

Public Safety Review Panel:

Report to the Washington State Legislature
Pursuant to RCW 10.77.270(6)

December 1, 2014

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Background

In 2010, the Public Safety Review Panel (PSRP) was established by the Legislature for the purpose of providing independent advice to the Secretary of DSHS and the Courts with respect to proposed Conditional Release or Final Discharge of psychiatric patients committed as not guilty by reason of insanity (NGRI). In 2013, the Legislature expanded the jurisdiction of the PSRP to include hospitalized criminal defendants who the Court had determined to be not competent to stand trial for a violent offense. The PSRP consists of seven volunteer members, each representing a different professional or public role germane to the review task. The PSRP meets regularly to review submissions of proposed releases from Western State Hospital (WSH) and Eastern State Hospital (ESH).

Report Required

This report was written to fulfil the requirement in RCW 10.77.270(6) for a report from the PSRP by December 1, 2014. The report provides the PSRP's findings and views on the following four questions:

- Whether the Public Safety Review Panel has observed a change in statewide consistency of evaluations and decisions concerning changes in the commitment status of persons found not guilty by reason of insanity;
- Whether the Public Safety Review Panel should be given the authority to make release decisions and monitor release conditions;
- Whether further changes in the law are necessary to enhance public safety when incompetency prevents operation of the criminal justice system and long-term commitment of the criminally insane; and
- Any other issues the Public Safety Review Panel deems relevant.

Characteristics of NGRI Offenses, Proposed Releases, and PSRP Review Decisions

Currently, 68% of the state's 220 NGRI patients are committed to WSH while the remainder, 32%, are committed to ESH. Over four years of operation,

the PSRP has received 89 referrals to review proposed changes in commitment status for 63 patients. The offenses related to the current commitment of these patients were: murder (27%, 17 individuals), assault (32%, 20 individuals), robbery (10%, 6 individuals), and arson (8%, 5 individuals); with 15 individuals committing various other crimes. Most proposed changes in status (56%) entailed greater independence for the patient within the hospital or as a participant in a closely supervised Community Program Ward. Proposals for community placement constituted 25% of submissions and 15% of submissions proposed the Unconditional Release (Final Discharge) of the patient.

The PSRP supported 73% of proposed releases. The majority, 61%, of the proposed releases were supported without modification, while 12% were supported by the PSRP after the hospital provided requested information or adopted a suggested modification to the original proposal. The PSRP found that 19% of hospital submissions did not adequately address public safety considerations.

Effect of PSRP on NGRI Inpatient Census

As a purely advisory body, the PSRP has no direct effect on conditional and unconditional release decisions. The Panel's recommendations are accepted by DSHS and the courts only to the extent that they contain reasonable approaches to improve patient care and community safety. Although DSHS statistics present substantial reliability issues, the increase in the NGRI inpatient census is most likely due to internal hospital practices at WSH and some increase in the number of persons asserting the NGRI defense in underlying criminal cases.

Status of the State's Management of NGRI Patients:

Several areas of improvements to evaluation and decision-making for the NGRI population since the inception of the PSRP are noted in this report. These include more consistent use of formal risk assessment methods applied near in time to the proposed release. Also, in response to PSRP urgings, Community Corrections supervision is more frequently included in recommended conditions of release.

Several shortcomings and areas of challenge observed by the PSRP in its initial year of reviewing submissions have persisted. Included in this set of issues are inadequate documentation of the chain of accountability for in-hospital

risk reviews and DSHS administrative reviews, weak correspondence of proposed releases to the patient's treatment plan, inconsistent diagnostic rigor and clarity weakening the clinical basis for the proposal, and the absence of a consistent approach to the formulation conditions of release.

The Need for Centralized Management of Forensic Services

Key among the observations made by the PSRP is consideration of current obstacles to the effective management and treatment of NGRI patients is the need for a paradigm shift from a general psychiatry model of assessment and intervention to a forensic perspective. In the forensic paradigm, safety, security, and reliability of practices are understood as integral to all aspects of patient care and management. This paradigm shift can be realized most effectively by a centralized Office of Forensic Mental Health Services within DSHS that would guide:

- Forensic practice standards that serve as the basis of a certification process for forensic mental health professionals.
- Consistency of policies, practices, and programs between WSH and ESH- -most urgently in regard to the increasing community transition opportunities for patients of ESH.
- Development and monitoring of in-patient treatments that directly address prominent problems of the forensic population, such as personality disorder and substance use disorders.
- Development and monitoring of dedicated forensic community services and resources, including forensic case management and transitional housing.
- Evaluation of feasibility, cost considerations, and quality implications of centering all long-term forensic treatment at one facility (as is the practice in most large states) while organizing community and transition resources on a regional basis.

Establishment of Quasi-Judicial Board (the Oregon Model)

While the PSRP advances these recommendations for system reform and improvement, the PSRP believes that more beneficial and far-reaching

improvements would come from the establishment of a Public Safety and Psychiatric Review Board. The PSRP and advisory groups that pre-dated the PSRP have observed and favorably evaluated the impact of Oregon State's PSRB on that state's mental health system. The recommended Board would have quasi-judicial authority over changes of conditions of commitment for NGRI patients. It would review patients on-site at the hospitals on a scheduled basis, and evaluate the appropriateness of treatment provided, the patient's response to treatment, and public safety considerations of changes in the current or proposed commitment status. Feedback and direction would be given by the Board to treatment staff and the patient to maintain momentum toward readiness for release.

Although adopting his model would result in costs for administrative support and per diem professional compensation for Board members, it would result in quality improvements and eliminate costs that are now marginalized and distributed within DSHS, the courts, jails, and local law enforcement. Establishing the Board model would:

- Eliminate the costs of custodial transportation of patients to county courts.
- Free judges to manage their dockets without the need to deal with commitment issues of patients whose hearings are set many months or years apart.
- Avoid distress and decompensation of patient's awaiting hearings in local jails.
- Reduce public safety concerns to the Courts and Hospitals related hearings held outside the hospitals.
- Serve as a counterbalance to in-patient culture and practices that promote extensive, low-dose treatments that are not focused on obstacles to the patient's safe release.
- Create opportunities for procedural participation by patients, victims, family members, and community representatives.
- Regularly review evidence that the patient continues to meet the commitment criteria.

- Make better clinical and public safety decisions based on the Board members being forensic specialists with periodic contact with each patient.
- Address appropriateness of treatment and maintain a focus on forensic treatment with the primary objective being preparing the patient for conditional release and final discharge.

PSRP INVOLVEMENT IN THE NGRI PROCESS

Background

In 2010, the Washington State Legislature amended RCW 10.77.270 through Engrossed Senate Bill 6610 and established the Public Safety Review Panel (PSRP or Panel). The Panel was created to independently provide advice to the Secretary of the Department of Social and Health Services (DSHS) and the courts with respect to potential risk to public safety related to a proposed Conditional Release or Final Discharge of patients civilly committed to Western State Hospital (WSH) or Eastern State Hospital (ESH) following a determination of not guilty by reason of insanity (NGRI).

This legislation was preceded by the 2009 three-day escape of an Eastern State Hospital NGRI patient from an escorted outing to the Spokane County Interstate Fair. Following the incident, the Secretary of DSHS convened a Panel of experts tasked with reviewing the matter and making recommendations to policy, protocols, and laws as they relate to patient, staff and community safety. The report generated by the 2009 State Psychiatric Safety Review Panel¹ included a recommendation to create an independent quasi-judicial Board, modeled after Oregon, to make and monitor release decisions involving NGRI patients. After considering this recommendation, the Legislature created the current advisory Public Safety Review Panel, codified in RCW 10.77.270, to further study the Oregon model and other NGRI issues. As part of its mission, the PSRP has conducted reviews to advise the courts and the Secretary of DSHS on 89 conditional and unconditional release issues.

¹ Veith., R.C. (2009), Final Report State Psychiatric Hospital Safety Review Panel

In accord with RCW 10.77.270(6) – with the benefit of four years of experience and investigation – the PSRP is submitting this 2014 report in response to the four questions raised in the statute. These questions are:

- Whether the Public Safety Review Panel has observed a change in statewide consistency of evaluations and decisions concerning changes in the commitment status of persons found not guilty by reason of insanity;
- Whether the Public Safety Review Panel should be given the authority to make release decisions and monitor release conditions;
- Whether further changes in the law are necessary to enhance public safety when incompetency prevents operation of the criminal justice system and long-term commitment of the criminally insane; and
- Any other issues the Public Safety Review Panel deems relevant.

In 2013, the Legislature expanded the jurisdiction of the PSRP through ESSHB 1114, 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 as defined in RCW 9.94A.030 (54). These cases are often referred to as “felony flips.” The PSRP has received only 5 of these referrals to date, starting in February, 2014. Although the PSRP has seen relatively few of these cases, it is worth noting that the mental health and forensic issues, offenses, and potential risk to public safety presented by this population are similar to, and may exceed, the diagnostic complexity and risks presented by the NGRI population.

Panel Membership

The PSRP is a seven member multi-disciplinary Panel with expertise from a variety of fields related to civil commitment, community supervision, and public safety. The members of the PSRP are appointed by the Governor for renewable, non-staggered, terms of three years.

The first Panel was appointed in December, 2010. Three of the individuals had served earlier on the 2009 State Psychiatric Hospital Safety Review Panel of experts. In early 2012, one member was unable to complete his term and was replaced by a new appointee. Recently all seven members were reappointed and are currently serving a second term, Dec. 11, 2013 – Dec. 10, 2016. The

PSRP prides itself on the caliber of its members and continues to consider appointment to the PSRP a privilege.

Current members, in order of the statute specific affiliations, are:

- Psychiatrist – John Chiles, M.D.
- Psychologist – Henry Richards, Ph.D. (Chair)
- Department of Corrections Representative - Scott Frakes, Deputy Director of Prisons
- Prosecuting Attorney – David Hackett, Senior Deputy Prosecutor, King County Prosecuting Attorney’s Office
- Law Enforcement Representative - Bret Farrar, Police Chief, City of Lakewood (Vice-Chair)
- Consumer and Family Advocate – Terri Mayer, Executive Director of Opengate
- Public Defender Representative – Kari Reardon, Spokane County Public Defender’s Office

Members of the PSRP volunteer their time and are not employees of DSHS. As per RCW 10.77.270(5), DSHS provides administrative support and financial support, which consists of the PSRP Executive Director position staffing the Panel, and reimbursement to members for travel expenses for any of the PSRP meetings held in-person. The PSRP has had three executive directors over the four years of its existence.

Process

The PSRP has adopted bylaws establishing the process and timeline for issues brought before the PSRP. The Panel primarily considers recommendations that are initiated by DSHS, but is also authorized to consider requests brought by the prosecutor or the person committed under the NGRI statute. In accord with the enabling legislation, the PSRP has endeavored to provide a recommendation anytime an NGRI matter was coming before the

Superior Court in a post commitment hearing. A copy of the Panel's bylaws are attached as "Appendix A" to this report.

The typical manner for issues coming before the Panel is through a DSHS-initiated recommendation. DSHS submits its recommendation to the PSRP for review and advice at least thirty days prior to forwarding a Department recommendation to the court for conditional release under RCW 10.77.150, or forty-five days prior to issuing a recommendation for a final discharge under RCW 10.77.200, or before a potential change in commitment status for persons civilly committed under the involuntary treatment act after a violent offense. The PSRP has created a submission checklist in order to ensure that the hospital's submission is sufficient for immediate consideration and action from the Panel. A copy of this checklist is attached as "Appendix B."

The Panel considers the matter, including relevant documentation about the case (e.g., risk assessment, treatment plan), in an executive session in order to allow for free deliberations. In addition to the materials submitted by the hospital, the PSRP also solicits input from the NGRI patient (via his or her defense attorney) and the prosecutor from the county of commitment. We have also encouraged any victim concerns to be brought to the Panel's attention. After deliberating on the matter, the PSRP issues a recommendation in writing to DSHS, which is responsible by statute to forward the PSRP's recommendation to the prosecutor, defense attorney, and the Superior Court.

The review and analysis function of the PSRP provides an objective assessment of the Department's proposed release recommendation, and specifically focuses on potential public safety risks when an NGRI or 1114 patient may be conditionally released to a less restrictive environment. The PSRP may support the Department's proposed recommendation, not support the recommendation, or independently generate a different recommendation. Through this process, the PSRP also provides advice and feedback to DSHS regarding related policies to Western and Eastern State Hospital.

PSRP Operation: 2011- 2014

In January, 2011, the PSRP began reviewing cases and rendering recommendations. Meetings are held at least monthly,² generally by conference

² The PSRP initially met every three weeks, but it quickly became apparent that the hospitals were not generating sufficient conditional and unconditional release decisions to fill the PSRP calendar. Although the PSRP has a regularly

call. The Panel’s review and deliberations are not open to the public due to the confidential and legally protected nature of the materials. A quorum of at least four of the seven members must be in attendance to review a case, and the Panel may issue a recommendation only when at least four members concur.³ Despite the diverse background and experience of the Panel members, nearly all Panel decisions have been unanimous.

Sources of Referrals to the PSRP

During the nearly four years of initial operation, the PSRP received referrals for review of 89 proposed release changes involving a total of 63 patients.

Currently 220 persons found NGRI are confined in the state hospitals – 150 (68%) are at Western State Hospital and 70 (32%) are at Eastern State Hospital. The two state hospitals made referrals to the PSRP, January 2011 – October, 2014, in approximate proportion to their relative number of forensic patients:

Hospital	Number of Referrals to the PSRP 2011- 2014	Portion of the 89 Total Referrals to the PSRP 2011- 2014
WSH	51	57%
ESH	34	38%
Total:	85	95%

An annual breakdown of the total number of hospital referrals to the PSRP highlights interesting variability. The reason for the dearth of hospital referrals in 2012 is not known by the PSRP:

- 2011: 30

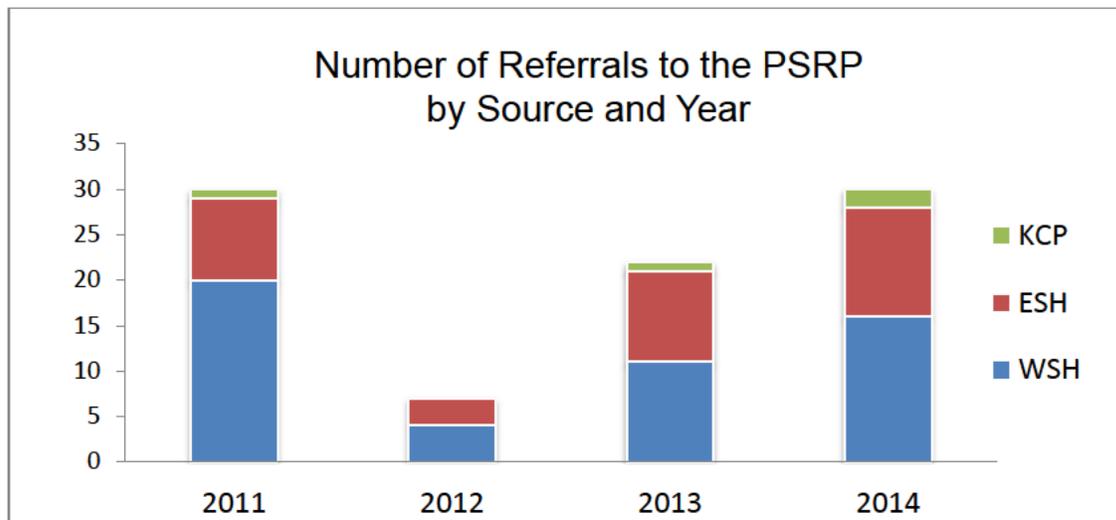
scheduled monthly meeting, it has also convened special meetings to consider time-sensitive matters.

³ Whenever a Panel member’s prior involvement with a case presents a possible conflict of interest, the Panel member has recused him or herself from the matter. For example, if one of the attorney members had served as a prosecutor or defense attorney in prior court proceedings that involved the patient, the Panel member would not participate in deliberations or decision-making on the case in order to preserve both actual fairness and/or the perception of fairness.

- 2012: 7
- 2013: 22
- 2014: 30 (through October)

One possible explanation provided to the PSRP by several sources is that some hospital staff and patient attorneys were encouraging patients to bypass the formal DSHS recommendation process – which triggers PSRP review – and instead directly petition the court for release. The 2013 legislation, ESSHB 1114, closed this loophole.

On four occasions (5% of the 89 total referrals to the PSRP), the Office of the King County Prosecuting Attorney independently requested the PSRP to review and provide a written recommendation regarding risk to public safety in order to inform the prosecutor, defense counsel and the court. This can occur when, as per the statute, a hospital patient directly petitions the court for a conditional or unconditional release, without going through the hospital and PSRP review process. One referral involved an individual acquitted NGRI who was not a patient at either hospital because the judge had remanded her directly to community supervision with Department of Corrections.



As expected, the majority of reviews thus far have involved a one-time referral of the individual to the PSRP (65%; or 41 of the 63 individuals). The Panel anticipates an increase in subsequent referrals for the same individual over time as patients progress or regress in their treatment. In these cases, the Panel is able to use its familiarity with a particular patient to monitor progress and

conditions over time. Up to this point, 18 (29%) of the 63 individuals have had a second recommendation referred to the PSRP, and four (5%) had a third referral.

There have also been occasions where a recommendation was withdrawn by the hospital due to changed circumstances. In these cases, the PSRP had already completed its review. The Panel's recommendation was Not Support in five cases, and Provisional Support in one case.

Characteristics

Of the 63 different patients who were the subject of a PSRP review for a potential release recommendation:

- 84% (53 individuals) were male; 16% (10) female;
- 92% (58) were committed NGRI, under RCW 10.77, and
- 8% (5) were committed civilly under RCW 71.05 with a designated violent offences following an inability to restore competence;

Most of the 63 patients had an extensive history of prior involvement with law enforcement. The most frequent offense related to their current commitment included: murder (27%, 17 individuals), assault (32%, 20 individuals), robbery (10%, 6 individuals), and arson (8%, 5 individuals); with 15 individuals committing various other crimes. The majority of the 63 individuals (59%) referred to the PSRP for review of a release recommendation had a single offense. However, 26 of the individuals are committed NGRI based on multiple concurrent offenses and those additional offenses mirror those identified above, including murder (2 individuals) and assault (13 individuals).

