State of Washington

Forensic Evaluation Report Guidelines:

Competency to Stand Trial

Office of Forensic Mental Health Services

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Acknowledgments

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About the Office of Forensic Mental Health Services

The Department of Social and Health Services' (DSHS) Behavioral Health Administration's (BHA) Office of Forensic Mental Health Services (OFMHS) is responsible for the leadership and management of Washington's adult forensic mental health care system. OFMHS provides forensic evaluations, competency restoration services, Not Guilty by Reason of Insanity - NGRI treatment services, and liaison services to effectively coordinate efforts with system partners to meet shared goals. The office is supported by RCW 10.77.280.

The vision of OFMHS is to be a leader of innovation and expertise in delivering mental health services.
The mission of OFMHS is to provide timely, high-quality, collaborative services, and assistance at the intersection of behavioral health and the law for the people of Washington.

OFMHS encompasses the following stations:

- Central Regional Office (CRO)
- Northern Regional Office (NRO)
- Eastern Regional Office (ERO)
- Snohomish Whatcom Island San Jan Skagit (SWISS)
- Southwest Regional Office (SRO)
- Inpatient Forensic Evaluation Services (IFES)
- Out-of-Custody/Personal Recognizance (PR)

Competency Restoration services are offered at:

- Eastern State Hospital (ESH)
- Fort Steilacoom Competency Restoration Program (FSCRP)
- Maple Lane Competency Restoration Program (MLCRP)
- Outpatient Competency Restoration Program (OCRP)
- Western State Hospital (WSH)

1. About This Manual

The objective of this manual is to provide guidance and information for writing competency to stand trial (CST) evaluation reports pursuant to Revised Code of Washington (RCW) 10.77 of the State of Washington. This manual is intended to promote consistency and quality in the completion of competency to stand trial evaluations by forensic mental health professionals who are authorized to conduct these evaluations. This includes OFMHS forensic evaluators as well as with those conducting competency evaluations throughout counties within the State of Washington. The latter entity is subject to quality review according to the standards set forth on this manual per Washington Administrative Code 388-875-0040.

This manual is not intended to be a substitute for formal training for forensic mental health professionals, or any other training program; rather, it is intended as a guide and resource for those already trained, or in the process of training, to be a forensic evaluator in Washington State. Both training in forensic psychological assessment and a working knowledge of the relevant State of Washington competency statutes pertaining to the treatment and involuntary hospitalization of persons with mental illness in our state are necessary for the completion of an adequate competency to stand trial evaluation in Washington.

This manual integrates accepted standards of forensic practice with the specific requirements of competency evaluations in the State of Washington. The manual provides relevant statutory and practice information including:

- Relevant, applicable legal standards
- Procedural information for the conducting of evaluations
- Accepted structure and outline for competency to stand trial reports
- Suggestions for ethical and effective communication with the court and attorneys
- Provision of sample reports
- Standards and procedures for Quality Control

2. Who Is Authorized to Conduct Forensic Evaluations in the State of Washington?

According to RCW 10.77.010 the following "professional persons" are authorized to be eligible to conduct evaluations:

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;
c) A psychiatric advanced registered nurse practitioner, as defined in RCW 71.05.020; or

d) A social worker with a master's or further advanced degree from a social work educational program accredited and approved as provided in RCW 18.320.010.

In addition to the above legally defined general requirements, forensic evaluators working under the aegis of OFMHS, or employed by Washington State as a contractor, should have:

- A Washington State license in good standing in their relevant profession;
- Satisfactorily passed a criminal background check;
- Knowledge of Washington State competency statutes;
- An understanding of psychological testing;
- Clinical assessment and diagnostic skills;
- Strong report writing skills;
- Experience performing competency evaluations of criminal defendants; and
- Utilization of relevant supervision and expertise in areas of forensic practice.

3. Quality Control and Supervision of Forensic Evaluations

Within OFMHS, the Forensic Evaluator has a strictly defined role. The scope of the evaluation is defined by RCW 10.77 and the referring court order. The evaluator does not conduct evaluations on issues or populations outside their area of expertise. All forensic evaluations are to be conducted from a neutral stance. An evaluator is neither an advocate for the defense nor the prosecution. The role of the forensic evaluator is to assist the trier of fact by providing information to the Court that is relevant, impartial, and data-driven. While the opinions of Forensic Evaluators are ultimately their own, Forensic Evaluators are presenting that opinion as an employee, or subcontractor, of the Washington State Department of Social and Health Services (DSHS). Forensic evaluators affiliated with, or employed by, OFMHS are assumed to be highly skilled and ethical clinicians, and their work product is expected to reflect professional standards.

The Forensic Services Supervisors, in conjunction with a peer review committee, are tasked with conducting quality reviews of forensic services that fulfill statutory obligations under RCW 10.77.280. All forensic evaluators participate in peer review and have their work reviewed, minimally, on an annual basis. The peer review committee is comprised of one peer review chairperson and one member from each of the six forensic units. The Forensic Services Supervisors oversee the peer review committee. The quality reviews focus on best practices and inform improvements to the quality of forensic mental health services within the State of Washington.

4. Legal Standards and Parameters for Competency in the State of Washington

In following what is known as the "Dusky standard," (*Dusky v. US*; 362 U.S. 402; 1960) a defendant must have both a factual as well as a rational understanding of the court proceedings against them. In ordered to be considered competent, they also must be able to meaningfully assist their attorney in their own defense. When such competence is called into question, the Court may order that a competency evaluation be completed. The purpose of the evaluation is to determine if the

individual: 1) has a mental disease or defect; and 2) if the mental disease or defect renders them incapable of understanding the nature of the proceedings against them or the capacity to assist in their own defense. Stated another way, competency to stand trial, or adjudicative competence, is the legal construct that refers to a criminal defendant's ability to participate in legal proceedings related to an alleged offense. The Dusky standard seeks to answer the question:

> Does the defendant have sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him? (*Dusky v. US*; 362 U.S. 402; 1960).

In Washington, the statute defines incompetency as:

> "… a person lacks the capacity to understand the nature of the proceedings against him or her or to assist in his or her own defense as a result of mental disease or defect." [RCW 10.77.010 (17)]

Although the Washington State competency statute does not directly address the rational component of a defendant's capacity to understand the nature of the proceedings or assist in their own defense; the Dusky standard sets the constitutional minimum bar of the competency standard, and the evaluator must also consider rational capacities when forming a competency opinion for the Court.

In the State of Washington, a defendant is presumed competent and the burden of proof for a finding of incompetence is placed on the party that is challenging competency. This burden does not shift if a defendant is found incompetent and ordered to complete restoration. The legal standard which the Court uses to determine a finding of competency/incompetence is a preponderance of evidence (Cooper v. Oklahoma, 517 U.S. 348 (1996).

Forensic competency evaluations are court ordered with the purpose of evaluating whether a person demonstrates the requisite capacities to proceed to trial. While the decision of whether a defendant is "competent" is a legal standard left to the *trier of fact*, a quality competency evaluation will describe and assess the functional components relevant to the legal concept of adjudicative competency.

