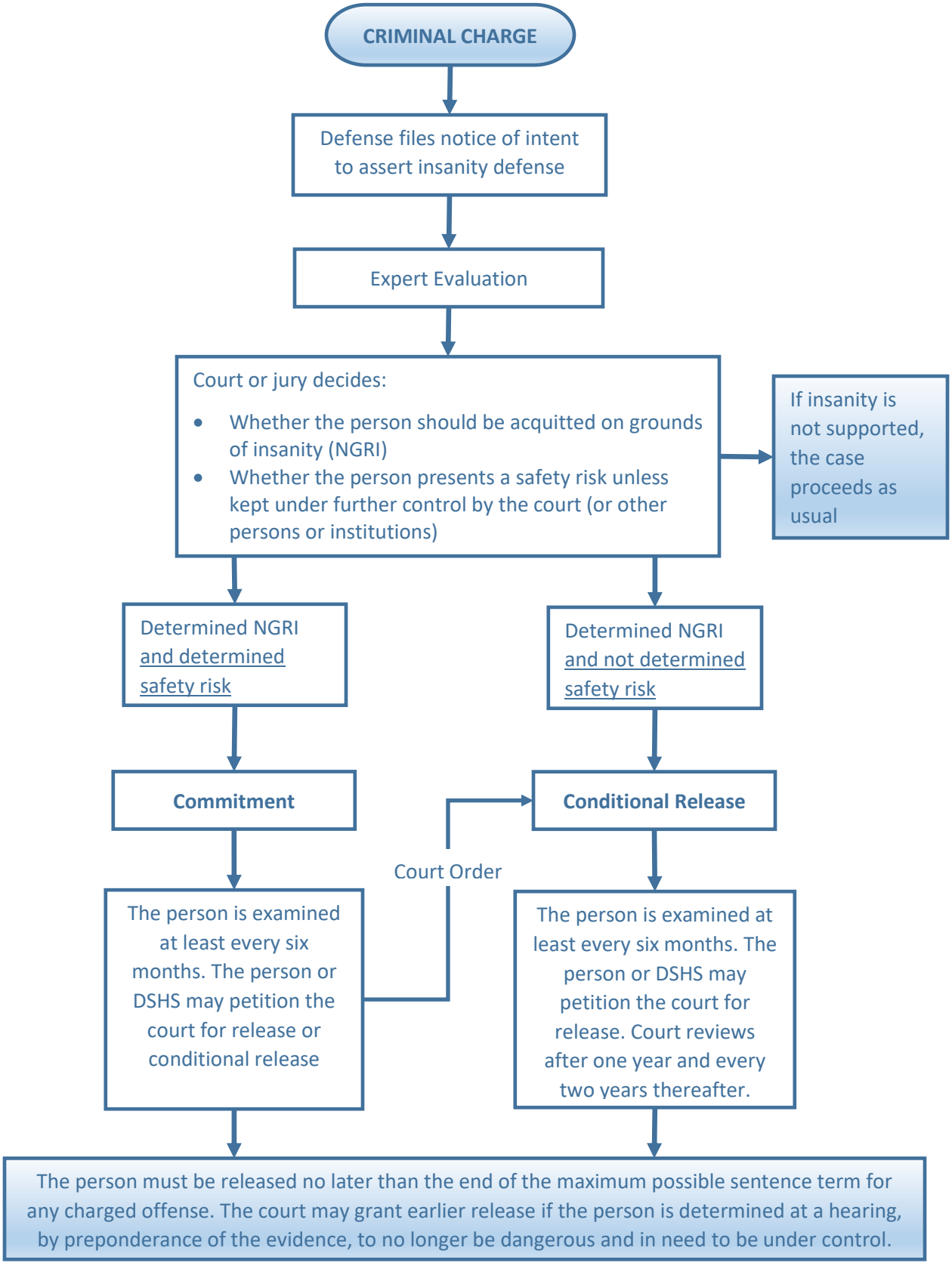
Civil Commitment means the determination by a court that a person should be detained for a period of either evaluation or treatment, or both, in an inpatient or a less restrictive setting (RCW 71.05.020)**.** The presence of a mental disorder is a prerequisite for civil commitment. Other criteria frequently include dangerous behavior toward self or others, grave disability, and the need for treatment.

## 6.2 Felony Conversions (Felony Flips)

A “Felony Flip” is when a defendant’s felony charges are dismissed and a civil commitment is pursued. A court may dismiss criminal charges due to the lack of competence. The individual is then sent to the state psychiatric hospital to be evaluated to determine if the individual meets criteria under RCW 71.05 for civil commitment to the hospital due to their mental illness. Pursuant to RCW 10.77.086(4) charges

are dismissed without prejudice, allowing the court to re-charge the individual in the future, if the individual is later determined to have regained competency.