Because each referral must be assessed in the context of relevant risk factors, and some characteristics changed over time for patients who had multiple referrals to the PSRP, the characteristics shared below are related to the 89 separate release referrals:

- 79% involved a patient with a history of substance abuse/dependence
- 31% involved a patient with a history of at least 1 prior failed Conditional Release
- The number of different psychotropic medications prescribed to the patient at the time of the release recommendation referral:

- 13% = 0
 - 78% = 1, 2 or 3
 - 9% = 4, 5 or 6
- Ages of the patient at the point of referral to the PSRP ranged from 24 – 73 years old, with:
 - 7% in their 20s
 - 33% in their 30s
 - 23% in their 40s
 - 26% in their 50s
 - 8% in their 60s
 - 3% in their 70s

Diagnoses of the patients associated with the 89 release recommendation referrals sometimes evolved over the course of hospitalization. Based on the DSM-IV criteria, the most frequent Axis I diagnosis was in the category of Schizophrenia (37% of the referrals) or Schizoaffective Disorder (21%), with Depressive and Bipolar Disorders being the next most common (22%). It is interesting to note that patients at the point of referral in six percent of the requests for PSRP review had either no Axis I diagnosis or only the diagnosis of substance abuse/dependence. In the majority of referrals to the PSRP (52%), the patient had no Axis II diagnosis. But of those that did have one, 35% of the referrals involved a patient diagnosed with a Personality Disorder (e.g., antisocial, narcissistic, schizoid, etc.); 10% with Antisocial Traits; and the remainder in other Axis II diagnostic categories.

The 89 referrals to the PSRP involved 63 patients from 19 of 39 Washington counties. The court of commitment is located in the county where the NGRI index crime occurred. Patients from the state hospitals committed NGRI must physically return to the court of commitment for adjudication of requested changes in commitment status with appropriate security arrangements. Although the hospitals submit periodic progress letters to update the court regarding the current status of the individual, there is no requirement for the court to regularly review in-patient cases. As indicated below, because of the dispersion and low volume, it is very unlikely that an individual judge will acquire experience and expertise with this type of specialized case. Even in counties with

higher volumes of cases, e.g. King, Spokane, the larger Superior Court bench limits the experience of individual judges in these specialized cases.

Number of Referrals to the PSRP 2011- 2014	County of the Crime and the Involved Court of Commitment
27	King
13	Spokane
6	Pierce
6	Skagit
5	Kittitas
5	Benton
4	Clark
4	Thurston
3	Yakima
2	Chelan
2	Grant
2	Island
2	Lewis
2	Walla Walla
2	Whatcom
1	Kitsap
1	Skamania
1	Snohomish
1	Whitman

PSRP Reviews and Recommendations

For 78% of all referral recommendations since 2011, the PSRP rendered a response based on the deliberations of a single meeting. In these cases:

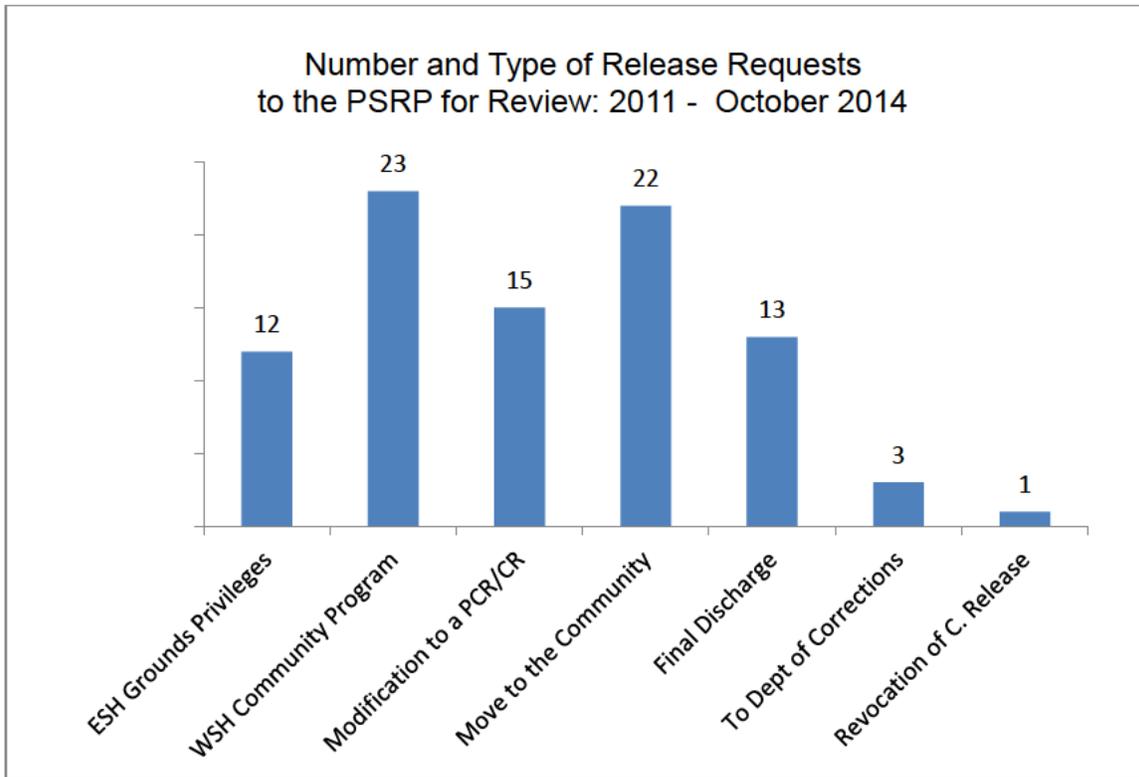
- On average, the PSRP conducted the monthly review meeting just 18 days after receipt of the referral packet from the state hospital, including situations where the hospital submission was untimely under the PSRP bylaws, and
- On average, the PSRP provided DSHS with a letter of response within 6 days after the review meeting.

For 22% of the hospital referrals to the PSRP since 2011, a second PSRP review meeting was necessary to evaluate the matter. In these cases, typically the PSRP members found during the initial review meeting they did not have some needed information related to an aspect of risk to public safety, or the patient's care. A second review was added to the agenda of the next monthly meeting upon receipt of the requested information from the hospital.

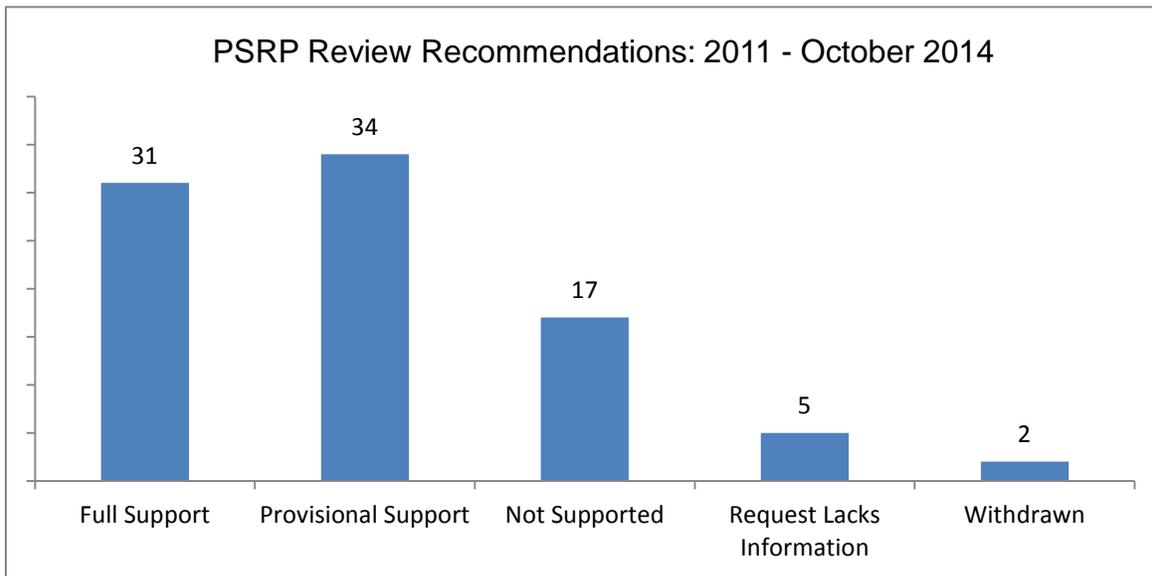
In a few unusual cases, there were several months between referral and the PSRP review letter of response back to DSHS. Factors that added time have included: obtaining an independent formal Risk Assessment (as per statute), and receiving input from, and at the request of, the family of the victim. The PSRP understands that the extended timeframe in these few cases is a source of frustration for the patient and hospital, but values the pertinent information to more fully inform the Panel's assessment of potential risk to public safety. The PSRP has also come to understand that the hospital process provides little opportunity for victim input and this has left the Panel in the position of considering victim concerns.⁴

To date, the largest number of referrals to the PSRP (39%) is for review of proposed conditional releases that involve providing patients with increasing independence within the boundaries of the secured forensic section of the hospital (ESH Partial Conditional Release grounds privileges; and admission to the WSH Community Program Ward) or modification to an existing Conditional Release (17%) such as adding permission for an off-campus outing location (e.g., going into town to receive treatment or for recreation). The PSRP has also assessed risk to public safety and provided advice on the proposed conditional releases of patients to move from ESH or WSH to live in the community (25%); and for the 15% of referrals involving requests for unconditional release (Final Discharge) of the patient.

⁴ The Panel has found that victim input can clarify areas of community risk unknown to the hospitals. For example, a victim can provide additional information on the underlying criminal act that is significant to both community safety and the patient's treatment. It is not uncommon for a patient to harbor delusional beliefs about their criminal acts, which the hospital has no way to challenge and correct absent victim input and knowledge of the crime. In a more direct circumstance, victim input was valuable to the Panel because the hospital was proposing a conditional release to the same area as the victim. Overall, the PSRP feels that community safety and patient care would be greatly enhanced by better considering the concerns of victims.



The PSRP rendered a recommendation of support for the proposed release action in the majority (61%) of initial reviews (either support as initially presented, or contingent on changes to some aspect of the recommendation, generally to the language of the proposed Conditions of Release). In 21 of the 89 referrals, the PSRP initial review necessitated that the hospital provide more information prior to the PSRP rendering a recommendation, often related to a need for clarification of specific aspects of risk or meeting the legal criteria for the proposed release. After that information was provided the PSRP rendered a recommendation. To date, the PSRP has issued a recommendation of Support (full, provisional or partial) in response to 73% of the 89 referral recommendations, and Not Support for 19%.



The DSHS and court response to the PSRP role and advice has varied over the first four years of operation. It is difficult for the PSRP to ascertain for this period of time the full extent that PSRP assessment and recommendations have impacted release decisions. There are numerous examples of cases when the advice was incorporated and also when it was not. The PSRP is also aware of cases where DSHS failed to forward the Panel's recommendations to the court and the parties.

The PSRP is collaborating with DSHS to refine data collection capabilities. The PSRP is committed to work in partnership with DSHS to support timely and successful community reintegration of patients committed NGRI or civilly committed with violent offenses, by facilitating identification and mitigation of relevant potential risks to public safety.

PSRP Impact on NGRI Inpatient Census and Conditional Release

Nonspecific concerns have been raised that the existence of the PSRP has caused an increase in the NGRI inpatient census and unnecessarily slowed the conditional release process. As an initial matter, it should be pointed out that the PSRP cannot have any direct impact on inpatient or conditional release census because it is currently a *purely advisory* body. The PSRP's advisory opinions impact the NGRI census only to the extent that the Panel's opinions offer sound, practical advice to improve public safety and patient treatment. Although it is reasonable to expect that the courts and/or DSHS might find such

advise useful, these bodies remain the sole decision-makers under the current system.

Even so, the PSRP understands that the NGRI inpatient census has increased since 2010. The Panel has endeavored to understand the factors that may have led to this increase. After a three month effort to acquire the underlying statistics that necessary to answer this question, it is apparent that the NGRI system faces substantial challenges tracking and maintaining key data points. The PSRP sought data primarily from DSHS. We received data with unexplained, substantial variability from prior data, or data that was inconsistent with other agency sources. Much of the data that we requested was unavailable or not supplied by the agency. There appears to be no readily available source of data documenting important stages of the NGRI process, especially data of the quality and reliability necessary to definitively determine why the NGRI population has experienced an increase since 2010.

Although the NGRI census has been portrayed as a “four percent increase per year,” figures supplied by DSHS actually demonstrate a fairly static NGRI population with a substantial, unexplained spike in the WSH NGRI population between June 2011 and June 2012:

As of midnight,	WSH NGRI Population	ESH NGRI Population	Total
6/30/2010	140	64	204
6/30/2011	135	65	200
6/30/2012	151	67	218
6/30/2013	148	72	220
6/30/2014	154	71	225

During this single year, the WSH census increased by 16 patients, which is a nearly twelve percent increase from the prior year. A similar increase did not occur at ESH during this timeframe, which is also subject to PSRP jurisdiction. The overall increase between June 2010 and June 2014 was 21 patients so understanding the factors contributing to this one year jump in the WSH population is crucial.

The most straightforward explanation for the 2012 WSH census jump appears to be a significant decline, during this same period, in WSH's referral of patients to the PSRP and the courts for conditional or unconditional release:

	2011	2012	2013	2014 (through October)
WSH Referrals to PSRP	20	4	11	16

The decline in WSH's referral rate from 20 in 2011 to only 4 in 2012 would be expected to greatly increase patient census at the hospital consistent with DSHS's inpatient data. The decreased referral activity from WSH during this period inhibits NGRI conditional and unconditional release cases from proceeding to the PSRP for a recommendation, or to the courts for an ultimate release determination.

Based on data from the courts, another possible factor contributing to the increase in overall NGRI inpatient census appears to an increase in the assertion of the not guilty by reason of insanity defense by criminal defendants in underlying criminal cases. An increased number of defendants entering the hospitals following successful assertion of the NGRI defense would be expected to increase the inpatient hospital census. According to data supplied by the courts, the NGRI defense was asserted in only 13 criminal filings in 2010. It then jumped to 25 filings in 2011 and another 22 filings in 2012.

Another important area where data is lacking is the number of persons found NGRI by the courts who were released directly into the community without an intervening period of inpatient observation or treatment at one of the state hospitals. Current state law does not require any period of observation or treatment in the hospital prior to a determination of not guilty by reason of insanity. Following an NGRI determination, state law allows a possible conditional release directly from the court house to the community. The grant of an immediate conditional release by the court is unusual, but it happens with some regularity. Although DSHS is statutorily responsible under RCW 10.77 for the care and treatment of all NGRI patients, including those who are inpatient or on conditional release status, the agency is not routinely informed of direct-from-the-court-house release cases and does not generally track or monitor these releases.

Overall, the PSRP recommends the development of reliable and readily accessible data bases to track all stages of the NGRI process, including key decision points for inpatient, conditional release, and unconditional discharge processes. Improved data collection and maintenance would greatly assist policy and other decision makers in performing their duties.

PSRP ASSESSMENT and RESPONSE TO LEGISLATIVE QUESTIONS

In the course of reviewing cases, the PSRP has endeavored to inform itself on all issues related to the specific legislative questions in RCW 10.77.270. As a result of the relevant subject matter expertise each Panel member acquired prior to serving on the PSRP and the years of PSRP participation, investigation, and deliberation, the PSRP has formed opinions regarding what is working well and what is in need of change to further mitigate risk to public safety and improve patient care.

To further their knowledge, PSRP members visited the Oregon Psychiatric Security Review Board (PSRB) during summer 2014 to attend hearings and meet with members of the Oregon PSRB. Informational meetings were also held with staff from the Forensic Services Division of the Oregon State Hospital and PSRB staff. This experience enabled the PSRP to better understand how the Oregon system is structured and operates.

Members of the PSRP also actively sought the perspectives of other interested and knowledgeable parties in Washington, through a series of meetings with representatives from Disability Rights Washington, NAMI, the Office of Crime Victim's Advocacy, DSHS, and the Superior Court Judges Association. Additionally, extensive information was obtained from the Executive Director of the Indeterminate Sentence Review Board.

The PSRP has also conducted numerous site visits to Eastern and Western State Hospitals. During these visits the Panel heard presentations from treatment professionals, hospital staff, and hospital administrators.

Question 1 – *Has the Public Safety Review Panel observed a change in statewide consistency of evaluations and decisions concerning changes in the commitment status of persons found not guilty by reason of insanity?*

The PSRP entered into an arena where the hospitals had developed practices and approaches with little sustained oversight from outside bodies. Even though the PSRP is merely an advisory body, its recommendations and observations on the hospitals' NGRI practices were not always greeted warmly. Given the limitation of the Panel's authority to advice and recommendations, our ability to bring out consistent and sustained change in the NGRI process has been mixed, but some positive changes have evolved over the four-year life of the Panel.

Areas of Developing and Sustained Progress

The PSRP can cite four areas of relative success in our collaborative effort with DSHS to improve the quality and consistency of evaluations and recommendations to the courts. Although work continues in these areas, we have seen a relative consistency of positive change in the practices of the hospitals.

Failure to submit recommendations for review. During the first years of the functioning of the PSRP, recommendations to the court for changes in commitment status were not consistently submitted to the PSRP for review. The hospitals cited inapposite legal concerns, as well as prior court orders that empowered the hospitals to make release decisions without consulting the newly authorized PSRP. Often, no explanation was given for the failure to submit recommendations for review. There were occasions of staff testifying in support of a patient-initiated request for change in status, which essentially entailed a hospital-supported recommendation that was neither officially approved by DSHS nor reviewed by the PSRP.

Fewer of these instances have been brought to our awareness over the last two years. We believe this reflects efforts by DSHS and the PSRP Executive Director to increase understanding and acceptance of the PSRP role and the responsibility of the hospital and its staff to submit recommendations to the PSRP prior to a court hearing.

Adequacy of Submission Content and Format. Initially, submissions to the PSRP were not well organized and were often deficient in pertinent case

information required to evaluate the public safety consequences of the recommendation. The deficiency in coherence and completeness of the submission presentation was quickly addressed by the PSRP Executive Director and the hospitals. The Panel set out clear expectations in both written bylaws and a submission checklist. We have since observed substantially improved submissions by the hospitals prior to the scheduled PSRP review.

Risk Assessment Practices. Modern risk assessment of dangerousness for future violence by mentally ill individuals is a formal process that takes into account stable patient characteristics that are known empirically to increase risk, protective factors, and clinical and adjustment factors, which are more changeable. Initially, recent risk assessments for dangerousness were not routinely performed to support the hospital's evaluation and recommendation. Risk assessment was frequently informal in nature, and at times of questionable objectivity because the assessment was performed or heavily influenced by the treating professionals.