5. Collection of Data Relevant to a Competence to Stand Trial Evaluation

There are a number of psychological measures and interview protocols, commonly called Forensic Assessment Instruments (FAI) which are in current use for the assessment of competency to stand trial (Zapf and Roesch, 2006). Often, the administration of these instruments is not practicable for a variety of reasons (length of time for administration, attorney present cases where the integrity of the instrument would be compromised). In these circumstances evaluators

devise their own worksheets or *aide memoire* for use during evaluation of CST to aid in applying structured professional judgement.

Accepted practice in the evaluation of competency to stand trial is based upon the assessment of competence within the context in which it is to be used. According to Golding and Roesch (1988, p.79):

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

It is therefore incumbent on the evaluator to address competency related abilities within the context of the defendant's current circumstances. Each portion of the examiner's opinion needs to be supported by data presented in prior sections of the report. The Summary of Opinions, Diagnostic Impressions, Evaluation of Competency to Stand Trial [conclusions], and Designated Crisis Responder (DCR) referral sections are the only sections where the forensic evaluator presents integrated findings and clinical opinion.

6. Evaluation Report Guidelines

The purpose of a competency evaluation report is to document and preserve a record of the competency assessment and conclusions of the forensic examiner. It is important that this document be accurate and easy to understand as it serves as the basis for review of the clinicians work by the Court before, during and after relevant legal proceedings.

Forensic evaluation reports of competency to stand trial in Washington State contain:

1. The purpose of the evaluation and the methods used to conduct the evaluation;
2. An executive summary like section which appears early in the report, titled *Summary of Opinions* that briefly outlines key opinions:
    a. Diagnosis or Current Mental Status
    b. Competency
    c. Restorability (if applicable)
    d. DCR Recommendation;
3. The data on which the opinion was based (e.g., current clinical interview, review of past medical records, prior involvement with the criminal justice system, recordings of observations of the individual from past court appearances);
4. Documentation of the defendant being notified about the limitations of confidentiality. The defendant should be informed of:
    a. The examiner's role the purpose and the authority of the evaluation
    b. That a report to the court will be made even if the defendant chooses not to participate

   c. The non-confidential nature of the report and lack of privilege even if the attorney is present
   d. The right to participate in whole or in part with the evaluation interview
   e. The right to have counsel present during interview
   f. The role of the examiner as a mandated reporter
   g. The ability of the forensic examiner to make recommendations for treatment and notice there is no treatment relationship with, or treatment provided by the examiner
   h. If telehealth is utilized for the evaluation, notification the interview is occurring on an encrypted line and is not recorded;
5. A brief relevant background of the defendant;
6. Current mental status and diagnostic conclusions with a description of the clinical interview;
7. Documentation of competency related abilities and deficits;
8. Forensic opinions with supporting data and full forensic conceptualization regarding:
   a. A description of the defendant's effort and reliability
   b. A diagnosis and description of the underlying reasons for deficiencies (e.g., mental illness, malingering, intoxication, situational causes)
   c. Opinion as to the defendant's competency to stand trial. A discussion of recommendations for remediation if relevant
   d. A referral for civil commitment under RCW 71.05 by a Designated Crisis Responder.

Included in this guidebook are samples of specific sections of the report, which appear in the annotated review of the report template. You will note that these samples, which use the standards and practices in the State of Washington, show variations in writing and presentation styles. Additionally, all these samples are excerpts from previously submitted reports in which formatting or small typographical errors have been adjusted/corrected and:

1. Follow a specific format.
   a. While each evaluation report is specific to the individual being evaluated, using a format makes it easier for those routinely reviewing these reports to know where specific information is located. It also helps the writer quickly identify if something is "missing."
2. The reports are problem-focused.
   a. The report strikes a balance – providing enough detail to inform the reader and base forensic opinion while not overwhelming in irrelevant or redundant data.
   b. Each piece of information in the report is used as a part of the reasoning for arriving at the outcome of the evaluation.
3. Reports avoid jargon.
   a. When technical terms are used, they are explained.
4. Evaluators clearly differentiate between different classes of data utilized.
   a. There are three general classes of information contained in forensic reports, which include:

i. Clinical and historical data relevant to the assessment of competency or clinical presentation
ii. inference or opinions
iii. the logic explaining the relationship between the data and opinions (e.g., nexus)

5. Evaluators offer opinions only in specific sections:
   a. Summary of Opinions section
   b. Diagnostic Impression
   c. Competency to Stand Trial Impression
   d. Recommendations for Restoration
   e. Necessity for a DCR evaluation

7. The Report Structure

Reports should include the following sections:

1. Identifying Data
2. Referral Information
3. Summary of Opinions
4. Nature of the Evaluation
5. Relevant Clinical History and Collateral Information
6. Mental Status Examination
7. Clinical Summary and Diagnostic Formulation
8. Competency to Stand Trial Impression
    i. Competency Opinion
    ii. Barriers to Competency
    iii. Restoration Opinions
    iv. Involuntary Administration of Medications
    v. Opinion Regarding Dangerousness
9. Necessity for Designated Crisis Responder (DCR) Evaluation
10. Signature and Report Copies

It is easier for courts to find information when a standard format and order of information is consistently used. Thus, it is recommended that forensic evaluator use the above sections in order. Each of these sections are described in detail below and examples are provided.

7.1 Identifying Data

The Identifying Data section of the report (see example on the next page) is the set of information the reader will see and must include, at a minimum; OFMHS (or contractor's) business address, the date the report was submitted, the relevant jurisdiction and cause number, followed by the defendant's name, medical record number (MRN) (e.g., Western or Eastern State Hospital, if applicable) and/or the Client Identification Number (CIN), and the defendant's date of birth. Finally, at the bottom of this section will be a disclaimer paragraph noting the intended recipient of the report and applicable legal guiding the release of the document.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Behavioral Health Administration
Office of Forensic Mental Health Services

DATE HERE

COMMUNITY FORENSIC EVALUATION SERVICE
COMPETENCY ASSESSMENT REPORT

RE: STATE OF WASHINGTON	**CAUSE NO: 11-11-11111**
vs.	**CIN (MRN): 111111**
JOHN SMITH	**DOB: 1/1/11**

The forensic evaluation reflected in this report was conducted pursuant to Court order under the authority of Revised Code of Washington (RCW) 10.77.060. This report was released only to the Court, its officers, and to others designated in statute and is intended for their use only. Any other use or distribution of this document is not authorized by the undersigned.

7.2 Referral Information

The Referral Information immediately follows the Identifying Data section and needs to include the authorizing court, the referral question, and the identification of the pending charges.

Example 1

REFERRAL INFORMATION

On April 14, 2017, the Superior Court of Anywhere County ordered Mr. John Smith to undergo an outpatient evaluation regarding his competency to proceed to trial. In addition to a competency opinion, an opinion as to whether the defendant should be evaluated by a designated crisis responder (DCR) under RCW 71.05 will also be addressed. The reason the defendant was referred for evaluation was not noted in available documents.

The defendant is charged with one count of Assault in the Third Degree, which allegedly occurred on or about April 12, 2017.