**Figure 7.** Not Guilty by Reason of Insanity (NGRI) process.



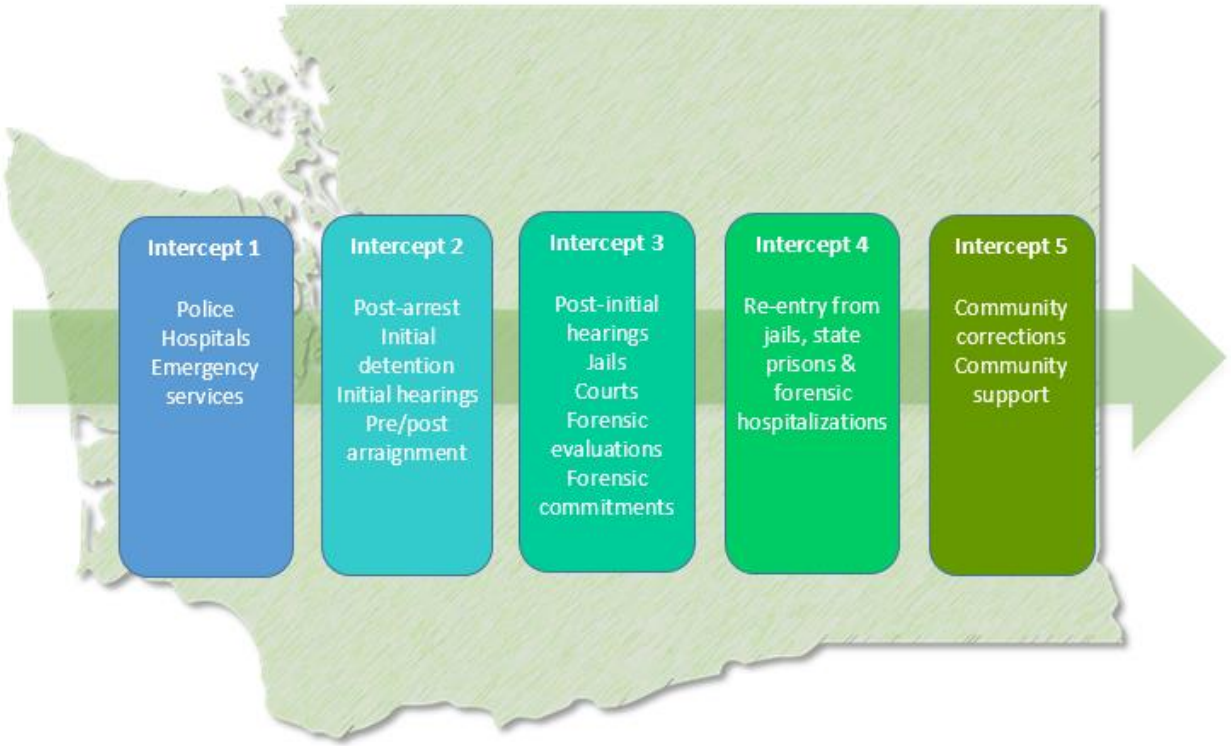
# 7. DIVERSION PROGRAMS

Successful screening and assessment early in the criminal justice process (including pre-trial) are key to diverting people into treatment programs. Diversion programs are often run by a police department, court, or behavioral health organization/outside agency designed to enable individuals to avoid criminal charges or a criminal convictions.

The Sequential Intercept Model (Munetz & Griffin, 2006) (See **Figure 7.**) provides a framework for conceptualizing the interface between the criminal justice and mental health systems. The intercept model has several key objectives that include (Munetz & Griffin, 2006):

- Preventing initial involvement with the criminal justice system
- Decreasing admissions to jail
- Engaging persons in treatment as soon as possible
- Minimizing time moving through the criminal justice system
- Connecting people to community treatment options
- Decreasing the rate of return to the criminal justice system

**Figure 8.** The Diversion (Sequential) Intercept Model.




**NOTE:** An Intercept 0, that refers to community services such as community crisis centers and mobile outreach teams, has also been proposed (Policy Research Associates, 2018)

## 7.1 Law Enforcement and Emergency Services

Pre-arrest diversion is the first point of interception for individuals with behavioral health needs. Law enforcement and emergency service professionals are often the initial point of contact for individuals in crisis. Oftentimes law enforcement officers may lack knowledge of alternatives or find it difficult to immediately access behavioral health services. Crisis Intervention Teams (CITs) and police-mental health co-responder teams are trained to link people with mental illnesses to treatment without arrest.