Independent, trained assessment staff now systematically assess empirically valid risk factors active in the patient's case to the patient's ability (with prescribed structure and supports) to safely manage and contain risk. A remaining weakness in the risk assessment process is the deficiency of information available to the assessor (or a review body, such as the PSRP) regarding the specifics of environmental, social, and support services involved in a proposed release. Although we have noted sustained improvement in this area, there is room for further progress.

Acceptance of Community Corrections Involvement. Community corrections involvement in the patient's supervision was rarely recommended to the court in the submissions reviewed during the initial years of PSRP case reviews. Hospital staff communicated their belief that DOC involvement in NGRI cases would "criminalize" the treatment process and that CCOs were across the board inadequately trained to understand and address the needs of the mentally ill.

The PSRP has noted an increased acceptance by hospital staff of the unique public safety and community awareness dimension that CCOs can bring in support of a successful transition. The concept of a Forensic Transition Team which includes a CCO as an integral member has been advocated by the PSRP, and more frequently the use of this approach is incorporated by DSHS in the conditions of release recommended to the Court.

Areas of Continuing Challenge

The following deficits and shortcomings in evaluations and decisions have *not* been successfully addressed in a way that has resulted in submissions that consistently contain adequate information, coherent and convincing clinical and forensic reasoning, and/or full administrative and procedural accountability for the proposed recommendations. This lack of consistency has resulted in the need to frequently return submissions to the hospitals with one or more requests for information about the patient's condition, response to treatment, the specific circumstances, resources, and services involved in a proposed release, or all of these elements. By listing an issue here, we do not mean to indicate that the hospitals have been completely unresponsive to PSRP requests and concerns regarding the issue. When an issue has been persistently problematic or inconsistent in how it has been managed, the PSRP has low confidence that structures and practices that would support consistency in the management of the issue have been established and are being monitored.

Documentation of Administrative Review. Submissions to the PSRP have often lacked sufficient documentation of the level of administrative review of the recommendation conducted by the hospitals and DSHS prior to the submission of the recommendation to the PSRP. Under RCW 10.77, DSHS action requires the approval of the DSHS Secretary or the Secretary's designee. The identity of the designee of the Secretary has not always been apparent and has been inconsistent during the Panel's existence.

Documentation of In-Hospital Risk Review. In some cases, it has been clear that the hospital had convened an internal Risk Review Board (RRB), but the membership and process of the RRB was often not clear. It was often unknowable from the submission if the treating psychiatrist participated in the either the RRB or the clinical conference where the proposed recommendation originated.

Adequate Clinical/Forensic Justification. Submissions have varied greatly in regard to whether an adequate clinical justification was offered for the proposed recommendation. That is, submissions do not consistently articulate how the recommended change in commitment status would further the patient's movement toward final discharge, i.e., how the recommendation relates to and supports the patient's treatment plan.

Diagnostic Rigor and Clarity. In more than a few instances, evaluations and draft recommendations have been in contradiction to the diagnosis of record, in that the recommendation contained statements suggesting that the diagnosis of record was not a reliable basis for making clinical and forensic decisions regarding the patient. Not infrequently, “Rule-out” and means of indicating tentative diagnoses made at the time of admission of the patient, or early in treatment, have gone unresolved to a definitive diagnosis even after years of treatment and after the process of transition has commenced. Diagnoses were maintained that were patently not supported by a corresponding, reasonably contemporaneous pattern of documented symptoms manifested by the patient.

Lack of Standard Conditions of Release. As noted in more detail below, proposed conditions for release have been inconsistent across cases without the provision of any clinical justification for the inconsistencies. A time-consuming consensus building process between PSRP members, DSHS and hospital staff resulted in identifying a standard set of conditions to be considered for each recommended release and modified as needed. To date, this set of model conditions has not been adopted or promulgated by the hospitals.

Addressing the Statutory Criteria. Recommendations have rarely cited the statutory requirements for granting of a conditional release or discharge, and therefore often failed to adequately address how the proposed release met the legal criteria. Although NGRI is a legal construct, the hospitals continue to struggle in developing a well-grounded forensic culture and practice.

Question 2 - *Should the Public Safety Review Panel be given the authority to make release decisions and monitor release conditions?*

Over the past four years, the PSRP has operated as a nascent, quasi-judicial administrative board when considering recommendations to the Secretary of DSHS and the Superior Courts. Although the PSRP arrived at its recommendations through an independent, deliberative and objective process, the PSRP has no real authority and its recommendations have been purely advisory. As noted above, the PSRP was able to bring some change to the Washington’s NGRI system, but the changes adopted by WSH and ESH were too often inconsistent and transitory.

As it currently stands, the fate of individual persons civilly committed under Washington’s NGRI statute is controlled by 174 Superior Court judges in

counties throughout the state. Although the PSRP certainly recognizes that Washington's judges have the inherent ability to handle these cases, a decentralized model of decision-making has too often resulted in conflicted approaches that sometimes confuse patients, confound the hospitals and place the public at unnecessary risk. The current disparate decision-making model leads to inconsistent approaches in a population where consistency serves an important purpose for both patient treatment and community safety. Because the NGRI population is relatively small, judges will see few (if any) of these cases during the course of their judicial careers. The area is also highly specialized, raising complicated questions of mental diagnosis, danger related to the diagnosis, available community resources, and complicated legal doctrines. When it comes to monitoring the process of a conditional release, the courts do not have the resources to closely monitor regular reports and rapidly respond to changed circumstances in the conditional release.

From our meetings with the various stakeholder groups, including the Superior Court Judge's Association, we have concluded that it is unlikely that consistent and productive change will come to Washington's NGRI commitment process in the absence of a centralized decision-making by a specialized administrative board. A centralized decision-making body would:

- Bring a high level of consistency and predictability to NGRI release and community monitoring decisions.
- Be able to use its specialized knowledge of supervision, community resources, and best treatment practices to improve public safety by maximizing the chances of a patient's successful reintegration into the community.
- Encourage a higher level of consistency and uniformity between the hospitals by providing clear and uniform expectations on how release decisions should proceed for both public safety and the best interests of patients.
- Be able to quickly adjust release conditions, or revoke a patient when necessary for community safety or the safety of the patient.
- Continue to encourage the adoption of best practices by the hospitals related to treatment, supervision, and transition of patients.

We base this conclusion in large part on our investigations of the Oregon PSRB, which is a quasi-judicial administrative board charged with conditional and unconditional release decisions for Oregon insanity acquitees. The centralizing influence of the Oregon PSRB has improved both community safety and the well-being of patients. It has brought stability and consistency to Oregon's NGRI civil commitment process. Oregon has followed this approach for over two decades with tremendous success, which essentially places a parole board with diverse experience and specialized knowledge in a position to adjudicate NGRI conditional and unconditional release decisions.

The PSRP is strongly in favor of adopting the Oregon PSRB model for Washington's NGRI population. We believe that this approach would enhance both community safety and patient care by centralizing decision-making authority and bringing a high degree of consistency to those decisions. We recommend that the current Public Safety Review Panel be replaced with a "Public Safety and Psychiatric Review Board" (PSPRB) that operates similar to the Oregon PSRB. A proposed draft bill is attached as "Appendix C" that would bring about this change.

The Oregon PSRB Model

The State of Oregon created its Psychiatric Security Review Board in the late 1970's. The PSRB is responsible for overseeing persons found guilty except for insanity by the Oregon courts in connection with a criminal charge.⁵ Such insanity acquitees are subject to commitment and the PSRB's jurisdiction so long as they continue to suffer from a mental condition that makes them a danger to others.

The Oregon PSRB is comprised of a five member board. Prior to the advent of the PSRB, decisions about Oregon's insanity acquitees were made by approximately 85 separate judges spread throughout Oregon. The PSRB determines, based on an evidentiary hearing, whether an insanity acquittee should be released subject to conditions. If it determines that conditional release is appropriate, the PSRB establishes release conditions and ensures provisions for adequate monitoring of the release. Reports from community housing and treatment providers come back to the PSRB, which keeps itself well-apprised of

⁵ The Oregon population of insanity acquitees is substantially larger than Washington's population. This is due to the broader definition of insanity contained in Oregon statutory law. See ORS §161.25. The larger population of insanity acquitees is not related to adoption of the Board approach.

the patient's progress or any problems with the community release. The PSRB is able to meet rapidly to adjust release conditions, or to revoke an insanity acquitees' conditional release when necessary for community safety.

The PSRB also has a statutory responsibility to regularly review the progress of insanity acquitees. The Oregon statutes require the PSRB to review a person's case within six months of entering the hospital, and at least every two years during the course of the commitment. In accord with the demands of the federal constitution, the PSRB is required to discharge any insanity acquitee who no longer suffers from a mental condition that makes the person a danger to others. Where it is believed that a person no longer meets the underlying statutory and constitutional criteria for civil commitment, the PSRB holds an evidentiary hearing to consider the issue. The PSRB is also responsible for discharging patients who have reached the maximum statutory time for commitment and account for the possibility of a commitment under Oregon's civil patient commitment statute.

The Washington PSRP was allowed to monitor several Oregon PSRB hearings, interact with the Oregon PSRB, and meet with the PSRB's Executive Director. The Oregon board conducts hearings about twice per month sitting in Panels of three members. The closest analogy in Washington to the Oregon PSRB would be our Indeterminate Sentence Review Board.

The Oregon PSRB has a hearing room at the Oregon State Hospital in Salem. The hearing room has the appearance and formality of a courtroom. It is open to the public. Patients are brought into the courtroom in appropriate court attire that they either owned or that the hospital loaned them. In accord with due process, patients are represented by counsel, which Oregon provides if they are indigent. The State of Oregon continues to be represented by County Prosecutors, but through the presence of an Oregon Assistant Attorney General that the prosecutors have pooled resources to retain. Also present in the hearing room is a victim advocate.

The PSRB accepted testimony from hospital staff and others in the usual manner. However, it appeared that proceedings were shorter than what we typically experience in Washington because the PSRB was well-acquainted with the patient, operation of the hospital treatment program, and available community release resources. The Oregon PSRB was also equipped to accept testimony by phone or video link. In one situation, where a person was subject to the joint

jurisdiction of the PSRB and the Oregon Department of Corrections, the person appeared before the board via the video link.

After taking evidence, the Oregon PSRB retired to an adjacent conference room to consider the matter. A decision was then announced in the patient's presence. Due to the Oregon PSRB's familiarity with the process, they were able to communicate their decisions in a manner that informed both the patient and the hospital of the steps necessary to progress through the treatment program or through the conditional release process. It was our impression that both patients and the hospital were respectful and appreciative of the board's direction.

We were also able to meet with hospital staff. Although we were told that there had been some friction between the board and the hospital in years past, we were assured that hospital staff currently viewed the board in a highly positive light. The hospital welcomed the advice and knowledge of the board. It relieved the hospital from serving the disfavored dual role of treatment provider and forensic decision-maker. Overall, the hospital and its staff appeared to appreciate the role of the PSRB in the process.

Creation of a Washington PSPRB

The PSRP believes that adoption of the Oregon model would provide a vehicle for increasing the consistency of practice between the hospitals, improving community safety, standardizing patient expectations, addressing criminogenic issues and improving patient care. A board model would also operate at lower costs and free up additional bed space over time.

Eliminate the Costs and Risk of Off Site Hearings

The transfer of jurisdiction over NGRI civil commitments from the Superior Court to a Washington Public Safety and Psychiatric Review Board would result in fiscal savings. DSHS incurs substantial costs for Superior Court hearings throughout the state. The NGRI patient must be transported from the state hospital to the local court for hearings. DSHS is responsible for both transportation costs and security on these trips. Security generally requires at least two uniformed hospital security officers with associated overtime costs. In addition, hospital staff is called to testify in these matters and must travel to the local Superior Court. These are generally professional level hospital staff who are spending time waiting to testify rather than treating patients on the ward. In addition to the direct costs related to these staff members, it is also often

necessary to backfill staffing on the ward. When the location of the Superior Court is distant, or the proceeding takes multiple days, it will usually be necessary for the patient and security staff to spend the night, which further increases costs.

The local counties also incur costs related to the transportation of the patient to the local Superior Court. The Superior Court and court staff incur costs for holding the hearing. The county jail incurs costs for housing the patient, who requires secure placement during the hearing. County stays are often disruptive to patient care, requiring interruptions in medications and more severe security measures. The Panel is aware of hearings in two separate counties where patients being recommended for conditional release into the community appeared before the local courts in shackles and leg irons; this practice is not uncommon. When a local court proceeding lasts longer than seven calendar days, the patient is required to be returned to the hospital before the judicial proceeding may conclude.

A PSPRB, by holding hearings at the hospital site, eliminates most of these costs and minimizes others. For example, all costs related to transportation and housing of the patient are eliminated. Although staff would still need to testify in these matters, such testimony would re-direct the staff for far less time. Although a PSPRB would require staff support to assist the board and prepare case reviews, we recommend that board members be compensated only on a per diem basis. The costs of maintaining and operating the Board should be kept at a modest level.⁶

Importantly, a PSPRB would conduct its hearings inside the secure perimeter of the state hospital. The transport of insanity acquittees to local counties and Superior Courts entails public risk. Anytime a patient is taken outside the secure perimeter of the hospital, the risk of escape increases. By eliminating the need to transport an NGRI patient outside the hospital perimeter and holding hearings on hospital grounds, the risk to public safety from an

⁶ The Oregon PSRB has more staff than would be required for a Washington adjudicative board. First, the Oregon insanity acquittee population is far larger due to Oregon's broad definition of insanity. Second, Oregon has assigned conditional release supervision tasks to the staff of the PSRB that exceeds the scope of the Panel's recommendations. The PSRP believes that a Washington PSPRB would be operational with an Executive Director, an administrative assistant, and two staff to work up detailed case reviews for the board. Similar to the ISRB, a PSPRB could operate cost effectively as an independent body within the DSHS structure.

escape is greatly diminished. An onsite hearing also maintains the civil liberties of the patient and the therapeutic environment. When a hearing is held within the secure perimeter of the hospital, there is no need for high security apparatus like shackles and leg irons.

Regular Review By the PSPRB Would Likely Free Bed Space

A key feature of the Oregon PSRB model is the requirement to review patient progress on a regular basis. As a general rule, due to the structure of RCW 10.77, the current Washington approach does not include regular court review of patient progress.⁷ The absence of a mechanism for regular judicial or quasi-judicial review of a patient's progress in treatment and the patient's risk to the community is one of the primary factors in Washington's unusually long in-patient hospital stays for NGRI patients.

The Panel has reviewed at least three cases where patients were retained in the hospital despite professional opinion from the hospital finding that the patient no longer satisfied statutory and constitutional criteria for NGRI commitment. In these cases, the PSRP informed the hospital of its duty to either recommend release of the patient, or explain its disagreement with its own professional opinion and provide a counter opinion. *E.g., Foucha v. Louisiana*, 504 U.S. 71, 112 S. Ct. 1780, 118 L. Ed. 2d 437 (1992). Instead, in each of these cases, the hospital continued to take actions inconsistent with the need to first determine if the patient was properly under the statutory and constitutional jurisdiction of the NGRI system.

The PSRP only saw patients who were brought before the Panel due to a request for conditional or unconditional release. Many of the patients who have been in the hospital for very long periods did not come before the Panel during our four years of operation. It is therefore unknown how many NGRI patients may be appropriate – consistent with public safety -- to transition from a hospital bed to conditional release in the community.

An important feature of the Oregon PSRB is to hold the hospital accountable for its diagnostic decisions and treatment plans. In the hearings that we observed, the Oregon Board would regularly inquire regarding refinements of

⁷ By statute, the hospitals submit periodic updates to the court by letter, but there is no statutory requirement for the courts to hold periodic review hearings for the inpatient population.

a patient's diagnosis and adjustments to a treatment plan. The board's inquiries encouraged a dynamic conversation centered on patient care and community safety that does not typically exist in Washington. Although some Washington judge's regularly make this type of inquiry, the Superior Courts around the state simply do not have the resources or see enough cases on a regular basis to provide an adequate check and balance to hospital decisions.

Regular review of patients by a PSPRB with decision-making authority would likely free additional bed space by helping to identify patients who are eligible for conditional release or who no longer meet the statutory criteria for commitment under the NGRI statute. At the very least, such review would clarify the road map for a patient to transition from in-patient care to conditional release consistent with community safety. Such an approach would enhance public safety and patient care by identifying patients who are adequately treated in a community setting rather than an expensive hospital bed. Scarce hospital resources could then be focused on patients who require more intensive treatment. Overall, a quasi-judicial administrative board with specialized knowledge could help develop a forensic culture of patient recovery, which is the ultimate way to enhance public safety.

Question 3 – Are further changes in the law necessary to enhance public safety when incompetency prevents operation of the criminal justice system and long-term commitment of the criminally insane?

Through ESSHB 1114, the Legislature in 2013 established enhanced civil commitments for persons who are found incompetent to stand trial for a violent offense and cannot be restored to competence within statutory time limits. Due to incompetence, these individuals cannot be tried criminally for their underlying acts, and cannot enter a plea of not guilty by reason of insanity. The bill states that this enhanced commitment law is necessary in order to “serve Washington’s compelling interest in public safety and to provide the proper care” of “a small number of individuals who commit repeated violent acts against others while suffering from the effects of a mental illness and/or developmental disability that both contributes to their criminal behaviors and renders them legally incompetent to be held accountable for those behaviors.” ESSHB 1114, §1. Rather than establishing a wholly separate commitment chapter applicable for enhanced “competency flip” cases, the Legislature created special 180 day commitments under the existing Involuntary Treatment Act, RCW 71.05. The enhanced commitments continue for an additional 180 days so long as the hospital

presents prima facial evidence of a continuing basis for the commitment. See RCW 71.05.320(c).

The PSRP is just beginning to see these “competency flip” commitment cases and has reviewed only five total cases. Under ESSHB 1114, the PSRP is required to provide advice to the Secretary and the courts regarding decisions “not to seek further commitment terms under RCW 71.05.320.” Appropriately, DSHS has interpreted this provision broadly and placed all recommendations before the Panel for conditional or unconditional release of this population.

Having reviewed only five of these cases, the PSRP is not yet in a position to fully answer the above question. We can, however, make a number of general observations.