7.3 Summary of Opinions

The Summary of Opinions Section needs to include the evaluator's conclusive opinions regarding the defendant's:

a. *Diagnosis or description of symptoms/current mental status;*

b. *Competency-related abilities;*
c. *Recommendations for restoration (if applicable); and*
d. *Necessity for a DCR assessment.*

Example 1

<u>SUMMARY OF OPINIONS</u>

The following are a summary of my opinions based on my evaluation of the defendant:

- <u>Diagnostic Impression</u>: Schizophrenia
- <u>Competency:</u> Mr. Smith has the capacity to understand the nature of the proceedings he faces and lacks the capacity to assist in his defense.
- <u>DCR Evaluation</u>: An evaluation by a DCR is warranted at this time.

Example 2

<u>SUMMARY OF OPINIONS</u>

The following are a summary of opinions based on the current evaluation of the defendant:

Diagnosis or Current Mental Status: Mr. Smith displays active symptoms of psychosis and meets diagnostic criteria for *Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (provisional).*

Competency: Mr. Smith continues to lack the capacity to understand the nature of the proceedings against him and the capacity to assist in his own defense due to active symptoms of a mental illness.

Restorability: In consultation with Mr. Smith's treating clinicians as well as a review of available clinical progress notes, there does not appear to be a substantial likelihood that further restoration would produce significant abatement of the observed barriers to his competency related abilities.

DCR Evaluation: An evaluation by a DCR is recommended prior to release from custody.

7.4 Nature of the Evaluation

The Nature of the Evaluation section includes information regarding who was present for the evaluation, as well as the notification given to the defendant about the purpose and scope of the evaluation, the limits on confidentiality, the right to have an attorney present, and the right to refuse to be interviewed. Additionally, the notification should include notice the evaluator is in a neutral role but still may make treatment recommendations and is a mandatory reporter. If the evaluation was conducted via telehealth, the nature of the evaluation must also address the location of all parties, the specific platform utilized, and the additional notification provided to the defendant including encryption, the lack of recording, and the

necessity of reporting any malfunctioning immediately. This section also contains a list of all of the sources of information that formed the basis for your opinion.

Example 1

NATURE OF THE EVALUATION

Notification and Agreement to Participate: Pursuant to RCW 10.77.060, Psychologist, Psy.D., a Licensed Psychologist and Forensic Evaluator, was designated as the qualified expert to evaluate and report upon the mental condition of Mr. Smith. Portions of this report were drafted by Fellow, Ph.D., Postdoctoral Fellow, under the direct supervision of Dr. Psychologist. The opinions contained herein are expressly that of Dr. Psychologist.

Mr. Smith's interview was conducted by videoconference at the Maple Lane Competency Restoration Program. Defense counsel, Ms. Attorney, was present by video. A certified Korean interpreter was present by telephone. The first interpreter, Mr. Interpreter (no. 000000), assisted the first 100 minutes of the interview until the call disconnected unexpectedly. The Maple Lane staff reconnected us to the Language Line, and interpreter, Ms. Interpreter (no. 000001), assisted for the remainder of the interview.

The video transmission between the facility, where Mr. Smith is a resident, and the examiners' private offices was tested prior to the evaluation. Any necessary adjustments were made to ensure the adequacy of the transmission. The interview was a live transmission through encrypted channels to ensure the privacy and confidentiality of the interview. The session was not recorded. Mr. Smith was instructed to immediately inform the examiner if at any time he had difficulty in hearing or understanding what was being said. He agreed to do so. There were no indications that conducting the interview by video interfered with our abilities to participate in the interview, nor did it interfere with the examiner's ability to form the requisite opinions. Defense counsel experienced some difficulty with her audio, which resolved by her logging out then back into the system.

Before beginning the interview, the examiner reviewed the role and expectations of the evaluation with the interpreter. The examiner then informed Mr. Smith of the purpose and authority for the evaluation, the distribution of the report, and the non-confidential nature of the assessment. Mr. Smith was told that he had the right to consult with his attorney at any time during the interview and that he could decline to answer questions. Mr. Smith was advised to not volunteer any specific information about the events that led to his charge. Mr. Smith was informed that recommendations concerning further assessment or treatment could be made to the Court and that the undersigned was solely in an evaluative role for the Court. Additionally, the defendant was informed of the examiner's statutory duties as a licensed psychologist to report, inform, and warn, should information relative to those responsibilities become evident during the evaluation.

To gauge Mr. Smith's understanding of these rights, I asked him to rephrase two of them. Mr. Smith recalled, "This video and audio not being recorded to guarantee confidentiality, but you will be keeping record of what I am saying, and me or my attorney can stop the evaluation." I asked to whom the report will be sent. Mr. Smith articulated, "People within court, judge, and two lawyers." Mr. Smith agreed to participate in the interview.

Sources of Information
The following information was reviewed and considered in the preparation of this report:

1. Court Order;
2. Discovery materials;
3. Office of Forensic Mental Health Services (OFMHS) / Western State Hospital (WSH) records;
    a. Competency Evaluation report authored by Evaluator, Psy.D., and references contained therein, dated October 17, 2021;
    b. Competency Evaluation report authored by Evaluator, Psy.D., and references contained therein, dated October 14, 2020;
    c. Western State Hospital discharge summary authored by Dr. Psychiatrist, dated January 21, 2020;
4. Maple Lane treatment records;
5. Personal interview of Mr. Smith on January 6, 2022, for approximately 135 minutes with a Korean interpreter.

Example 2

NATURE OF THE EVALUATION

Notification and Agreement to Participate
Pursuant to RCW 10.77.060, Supervisor, Ph.D., licensed psychologist/forensic evaluator, was designated as the qualified expert to evaluate and report upon the mental condition of Mr. Smith. Mr. Smith's attorney, James Doe, attended the evaluation via telephone. Before beginning the interview, I advised Mr. Smith of the nature and purpose of the evaluation. I informed him of the limited confidentiality of the evaluation interview and that his remarks and observed behaviors may be included in the evaluation report. I also told him to whom the report would be distributed. I notified him the evaluation interview was voluntary, and he could request to terminate the interview at any time. I informed him of the right to have his attorney present for the interview, and that he could speak with them at any time. In addition, I notified him that recommendations concerning further assessment or treatment could be made to the Court, and I was only serving in a neutral, evaluative role for the Court. Lastly, I told Mr. Smith of my statutory duties as a licensed psychologist to report, inform, and warn, should information relative to those responsibilities become evident during the evaluation.

To gauge Mr. Smith's understanding of these rights, he was asked to rephrase two of them. He reported that he had the "right to remain silent – not talk at all" and the "right to have my attorney present." Mr. Smith denied having questions about the notification and verbally agreed to participate in the interview.

Sources of Information
The following information was reviewed and considered during the completion of this evaluation:

1. Prosecutor's discovery information.
2. Behavioral Health Reporting System Database.

3. An approximately one hour and 30-minute clinical interview of Mr. Smith at the Anywhere County Jail on 12/18/17. The parties present for the evaluation were Mr. Smith, Mr. Doe, and the undersigned.
4. Mental Status Examination.
5. Criminal History Report, as provided in discovery.
6. Jail mental health records.
7. Eastern State Hospital (ESH)/Office of Forensic Mental Health Services (OFMHS) records (no prior admissions or evaluations).
8. Selected Items from the Revised Competency Assessment Instrument (R-CAI).