Police diversion programs are built on partnerships between mental health providers in the community and designated police units, with the aim of identifying serious mental illness, de-escalating situations with minimal police force, decreasing stigmatization, and when appropriate, linking a person to treatment rather than booking them into jail.

## 7.2 Jails and Courts

Jail diversion helps people with behavioral health needs receive treatment through various alternatives to incarceration. While programs that divert people to treatment incur healthcare system costs, providing treatment in the community is typically less expensive than serving people in criminal justice settings. There is also the potential for large cost offsets, because diversion can prevent further criminal justice involvement. Jail diversion helps reduce expenditures associated with unnecessary arrests and detentions.

Post arrest diversion options include the use of mental health screening tools after arrest to quickly identify individuals who have behavioral health needs and refer them to appropriate services either in-jail or in the community. In addition, specialized courts, including drug, mental health, and veterans' courts have shown to be an effective way to divert people with behavioral health needs from incarceration and into treatment (Sarteschi, Vaughn, & Kim, 2011). These voluntary programs operate both pre- and post-adjudication, and allow participants to access treatment as an alternative to incarceration.

## 7.3 Who to Contact About Diversion Programs

If you would like additional information about county-specific diversion programming, please contact your county Behavioral Health Organization (BHO). The Office of Forensic Mental Health Services can also connect partners and stakeholders to appropriate contacts at the BHO level and can help facilitate diversion conversations activities in your local area. For more information please contact Tim Hunter, Liaison and Diversion Specialist, at huntetj@dshs.wa.gov.

## ADDITIONAL RESOURCES

**The Office of Forensic Mental Health Services** web site (https://www.dshs.wa.gov/bha/office-service-integration/office-forensic-mental-health-services) provides useful information and contact information for forensic mental health services in the State of Washington.

**Cultural Competence in Forensic Mental Health: A Guide for Psychiatrists, Psychologists, and Attorneys.** Tseng, W., Matthews, D., Elwyn, T. S. (2004). Brunner-Routledge.

**Ethical Principles of Psychologists and Code of Conduct**, American Psychological Association. (2010). Available online at www.apa.org/ethics/code/index.aspx

**Specialty Guidelines for Forensic Psychology**. American Psychological Association. (2012). Available online at www.apapracticecentral.org/ce/guidelines/index.aspx

**Testifying in court: Guidelines and maxims for the expert witness (2nd ed.).** Brodsky, S. (2012). Washington, DC: American Psychological Association.

**The National Alliance on Mental Illness (NAMI)** website.

**Administrative Office of the Courts** website. The site provides forms that are used statewide in Washington Courts.

The **Washington State Health Care Authority** Behavioral Health and Recovery website.

## GLOSSARY

**BHO** – Behavioral Health Organization

**CFS** – Center for Forensic Services

**CBT** – Cognitive Behavioral Therapy

**Competency restoration** – The process of helping a person regain or achieve the capacity to assist an attorney in his or her defense.

**Crisis intervention teams (CITs)** – A model for community policing that brings together law enforcement, mental health providers, hospital emergency departments and individuals with mental illness and their families to improve responses to people in crisis.

**CSTC** – Child Study and Treatment Center

**DBT** – Dialectical Behavioral Therapy

**DCR –** Designated Crisis Responder

**DSM-5** – Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

**Felony Flip** – When a defendant's felony charges are dismissed and a civil commitment is pursued.

**Forensic Commitment** – The act of involuntarily placing an adult defendant in a secure facility due to incompetence to proceed or insanity and the need for care due to dangerousness or self-neglect.

**Incompetent to Proceed/Incompetent to Stand Trial** – A mental illness or developmental disability renders the defendant incapable of effectively helping in his or her defense.

**ITA - Involuntary Treatment Act**–The involuntary placement of an adult person for the purpose of treating a mental illness that renders the person dangerous to themselves or others or gravely disabled.

**MCO –** Managed Care Organization

**NGRI** – Not Guilty by Reason of Insanity

**NRO** – Northern Regional Office

**OFMHS** – Office of Forensic Mental Health Services

**Pretrial intervention** – Persons charged with a non-violent felony in the third degree may be eligible for interventions such as victim restitution, counseling and community service. The completion of conditions results in the State Attorney's Office not prosecuting the case.

**RCW –** Revised Code of Washington

**Sell Order** – An authorization to administer medications involuntarily for the purpose of competency restoration.

**Trauma-informed care** – a treatment approach used to engage people with histories of trauma.

## REFERENCES


American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5). Washington DC: American Psychiatric Press Inc.

Blandford, A. M., & Osher, F. (2013). Guidelines for the successful transition of people with behavioral health disorders from jail and prison: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, Delmar, New York: The Council of State Governments Justice Center.