First, the statute passed in ESSHB 1114 merits further study and revision. The nature of the commitment established by the statute is unclear. Although the Legislature appears to envision an indefinite commitment sustained by periodic hospital and court review in accord with the approach approved by the Washington Supreme Court in *In re McCuiston*, 174 Wn.2d 369, 78 A.L.R.6th 747, 275 P.3d 1092 (2012), *cert. denied*, 133 S.Ct. 1460 (U.S. 2013), ESSHB 1114 is silent on some of the key components that were present in the RCW 71.09 review statute approved by the Washington Supreme Court in *McCuiston*.

Second, the standards governing when an enhanced competency flip commitment should continue for an additional 180 day term are not clear in the statute. The PSRP has had a difficult time advising the courts and the Secretary due to this disclarity. Operation and administration of the statute would be enhanced if these standards are further defined, including the standards applicable for conditional release of this population.

Third, by including the enhanced competency flip commitments in RCW 71.05, the general provisions of RCW 71.05 apply without regard to the increased needs of the enhanced competency flip population. As noted above, the Panel believes that the competency flip population presents a danger to the community that is equal to, or greater than, the NGRI population. Both populations commit roughly the same type of violent crimes,⁸ but the competency flip population presents a higher dynamic risk due to the mental conditions that

⁸ It is noted that a person can plea NGRI on a non-violent crime, or a misdemeanor, which is not an option for the competency flip commitment population.

underlie the active competence problem. One problem noted by the Panel is that the hospitals sometimes treat the enhanced competency flip population as presenting the same set of problems and circumstances as the regular RCW 71.05 commitment population.

Finally, the statute identifies and creates an enhanced commitment scheme for violent competency flips, but then fails to provide adequate tools for conditional release. For example, the NGRI statute allows DOC to assist with monitoring a patient on conditional release to the community, but similar provisions are not apparent in RCW 71.05 for the enhanced competency flip population. The result is either a reduced opportunity for conditional release, which raises constitutional concerns, or conditional release without adequate supervision, which raises substantial community safety concerns. The statute should be amended to allow the same community supervision resources for enhanced competency flip conditional releases as are available for the NGRI population. In particular, the Panel strongly recommends that DOC community supervision be made available for conditional release of the enhanced competency flip population.

Overall, the PSRP recommends that the Legislature closely review and amend the enhanced competency flip statute in order to address the problems outlined above. A workgroup process may be the best way to improve administration and operation of this statute.

Question 4 - Any other issues the Public Safety Review Panel deems relevant?

The PSRP has observed a number of reoccurring issues during our review of conditional and unconditional release cases. Our concerns relate to inpatient and conditional release issues.

Better Inpatient Tools

Develop Forensic Practice Standards

One aspect of the Oregon system that impressed the Panel was a training and certification process for mental health professionals engaged in the field of forensic practice. In our understanding, Oregon requires forensic certifications for professionals who opine on issues related to the commitment of insanity

acquittees. There is also a certification process for persons who treat conditionally released insanity acquittees in the community. These certification processes make sure that mental health professionals are well-aware of the appropriate statutory standards for commitment as an NGRI, conditional release, and unconditional release.

We found that the ability of the state hospitals to pose and answer forensic questions under RCW 10.77 was too often absent. Unlike many states, Washington combines its NGRI forensic patients with civil patients in with a much larger civil hospital. In our observations, it was difficult for the hospital leadership to simultaneously administer both the forensic and civil missions of the hospital.⁹ Although this sometimes improved over the course of the Panel's existence, the hospitals were often lacking a forensic culture and the rigorous thinking that necessarily accompanies such a culture. We too often received reports recommending conditional or unconditional release that either grossly misstated the statutory release criteria or omitted it altogether.

In accord with the recommendations made in the Groundswell Report,¹⁰ we agree that a centralized Office of Forensic Mental Health Services should be established. Statewide procedures for forensic evaluations should be established based on evidence-based best practices. A certification process for forensic evaluators should be developed and made a requirement for employment in this capacity.

Treatment for the NGRI Patient

We concur with the 2009 recommendation of the Veith Report that treatment of all NGRI patients should be consolidated at WSH. Very few states maintain two forensic hospitals for the NGRI population. This option provides the benefits of consolidation of expertise and a more cost efficient model for services. Importantly, it also provides all Washington NGRI patients with the same opportunities for treatment and community transition programs. At this point, WSH patients have the opportunity to enter the community program and ESH patients have no access to a similar program.

⁹ It is unclear to the PSRP why the Center for Forensic Services is grouped together with the larger civil hospital. Another hospital on the WSH grounds, the Center for Child Studies, operates as a separate institution. Moreover, DSHS operates the Special Commitment Center, which houses civilly committed sexually violent predators, as a separate forensic institution.

¹⁰ Gowensmith *et al.*, Forensic Mental Health Consultant Review Final Report (June 30, 2014).

If the hospitals remain separate, then we recommend that equal patient services be available at both WSH and ESH. Despite commitments from DSHS leadership to standardize policy and programming at both institutions, insufficient progress has been made in this area over the past four years. The two hospitals seem unable to move past their historical practices toward a unified approach for all Washington NGRI patients. If the hospitals remain separate for NGRI patients, all evaluations and conditions should be standardized. A Community Program should be developed at ESH modeled on the current program at WSH.

In addition, a treatment mall specifically addressing the needs of the NGRI population should be developed. Specifically, Substance abuse/dependency and Personality Disorders – specifically Antisocial and Borderline Personality Disorders – are issues for many NGRI patients and should be targeted in the treatment mall. The PSRP is concerned that progress on treating a mental condition quickly dissipates and the public is placed at risk if a patient's underlying substance abuse and personality disorder problems are not fully addressed during in-patient treatment.

We were told on several occasions that the hospitals do not believe they have an obligation to treat co-occurring substance abuse and Axis II disorders. Such an approach is contrary to applicable standards of care and places the public at great risk. A patient's mental condition is a combination of all applicable disorders. For example, progress in treating Schizophrenia is of little utility if insufficient treatment is offered for the co-occurring substance abuse disorder and/or personality disorder that interferes with stable behavior and the necessary intake of therapeutic drugs. Addressing treatment to only part of a patient's mental condition is akin to fixing a car's engine while simultaneously ignoring well-documented problems with the brakes. Both public safety and the well-being of the patient suffer when important patient needs are left untreated and unresolved *prior to* conditional or unconditional release.

Better Outpatient Tools

Persons committed under the NGRI statute remain inpatient for longer than is necessary when the hospitals fail to devote sufficient resources to release planning, implementation, and the development of adequate community resources for safe conditional releases. An average inpatient bed at one of the

state hospitals costs taxpayers at least \$504 per day.¹¹ The greater goal is to treat, and safely return patients to the community. Increased attention to release planning can speed the transition of patients and free up bed space without increasing public risk.

Improve Conditional Release Planning

Despite the substantial resources that it takes to maintain a person on inpatient status, the Panel found that the hospitals were largely unwilling or unable to undertake the type of rigorous and detailed release planning that is necessary for successful placement of an NGRI patient in the community. In the Panel's view, public safety is maintained and the NGRI patient's care advanced when the patient is placed in a well-defined and coordinated outpatient conditional release plan. The hospitals, despite repeated requests from the Panel, generally failed to submit release plans specifying enforceable standard conditions, naming actual treatment providers, treatment plans, and specified housing addresses. It is difficult to support a release plan when the Panel is unaware if the patient will be treated by an inexperienced therapist, or living in the same environment that led to the commitment. Such uncertainty in release planning and resources place both community safety and the patient at risk.

Most often, the Panel found that the hospital would recommend that a patient be placed on "conditional release" without identifying the specifics of the release plan. The exact composition of the hospital's release plan would be nebulous, specifying only that the patient would be treated by an unidentified provider and would live at an unknown location that would presumably be specified upon release. Although the hospitals purported to impose "standard conditions" for proposed conditional releases, the Panel found substantial variability in the proposed hospital conditions and different wording from case-to-case. Without actual standard conditions, the hospital's inconsistent approach resulted in significant omissions of necessary conditions, or poor wording that rendered conditions unenforceable. For example, the hospital might add a "no illegal drugs" provision, but neglect to add a "no alcohol" provision for a patient with known substance abuse issues.

It does not appear from the majority of requests for conditional release that the NGRI patient has had the opportunity to meet with his or her new treatment provider prior to conditional release and there is generally no

¹¹ The PSRP has asked this question to DSHS officials several times in 2014. Answers have ranged from \$504 per day to \$687 per day.

coordination with an identified community treatment provider in assembling the release plan. The NGRI patient often will be unaware of where he or she will obtain food, clothing and medications, nor will the patient know who will be treating him or her in the community. The patient will have no opportunity to build any relationship with those who will help with the patient's success in the community. Unfortunately, these unknowns implicate the likely success of the patient in the community. A patient who has been in a supportive hospital environment for years cannot be expected to transition successfully absent substantial direction and assistance throughout the conditional release process.

Successful re-entry into the community requires firm planning and addressing of needs before release, including:

- Affordable appropriate housing;
- Household furnishings, including kitchen items, cleaning supplies, sheets, blankets, towels, etc.;
- Provisions for basic daily living, including food stamps (if necessary), clothing, grooming supplies, etc.;
- Employment (if they are employable);
- Transportation;
- Ongoing case management to assist with things like social security applications, DSHS services, medical applications, and other concerns of daily living;
- DOC supervision (someone to call to help bring them "back on track" if they fall down); and
- Continuing mental health treatment in the community by a qualified and experienced provider familiar with the persons' case who can also monitor the NGRI patient for concerning behaviors;

Without these services in place, a conditional release is not sustainable and the public is placed at unnecessary risk.

In accord with the applicable standard of care, the PSRP believes that the current level of release planning and implementation offered by the hospitals unnecessarily increases community risk and hampers a patient's successful re-integration into the community. It is unreasonable to expect that a person with a serious mental condition that has resulted in prior, serious criminal acts can safely and successfully transition to the community when the DSHS release plan fails to specify a treatment provider or housing. Such individuals need substantial assistance transitioning into the community due to long institutional stays, the effects of mental illness, and other challenges. Rather than leave the choice of a treatment provider unspecified in the release plan, the hospitals should be designating a highly qualified community treatment professional, allowing the patient to work with that professional *prior to* the transition, and making sure that the professional acts as cooperative member of the overall transition. Housing also needs to be specific and appropriate for the needs of the patient. It raises substantial community safety concerns when, due to a lack of planning, housing is not identified and cannot be fully vetted prior to the release.

DSHS has informed the Panel that it is not possible to specify or investigate a housing location prior the approval of conditional release because it lacks funds to hold the placement pending review and approval. Such a deposit was believed to be in the \$400-600 per month range. The PSRP recommends that DSHS budget for such modest amounts, particularly when delays in transitioning from inpatient to outpatient status cost the agency at least \$504 per day.

DSHS has also claimed that community treatment providers cannot be identified and incorporated into release planning and approval considerations because the provision of community treatment providers is the responsibility of the Regional Support Networks (RSNs). Upon further inquiry, the Panel learned that the hospitals seldom approached the RSNs to pre-arrange for the provision of experienced treatment providers for this population. An interview with the head of one RSN revealed that the hospitals did little to differentiate NGRI conditional releases from more standard Involuntary Treatment Act (ITA) conditional releases. The result was to leave the RSN largely unaware that a person committed as criminally insane was among the group of patients regularly transferred from the hospital to the RSN's authority. The RSN head indicated that more release planning for this special and dangerous population would be welcomed by the RSNs.

The periodic unwillingness of the hospitals to accept full and continuing responsibility for patients on conditional release status was a substantial problem noted by the PSRP. Although the WSH community program represents an excellent supported release model, many patients transition to the community outside this model. Such is the case for all persons conditionally released from ESH. Even for WSH, the hospital would sometimes recommend that patients transition to the community without first completing the community program; the reasons for recommending that a patient skip this transition step were not always apparent. Other patients are committed as NGRI by the courts, but allowed to directly enter the community without a hospital stay.

In order to protect public safety and ensure sound community treatment practices, the PSRP believes that DSHS and its hospitals should fully embrace their responsibility for all conditionally released NGRI patients. All persons committed under the NGRI statute – whether on inpatient or outpatient status – are subject to the statutory jurisdiction of DSHS. See RCW 10.77.120 (requiring the Secretary of DSHS “to provide adequate care and individualized treatment to persons found criminally insane”); RCW 10.77.010 (defining “commitment “to include both inpatient and outpatient placements). For all persons committed under RCW 10.77, “[t]he department shall be responsible for all costs relating to the evaluation and treatment of persons committed to it pursuant to any provisions of this chapter, *and the logistical and supportive services pertaining thereto.*” RCW 10.77.250 (emphasis added). It is inconsistent with these statutes – and the constitutional requirements that underlie an NGRI commitment – for DSHS to shift the burden of sound release planning to the RSN or other outside agencies. Public safety will be enhanced if responsibility for this population becomes less diffuse and more centered on DSHS -- the agency with actual statutory and constitutional responsibility for NGRI patients.

When the PSRP has recommended against conditional release, it was most often due to the submission of an inadequate release plan by the hospital that failed to specify a treatment provider, housing, or adjunct supervision by a DOC mental health specialist.¹² The hospitals have appeared to hold that view that release plans are entirely fungible, meaning that *any* treatment provider or housing would suffice regardless of the NGRI patient’s needs or level of danger. The PSRP believes that a release plan should be specifically tailored to the

¹² To its credit, the Department of Corrections appears entirely willing to supervise the NGRI population and to assist with sound transition planning. The availability of DOC supervision for the NGRI population is specified in RCW 10.77.

dangers presented by the patient and the needs of that patient. People are committed under the NGRI statute because they present a substantial risk to others due to the effects of a mental condition. The very nature of this population requires experienced treatment providers, supportive housing, and concise release conditions. When a conditional release plan meets these requirements, it is possible to conditionally release more individuals from inpatient care consistent with public safety, while better utilizing scarce inpatient beds.

Identification of Transitional Housing

A significant challenge to the conditional release of Washington's NGRI population is the lack of supported housing options. In contrast to Washington, the Oregon NGRI system has a wide range of supported and unsupported community housing options for NGRI patients, which has resulted in a higher percentage of NGRI patients on conditional release than what we have in Washington. The Oregon community housing includes locations that are operated by the state and others that are available by contract with the state. Some are secure transitional release facilities with 24 hour staff, while others have no staff in residence but offer other supported living services. Oregon uses this system to gradually transition NGRI patients from inpatient care to the least restrictive community setting that is consistent with public safety. It is worth noting that Oregon developed this outpatient approach, constructed two new hospitals, and increased staffing in response to investigations by the United States Department of Justice.

For the Washington NGRI population, a significant increase in the number of clinically staffed residential programs is the biggest need and the biggest impediment to reducing the inpatient population. While expensive to address, in the longer term, providing this resource is cost effective and will produce a better product at a better price. The Panel believes that sound community housing options will greatly enhance public safety and the treatment of NGRI patients.

Model Conditional Release Standards

Under a charter from a DSHS assistant secretary, Panel members met with a variety of stakeholders in 2013-14 to establish "Standard Conditions of Release." The purpose of this charter and the resulting meetings was to resolve PSRP concerns over the lack of standard conditions. The stakeholders included representatives from DSHS, WSH, DOC, ESH, and Disability Rights Washington. In accord with the charter, the workgroup was able to reach agreement on a

standard set of conditions for patients transitioning from WSH to the Community Program,¹³ and a standard set of conditions for patients transitioning from the Community Program to placement in the community.¹⁴ The Standard Conditions were finalized among the stakeholders in early 2014 after an extended series of meetings and forwarded to DSHS for implementation.

After reaching agreement on the Standard Release Conditions with the PSRP and the other stakeholders, DSHS failed to implement these conditions. The Panel has been informed that DSHS does not believe that it should have any specified responsibilities in the conditional release court order despite its statutory responsibility for NGRI patients on conditional release status. The agency has promised proposed revisions to the standard conditions, but has not yet delivered any revisions. In the meantime, the hospitals continue to issue varying versions of nonstandard conditions.

In accord with the actions of the stakeholder group and the prior agreement of DSHS, the PSRP has adopted the Standard Release Conditions for all proposed conditional releases because they improve community safety and the attendant success of the NGRI patient on conditional release. The Panel is well aware that for success of the patient and thus, community safety, conditions of release must be tailored for each patient. The Panel is also aware that standard conditions of release insure continuity of care for the patient as the patient transitions to the next stage in commitment. The proposed standard conditions of release addressed in sufficient detail key areas for release and for success of the patient.

The Standard Release Conditions reflect the multi-disciplinary “transition team” approach to community supervision that has successfully reduced recidivism in similar conditional release settings. The Panel believes in the need to consistently implement a transition team approach to the planning, implementation and monitoring of conditional releases. The Panel believes that the use of community custody officers from the Special Needs Unit of DOC or the use of community corrections officers that have training in supervising mentally ill offenders should be utilized in cases in which the NGRI patient will be living in the community. Utilizing meetings with the DOC officer in the community promotes a graduated and safe transfer from the confines and structure of the

¹³ These are attached as Appendix D.

¹⁴ These are attached as Appendix E.

hospital to a conditional release. It also avoids the ethical conflicts that result when the treating entity is also primarily responsible for community supervision.

The State of Oregon uses the Short Term Assessment Risk Treatment (START). The START is a process/form that is the foundation for treatment, risk review, therapy and monitoring after release. That process has led to an increase in the success of those released to the community and with the patient understanding of how to be most successful in the transition from hospital to community.

NGRI patients need an increased emphasis on continuity of care and treatment. Such an emphasis will promote community safety and the long-term success of the patient, while better utilizing expensive, inpatient bed space. It will likely take several years to plan, implement and perfect these approaches. The PSRP recommends that such work commence immediately in order to avoid potential federal involvement in our NGRI conditional release system.

Furlough and Authorized Leaves

The PSRP was created in response to an authorized leave incident from ESH where a patient escaped. Under RCW 10.77.270, the hospitals were required to obtain the advice of the PSRP on furlough and authorized leave questions: “The Panel shall provide advice regarding all recommendations to the secretary, decisions by the secretary, or actions pending in court . . . (b) to allow furloughs or temporary leaves accompanied by staff . . . (d) to permit movement about the grounds of the treatment facility, with or without the accompaniment of staff.”

The PSRP would like to be in a position to report to the Legislature on furloughs and authorized leaves, but DSHS has declined to submit any such cases for the Panel’s recommendation. Neither hospital has submitted any furlough or authorized leave requests to the Panel. Nevertheless, in the course of reviewing other recommendations, the Panel was able to determine – after the fact – that the hospitals have continued to allow furloughs and authorized leaves for NGRI patients without submitting the matters for PSRP consideration.