Note: The defendant's records from the Department of Corrections were requested for this evaluation. As of the submission of this report, those records have not been received. If the records are received, and substantively change the opinions expressed in this report, an addendum will be submitted to parties.

Example 3

NATURE OF EVALUATION

Notification and Agreement to Participate

Mr. Smith was interviewed by the undersigned in a conference room in the intake area of the Anywhere County Correctional Facility on January 11, 2018 for approximately one hour. Attorney Jane Johnson was present for the interview. Mr. Smith was informed of the purpose and authority for the evaluation, the distribution of the report, and the non-confidential nature of the evaluation. He was informed he had the right to have his attorney present and to decline to answer questions. He was also told that recommendations concerning further assessment or treatment could be made to the Court, and that the undersigned was solely in an evaluative role for the court. He was told the examiner was a mandated reporter. He agreed to continue the interview.

Sources of Information

1. Discovery materials.
2. Personal interview of Mr. Smith on January 11, 2018.
3. Anywhere County Correctional Facility- consultation with mental health staff.
4. Western State Hospital records.
5. State of Washington Division of Mental Health online databases.
6. Criminal history reports – not available.

7.5 Relevant Clinical History and Collateral Information

This section includes relevant information about the defendant's background, based on the personal interview and collateral information; it is not meant to be an exhaustive history of the defendant. It is important to be clear in attributing the information summarized in this section to its source (e.g., self-report, jail records, specific database). Also important is designating a section of relevant records (e.g., jail records) to addressing any current medications and the defendant's treatment adherence. If relevant

psychosocial data has been outlined for the court in a previous report under the same cause number (see Example 2), and no new historical data was discussed in the current forensic interview, referring the court to the specific previous evaluation(s) may be acceptable.

Example 1

RELEVANT CLINICAL HISTORY AND COLLATERAL INFORMATION

Except where otherwise noted, the following psychosocial history was supplied solely by the defendant's self-report and is thus limited by the credibility of the defendant. Only that subset of information relevant to the purpose of this evaluation as reported here and it therefore does not represent a complete history of the defendant. The accuracy of the historical information provided is limited by the veracity of those sources.

Brief Psychosocial Background: Mr. Smith was born and raised in Place. He was raised primarily by his mother. His father died in 2011. He has four brothers and one sister. He has no contact with his mother. He reported that he was residing with his brother prior to his incarceration. He said that his mother may have a history of mental illness. He denied any knowledge of a family history of substance abuse. He endorsed a history of abuse and neglect during his childhood, but he did not want to disclose more specific details.

Mr. Smith obtained his General Equivalency Diploma (GED) in 1998. He did not know the highest grade that he completed while in school. He denied receiving any special education services. He denied having any behavioral problems. He reported being retained for the first grade because "I wasn't really there enough."

When asked about his occupational history, Mr. Smith said, "I know almost any trade there is." He reported a history of employment "splitting firewood" but could not identify any other specific employment experiences. He has a history of receiving disability income, but he denied receiving these benefits recently.

Mr. Smith has never married. He reported having one son that is about 21 years old. He denied having any contact with his son.

Prior to his incarceration, Mr. Smith was residing in a cabin that is owned by a friend. He reported being there for the past several months. It also appears that he has a lengthy history of homelessness.

Medical: When asked about his medical history, Mr. Smith said, "Wanted to get an MRI or CAT scan, something going on with my head. I have parasites moving around, drives me nuts. I suspect they are not good." He reported sustaining a possible head injury during his childhood when he was struck in the head by a swing. He explained, "Split my skull open." He also reported that after being incarcerated, he was banging his head on a cell door.

Substance Use: Mr. Smith could not recall when he first consumed alcohol. He denied a history of alcohol abuse. He also could not recall when he first used marijuana, but he denied a history of

abuse. When asked about his use of other illicit substances, he said, "I don't want to go over different substance use issues." He denied a history of substance abuse treatment.

Mental Health: Mr. Smith said that during his childhood, he may have received some type of psychiatric treatment due to experiencing abuse and neglect. He also may have been at a "facility for abused children." When asked about his history of treatment as an adult, he said, "I'm having head pains. It's hard to focus." He reported having one hospitalization at Fairfax Hospital, but he could not explain the circumstances surrounding this treatment. He denied having any outpatient treatment. He denied a history of suicide attempts.

County Jail Records: Mr. Smith was booked into this facility on 06/06/2019. He is currently prescribed Zyprexa 10 mg daily. His compliance has been inconsistent. On 06/12/2019, a nurse noted that he had to be treated for lice and pin worm infestation.

On 06/19/2019, Mr. Smith was evaluated by a Mental Health Professional (MHP). The MHP attempted to explain the services available to him at the jail. She noted, "Mr. Smith spent much of the time with his eyes downcast and explained how he is followed, how people steal from him, how he is being held unfairly and that the police are stealing from him and how he just wants to find a way to have an end-of-life injection as he does not want to live anymore." She noted that "it was clear that he is not actively suicidal, and that he is overwhelmed by this unwelcome situation and does not trust his life in the hands of the judicial system."

On 06/22/2019, a nurse noted that Mr. Smith began refusing medications due to complaints of dizziness. It appears that since this date, he has been inconsistent in his compliance.

On 06/26/2019, a deputy noted that at approximately 2:00 AM, Mr. Smith was "kicking the door to his cell. He was yelling and screaming creating a disturbance in his cell block. I asked him to stop, but he would not listen. He continued kicking on and off for an hour."

Current Medication/Treatment Adherence: Per available records, Mr. Smith is not currently adherent to prescribed medication.

Behavioral Health Reporting System: According to this database, Mr. Smith is registered with the North Sound Behavioral Health Organization (BHO). He has the following history of mental health treatment or contacts:

- Mr. Smith had nine outpatient contacts between 08/04/2000 and 09/25/2018 through LifeNet Health, Skagit Counseling and Psychiatric Services, and Volunteers of America-Snohomish. The diagnoses listed are Mental disorder, not otherwise specified and Illness unspecified.

- Mr. Smith had one Consumer Hearing with the following outcome:
    - 09/25/2018 – Revoke LRA

- Mr. Smith had one involuntary psychiatric hospitalization:
    - 09/21/2018-10/09/2018; Telecare North Sound Evaluation and Treatment

- **Diagnosis**: Schizophrenia, unspecified

Mr. Smith is registered with the King County BHO. He has the following history of mental health treatment or contacts:

- Mr. Smith had two Consumer Hearings with the following outcomes:
    - 07/11/2018 – 14-Day Commitment
    - 07/26/2018 – 90-Day LRA or LRA Extension

Western State Hospital Records: Mr. Smith does not have a history of inpatient psychiatric treatment at WSH. Further, his competency to stand trial has not previously been evaluated by OFMHS.