Colwell, L. H., & Gianesini, J. (2011). Demographic, criminogenic, and psychiatric factors that predict competency restoration. *Journal of the American Academy of Psychiatry and the Law. 39(3),* 297-306.

Cutler, B. L., (2008). Encyclopedia of Psychology and Law. Thousand oaks, CA: Sage Publications.

Ditton, P. M. (1999). Mental Health and Treatment of Inmates and Probationers. Bureau of Justice Statistics Special Report No. NCJ 174463. Washington, DC: US Department of Justice, Office of Justice Programs.

Gowensmith, W. N., Murrie, D. C., & Packer, I. K., (2014). Forensic Mental Health Consultant Review Final Report. Retrieved from: http://app.leg.wa.gov/ReportsToTheLegislature/Home/

James, D. J., & Glaze. L. E., (2006). Mental Health Problems of Prison and Jail Inmates." Bureau of Justice Statistics Special Report No. NCJ 213600. Washington, DC: US Department of Justice, Office of Justice Programs.

Massaro, J., & Pepper, B. (1994). The relationship of addiction to crime, health, and other social problems. Chapter 2 in Treatment for alcohol and other drug abuse: Opportunities for coordination. Technical Assistance Publication Series 11. DHHS Publication No. (SMA) 94-2075. Rockville, MD: Center for Substance Abuse Treatment.

McFarland, B. H., Faulkner, L. R., Bloom J. D.,& Hallaux, R., & Bray J. D. (1989). Chronic mental illness and the criminal justice system. *Hospital and Community Psychiatry, 40,* 718-723.

Mossman, D. (2007). Predicting restorability of incompetent criminal defendants. *Journal of the American Academy of Psychiatry and the Law, 35*, 34-43.

Mossman, D., Noffsinger, S. G., Ash, P., Frierson, R. L., Gerbasi, J., Hackett, M., Lewis, C. F.,, Pinals, D. A., Scott, C. L.,, Sieg, K. G., , Wall, B. W.,, & Zonana, H. V. (2007). AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial. 35(4), Supplement.

Munetz, M. R., & Griffin, P. A., (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57(4),* 544-549.

Parker, G. F., (2014). DSM-5 and Psychotic and Mood Disorders. *Journal of the American Academy of Psychiatry and the Law, 42(2),* 182–190.

Peters, R. H., & Hills, H. A. (1997). Intervention strategies for offenders with co-occurring disorders: What works. Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System.

Policy Research Associates (2018). The Sequential Intercept Model. Retrieved from: https://www.prainc.com/wp-content/uploads/2018/06/PRA-SIM-Letter-Paper-2018.pdf

Sarteschi, C. M., Vaughn, M. G., & Kim, K. (2011). Assessing the effectiveness of mental health courts: A quantitative analysis. *Journal of Criminal Justice, 39,* 12-20. doi: 10.1016/j.jcrimjus.2010.11.003;

Sell v. United States, 539 U.S. 166 (2003).

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (February 28, 2014). The NSDUH Report: State Estimates of Adult Mental Illness from the 2011 and 2012. Rockville, MD: National Surveys on Drug Use and Health.

Substance Abuse and Mental Health Services Administration, GAINS Center. (2016). Trauma Training for Criminal Justice Professionals. Retrieved from: http://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. Retrieved from: http://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf

Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., Samuels, S. (2009). Prevalence of Serious Mental Illness among Jail Inmates. *Psychiatric Services, 60(6),* 761-765.

Tseng, W., Elwyn, T. S., & Matthews, D. (2004). Cultural Competence in Forensic Mental Health: A guide for Psychiatrists, Psychologists, and Attorneys. New York, NY: Brunner-Routledge.

Torrey, E. F., Zdanowicz, M. T., Kennard, A. D., et al. (2014, April). The treatment of persons with mental illness in prisons and jails: a state survey. Treatment Advocacy Center and National Sheriff's Association. Retrieved from: http://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf

Veysey, B. M., & Bichler-Robertson G. (2002). Health status of soon-to-be released inmates, vol. 2, Report to Congress. Providing psychiatric services in correctional settings. Chicago, IL: National Commission on Correctional Health Care.

Teller, J., Munetz, M., Gil, K. & Ritter, C. (2006). Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric Services, 57*, 232-237.

Warren, J. I., Chauhan, P., Kois, L., Dibble, A., Knighton, J. (2013). Factors influencing 2,260 opinions of defendants' restorability to adjudicative competency. *Psychology, Public Policy, and Law, Vol 19(4)*, 498-508. http://dx.doi.org/10.1037/a0034740

Washington State Department of Social and Health Services (2016). Child Study and Treatment Center. Retrieved from: https://www.dshs.wa.gov/bha/division-state-hospitals/child-study-and-treatment-center