The agency’s actions in failing to comply with RCW 10.77.270 go beyond mere oversight. For at least two years, the Panel has repeatedly raised its concerns over the agency’s failure to submit furlough and authorized leave cases

to the Panel with hospital and DSHS officials. Compliance with the statute was not forthcoming. As a result, the PSRP is unable to inform the Legislature on furlough and authorized leave questions, even though such questions were an impetus for the creation of the Panel.

In the course of reviewing other recommendations, however, we do have some anecdotal concerns with the hospitals' administration of furloughs and authorized leaves. In one case, WSH granted unescorted weekend trips to a patient in the community program. The trips took him to visit relatives 2-3 hours distant from the hospital without substantial controls on the patient's route or visit. The patient was allowed to purchase a car, but obtained his driver's license using a false address. If the PSRP had been presented with this case, we would have urged better oversight of the patient's activities. Apart from using a false address to obtain a license, the patient was visiting family the same area where he had already murdered one relative and assaulted another relative. The Panel was particularly concerned – due to the false address – that a law enforcement officer contacting the NGRI patient for a traffic infraction or other reason would have no idea that he was dealing with a person deemed criminally insane.

In another case, the PSRP learned that a patient had been allowed by the hospital to take multi-day, overnight visits to a proposed community residence *before* being approved for conditional release to this location. The residence was in a high crime and drug use area. Although no issues came to light as a result of the furlough/authorized leave, it is unclear why the hospital took it upon itself to allow the patient this degree of community access without a court order, or why the hospital did not first present this proposal to the PSRP.

SUMMARY

The members of the PSRP thank the Governor and the Legislature for their engagement in this important process of evaluation and reform. Although small in number, the persons committed under the NGRI statute raise substantial public safety and treatment concerns. We look forward to continuing to improve operation of this system in conjunction with DSHS leadership, the hospitals, and other stakeholders.

ATTACHMENTS

Appendix A: Public Safety Review Panel Bylaws

Appendix B: PSRP Submission Packet Checklist

Appendix C: Proposed Draft Legislation To Establish A Washington Public Safety And Psychiatric Review Board (PSPRB)

Appendix D: Standard Release Conditions – WSH Community Program

Appendix E: Standard Release Conditions – From WSH Community Program to Placement in the Community

PUBLIC SAFETY REVIEW PANEL BYLAWS

1.0 Purpose

1.1 The purpose of these guidelines is to communicate the processes and procedures to be followed at meetings of the Public Safety Review Panel (PSRP). They are intended to provide consistency, predictability, fairness and efficiency to the meeting process.

1.2 If certain case types are not addressed within these guidelines, the PSRP will determine the processes and procedures to be followed on a case by case basis by a majority vote.

2.0 Definitions

Change in Commitment Status: The transfer of a person through court, or internal hospital processes from a secure residential placement to a less secure residential placement, including conditional or unconditional release into the community.

Community Program: A DSHS operated-conditional release facility located on the grounds of the Western State Hospital (WSH) campus.

Conditional Release: Court-ordered release, or partial release, from a secure residential setting on hospital grounds subject to a specified set of conditions that allow the NGRI patient to be released conditionally to a specific residential placement without substantial danger to other persons, or substantial likelihood of committing criminal acts jeopardizing public safety or security.

Executive Director: The PSRP Executive Director employed by the Secretary of the Department of Social and Health Services (DSHS) to assist the Panel with its statutory duties.

Hospital: Eastern State Hospital (ESH) or Western State Hospital (WSH).

Member: A member of PSRP.

Patient: A patient who has been found Not Guilty by Reason of Insanity (NGRI) who is currently under the civil commitment jurisdiction of a Washington Superior Court or persons committed under the involuntary treatment act where the court has made a special finding under RCW 7.05.280 (3) (b).

Panel or PSRP: The Public Safety Review Panel established by RCW 10.77.270.

Risk Assessment: A comprehensive evaluation signed by a licensed mental health professional with appropriate training that addresses the NGRI Patient's danger to other persons and likelihood of committing criminal acts following the proposed change in commitment status, that: (1) utilizes accepted actuarial and clinical risk considerations, including static and dynamic risk factors, (2) identifies qualitative risk considerations under the relevant statutory risk criteria, and (3) evaluates risk in the context of the specific release conditions and residential placement location that would control the NGRI Patient's actions if the proposed change in commitment status is made effective. A risk assessment shall address the NGRI Patient's criminal history, treatment history, current progress in treatment, current DSM diagnoses, current medications, and treatment plan following the proposed change in commitment status.

RPP: Relapse Prevention Plan details static and dynamic risk factors particular to the NGRI Patient and contains a written plan of interventions for the purpose of reducing the risk of offending.

Secretary: The Secretary of DSHS.

Secretary's Designee: The person in DSHS who has been authorized by the Secretary of DSHS to act on his or her behalf to recommend changes in commitment status and other matters related to particular NRG I patients.

Unconditional Release: court-ordered discharge from civil commitment under RCW 10.77 when an NGRI patient no longer presents, as a result of a mental disease or defect, a substantial danger to other persons, or 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.

3.0 Meetings And Scheduling

3.1 Quorum and Voting.

3.1.1 A quorum of four (4) members of the Panel must be in attendance in order for the Panel to review cases and make recommendations.

3.1.2 The Panel may issue a recommendation only when at least four (4) members of the Panel concur.

3.1.3 The Panel shall elect a Chair and Vice-Chair by majority vote, at the beginning of each calendar year, or as necessary due to resignations.

3.1.4 Attendance at meetings may be in person or by electronic means, including telephone, videoconference, or the internet when authorized by the Chair.

3.2 Meetings

3.2.1 The Panel will meet at least once per month on a schedule established by the Chair. The Chair may convene special meetings when necessary.

3.2.2. The meeting will be conducted by the Panel Chair, or in the absence of the Chair, the Panel's Vice Chair.

3.2.3 Each meeting will include a Panel Business Session open to the public and an Executive Session to discuss case recommendations.

3.3 Agenda

3.3.1 The Chair shall set an agenda which will be distributed by the Executive Director with packet materials at least one business day prior to the meeting.

3.4 Executive Director

3.4.1 The Executive Director shall report to the Panel Chair.

3.4.2 Prior to each meeting, the Executive Director shall complete a case summary outlining a person's criminal history, index offense, mental health diagnosis, treatment progress, and other matters useful to assist the Panel in reviewing a case.

3.4.3 The Panel may include the Executive Director in its Executive Sessions where he or she shall maintain minutes.

3.4.4 The Executive Director, under the direction of the Panel Chair, shall compose a preliminary results letter and Final Panel Recommendation Letter to memorialize the Panel's recommendations.

3.4.5 The Executive director shall maintain statistics and other data helpful to the Panel in preparing its 2014 report to the Washington Legislature.

4.0 PSRP Jurisdiction and Recommendations

4.1 Jurisdiction.

4.1.1 Under RCW 10.77.270(1), the PSRP is established for the statutory purpose of advising the Secretary and the courts with respect to persons who have been found not guilty by reason of insanity or persons committed under the involuntary treatment act where the court has made a special finding under RCW 71.05.280 (3) (b).

4.1.2 The Panel shall provide advice regarding all recommendations:

4.1.2.1 For a change in commitment status;

4.1.2.2 To allow furloughs or temporary leaves accompanied by staff;

4.1.2.3 Not to seek further commitment terms under RCW 71.05.320 or

4.1.2.4 To permit movement about the grounds of the treatment facility, with or without the accompaniment of staff.

4.2 Initiating a Panel Recommendation

4.2.1 Pursuant to RCW 10.77.270 (3), *at least* thirty days prior to issuing any recommendation for conditional release under RCW 10.77.150 or forty-five days prior to issuing a recommendation for unconditional release under RCW 10.77.200, the Secretary or her designee shall submit the matter to Panel for a recommendation. The Panel shall consider the case and issue a recommendation.

4.2.2 Pursuant to RCW 10.77.270 (1) the Panel may consider a case and issue a recommendation when requested by the court, the prosecutor, or defense counsel, and where a change in the NGRI Patient's commitment status is being actively adjudicated by the court.

4.3 Review Materials

4.3.1 The Executive Director shall review the entire file of the Patient and provide a case summary to the Panel.

4.3.2 The Hospital shall make the following materials available for the Panel's review by delivering them to the Executive Director: (1) A draft letter stating the Hospital's recommendation that addresses the relevant statutory criteria and discloses the proposed conditions of release, including the specific release address; (2) A current Risk Assessment (and Risk Assessment update if applicable); (3) An NCIC and Washington State criminal history report; (4) All prior psychological evaluations, including the initial NGRI evaluations; (5) The Patient's entire Hospital file; (6) All prior Hospital court letters; and (7) Any other materials deemed relevant by the Hospital.

4.3.3 The time limits under RCW 10.77.270(3) and Section 4.2 shall not begin to run until the Hospital has made a complete submission under Section 4.3.2. If the materials in Section 4.3.2 are submitted at least two weeks prior to the Panel's next scheduled meeting, the Patient's case shall be placed on the agenda for that meeting.

4.4 Panel Review Packet.

4.4.1 At least three business days prior to the next scheduled Panel meeting, for all items on the Executive Session agenda, the Executive Director shall prepare a review packet consisting of the case summary, the Hospital's draft recommendation letter, a current risk assessment, all prior Hospital court letters, all prior psychological evaluations, and any other materials that the Executive Director deems appropriate in consultation with the Panel Chair.

4.4.2 The complete Hospital file, including all current progress reports, etc., shall be available to the Panel during its Executive Session.

4.5 Additional submissions. At least one week prior to the Panel's meeting, the Executive Director shall solicit written input and additional information from the prosecutor and defense attorney with responsibility for the Patient's case. Copies of any written materials shall be made available to Panel members.

4.6 Independent Assessment

4.5.1 The PSRP shall provide its assessment and recommendation in writing to the Secretary, who will provide a copy to the court, prosecutor and defense attorney who are responsible for the Patient's case. The Panel's written recommendation shall be signed by the Chair or Vice-Chair on behalf of the Panel.

4.5.2 Where the Panel deems it necessary and where funds are appropriated for this purpose, the Panel may request an additional evaluation of the Patient by an evaluator chosen by the Panel.

4.7 In accord with RCW 10.77.270(4), the Hospital shall inform the Panel on the following regarding a patient

4.7.1 The disposition entered by the court in all cases where the Panel has issued a recommendation to the court and the Secretary.

4.7.2 When an NGRI Patient is discharged from commitment under RCW 10.77 due to death or expiration of the maximum term of commitment.

4.7.3 When an NGRI Patient is returned to the Hospital and the reasons for the person's return.

4.7.4 When an NGRI Patient is arrested for committing a new criminal act, or

4.7.5 When an NGRI Patient escapes from the Hospital grounds, or absconds from conditional release.

5.0 Conflicts of interest

5.1 Members of the Panel shall not participate in deciding a case where their participation presents an actual conflict of interest. Examples of actual conflicts may include, but are not limited to, the following:

5.1.1 Being related to the patient

5.1.2 Actively representing or prosecuting the patient.

5.1.3 Being currently retained by the patient or the State for evaluative or other services related to the particular patient being considered by the Panel.

5.2 Panel members shall disclose any potential conflicts of interest to other members of the Panel prior to consideration of a case for further consideration.

6.0 Confidentiality

6.1 Consistent with state and federal patient confidentiality laws applicable to Patients, the Panel will protect the confidentiality of all patient information that is outside the public record.

6.2 All packets will be forwarded to Panel members using encrypted emails. When communicating about a Patient by email, Panel Members will use encrypted email or other secure communications adopted by the Panel.

6.3 The Executive Director will keep a copy of the materials considered by the Panel with regard to a Patient in a confidential locked file cabinet.

6.4 Nothing in this section shall preclude the Panel from advising the Legislature under RCW 10.77.270(6), or providing necessary information to the Secretary and the courts when making written recommendations under RCW 10.77.270.

- 6.5 It is recognized that certain Panel members have access to information on Patients through their normal employment and subject to the rules of that employment. Nothing in this section is intended to create confidentiality obligations for information that is available to Panel members through other means or otherwise available in the public record.

7.0 Public and Media Comment

- 7.1 The Chair shall act as the official spokesperson for the Panel.
- 7.2 The Executive Director shall forward all requests for public or media comment directly to the Chair.
- 7.3 Panel members should alert the Chair to any issue or situation that may attract media attention.

PSRP Submission Packet Checklist

Conditional Release

Thirty days prior to issuing a recommendation to the Court, please electronically submit the following to the Coordinator for Panel review:

- The PSRP cover sheet
- Current NCIC and WATCH (if available)
- A copy of the latest Psychosocial Assessment
- A copy of the latest Psychiatric Assessment
- A copy of the latest Risk Assessment (if available)
- A copy of the latest Treatment Plan
- A copy of the last submitted Court Letter
- A copy of the DRAFT Court letter (either supporting or not supporting a CR)
- A copy of the patient's Relapse Prevention Plan or Wellness Recovery Action Plan (if available)
- A copy of the patient's application (if applicable)
- A copy of the Proposed Conditions of Release (If CR supported. Listing in DRAFT Court Letter is acceptable)
- The Hospital's written recommendation (reasons for supporting or not supporting)

Final Discharge/Full Release

Forty-five days prior to issuing a recommendation to the Court, please electronically submit the following to the Coordinator for Panel review:

- The PSRP cover sheet
- Current NCIC and WATCH (if available)
- A copy of the latest Psychosocial Assessment
- A copy of the latest Psychiatric Assessment
- A copy of the latest Risk Assessment
- A copy of the latest Treatment Plan
- A copy of the last submitted Court letter
- A copy of the DRAFT Court letter (either supporting or not supporting a Final Discharge/Full Release)
- A copy of the patient's Relapse Prevention Plan or Wellness Recovery Action Plan (if available)
- A copy of the patient's application (if applicable)
- A copy of the Conditions of Release
- The Hospital's written recommendation (reasons for supporting or not supporting)

Please send electronic submissions to:

Lori Melchiori, PhD

PSRP Executive Director

lori.melchiori@dshs.wa.gov

**PROPOSED DRAFT LEGISLATION TO ESTABLISH A
WASHINGTON PUBLIC SAFETY AND PSYCHIATRIC REVIEW
BOARD (PSPRB)**

AN ACT Relating to the creation of an administrative board to adjudicate certain matters related to the civil commitment of persons found not guilty by reason of insanity.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** All provisions of RCW 10.77 related to civil commitment of the criminally insane following a determination of not guilty by reason of insanity will be re-codified into a new chapter. These sections are: .010, .020, .025, .027, .030, .040, .070, .080, .091, .094, .100, .110, .120, .140, .145, .150, .152, .155, .160, .163, .165, .170, .180, .195, .200, .205, .207, .210., .2101, .220, .230, .240, .250, .260, .270, .900, and .910. The heading of RCW Chapter 10.77 will be re-titled, "Criminal Competence – Procedures and Restoration." The new chapter will be entitled, "Criminal Insanity – Procedures and Civil Commitment" and placed in RCW Title 71. The following statutory sections, which include provisions that relate both to criminal competence and criminal insanity, shall be included in both chapters: .010, .020, .060, .070, .100, .145, .163, .165, .210, .2101, .230, .240, .250, .260, .900, & .910. The version that is retained in the criminal competence chapter, RCW Ch. 10.77, shall not include the revisions in this bill.

NEW SECTION. **Sec. 2.** The Legislature finds that persons subject to civil commitment following a determination of not guilty by reason of insanity present unique diagnostic, treatment, and public safety challenges that differ substantially from the general population subject to commitment under RCW Chapter 71.05. In accord with the practices of some other states, a centralized, quasi-judicial administrative review board with specialized expertise in the unique nature of this population will enhance both patient care and public safety.

Sec. 3 RCW 10.77.010 is amended to read as follows:

As used in this chapter:

~~(1) "Admission" means acceptance based on medical necessity, of a person as a patient.~~

(1) "Board" means the Public Safety and Psychiatric Review Board

(2) "Commitment" means the determination by a court that a person is a substantial danger to other persons, or presents a substantial likelihood of committing criminal acts jeopardizing public safety or security as a result of a mental disease or defect absent control by the court or other persons or institutions. The term also includes persons that

should be detained for a period of either evaluation or treatment, or both, in an inpatient or a less-restrictive setting under the terms of this chapter.

(3) "Conditional release" means modification of a court-ordered commitment, which may be revoked upon violation of any of its terms.

(4) A "criminally insane" person means any person who has been acquitted of a crime charged by reason of insanity, and committed under the provisions of this chapter regardless of inpatient or conditional release dispositional status, 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.

(5) "Department" means the state department of social and health services.

(6) "Designated mental health professional" has the same meaning as provided in RCW 71.05.020.

~~(7) "Detention" or "detain" means the lawful confinement of a person, under the provisions of this chapter, pending evaluation.~~

(~~8~~7) "Developmental disabilities professional" means a person who has specialized training and three years of experience in directly treating or working with persons with developmental disabilities and is a psychiatrist or psychologist, or a social worker, and such other developmental disabilities professionals as may be defined by rules adopted by the secretary.

(~~9~~8) "Developmental disability" means the condition as defined in *RCW 71A.10.020(3).

~~(10) "Discharge" means the termination of hospital medical authority. The commitment may remain in place, be terminated, or be amended by Boardcourt order.~~

(~~11~~9) "Furlough" means an authorized leave of absence for a resident of a state institution operated by the department designated for the custody, care, and treatment of the criminally insane, consistent with an order of conditional release from the ~~court~~Board under this chapter, without any requirement that the resident be accompanied by, or be in the custody of, any law enforcement or institutional staff, while on such unescorted leave.

(~~12~~10) "Habilitative services" means those services provided by program personnel to assist persons in acquiring and maintaining life skills and in raising their levels of physical, mental, social, and vocational functioning. Habilitative services include education, training for employment, and therapy. The habilitative process shall be undertaken with recognition of the risk to the public safety presented by the person being assisted as manifested by prior charged criminal conduct.

(~~13~~11) "History of one or more violent acts" means violent acts committed during: (a) The ten-year period of time prior to the filing of criminal charges; plus (b) the amount of time equal to time spent during the ten-year period in a mental health facility or in confinement as a result of a criminal conviction.

(~~14~~12) "Immediate family member" means a spouse, child, stepchild, parent, stepparent, grandparent, sibling, or domestic partner.

~~—(15) "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.~~

(~~16~~13) "Indigent" means any person who is financially unable to obtain counsel or other necessary expert or professional services without causing substantial hardship to the person or his or her family.