Example 2

<u>RELEVANT CLINICAL HISTORY AND COLLATERAL INFORMATION</u>

The Court is respectfully referred to the Competency Evaluation Report authored by EVALUATOR NAME dated DATE, for a review of Mr. Smith's clinical history and other collateral information in the above-referenced cause number. Optional, if applicable

Self-Report

The following psychosocial history was supplied solely by the defendant's self-report and is thus limited by the credibility of the defendant. Only that subset of information relevant to the purpose of this evaluation is reported here and it therefore does not represent a complete history of the defendant.

Mr. Smith reported that he was born in Anyplace and raised primarily by his grandmother in his early years. Mr. Smith indicated that he first came to Washington around the age of six to stay with his mother. He subsequently moved back and forth between Anytown and Anywhere until 2009 when he came here to stay. Mr. Smith reported that his mother, sister, and his children live in Washington, but then he stated, "They say my mom's been dead for a long time, so I don't know who I be talking to…" Attempts to clarify this response were unsuccessful as he was confused whether his mother was alive or deceased. Mr. Smith indicated that he had been married once "in this body, but a bunch of times." He then indicated that he had been "told" that he had been a number of different people, including "John Johnson," and others, and had been married as those people, but only married "once as John Smith." Mr. Smith reported that he had four children that he knows are biologically his, but there are up to nine children that "call me dad." It was again unclear if Mr. Smith believed that he had fathered these other children when he was someone else. Mr. Smith has been homeless since 2013. He indicated that at some point a movie producer had offered him "$20,000," for being part of a movie, and that at various times he was told to go different places; ostensibly to begin production of this movie or to have a place to live.

Mr. Smith reported that he had graduated from high school, and attended community college when he was in prison. It did not appear that he had obtained a college degree. Mr. Smith denied any history of learning disability or special education for learning issues, but he stated that he had

special education for "behavior disorder." When asked if he had ever served in the military, Mr. Smith referenced "in this body, I tried to, but I was a felon before 18." He went on to speaking about his family history of military involvement. Mr. Smith was asked about his meaning in reference to "this body," and he stated, "who I am now. [Who were you before?] A lot of people. I became confused. [How long have you been this person?] I thought forever, but they tell me I was other people I don't remember. [Who tells you?] I used to think it was God, then I thought it was the producer, then I thought I was crazy." He then described having a history of working in construction and janitorial services, but he has been on disability since 2001 for a diagnosis of Schizoaffective Disorder.

According to Mr. Smith, he was diagnosed with Schizoaffective Disorder in 1998. At that time he was receiving treatment from "CPC" (Community Psychiatric Clinic). Mr. Smith indicated that he had a history of taking a number of different antipsychotic and mood stabilizing medications, but he had not been on medications for some time. He stated that he was currently "scared" to take medications due to a bad experience in 2013 when he had an irregular heartbeat as the result of medication combination effects. Mr. Smith described symptoms such as auditory hallucinations that "told me to kill myself, I used to think it was God, one time my mom, one time a friend, he was dead." He indicated a history of hearing various different voices at different times, and he had believed it was God's voice but when he "started being wrong," he seemed to question the source of the voice. He last heard voices the day before the interview. He stated he had a history of visual hallucinations, but not "for a long time." In passing, Mr. Smith described noticing "symbols" when mentioning the voices he had heard, and when asked more about this symptom he stated, "I don't know the church said I must've… But they said I broke the code… 0÷1 equals infinity squared was supposed to be impossible; binary code… Seven heavens and seven Hells… Must be in the other realm for infinity to be squared…" When asked about people being able to read his mind, Mr. Smith referenced, "they said they can, working on my cognitive response technology… Influence behavior patterns and actions… They're trained to train you but that was from the military and I'm not sure I'm supposed to be talking to you about that…" He indicated that he had attempted suicide in 2001 by overdosing on pills. He stated he had been in a coma for "a couple weeks" and has short-term memory problems as a result. He further referenced other suicide attempts in 2014 or 2013, and it was unclear if he was referencing the 2001 incident or one of the subsequent incidents when he stated that he "took all my pills. The voice told me everyone else was dead and I went home and took all the pills…"

Regarding health, Mr. Smith stated, "my spiritual health is low, physical health I'm doing great." Mr. Smith went on to describe "pain" as being a "state of mind," but his statements were difficult to follow or understand. Mr. Smith was asked about his substance abuse history, and he denied drinking alcohol with any frequency, and stated he had used marijuana "4 to 5 times" in the last four years. He indicated that he had used cocaine and methamphetamine during the last "couple years," and stated that he "thought I was doing a documentary on the short-term and long-term effects, a lot of times I was smoking stuff and other stuff… They tell me, the voices, I don't know, they want me to desensitize the people… Supposed to tell them it's okay to do the drugs in here…" His description of these events and beliefs was difficult to follow or comprehend.

WSH/OFMHS Records
Available records indicate Mr. Smith has no history of previous forensic psychological evaluations through WSH/OFHMS, and no hospitalizations at WSH.

Washington State Health Care Authority[1]
There was no documented record within the database of any inpatient treatment services, outpatient services, services at Evaluation and Treatment programs, or investigations or hearings towards civil commitment for Mr. Smith.

County Jail Medical Records
Mr. Smith was booked into jail on 11/2/17. At the time of booking, he denied any medical or dental concerns. He had a history of Schizoaffective Disorder and Posttraumatic Stress Disorder, but was not on any medications. He was cleared for general population housing and his chart was to be reviewed in the future due to his history of mental health issues. On 11/15/17, a chart review noted that Mr. Smith was reporting no psychiatric concerns or symptoms. A progress note on 12/9/17 showed that Mr. Smith was not reporting any issues, and his presentation and functioning were unremarkable. Mr. Smith reported voices of "talking to myself" but there was no evidence of that at the time of assessment by jail mental health staff. He was cleared for non-psychiatric housing, and he would be invited to general population clinic for discussion with the provider in 2 to 4 weeks due to his history of taking medications.

Current Medication/Treatment Adherence
At the time of evaluation, Mr. Smith was not prescribed any psychotropic medications, and he was not under the care of jail mental health services.

Example 3

RELEVANT CLINICAL HISTORY AND COLLATERAL INFORMATION

Personal Interview
The following psychosocial history was supplied solely by the defendant's self-report and is thus limited by the credibility of the defendant. Only that subset of information relevant to the purpose of this evaluation is reported here and it therefore does not represent a complete history of the defendant.

Status Current and Prior to Incarceration: Mr. Smith reported that he lived with his wife. He had received SSDI for the past two years. He indicated he was taking medication for stomach problems and his "mental well-being," though he could not recall the names of the medicines. Mr. Smith described that he had a caregiver, Ms. Sally Smart, for, "Someone to talk to and be there." He indicated Ms. Smart came to his home twice a week.

Early History, Education and Employment: The defendant stated that he was originally from Any County and had four sisters. He completed the 8th grade and was thereafter expelled for fighting.

[1] The state of Washington has transitioned from the Mental Health Division database to the Washington State Health Care Authority – Behavioral Health Reporting System. The information contained in the database may not reflect a complete record of mental health contacts.

He described that he had difficulty paying attention and earned "poor grades." However, he later earned a GED. His employment history included steel-worker and boiler-maker. He married four times. He had two children and a grand-child.

Medical History: The defendant reported that he had a stroke and heart attack a couple of months ago. He thought he had been wheelchair-bound since his first stoke; although he did not recall when that occurred he indicated he had been in the wheelchair for the past year. He reported history of head injury when he was in a motorcycle accident as a youngster; he regained consciousness in the hospital. He did not recall how long he had been at/in the hospital. Mr. Smith reported he had a history of medication for seizures. He also reported that he took "INH" and when asked if he had tuberculosis he indicated this was the case [Ms. Smart indicated the defendant did not have tuberculosis].

Substance Abuse History:
Alcohol: Current use: a couple of times a month, drank whiskey, up to a pint at a time and became intoxicated; most recent use "a couple months" ago; reported history of blackouts (amnesia for what occurred while drinking), most recently "a long time ago." Denied any history of physical withdrawal symptoms when he stopped drinking.

Cannabis: Twice a month since the age of 12.

Hallucinogens: Used PCP "years ago," LSD in the 1960's and 1970's, and hallucinogenic mushrooms in the 1980's

Inhalants: Inhaled glue when he was 13 or 14 years old.

Opioids: Reported injecting heroin daily for two years, two to three years ago. Reported use of un-prescribed Vicodin, Percocet and Oxycodone in the 1960's and 1970's.

Sedatives/Hypnotics/Anxiolytics: Reported using un-prescribed benzodiazepines in the 1960's and 1970's.

Stimulants: Reported using speed pills in the 1960's and 1970's.

Overuse of Prescription or Over-the-Counter Medications: Reported he had over-used prescribed pain pills and never informed his physician. Denied over-use of over-the-counter medicines.

Substance Use Treatment History: Reported having been in three 28-day residential treatment programs, completed all programs. Most recent such treatment was two years ago.

Psychiatric History: The defendant reported he had no history of psychiatric hospitalizations. He stated he was taking "nut medication," for "being angry," and that he had been on this medicine since he had been in prison. He indicated his first prescribed psychiatric medications had been while in prison. He offered that someone, "Told me over time I was like a guy that had been in war. I've never been in the service."

Legal history: Mr. Smith reported he had six felony convictions and had a history of imprisonment in Washington. His most recent prison stay was over 10 years ago. He stated he had several misdemeanor convictions.

Record Review/Collateral Record Information

The Washington State Healthcare Authority Behavioral Health Reporting System showed no state or community psychiatric hospitalizations for the defendant. He had been seen by Anytown Mental Health at an emergency room on 10/31/15, diagnosis was illness unspecified.

The defendant's Anytown Health Center medical record included two clinic visits. On 10/13/17 the defendant presented after onset of seizures on 9/7/17. This was identified as an "isolated" problem, but the defendant had gone to the ER because he lost consciousness. He was described as "increasingly forgetful and disoriented," though at the time of the assessment he was fully oriented to person, time, place and situation. His memory was listed as "moderately impaired short term memory," though no information on how this was tested or whether this was per self-report or caregiver report was included in this evaluation. His affect and mood were appropriate and his insight and judgment were normal. He did not show signs of depression such as feeling down, depressed, hopeless, or having little interest or pleasure in doing things. The charting indicated, "He has a history of polysubstance abuse and recently had meth in his UA." Mr. Smith was referred to a methadone clinic for heroin abuse.

On 11/10/17 the defendant reported problems with headaches for the past two months, though this was not a new problem since the previous visit. Charting indicated that he asked for "something to help him slow down" and that he became angry. On this day he was positive for loss of interest and pleasure for several days' duration, but he did not report feeling down, depressed or hopeless. Mr. Smith's memory was rated as "normal." He was fully oriented to person, time, place and situation. His affect and mood were appropriate; insight and judgment were normal.

Mr. Smith had several diagnoses, included medical conditions of hyperlipidemia, gastroesophageal reflux disease with esophagitis, and seizures. His history showed paralysis of dominant side as complication of stroke (onset date 8/18/14) and right middle cerebral artery stroke (onset 5/11/17). Psychiatric conditions were panic attacks and primary insomnia (both onset of 5/11/17). Substance use diagnoses were uncomplicated alcohol dependence and heroin abuse. Mr. Smith was also listed as having poor compliance with medication at both clinic visits.

Mr. Smith's caregiver, Ms. Sally Smart, was interviewed following interview of the defendant on 1/4/18 and in his presence. Ms. Smart described that she was employed by Anytown Community Services; she described herself as "non-nurse delegated." Mr. Smith had obtained assistance as a result of an assessment by Area on Aging. Ms. Smart reported that the defendant had a heart attack approximately three weeks prior; he was taken by emergency responders to Anytown Hospital but not admitted. She indicated he had other strokes and heart attacks prior to her work with him, as far back as when he was in the prison system.

Ms. Smart gave some examples of the types of problems Mr. Smith was having with his memory. She indicated the defendant referred to Ms. Jane Smith as "his wife" and did not recall that they

were divorced. Ms. Smart stated when she asked him if he had already taken his medications he sometimes knew and sometimes did not know. Ms. Smith administered the defendant his medications. The caregiver reported the defendant did not remember what he had done the day before, including what he had eaten. He independently attended to hygiene; any help he needed in these tasks as due to his physical limitations.

Current Medication/Treatment Adherence

The defendant's psychiatric medications as of 1/18/18 were Vistaril for panic attacks and Remeron for insomnia. He was on several medications for medical conditions. Per records, he was adherent to all medications.

7.6 Mental Status Examination

The mental status examination sections should include, at minimum, observations of:

a. *Appearance, attitude, activity*
b. *Mood and affect*
c. *Suicidal and homicidal ideation*
d. *Speech and language*
e. *Thought process/content and perception*
f. *Cognition*
g. *Insight and judgement*

Effort and Reliability: Descriptions should include atypical or unusual report of symptoms; impression management; and concerns about suboptimal effort. Descriptions of testing should also be included here if relevant.

Note: If it is not possible to document all of these observations, explanations should be provided.

Example 1

MENTAL STATUS EXAM AND BEHAVIORAL OBSERVATIONS

Appearance, Attitude and Activity: Mr. Smith presented as a mid-30's Caucasian male, of average height and build. His appearance was consistent with his listed age. Mr. Smith made appropriate eye contact and was cooperative with the evaluation. He demonstrated no unusual behavior during the evaluation. His motor skills were grossly within normal limits.

Mood and Affect: Mr. Smith reported his mood as "Good." His affect was euthymic, consistent with his reported mood. The defendant indicated his pattern of sleep, level of energy, and present appetite were all within normal limits.

Suicidal/Homicidal Ideation: When directly questioned about having thoughts or plans to harm himself or anyone else, Mr. Smith denied present suicidal or homicidal ideation.

Speech and Language: The prosody of Mr. Smith's speech (i.e., rate/rhythm/stress) was generally within normal limits. He spoke with a normal tone. His expressive and receptive language

appeared within normal limits as evidenced by correct spontaneous naming of common objects and execution of commands of increasing complexity. The defendant's ability to communicate was intact.