(~~17~~14) "Individualized service plan" means a plan prepared by a developmental disabilities professional with other professionals as a team, for an individual with developmental disabilities, which shall state:

(a) The nature of the person's specific problems, prior charged criminal behavior, and habilitation needs;

(b) The conditions and strategies necessary to achieve the purposes of habilitation;

(c) The intermediate and long-range goals of the habilitation program, with a projected timetable for the attainment;

(d) The rationale for using this plan of habilitation to achieve those intermediate and long-range goals;

(e) The staff responsible for carrying out the plan;

(f) Where relevant in light of past criminal behavior and due consideration for public safety, the criteria for proposed movement to less-restrictive settings, criteria for proposed eventual release, and a projected possible date for release; and

(g) The type of residence immediately anticipated for the person and possible future types of residences.

(~~18~~15) "Professional person" means:

(a) A psychiatrist licensed as a physician and surgeon in this state who has, in addition, completed three years of graduate training in psychiatry in a program approved by the American medical association or the American osteopathic association and is

certified or eligible to be certified by the American board of psychiatry and neurology or the American osteopathic board of neurology and psychiatry;

(b) A psychologist licensed as a psychologist pursuant to chapter 18.83 RCW; or

(c) A licensed social worker or licensed mental health counselor with a master's or further advanced degree from an accredited program. ~~social work educational program accredited and approved as provided in RCW 18.320.010.~~

~~(1916)~~ "Registration records" include all the records of the department, regional support networks, treatment facilities, and other persons providing services to the department, county departments, or facilities which identify persons who are receiving or who at any time have received services for mental illness.

~~(2117)~~ "Secretary" means the secretary of the department of social and health services or his or her designee.

~~(2218)~~ "Treatment" means any currently standardized medical or mental health procedure including medication.

~~(2319)~~ "Treatment records" include registration and all other records concerning persons who are receiving or who at any time have received services for mental illness, which are maintained by the department, by regional support networks and their staffs, and by treatment facilities. Treatment records do not include notes or records maintained for personal use by a person providing treatment services for the department, regional support networks, or a treatment facility if the notes or records are not available to others.

~~(2020)~~ "Unconditional Release" means final discharge and legal termination of the court-ordered commitment under the provisions of this chapter.

~~(2421)~~ "Violent act" means behavior that: (a)(i) Resulted in; (ii) if completed as intended would have resulted in; or (iii) was threatened to be carried out by a person who had the intent and opportunity to carry out the threat and would have resulted in, homicide, nonfatal injuries, or substantial damage to property; or (b) recklessly creates an immediate risk of serious physical injury to another person. As used in this subsection, "nonfatal injuries" means physical pain or injury, illness, or an impairment of physical condition. "Nonfatal injuries" shall be construed to be consistent with the definition of "bodily injury," as defined in RCW 9A.04.110.

Sec. 4 RCW 10.77.020 is amended to read as follows:

(1) At any and all stages of the proceedings pursuant to this chapter, any person subject to the provisions of this chapter shall be entitled to the assistance of counsel, and if the person is indigent the court (for the initial NGRI determination) or the Board (for subsequent NGRI proceedings) shall appoint counsel to assist him or her. A person may

waive his or her right to counsel; but such waiver shall only be effective if a court or the Board makes a specific finding that he or she is or was competent to so waive and understands the nature of the proceedings. ~~In making such findings, the court shall be guided but not limited by the following standards: Whether the person attempting to waive the assistance of counsel, does so understanding:~~

~~(a) The nature of the charges;~~

~~(b) The statutory offense included within them;~~

~~(c) The range of allowable punishments thereunder;~~

~~(d) Possible defenses to the charges and circumstances in mitigation thereof; and~~

~~(e) All other facts essential to a broad understanding of the whole matter.~~

(2) Whenever any person is subjected to an examination pursuant to any provision of this chapter, he or she may retain an expert or professional person to perform an examination in his or her behalf. In the case of a person who is indigent, the court (for the initial NGRI determination) or the Board (for subsequent NGRI proceedings) shall upon his or her request assist the person in obtaining an expert or professional person to perform an examination or participate in the hearing on his or her behalf. An expert or professional person obtained by an indigent person pursuant to the provisions of this chapter shall be compensated for his or her services out of funds of the department, in an amount determined by the secretary to be fair and reasonable.

(3) Any time the defendant is being examined by court or Board appointed experts or professional persons pursuant to the provisions of this chapter, the defendant shall be entitled to have his or her attorney present.

~~(4) In a competency evaluation conducted under this chapter, the defendant may refuse to answer any question if he or she believes his or her answers may tend to incriminate him or her or form links leading to evidence of an incriminating nature.~~

~~(5)~~ In a sanity evaluation conducted under this chapter, if a defendant refuses to answer questions or to participate in an examination conducted in response to the defendant's assertion of an insanity defense, or petition for unconditional release, the court shall exclude from evidence at trial any testimony or evidence from any expert or professional person obtained or retained by the defendant.

Sec. 5. RCW 10.77.094 is amended to read as follows:

(1) A state hospital may administer antipsychotic medication without consent to an individual who is committed under this chapter as criminally insane by following the same procedures applicable to the administration of antipsychotic medication without consent to a civilly committed patient under RCW [71.05.217](#), except for the following:

(a) All proceedings will take place before the Board and the petition for involuntary medication shall be decided by the Board; and

(a**b**) The maximum period during which the ~~Board~~~~court~~ may authorize the administration of medication without consent under a single involuntary medication petition shall be the time remaining on the individual's current order of commitment or one hundred eighty days, whichever is shorter; and

~~(b) A petition for involuntary medication may be filed in either the superior court of the county that ordered the commitment or the superior court of the county in which the individual is receiving treatment, provided that a copy of any order that is entered must be provided to the superior court of the county that ordered the commitment following the hearing. The superior court of the county of commitment shall retain exclusive jurisdiction over all hearings concerning the release of the patient.~~

(2) The state has a compelling interest in providing antipsychotic medication to a patient who has been committed as criminally insane when refusal of antipsychotic medication would result in a likelihood of serious harm or substantial deterioration or substantially prolong the length of involuntary commitment and there is no less intrusive course of treatment than medication that is in the best interest of the patient.

Sec. 6. RCW 10.77.110 is amended to read as follows:

(1) If a defendant is acquitted of a crime by reason of insanity, and it is found that he or she is not a substantial danger to other persons, and does not 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, the court shall direct the defendant's release. If it is found that such 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, the court shall order his or her hospitalization, or any appropriate alternative treatment less restrictive than detention in a state mental hospital, pursuant to the terms of this chapter.

(2) If the defendant has been found not guilty by reason of insanity and a substantial danger, or presents a substantial likelihood of committing criminal acts jeopardizing public safety or security, so as to require treatment then the secretary shall immediately cause the defendant to be evaluated to ascertain if the defendant is developmentally disabled. When appropriate, and subject to available funds, the defendant may be committed to a program specifically reserved for the treatment and training of developmentally disabled persons. A person so committed shall receive habilitation services according to an individualized service plan specifically developed to treat the behavior which was the subject of the criminal proceedings. The treatment program shall be administered by developmental disabilities professionals and others trained

specifically in the needs of developmentally disabled persons. The treatment program shall provide physical security to a degree consistent with the finding that the defendant is dangerous and may incorporate varying conditions of security and alternative sites when the dangerousness of any particular defendant makes this necessary. The department may limit admissions to this specialized program in order to ensure that expenditures for services do not exceed amounts appropriated by the legislature and allocated by the department for such services. The department may establish admission priorities in the event that the number of eligible persons exceeds the limits set by the department.

(3) If it is found that such defendant is not a substantial danger to other persons, and does not present a substantial likelihood of committing criminal acts jeopardizing public safety or security so long as the defendant is subject to, ~~but that he or she is in need of control~~ by the court or other persons or institutions, the court shall direct the defendant's conditional release. Within five judicial days of ordering conditional release, the court shall provide a copy of its conditional release order to the Board and the secretary. The Board shall assume all further jurisdiction over the matter. When appropriate for public safety or the best interests of the defendant, the Board may modify the release conditions or add additional conditions.

Sec. 7. RCW 10.77.120 is amended to read as follows:

(1) The secretary shall provide adequate care and individualized treatment to persons found criminally insane at one or several of the state institutions or facilities under the direction and control of the secretary. In order that the secretary may adequately determine the nature of the mental illness or developmental disability of the person committed as criminally insane, all persons who are committed to the secretary as criminally insane shall be promptly examined by qualified personnel in order to provide a proper evaluation and diagnosis of such individual. The examinations of all persons with developmental disabilities committed under this chapter shall be performed by developmental disabilities professionals. Any person so committed shall not be released from the control of the secretary except by order of the Board ~~a court of competent jurisdiction~~ made after a hearing and judgment of release.

(2) Whenever there is a hearing which the committed person is entitled to attend, the secretary shall send the person in the custody of one or more department employees to the hearing of the Board, unless the Board authorizes the appearance of the person by video or telephonic means. ~~to the county in which the hearing is to be held at the time the case is called for trial.~~ During the time the person is absent from the facility, the person may be confined in a facility designated by and arranged for by the department, but shall at all times be deemed to be in the custody of the department employee and provided necessary treatment. If the decision of the hearing remits the person to custody, the department employee shall return the person to such institution or facility designated by the secretary. If the state appeals an order of release, such appeal shall operate as a stay,

and the person shall remain in custody and be returned to the institution or facility designated by the secretary until a final decision has been rendered in the cause.

Sec. 8. RCW 10.77.140 is amended to read as follows

(1) Each person committed to a hospital or other facility or conditionally released pursuant to this chapter shall have a current examination of his or her mental condition made by one or more experts or professional persons at least once every six months. The person may retain, or if the person is indigent and so requests, the ~~Board~~~~court~~ may appoint a qualified expert or professional person to examine him or her, and such expert or professional person shall have access to all hospital records concerning the person. In the case of a committed or conditionally released person who is developmentally disabled, the expert shall be a developmental disabilities professional. The secretary, upon receipt of the periodic report, shall provide copies to the Board, the prosecuting attorney, and counsel for the defendant. ~~written notice to the court of commitment of compliance with the requirements of this section.~~

(2) The Board shall review the status of each person committed under this section immediately following receipt of the initial six month report. Thereafter, the Board shall review each case at least every two years.

Sec. 9. RCW 10.77.145 is amended to read as follows:

(1) No person committed to the custody of the department ~~for the determination of competency to stand trial under RCW 10.77.060, the restoration of competency for trial under RCW 10.77.084, 10.77.086, or 10.77.088, or~~ following an acquittal by reason of insanity shall be authorized to leave the facility where the person is confined, except in the following circumstances:

- (a) In accordance with conditional release or furlough authorized by ~~the Board~~~~court~~;
- (b) For necessary medical or legal proceedings not available in the facility where the person is confined;
- (c) For visits to the bedside of a member of the person's immediate family who is seriously ill; or
- (d) For attendance at the funeral of a member of the person's immediate family.

(2) Unless ordered otherwise by ~~the Board~~~~court~~, no leave under subsection (1) of this section shall be authorized unless the person who is the subject of the authorization is escorted by a person approved by the secretary. During the authorized leave, the person approved by the secretary must be in visual or auditory contact at all times with the person on authorized leave.

(3) Prior to the authorization of any leave under subsection (1) of this section, the secretary must give notification to any county or city law enforcement agency having jurisdiction in the location of the leave destination.

Sec. 10. RCW 10.77.150 is amended to read as follows:

(1) Persons examined pursuant to RCW [10.77.140](#) may make application to the secretary for conditional release. The secretary shall, after considering the reports of experts or professional persons conducting the examination pursuant to RCW [10.77.140](#), forward to the ~~Board~~court of the county which ordered the person's commitment the person's application for conditional release as well as the secretary's recommendations concerning the application and any proposed terms and conditions upon which the secretary reasonably believes the person can be conditionally released. Conditional release may also contemplate partial release for work, training, or educational purposes.

(2) In instances in which persons examined pursuant to RCW [10.77.140](#) have not made application to the secretary for conditional release, but the secretary, after considering the reports of experts or professional persons conducting the examination pursuant to RCW [10.77.140](#), reasonably believes the person may be conditionally released, the secretary may submit a recommendation for release to the ~~Board~~court of the county that ordered the person's commitment. The secretary's recommendation must include any proposed terms and conditions upon which the secretary reasonably believes the person may be conditionally released. Conditional release may also include partial release for work, training, or educational purposes. Notice of the secretary's recommendation under this subsection must be provided to the person for whom the secretary has made the recommendation for release and to his or her attorney.

(3)(a) The ~~Board~~court of the county which ordered the person's commitment, upon receipt of an application or recommendation for conditional release with the secretary's recommendation for conditional release terms and conditions, shall within thirty days schedule a hearing. The ~~Board~~court may schedule a hearing on applications recommended for disapproval by the secretary.

(b) The prosecuting attorney of the county which ordered the person's commitment shall represent the state at such hearings and shall have the right to have the patient examined by an expert or professional person of the prosecuting attorney's choice. If the committed person is indigent, and he or she so requests, the ~~Board~~court shall appoint a qualified expert or professional person to examine the person on his or her behalf.

(c) The issue to be determined at such a hearing is whether ~~or not~~ the person may be released conditionally without substantial danger to other persons, or substantial likelihood of committing criminal acts jeopardizing public safety or security. Any ruling of the Board that disapproves of a conditional release recommended by the secretary may do so only on the basis of substantial evidence.

(d) ~~The court, after the hearing, shall rule on the secretary's recommendations, and if it disapproves of conditional release, may do so only on the basis of substantial evidence.~~ The ~~Board~~~~court~~ may modify the suggested terms and conditions on which the person is to be conditionally released. Pursuant to the determination of the ~~Board~~~~court~~ after hearing, the committed person shall thereupon be released on such conditions as the ~~Board~~~~court~~ determines to be necessary, or shall be remitted to the custody of the secretary. If the order of conditional release includes a requirement for the committed person to report to a community corrections officer, the order shall also specify that the conditionally released person shall be under the supervision of the secretary of corrections or such person as the secretary of corrections may designate and shall follow explicitly the instructions of the secretary of corrections including reporting as directed to a community corrections officer, remaining within prescribed geographical boundaries, and notifying the community corrections officer prior to making any change in the offender's address or employment. If the order of conditional release includes a requirement for the committed person to report to a community corrections officer, the community corrections officer shall notify the secretary or the secretary's designee, if the person is not in compliance with the court-ordered conditions of release.

(4) If the ~~Board~~~~court~~ determines that receiving regular or periodic medication or other medical treatment shall be a condition of the committed person's release, then the ~~Board~~~~court~~ shall require him or her to report to a physician or other medical or mental health practitioner for the medication or treatment. In addition to submitting any report required by RCW [10.77.160](#), the physician or other medical or mental health practitioner shall immediately upon the released person's failure to appear for the medication or treatment or upon a change in mental health condition that renders the patient a potential risk to the public report to the ~~Board~~~~court~~, to the prosecuting attorney of the county in which the released person was committed, to the secretary, and to the supervising community corrections officer.

(5) Any person, whose application for conditional release has been denied, may reapply after a period of six months from the date of denial.

Sec. 11. RCW 10.77.155 is amended to read as follows:

~~The Board may not~~~~No court may~~, without a hearing, enter an order conditionally releasing or authorizing the furlough of a person committed under this chapter, unless the secretary has recommended the release or furlough. If the secretary has not recommended the release or furlough, a hearing shall be held under RCW [10.77.150](#).
[1994 c 150 § 1.]

Sec. 12. RCW 10.77.160 is amended to read as follows:

When a conditionally released person is required by the terms of his or her conditional release to report to a physician, department of corrections community corrections officer,

or medical or mental health practitioner on a regular or periodic basis, the physician, department of corrections community corrections officer, medical or mental health practitioner, or other such person shall monthly, for the first six months after release and semiannually thereafter, or as otherwise directed by the ~~Board~~court, submit to the ~~Board~~court, the secretary, the institution from which released, and to the prosecuting attorney of the county in which the person was committed, a report stating whether the person is adhering to the terms and conditions of his or her conditional release, and detailing any arrests or criminal charges filed and any significant change in the person's mental health condition or other circumstances.

Sec. 13. RCW 10.77.163 is amended to read as follows:

(1) Before a person committed under this chapter is permitted temporarily to leave a treatment facility for any period of time without constant accompaniment by facility staff, the superintendent, professional person in charge of a treatment facility, or his or her professional designee shall in writing notify the prosecuting attorney of any county to which the person is released and the prosecuting attorney of the county in which the criminal charges against the committed person were dismissed, of the decision conditionally to release the person. The notice shall be provided at least forty-five days before the anticipated release and shall describe the conditions under which the release is to occur.

(2) In addition to the notice required by subsection (1) of this section, the superintendent of each state institution designated for the custody, care, and treatment of persons committed under this chapter shall notify appropriate law enforcement agencies through the state patrol communications network of the furloughs of persons committed under ~~this chapter~~RCW 10.77.086 or 10.77.110. Notification shall be made at least thirty days before the furlough, and shall include the name of the person, the place to which the person has permission to go, and the dates and times during which the person will be on furlough.

(3) Upon receiving notice that a person committed under this chapter is being temporarily released under subsection (1) of this section, the prosecuting attorney may seek a temporary restraining order from the Board to prevent the release of the person on the grounds that the person is dangerous to self or others. The Board shall hear the prosecutor's motion prior to the scheduled date of the proposed temporary release.

(4) The notice requirements contained in this section shall not apply to emergency medical furloughs.

(5) The existence of the notice requirements contained in this section shall not require any extension of the release date in the event the release plan changes after notification.

(6) The notice provisions of this section are in addition to those provided in RCW 10.77.205.

Sec. 14. RCW 10.77.165 is amended to read as follows:

(1) In the event of an escape by a person committed under this chapter from a state facility or the disappearance of such a person on conditional release or other authorized absence, the superintendent shall provide notification of the person's escape or disappearance for the public's safety or to assist in the apprehension of the person.

(a) The superintendent shall notify:

(i) State and local law enforcement officers located in the city and county where the person escaped and in the city and county which had jurisdiction of the person on the date of the applicable offense;

(ii) Other appropriate governmental agencies;~~and~~

(iii) The person's relatives;:-

(iv) The prosecuting attorney;

(v) The person's defense counsel; and

(vi) The Board.