Thought Processes, Thought Content, and Perception: Mr. Smith's thought processes appeared logical, linear, and connected. His thought content was dominated by over-valued religiously themed ideas. Mr. Smith expressed his belief that he was part of an inclusive religion that consisted of beliefs from several prominent theological traditions, although he ascribed to no specific sect. Mr. Smith's primary thesis is that he, like all mankind, can be the "son of God," and therefore can be God. This belief is a reference to the Christian biblical passage located in John 10:30, "I and the Father are one," (New International Version) which the defendant referred to several times. Notably, the defendant did not claim to have any special powers or abilities that he could exercise in a God-like fashion. While the defendant did perseverate on religious themes, he was redirectable to the task at hand. The defendant denied auditory or visual hallucinations. He did not appear to be responding to internal stimuli.

Cognition: He was alert and fully oriented to person, place, situation, and time (i.e., who he was, where he was, why he was there, and the date). On cognitive screening tasks, his attention span, concentration, and immediate and delayed (2-3 minutes) memory functions appeared grossly normal. His fund of information and ability to understand and express abstract verbal concepts also appeared grossly normal. On a task of recent memory, Mr. Smith correctly recalled three out of three words immediately and after a brief delay (2-3 minutes). On a task of remote memory, he indicated he could not recall historical events (i.e., events of September 11, 2001).

Insight and Judgment: When given a hypothetical scenario designed to measure his insight and judgment, Mr. Smith's responses were grossly appropriate.

Effort and Reliability: Mr. Smith appeared to put forth his best effort throughout the interview. When responding to questions, Mr. Smith frequently asked if he "got the question right" and appeared invested in performing well during the interview. There was no indication of malingering, exaggeration, or misleading responses.

Example 2

MENTAL STATUS EXAM AND BEHAVIORAL OBSERVATIONS

Jail staff informed this evaluator on January 23, 2018, Ms. Doe was ill, and it was uncertain whether she would be able to participate in an interview as she had been vomiting a short time before. However, she agreed to come to the interview room and participate in the evaluation. Ms. Doe presented as Caucasian female who appeared older than her documented age of 30. She was short in stature and thin in build. She was dressed in clean jail-issued clothing, and her grooming and hygiene appeared to be poor. Her hair was unkempt and disheveled, and she was malodorous. Ms. Doe's appearance was most remarkable for tattoos. She had star tattoos on the side of her face, and her arms were heavily tattooed. It was noted Ms. Doe was shivering at times, and she complained she was cold and felt nauseated. Her psychomotor responses were slow, though that could be related to her feeling unwell. She made poor eye contact was poor as she established eye contact only once and looked down the remainder of the interview with her head lowered and hair

covering part of her face. Her speech was slow and low in volume, making it difficult to understand her. At times, she was asked to repeat her mumbled responses.

With respect to mood symptoms, Ms. Doe described her mood as "okay, not really good." Her observed mood was dysphoric, and her affect was constricted. She indicated she has been sleeping poorly lately due to being ill and said she wakes up often at night. Prior to getting sick she stated she was sleeping fairly well and felt rested when she wakes in the morning. Ms. Doe reported she was eating well prior to getting sick and has not noticed any changes in weight. She described currently having low energy. Ms. Doe endorsed passive suicidal thoughts, stating she at times thinks she would be "better off dead." However, she denied having a plan or intent to commit suicide, stating she "loves" her life too much. She denied homicidal ideations, plan, or intent to harm others.

Ms. Doe's thought processes were mildly disorganized and tangential. She oftentimes jumped from topic to topic without responding to the questions. However, she was improved over her presentation two weeks ago. Ms. Doe expressed she was uncertain of what is real, stating, "I don't know what is real anymore." Multiple times, she complained of losing track of reality as well as where and who she was. She evidenced paranoid ideation, believing others, including family members, are conspiring to kidnap her for sex trafficking. She expressed she knows her family is part of this conspiracy because she noticed their porch light was not on one night, which "means sex trafficking." As a result, she reported she called law enforcement multiple times to report her family's intent to sell her into sex trafficking. Ms. Doe reported hearing voices calling her derogatory names and threatening to assault her. It was not she was also observed to be responding to internal stimuli as evidenced by her mumbling and laughing to herself.

Ms. Doe was alert and grossly oriented in all spheres. Her immediate memory was intact as she recalled three words after they had been given to her. Her short-term memory was also intact as she recalled the same three word approximately ten minutes later. Attention and concentration were poor as she evidenced difficulty remaining on topic when responding to questions. No expressive and receptive language impairment was noted. Her abstraction skills were poor as well as her insight and judgment. Ms. Doe's intellectual functioning is grossly estimated to be in the average range.

Effort and Reliability: Ms. Doe appeared to put forth minimal effort throughout the interview. This appeared to be due to Ms. Doe's illness, dysphoric mood, and low energy and possibly a lack of motivation, rather than malingering.

Example 3

MENTAL STATUS EXAM AND BEHAVIORAL OBSERVATIONS

Mr. Smith presented as a 42-year-old male of somewhat stocky build who appeared approximately his chronological age. Mr. Smith was interviewed in a private room with defense counsel present for the duration of the interview. Mr. Smith came willingly to the interview location, and he was not cuffed during the interview. Mr. Smith's gait and movements were unremarkable. His hygiene was adequate, but his grooming was somewhat marginal. He was observed to have pieces of an unknown substance flaked in the front part of his hair. Mr. Smith's eye contact was within normal

limits. He was cooperative with answering examiner questions, but his responses had to frequently be curtailed so that he would not divulge specific information regarding the current allegations. There was no indication that Mr. Smith was attempting to over endorse or exaggerate symptoms of mental illness, rather he seemed genuinely confused by his symptoms and at times he expressed insight into how his report may make him look "crazy." He also seemed to minimize the impact of his symptoms on his functioning and ability to think clearly and without distraction. On several occasions Mr. Smith was observed to mumble under his breath to himself and he was easily distracted and confused. Although he reported his last experience of auditory hallucinations was the day prior to the interview, behavioral observations indicate he was likely internally preoccupied and responding to internal stimuli.

Mr. Smith's affect was mildly dysphoric and blunted. He reported his current mood as "I stay level until other people's moods (further response could not be understood or documented). I'm calm." He denied any issues with his sleep, appetite, or energy level. When Mr. Smith had been asked about his appetite he referenced "36 people killed in the Bush motel a couple years back, I look like him but it's not me." Clarification attempts were unsuccessful. When asked about thoughts of harm to himself, Mr. Smith stated "no, I think that's what they're trying to make me do. I don't know who, the producer, God…" He did not report any thoughts of harm to others.

Mr. Smith's speech was within normal limits in rate, volume, and tone. His speech was somewhat mumbled and slightly slurred, but intelligible. Mr. Smith's thought processes were at times organized and linear, but at other times tangential, confused, and poorly organized. A number of his responses were irrelevant or could not be understood in the context of the discussion. Mr. Smith appeared confused by his own thinking, and at times he would try to explain his beliefs and then would stop when he could not make sense of what he was trying to explain. He endorsed hallucinations and paranoid, grandiose, and referential beliefs as described previously in this report. On multiple occasions Mr. Smith evidenced identity delusions such as believing the undersigned was several different people he had had contact with in the past, as well as believing his defense counsel may have been other people as well. He appeared confused by his beliefs in this regard.