(b) The superintendent shall provide the same notification as required by (a) of this subsection to the following, if such notice has been requested in writing about a specific person committed under this chapter:

(i) The victim of the crime for which the person was convicted or the victim's next of kin if the crime was a homicide;

(ii) Any witnesses who testified against the person in any Board or court proceedings if the person was charged with a violent offense; and

(iii) Any other appropriate persons.

(2) Information regarding victims, next of kin, or witnesses requesting the notice, information regarding any other person specified in writing by the prosecuting attorney to receive the notice, and the notice are confidential and shall not be available to the person committed under this chapter.

(3) The notice provisions of this section are in addition to those provided in RCW [10.77.205](#).

Sec. 15. RCW 10.77.180 is amended to read as follows:

Each person conditionally released pursuant to RCW [10.77.150](#) shall have his or her case reviewed by the ~~Board~~ which conditionally released him or her no later than one year after such release and no later than every two years thereafter, such time to be scheduled by the ~~Board~~. Review may occur in a shorter time or more frequently, if the ~~Board~~, in its discretion, on its own motion, or on motion of the person, the secretary of social and health services, the secretary of corrections, medical or mental health practitioner, or the prosecuting attorney, so determines. The sole question to be determined by the ~~Board~~ is whether the person shall continue to be conditionally released. The ~~Board~~ in making its determination shall be aided by the periodic reports filed pursuant to RCW [10.77.140](#) and [10.77.160](#), and the opinions of the secretary and other experts or professional persons.

Sec. 16. RCW 10.77.190 is amended to read as follows:

(1) Any person submitting reports pursuant to RCW [10.77.160](#), the secretary, or the prosecuting attorney may petition the ~~Board~~ to, or the ~~Board~~ on its own motion may schedule an immediate hearing for the purpose of modifying the terms of conditional release if the petitioner or the ~~Board~~ believes the released person is failing to adhere to the terms and conditions of his or her conditional release or is in need of additional care and treatment.

(2) If the prosecuting attorney, the secretary of social and health services, the secretary of corrections, or the ~~Board~~, after examining the report filed with them pursuant to RCW [10.77.160](#), or based on other information received by them, reasonably believes that a conditionally released person is failing to adhere to the terms and conditions of his or her conditional release the ~~Board~~ or secretary of social and health services or the secretary of corrections may order that the conditionally released person be apprehended and taken into custody. The ~~Board~~ shall be notified of the apprehension before the close of the next judicial day. The ~~Board~~ shall schedule a hearing within thirty days to determine whether or not the person's conditional release should be modified or revoked. Both the prosecuting attorney and the conditionally released person shall have the right to request an immediate mental examination of the conditionally released person. If the conditionally released person is indigent, the ~~Board~~ or secretary of social and health services or the secretary of corrections or their designees shall, upon request, assist him or her in obtaining a qualified expert or professional person to conduct the examination.

(3) If the hospital or facility designated to provide outpatient care determines that a conditionally released person presents a threat to public safety, the hospital or facility shall immediately notify the secretary of social and health services or the secretary of corrections or their designees. The secretary shall order that the conditionally released person be apprehended and taken into custody.

(4) The ~~Board~~, upon receiving notification of the apprehension, shall promptly schedule a hearing. The issue to be determined is whether the conditionally released person did or did not adhere to the terms and conditions of his or her release, or whether

the person presents a threat to public safety. Pursuant to the determination of the ~~Board~~ upon such hearing, the conditionally released person shall either continue to be conditionally released on the same or modified conditions or his or her conditional release shall be revoked and he or she shall be remitted to the custody of the secretary ~~committed~~ subject to release only in accordance with provisions of this chapter.

Sec. 17. RCW 10.77.195 is amended to read as follows:

For persons who have received ~~court~~ approval for conditional release, the secretary or the secretary's designee shall supervise the person's compliance with the ~~court~~-ordered conditions of release. The level of supervision provided by the secretary shall correspond to the level of the person's public safety risk. In undertaking supervision of persons under this section, the secretary shall coordinate with any treatment providers designated pursuant to RCW [10.77.150](#)(3), any department of corrections staff designated pursuant to RCW [10.77.150](#)(2), and local law enforcement, if appropriate. The secretary shall adopt rules to implement this section.

Sec. 18. RCW 10.77.200 is amended to read as follows:

(1) Upon application by the committed or conditionally released person, the secretary shall determine whether or not reasonable grounds exist for unconditional release. In making this determination, the secretary may consider the reports filed under RCW [10.77.060](#), [10.77.110](#), [10.77.140](#), and [10.77.160](#), and other reports and evaluations provided by professionals familiar with the case. If the secretary approves the release he or she then shall authorize the person to petition the ~~Board~~.

(2) In instances in which persons have not made application for release, but the secretary believes, after consideration of the reports filed under RCW [10.77.060](#), [10.77.110](#), [10.77.140](#), and [10.77.160](#), and other reports and evaluations provided by professionals familiar with the case, that reasonable grounds exist for release, the secretary may petition the ~~Board~~. If the secretary petitions the ~~Board~~ for release under this subsection, notice of the petition must be provided to the person who is the subject of the petition and to his or her attorney.

(3) The petition shall be served upon the ~~Board~~ and the prosecuting attorney. The ~~Board~~, upon receipt of the petition for release, shall within forty-five days order a hearing. Continuance of the hearing date shall only be allowed for good cause shown. The prosecuting attorney shall represent the state, and shall have the right to have the person who is the subject of the petition examined by an expert or professional person of the prosecuting attorney's choice. If the secretary is the petitioner, the attorney general shall represent the secretary. If the person who is the subject of the petition is indigent, and the person so requests, the ~~Board~~ shall appoint a qualified expert or professional person to examine him or her. If the person who is the subject of the petition has a developmental disability, the examination shall be performed by a developmental disabilities professional. ~~The hearing shall be before a jury if demanded by either the petitioner or the prosecuting attorney.~~ The burden of proof shall be upon the petitioner to

show by a preponderance of the evidence that the person who is the subject of the petition no longer presents, as a result of a mental disease or defect, a substantial danger to other persons, or a substantial likelihood of committing criminal acts jeopardizing public safety or security, unless kept under further control by the Board or other persons or institutions. If the person who is the subject of the petition will be transferred to a state correctional institution or facility upon release to serve a sentence for any class A felony, the petitioner must show that the person's mental disease or defect is manageable within a state correctional institution or facility, but must not be required to prove that the person does not present either a substantial danger to other persons, or a substantial likelihood of committing criminal acts jeopardizing public safety or security, if released.

(4) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect requiring supervision when the disease may, with reasonable medical probability, occasionally become active and, when active, render the person a danger to others. Upon a finding that the person who is the subject of the petition has a mental disease or defect in a state of remission under this subsection, the Board may deny release, or place or continue such a person on conditional release.

(5) Nothing contained in this chapter shall prohibit the patient from petitioning the Board for release or conditional release from the institution in which he or she is committed. The petition shall be served upon the Board, the prosecuting attorney, and the secretary. Upon receipt of such petition, the secretary shall develop a recommendation as provided in subsection (1) of this section and provide the secretary's recommendation to all parties and the Board. The issue to be determined on such proceeding is whether the patient, as a result of a mental disease or defect, 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 Board or other persons or institutions.

(6) Nothing contained in this chapter shall prohibit the committed person from petitioning for release by writ of habeas corpus.

Sec. 19. RCW 10.77.205 is amended to read as follows:

(1)(a) At the earliest possible date, and in no event later than thirty days before conditional release, release, authorized furlough pursuant to RCW [10.77.163](#), or transfer to a less-restrictive facility than a state mental hospital, the superintendent shall send written notice of the conditional release, release, authorized furlough, or transfer of a person who has been found not guilty by reason of insanity of a sex, violent, or felony harassment offense by reason of insanity and who is now in the custody of the department pursuant to this chapter, to the following:

(i) The chief of police of the city, if any, in which the person will reside; and

(ii) The sheriff of the county in which the person will reside.

(b) The same notice as required by (a) of this subsection shall be sent to the following, if such notice has been requested in writing about a specific person committed under this chapter:

(i) The victim of the crime for which the person was committed or the victim's next of kin if the crime was a homicide;

(ii) Any witnesses who testified against the person in any court or Board proceedings; and

(iii) Any person specified in writing by the prosecuting attorney.

Information regarding victims, next of kin, or witnesses requesting the notice, information regarding any other person specified in writing by the prosecuting attorney to receive the notice, and the notice are confidential and shall not be available to the person committed under this chapter.

(c) In addition to the notice requirements of (a) and (b) of this subsection, the superintendent shall comply with RCW [10.77.163](#).

(d) The thirty-day notice requirement contained in (a) and (b) of this subsection shall not apply to emergency medical furloughs.

(e) The existence of the notice requirements in (a) and (b) of this subsection shall not require any extension of the release date in the event the release plan changes after notification.

(2) If a person who has been found not guilty of a sex, violent, or felony harassment offense by reason of insanity and who is committed under this chapter escapes, the superintendent shall immediately notify, by the most reasonable and expedient means available, the chief of police of the city and the sheriff of the county in which the person resided immediately before the person's arrest. If previously requested, the superintendent shall also notify the witnesses and the victim, if any, of the crime for which the person was committed or the victim's next of kin if the crime was a homicide. The superintendent shall also notify appropriate persons pursuant to RCW [10.77.165](#). If the person is recaptured, the secretary shall send notice to the persons designated in this subsection as soon as possible but in no event later than two working days after the department learns of such recapture.

(3) If the victim, the victim's next of kin, or any witness is under the age of sixteen, the notice required by this section shall be sent to the parents or legal guardian of the child.

(4) The department shall send the notices required by this chapter to the last address provided to the department by the requesting party. The requesting party shall furnish the department with a current address.

(5) For purposes of this section the following terms have the following meanings:

(a) "Violent offense" means a violent offense under RCW [9.94A.030](#);

(b) "Sex offense" means a sex offense under RCW [9.94A.030](#);

(c) "Next of kin" means a person's spouse, state registered domestic partner, parents, siblings, and children;

(d) "Authorized furlough" means a furlough granted after compliance with RCW [10.77.163](#);

(e) "Felony harassment offense" means a crime of harassment as defined in RCW [9A.46.060](#) that is a felony.

Sec. 20. RCW 10.77.210 is amended to read as follows:

(1) Any person ~~involuntarily detained, hospitalized, or committed~~ pursuant to the provisions of this chapter shall have the right to adequate care and individualized treatment. The person who has custody of the patient or is in charge of treatment shall keep records detailing all medical, expert, and professional care and treatment received by a committed person, and shall keep copies of all reports of periodic examinations of the patient that have been filed with the secretary pursuant to this chapter. Except as provided in RCW [10.77.205](#) and [4.24.550](#) regarding the release of information concerning insane offenders who are acquitted of sex offenses and subsequently committed pursuant to this chapter, all records and reports made pursuant to this chapter, shall be made available only upon request, to the committed person, to his or her attorney, to his or her personal physician, to the supervising community corrections officer, to the prosecuting attorney, to the ~~Board~~court, to the protection and advocacy agency, or other expert or professional persons who, upon proper showing, demonstrates a need for access to such records. All records and reports made pursuant to this chapter shall also be made available, upon request, to the department of corrections or the indeterminate sentence review board if the person was on parole, probation, or community supervision at the time of detention, hospitalization, or commitment or the person is subsequently convicted for the crime for which he or she was detained, hospitalized, or committed pursuant to this chapter.

(2) All relevant records and reports as defined by the department in rule shall be made available, upon request, to criminal justice agencies as defined in RCW [10.97.030](#).

Sec. 21. RCW 10.77.220 is amended to read as follows:

No person confined pursuant to this chapter shall be incarcerated in a state correctional institution or facility: PROVIDED, That nothing herein shall prohibit confinement in a mental health facility located wholly within a correctional institution. Confinement in a county jail or other local facility while awaiting either placement in a treatment program or a ~~Board~~ hearing pursuant to this chapter is permitted for no more than seven days.

Sec. 22. RCW 10.77.230 is amended to read as follows:

Either party may seek appellate review of the judgment of any hearing held pursuant to the provisions of this chapter. Any appeal from a ruling of the Board shall be filed before the division of the Washington Court of Appeals where the county of the person's commitment under this chapter is located.

Sec. 23. RCW 10.77.260 is amended to read as follows:

- (1) In determining whether a defendant has committed a violent act the court must:
 - (a) Presume that a past conviction, guilty plea, or finding of not guilty by reason of insanity establishes the elements necessary for the crime charged;
 - (b) Consider that the elements of a crime may not be sufficient in themselves to establish that the defendant committed a violent act; and
 - (c) Presume that the facts underlying the elements, if unrebutted, are sufficient to establish that the defendant committed a violent act.
- (2) The presumptions in subsection (1) of this section are rebuttable.
- (3) In determining the facts underlying the elements of any crime under subsection (1) of this section, the court may consider information including, but not limited to, the following material relating to the crime:
 - (a) Affidavits or declarations made under penalty of perjury;
 - (b) Criminal history record information, as defined in chapter [10.97](#) RCW; and
 - (c) Its own or certified copies of ~~another~~ court's records such as criminal complaints, certifications of probable cause to detain, dockets, and orders on judgment and sentencing.

Sec. 24. RCW 10.77.270 is amended to read as follows:

- (1) An independent Public Safety and Psychiatric Review Board is established to perform quasi-judicial duties as set forth in this chapter. The Board shall be comprised of seven

members appointed by the Governor for staggered four-year, renewable terms. Board membership shall consist of the following:

(a) A psychiatrist (four year terms commencing July 1, 2015);

(b) A licensed clinical psychologist (two year term commencing July 1, 2015; four year terms thereafter);

(c) A representative of the department of corrections (four year terms commencing July 1, 2015);

(d) A prosecutor or a representative of a prosecutor's association (two year term commencing July 1, 2015; four year terms thereafter);

(e) A representative of law enforcement or a law enforcement association (four year terms commencing July 1, 2015);

(f) A consumer and family advocate representative (two year term commencing July 1, 2015; four year terms thereafter); and

(g) A public defender or a representative of a defender's association (four year terms commencing July 1, 2015).

The Board may select its own chairperson by majority vote of the full Board. The members shall not be removable during their respective terms except for cause determined by the Thurston County Superior Court.

(2) The Board is created within the department, which shall provide administrative, financial and staff support for the Board. The secretary may employ an Executive Director and such other personnel as may be necessary to assist the Board in carrying out its duties.

(3) Each member of the board shall receive a per diem for attending to Board business that is based on a salary fixed by the governor in accordance with the provisions of RCW 43.03.040. The per diem shall reflect the professional qualifications and experience necessary for each Board position. In addition to a per diem, each member of the Board shall receive travel expenses incurred in the discharge of their official duties in accordance with RCW 43.03.050 and 43.03.060.

(4) All Board hearings shall be open to the public and shall be held at Western or Eastern State Hospital when practical and convenient. If a person committed under this chapter is not resident at the facility where the hearing is held, the Board may allow the defendant to appear by telephone or video in lieu of a personal appearance. The Board may also allow attorneys to appear by telephone or video and present witnesses in this manner. The Board shall follow all constitutional requirements applicable to civil commitment proceedings in conducting its hearings.

(5) The Board may meet and transact business in panels. Each Board panel shall consist of at least three members of the Board. The chair of the Board with the consent of a majority of the Board may designate any three members to exercise all the powers and duties of the Board in connection with any hearing before the Board. If the three members so designated cannot unanimously agree as to the disposition of the hearing assigned to them, such hearing shall be reheard by the full Board. All actions of the full board shall be by concurrence of a majority of the Board members. In all matters concerning the internal affairs of the Board, including rule and policy-making decisions, a majority of the full Board must concur in such matters.

(6) The Board shall make a reasonable effort to notify any victim of a person committed under this chapter of all Board hearings involving the person, including hearings on conditional release, revocation and unconditional discharge. When conducting such a hearing, the Board shall afford the victim an opportunity to be heard, either orally or in writing, at the hearing. Nothing in this subsection authorizes the Board or the department to disseminate information that is otherwise privileged by law.

(7) The board shall adopt all necessary rules and policies to carry out the Board's duties under this chapter.

~~(1)(8) The Board shall advise -secretary shall establish an independent public safety review panel for the purpose of advising the secretary and the courts with respect to persons who have been found not guilty by reason of insanity, or persons committed under the involuntary treatment act where the court has made a special finding under RCW 71.05.280(3)(b). The Board panel shall provide advice regarding all recommendations to the secretary, decisions by the secretary, or actions pending in court: (a) For a change in commitment status; (b) to allow furloughs or temporary leaves accompanied by staff; (c) not to seek further commitment terms under RCW 71.05.320; or (d) to permit movement about the grounds of the treatment facility, with or without the accompaniment of staff. The secretary shall notify the Board at appropriate intervals concerning any changes in the commitment or custody status of persons committed under the involuntary treatment act where the court has made a special finding under RCW 71.05.280(3)(b). The panel shall have access, upon request, to a committed person's complete hospital record, and any other records deemed necessary by the Board.~~

~~(2) The members of the public safety review panel shall be appointed by the governor for a renewable term of three years and shall include the following:~~

~~(a) A psychiatrist;~~

~~(b) A licensed clinical psychologist;~~

~~(c) A representative of the department of corrections;~~

- (d) A prosecutor or a representative of a prosecutor's association;
- (e) A representative of law enforcement or a law enforcement association;
- (f) A consumer and family advocate representative; and
- (g) A public defender or a representative of a defender's association.

(3) ~~Thirty days prior to issuing a recommendation for conditional release under RCW [10.77.150](#) or forty five days prior to issuing a recommendation for release under RCW [10.77.200](#), the secretary shall submit its recommendation with the committed person's application and the department's risk assessment to the public safety review panel. The public safety review panel shall complete an independent assessment of the public safety risk entailed by the secretary's proposed conditional release recommendation or release recommendation and provide this assessment in writing to the secretary. The public safety review panel may, within funds appropriated for this purpose, request additional evaluations of the committed person. The public safety review panel may indicate whether it is in agreement with the secretary's recommendation, or whether it would issue a different recommendation. The secretary shall provide the panel's assessment when it is received along with any supporting documentation, including all previous reports of evaluations of the committed person in the person's hospital record, to the court, prosecutor in the county that ordered the person's commitment, and counsel for the committed person.~~

(4) ~~The secretary shall notify the public safety review panel at appropriate intervals concerning any changes in the commitment or custody status of persons found not guilty by reason of insanity, or persons committed under the involuntary treatment act where the court has made a special finding under RCW [71.05.280](#)(3)(b). The panel shall have access, upon request, to a committed person's complete hospital record, and any other records deemed necessary by the public safety review panel.~~

(5) ~~The department shall provide administrative and financial support to the public safety review panel. The department, in consultation with the public safety review panel, may adopt rules to implement this section.~~

(6) ~~By December 1, 2014, the public safety review panel shall report to the appropriate legislative committees the following:~~

(a) ~~Whether the public safety review panel has observed a change in statewide consistency of evaluations and decisions concerning changes in the commitment status of persons found not guilty by reason of insanity;~~

(b) ~~Whether the public safety review panel should be given the authority to make release decisions and monitor release conditions;~~

(c) ~~Whether further changes in the law are necessary to enhance public safety when~~

~~incompetency prevents operation of the criminal justice system and long term commitment of the criminally insane; and~~

~~(d) Any other issues the public safety review panel deems relevant.~~

NEW SECTION. Sec. 25. Deliberative records produced when the Board is in executive session and acting in its quasi-judicial capacity are confidential in their entirety and shall not be disclosed to the public .

NEW SECTION. Sec. 26. All commitments existing on, before, or after July 1, 2015 shall fall under the exclusive jurisdiction of the Board upon the effective date of this act. Any proceedings under this chapter for review of a commitment, conditional release, revocation or modification of conditional release, or unconditional release that are pending on or after the effective date of this act shall be immediately transferred to the Board for adjudication.

NEW SECTION. Sec. 27. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. Sec. 28. This bill shall take effect on July 1, 2015.

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STATE OF WASHINGTON
_____ COUNTY SUPERIOR COURT

In re the Detention of:

Respondent.

NO.

CONDITIONAL RELEASE ORDER –
WSH COMMUNITY PROGRAM
WARD

This matter comes before the court through an agreed motion for conditional release under RCW 10.77.150 to the Western State Hospital (WSH) Community Program (CP). In evaluating whether Respondent’s conditional release is appropriate under RCW 10.77, the Court has considered the following materials:

1. All pleadings on file with the court;
2. The risk assessment by Dr. _____ dated _____, 20__;
3. The recommendation of the Secretary of DSHS, through the Secretary’s designee, the WSH Risk Review Board (RRB);
4. The Respondent’s current treatment contract; and
5. The recommendations of the Public Safety Review Panel (PSRP).

Based on these materials and the arguments of counsel, the Court hereby enters the following:

I. FINDINGS OF FACT

1 A. Respondent was civilly committed under RCW 10.77 following a determination of
2 Not Guilty by Reason of Insanity (NGRI). Respondent remains subject to commitment under
3 RCW 10.77 until and unless the Respondent is unconditionally released following appropriate
4 statutory proceedings.

5 B. The Secretary of DSHS, through the Secretary's designee, supports the
6 Respondents request to be granted conditional release to the WSH CP under the terms and
7 conditions specified herein.

8 C. If conditionally released to the WSH CP under the terms and conditions specified
9 herein, Respondent is not a substantial danger to other persons and does not present a substantial
10 likelihood of committing criminal acts jeopardizing public safety or security.

11
12 **II. CONCLUSIONS OF LAW**

13 A. The Court has jurisdiction over the parties and subject matter of this criminal
14 insanity proceeding.

15
16 B. Under RCW 10.77.150, Respondent should be released upon such conditions as
17 are necessary to protect the safety and security of the public and provide for the care and treatment
18 of the Respondent.

19
20 Based on the foregoing Findings of Fact and Conclusions of Law, the Court hereby
21 ORDERS the following:

22
23 1. Respondent shall be conditionally released to the Western State Hospital
24 Community Program;

25 2. Respondent's conditional release to the Western State Hospital Community
26 Program shall be subject to the following release conditions:

1 III. ORDER

2 For the purposes of this Order and any subsequent modification thereto, the
3 Respondent's "Transition Team" is defined as a representative from the WSH CP, a
4 representative from the Department of Corrections (DOC), and a designated representative of
5 WSH Center for Forensic Services (CFS). During his conditional release, Respondent shall
6 always act in a manner that is consistent with the goal of community safety and treatment for
7 his mental condition. Respondent shall construe the Court's conditions in the broadest possible
8 manner for these dual purposes. If Respondent is unsure whether his behavior is prohibited or
9 if he receives conflicting information from different members of his Transition Team, he shall
10 refrain from engaging in the behavior until he obtains approval from the Transition Team.

11 **Section 1: Residential Conditions**

- 12 1. Respondent shall abide by all rules, regulations, and policies of the Court, DOC, and
13 the Community Program, which shall be provided to Respondent and signed by him.
14 Respondent shall also follow directives given by the WSH Community Program, DOC
15 or DSHS staff.
- 16 2. The Community Program shall immediately notify law enforcement if Respondent
17 leaves the approved residence without permission. The Community Program shall
18 also immediately report to the Court, the prosecutor, the PSRP and DOC if the
19 Respondent leaves the housing/perimeter to which he has been assigned without
20 authorization or violates any of the treatment conditions or this Court's order.
21 Respondent shall reside at the WSH Community Program Ward. Respondent shall not
22 change his residence without further order of the Court an in compliance with RCW
23 10.77.180.
- 24 3. Respondent's movement in the community will be controlled by the Transition Team
25 subject to applicable statutes. If granted authorized leave while residing on the
26 Community Program Ward, the Respondent shall refrain from visiting any location
that is not included in the established geographic zones approved by the Transition
Team. The Respondent shall also refrain from visiting any location specifically
prohibited by his Transition Team.
4. The Community Program shall notify local law enforcement of Respondent's presence
in the community and the terms of his conditional release order. If Respondent is
granted an authorized leave for an overnight stay within another police jurisdiction,
The Community Program shall extend notification to that jurisdiction.

1 **Section 2: Treatment Conditions**

- 2
- 3 1. Respondent shall engage in treatment with the Community Program. A written
- 4 treatment contract is attached that outlines expected treatment. The Community
- 5 Program may modify the terms of treatment contract upon written notice to
- 6 Respondent and the Transition Team. Any disagreement with the change of the
- 7 treatment contract may be taken to the RRB for review and decision.
- 8
- 9 2. Respondent shall comply fully with all provisions of the treatment contract and any
- 10 treatment recommendations made by the Community Program.
- 11
- 12 3. Respondent shall participate in any treatment recommended by the Transition Team
- 13 and provided by the Community Program, including but not limited to mental health
- 14 treatment and/or drug and alcohol treatment.
- 15
- 16 4. The Community Program shall submit a written report to the Court every six months
- 17 addressing Respondent's treatment progress and compliance with this Court's order,
- 18 with copies to Respondent's attorney, the prosecutor, DOC, the PSRP and each
- 19 member of the Respondent's Transition Team. The report shall include input from
- 20 Respondent's Transition Team.
- 21
- 22 5. The Community Program shall immediately report to the Court, the prosecutor, and
- 23 the DOC any violations of this Court's order or treatment conditions.
- 24
- 25 6. The members of the Transition Team shall be notified within five (5) business days if
- 26 the Respondent's prescription for any drugs with a psychiatric effect is initiated,
- changed or altered.
7. At Respondent's request, and with the concurrence of the Transition Team, Respondent may return to temporary residence at WSH for voluntary stabilization. If Respondent is voluntarily re-hospitalized, WSH shall notify the Respondent's attorney, the prosecutor, and the Court by the close of the next business day with a brief explanation of the circumstances surrounding the voluntary re-hospitalization. Respondent may not return to his community placement until the case is reviewed by the CFS Risk Review Board (RRB), the RRB approves his return to the community, and adequate notice of the anticipated return is provided to the Transition Team, the Respondent's attorney, the prosecutor and the Court. If the Respondent chooses to leave the hospital without following this process, the hospital may detain the Respondent pursuant to RCW 10.77.190 (1). Nothing in this provision precludes a proceeding to revoke the conditional release based upon the circumstances surrounding the voluntary re-hospitalization.

1 **Section 3: Supervision Conditions:**

- 2
- 3 1. The Community Program and the DOC shall ensure Respondent's compliance with
- 4 this order.
- 5 2. The Community Program and DOC shall immediately report to the Court, the
- 6 Respondent's attorney, the prosecutor, and DSHS any violations of this Court's Order,
- 7 or treatment conditions.
- 8 3. Respondent shall be subject to supervision by DOC. DOC shall assigned a Community
- 9 Corrections Officer (CCO) familiar with Respondent's case and treatment plan. The
- 10 CCO shall have training and experience supervising persons who suffer from mental
- 11 illness, including de-escalation and crisis intervention techniques.
- 12 4. Respondent shall comply with all verbal and written instructions from the Community
- 13 Program and the CCO. The CCO shall meet with the Respondent at the WSH
- 14 Community Program within 72 hours of conditional release and monthly thereafter or
- 15 as directed.
- 16 5. Respondent shall have no intentional direct or indirect contact with any prior victims
- 17 or their families, except as listed here: _____
- 18 _____
- 19 or as approved in writing by members of the Transition Team. Any prior no contact
- 20 court orders remain in full effect and cannot be altered by the Transition Team.
- 21 6. Respondent shall not own, possess, receive, ship, or transport any firearm,
- 22 ammunition, incendiary device, or explosive, nor shall he have any parts thereof.
- 23 7. Respondent shall not drive any motor vehicle or possess a driver's license until
- 24 granted written permission from the Transition Team
- 25 8. Respondent shall not use or possess alcohol or marijuana unless ordered by the court.
- 26 Respondent shall not possess any controlled substance except pursuant to a lawfully
- issued prescription made out for him/her by a licensed physician. Respondent shall
- immediately provide written verification and notice of any prescription medication to
- the Transition Team.
9. Respondent shall submit to tests for alcohol, marijuana, or other controlled substances
- upon request.
10. Respondent shall obey all state, federal, tribal, and municipal laws.

11. Respondent shall remain in the current state of remission from the effects of mental disease or defect and have no significant deterioration of mental condition or other significant sign of decompensation.
12. To maintain compliance with the conditions of this order, Respondent shall submit to searches of his person, residence or property at the discretion of the Community Program or DOC.
13. Respondent shall not leave the State of Washington without the prior written approval of the Transition Team and an Order from the Court.
14. The conditions required of the Respondent by the Community Program, DOC, and this Order, should, where possible, be read together and in harmony with one another. However, there may be a situation where they conflict. If this occurs, The Community Program and DOC shall consult one another to resolve the conflict. If the Transition Team is unable to resolve the conflict, the Court will determine the matter. Until such time as any conflict is determined, the Respondent is to follow the strictest rule applicable.
15. Respondent shall comply with all provisions of this Order and any subsequent modifications thereof. Respondent shall notify the Transition Team if he has questions regarding any provision of the order or has violated provisions of this order.

DATED this _____ day of _____, 2013.

 THE HONORABLE _____
 Judge of the Superior Court

Agreed by:

 WSBA # _____
 Attorney for Respondent

 Respondent

 WSBA # _____
 Attorney for Petitioner/Prosecutor

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STATE OF WASHINGTON
_____ COUNTY SUPERIOR COURT

In re the Detention of:

Respondent.

NO.

CONDITIONAL RELEASE ORDER
FROM WSH COMMUNITY
PROGRAM TO PLACEMENT IN
THE COMMUNITY

This matter comes before the court through an agreed motion for Respondent’s further conditional release under RCW 10.77.150 from the Western State Hospital (WSH) Community Program (CP) to placement in the community. In evaluating whether Respondent’s conditional release to the community is appropriate under RCW 10.77, the Court has considered the following materials:

1. All pleadings and reports on file with the court;
2. The risk assessment by Dr. _____ dated _____, 20__;
3. The recommendation of the Secretary of DSHS, through the Secretary’s designee, the WSH Risk Review Board (RRB);
4. The Respondent’s current treatment contract;
5. The recommendations of Respondent’s community treatment provider, Dr. _____;
6. The recommendations of the Department of Corrections set forth in the _____, 20__ investigative report; and
7. The recommendations of the Public Safety Review Panel (PSRP).

1
2 Based on these materials and the arguments of counsel, the Court hereby enters the
3 following:

4
5 I. FINDINGS OF FACT

6 A. Respondent was civilly committed under RCW 10.77 following a determination of
7 Not Guilty by Reason of Insanity (NGRI). Respondent remains subject to commitment under
8 RCW 10.77 until and unless the Respondent is unconditionally released following appropriate
9 statutory proceedings.

10 B. The Secretary of DSHS, through the Secretary's designee, supports the
11 Respondents request to be granted conditional release from the WSH CP to placement in the
12 community under the terms and conditions specified herein.

13 C. If conditionally released to the community under the terms and conditions
14 specified herein, Respondent is not a substantial danger to other persons and does not present a
15 substantial likelihood of committing criminal acts jeopardizing public safety or security.

16
17 II. CONCLUSIONS OF LAW

18 A. The Court has jurisdiction over the parties and subject matter of this criminal
19 insanity proceeding.

20 B. Under RCW 10.77.150, respondent should be released upon such conditions as are
21 necessary to protect the safety and security of the public and provide for the care and treatment of
22 the Respondent.
23

24
25 Based on the foregoing Findings of Fact and Conclusions of Law, the Court hereby
26 ORDERS the following:

1 **Section 2: Treatment Conditions**

- 2
- 3 1. Respondent shall engage in treatment with his CMHTP, Dr. _____. A written
- 4 treatment contract is attached that outlines expected treatment. The CMHTP may
- 5 modify the terms of the treatment contract only upon written notice to Respondent and
- 6 the Transition Team.
- 7 2. Respondent shall comply fully with all provisions of the treatment contract and any
- 8 treatment recommendations made by the CMHTP.
- 9 3. Respondent shall participate in any treatment recommended by the Transition Team,
- 10 including but not limited to mental health treatment and/or drug and alcohol treatment.
- 11 4. The Community Program shall submit a written report to the Court every six months
- 12 addressing Respondent's treatment progress and compliance with this Court's order,
- 13 with copies to Respondent's attorney, the prosecutor, DOC, the PSRP and each
- 14 member of the Respondent's Transition Team. The report shall include input from
- 15 Respondent's Transition Team, including the CMHTP.
- 16 5. Any member of the Transition Team shall immediately report to the Court, the
- 17 prosecutor, and the DOC any violations of this Court's order or treatment conditions.
- 18 6. The members of the Transition Team shall be notified within five (5) business days if
- 19 the Respondent's prescription for any drugs with a psychiatric effect is initiated,
- 20 changed or altered.
- 21 7. At Respondent's request, and with the concurrence of the Transition Team,
- 22 Respondent may return to temporary residence at WSH for voluntary stabilization. If
- 23 Respondent is voluntarily re-hospitalized, WSH shall notify the Respondent's
- 24 attorney, the prosecutor, and the Court by the close of the next business day with a
- 25 brief explanation of the circumstances surrounding the voluntary re-hospitalization.
- 26 Respondent may not return to his community placement until the case is reviewed by
- the CFS Risk Review Board (RRB), the RRB approves his return to the community,
- and adequate notice of the anticipated return is provided to the Transition Team, the
- Respondent's attorney, the prosecutor and the Court. If the Respondent chooses to
- leave the hospital without following this process, the hospital may detain the
- Respondent pursuant to RCW 10.77.190 (1). Nothing in this provision precludes a
- proceeding to revoke the conditional release based upon the circumstances
- surrounding the voluntary re-hospitalization.

24 **Section 3: Supervision Conditions:**

- 25 1. The Community Program and the DOC shall ensure Respondent's compliance with
- 26 this order.

- 1
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3 2. The Community Program and DOC shall immediately report to the Court, the
Respondent's attorney, the prosecutor, and DSHS any violations of this Court's Order,
or treatment conditions.
- 4
5
6 3. Respondent shall be subject to supervision by the CP and DOC. DOC shall assign a
Community Corrections Officer (CCO) familiar with Respondent's case and treatment
plan. The CCO shall have training and experience supervising persons who suffer
from mental illness, including de-escalation and crisis intervention techniques.
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9 4. Respondent shall comply with all verbal and written instructions from the CP and
CCO. The CCO shall meet with the Respondent within 72 hours of conditional release
(not including weekends or holidays). The CCO shall meet with the Respondent at least
___ times for the first six months/one year and thereafter as determined necessary by
the Transition Team.
- 10
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12 5. Respondent shall have no intentional direct or indirect contact with any prior victims
or their families, except as listed here: _____

or as approved in writing by members of the Transition Team. Any prior no contact
court orders remain in full effect and cannot be altered by the Transition Team.
- 13
14
15 6. Respondent shall not own, possess, receive, ship, or transport any firearm,
ammunition, incendiary device, or explosive, nor shall he have any parts thereof.
- 16
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18 7. Respondent shall not drive any motor vehicle or possess a driver's license until
granted written permission from his Transition Team unless already given permission
by the prior Transition Team.
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21 8. Respondent shall not use or possess alcohol or marijuana unless ordered by the court.
Respondent shall not use or possess any controlled substance except pursuant to a
lawfully issued prescription made out for him/her by a licensed physician. Respondent
shall immediately provide written verification and notice of any prescription
medication to the Transition Team.
- 22
23 9. Respondent shall submit to tests for alcohol, marijuana, or other controlled substances
upon request.
- 24
25 10. Respondent shall obey all state, federal, tribal, and municipal laws.
- 26 11. Respondent shall remain in the current state of remission from the effects of mental
disease or defect and have no significant deterioration of mental condition or other
significant sign of decompensation.

1 12. To maintain compliance with the conditions of this order, Respondent shall submit to
2 searches of his person, residence or property at the discretion of the CP or DOC.

3 13. Respondent shall not leave the State of Washington without the prior written approval
4 of the Transition Team and an Order from the Court.

5 14. The conditions required of the Respondent by the CP, DOC, the CMHTP and this
6 Order, should, where possible, be read together and in harmony with one another.
7 However, there may be a situation where they conflict. If this occurs, The CP, the
8 CMHTP and DOC shall consult one another to resolve the conflict. If the Transition
9 Team is unable to resolve the conflict, the Court will determine the matter. Until such
10 time as any conflict is determined, the Respondent is to follow the strictest rule
11 applicable.

12 15. Respondent shall comply with all provisions of this Order and any subsequent
13 modifications thereof. Respondent shall notify the Transition Team if he has questions
14 regarding any provision of the order or has violated provisions of this order.

15 DATED this _____ day of _____, 2013.

16 _____
17 THE HONORABLE _____
18 Judge of the Superior Court

19 Agreed by:

20 _____
21 WSBA # _____
22 Attorney for Respondent

23 _____
24 Respondent

25 _____
26 WSBA # _____
Attorney for Petitioner/Prosecutor