Mr. Smith was alert, and oriented to person, place, and time. His attention and concentration were impaired by his level of distractibility and apparent interference from internal stimuli and confusion. His memory was within normal limits. He evidenced a good fund of knowledge and abstract reasoning abilities. Based on his use of vocabulary and expressive capabilities, it appeared he functioned at least within the average range of intelligence. Mr. Smith's insight and judgment were impaired.

Effort and Reliability: Mr. Smith was calm and cooperative, and appeared to put forth adequate effort when responding to questions. There were no indications Mr. Smith was exaggerating, malingering, or attempting to provide misleading responses.

7.7 Clinical Summary and Diagnostic Formulation

In this section, pull together all of the relevant information related to symptoms, course of illness, response style, and diagnostic considerations. Include a description of the relevant symptoms of mental illness and an explanation of how those symptoms do or do not meet the criteria for a specific DSM-5 diagnosis. Be

clear in your diagnostic reasoning (as much as the available data allows) and do not merely continue the same diagnoses that previous evaluators have used without explanation. If a diagnosis cannot be made, explain why and highlight the symptoms most relevant to competency for the court.

Example 1

CLINICAL SUMMARY AND DIAGNOSTIC FORMULATION

Mr. Smith's presentation during this evaluation was consistent with all of the prior competency evaluation reports, except for Dr. Jones' evaluation where he refused to discuss whether his delusional beliefs were or were not related to his criminal charges. In the current interview, Mr. Smith presented with what appeared to be fixed persecutory and grandiose beliefs such as government conspiracies, filing multi-billion dollar lawsuits against the state government, and intervention by the Russian Embassy to provide legal representation on his case. He also presented with significant thought disorganization and symptoms of mania, including rapid and pressured speech and hostility.

Diagnostically, Mr. Smith presents with a psychotic-spectrum disorder, but a specific diagnosis is unclear. If he has a Delusional Disorder, it appears to be a mixed type, with persecutory and grandiose delusions or a mood disorder with psychosis, possibly Schizoaffective Disorder as recently offered by Dr. Johnson. In either case, the diagnostic differential is not essential in forming an opinion about Mr. Smith's trial competence, as both diagnoses are major mental disorders. Based on the available data, the following diagnostic impressions are offered in accordance with the criteria set forth in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition – Text Revision (DSM-5-TR)*:

- Delusional disorder, mixed type (persecutory and grandiose delusions), continuous versus Schizoaffective Disorder, Bipolar Type.

Example 2

CLINICAL SUMMARY AND DIAGNOSTIC FORMULATION

Mr. Smith has been under the direct observation of Western State Hospital psychiatrists, psychologists, and nursing staff periodically during the past two years. During this time, a variety of different disorders have been diagnosed or considered, including Schizophrenia Spectrum Disorders, Schizoaffective Disorder, and feigning or exaggeration of symptoms. Mr. Smith has been noted during the current evaluation period to display behavioral and self-report inconsistencies in his presentation of mental health symptoms. Available records indicate that Mr. Smith's symptoms during periods of decompensation have been noted to include possible delusional ideation, disorganized thoughts, purported auditory hallucinations, rapid thought processes, disturbed sleep patterns, agitation, irritability, and tangential thought processes. Available documentation indicates that Mr. Smith's symptoms are particularly salient during periods of increased stress and appear to reduce in intensity with consistent medication adherence and reduction in environmental stressors.

Progress notes from his current hospitalization period indicate that his behavioral presentation was inconsistent with the intensity and duration of his self-reported frequent auditory hallucinations. While currently available data indicates that Mr. Smith may have experienced symptoms of an underlying psychotic or mood disorder during previous admissions, it is also likely that his purported symptoms of severe auditory hallucinations was reflective of his personality structure and efforts to delay or avoid prosecution. His observed effective functioning on the ward during the evaluation period did not support his purported symptoms. While he purported to be suspicious of virtually everyone on the ward, aside from two staff members, he was noted to remain polite and respectful with no undue irritability or attention to internal stimuli. Similarly, while he reported believing that all medications were poison to peoples' bodies, he effectively and politely advocated for, and accepted, medications that he perceived as beneficial to assist in sleep management.

Based upon the information referred to above, there is sparse and contradictory evidence to substantiate any genuine symptoms of a psychotic or mood disorder due to the high likelihood that Mr. Smith's inconsistent presentation was a product of exaggerated or feigned symptomatology. His apparent current attempts to dissimulate psychological symptoms precluded the ability to discern any genuine underlying mental illness. Mr. Smith was not willing to engage in psychological testing to assess the degree to which a full diagnosis of malingering would be appropriate; however, Mr. Smith's behaviors and presentation was indicative of individuals engaging in the exaggeration, embellishment, and feigning of symptoms of mental illness. While it is possible that Mr. Smith has experienced symptoms of psychosis, a psychotic disorder could not be offered in the current diagnoses and the possible presence of symptoms of psychosis should continue to be a focus of clinical observation and diagnostic consideration. As such, no diagnoses can be offered at this time with any psychological certainty.

Example 3

CLINICAL SUMMARY AND DIAGNOSTIC FORMULATION

Mr. Smith reported he was first diagnosed with schizophrenia at approximately age 30 and received treatment (including psychiatric hospitalization at XXX Hospital and prescription of Risperdal Consta) on the East Coast. He indicated he receives Social Security disability income for his diagnosis of schizophrenia. He has also reported receiving mental health treatment through XXX Mental Health in Washington State. Unfortunately, limited collateral records are available at the current time, so the long-term course of his illness is largely unknown. However, jail and WSH records document observations of psychotic symptoms, including tangential and disorganized thought processes, auditory hallucinations, paranoia, delusional beliefs (e.g., another person inside his body, religious preoccupation, ideas of reference, somatic, magical, grandiose), hyperverbal and pressured speech, difficulty learning and retaining new information, irritability, and difficulty sustaining attention. Based on Mr. Smith's pattern of hallucinations, delusions, disorganized speech, and negative symptoms, schizophrenia appears to be the most explanatory diagnosis at this time. He is currently experiencing an acute episode, but an episodic course specifier (e.g., first episode, multiple episodes) is deferred due to the limited information known about the long-term course of his illness. Some providers have questioned whether Mr. Smith's illness may include a major mood component as well, but there is currently insufficient information to indicate he has experienced a manic or major depressive episode. There is also the possibility (given his history of methamphetamine and MDMA use) that some of his symptoms have been

exacerbated or induced by substances at times; however, given the onset of his current psychotic episode during a jail detention and the persistence of his symptoms throughout the current hospitalization (when he presumably has not had access to substances), an organic psychotic disorder appears more likely.

Mr. Smith's substance use history is also relevant to his clinical picture. He appeared to underreport his history during the current interview, reporting he did not recall which substances he had ever tried and denying using any substances in the time period leading up to his arrest. However, Mr. Smith has reported to prior forensic evaluators that he began using substances during his teen years and was using methamphetamine in the time period around his arrest. Jail records reviewed by Dr. XXX indicated he tested positive for methamphetamine and MDMA on a urinalysis when booked into the jail. While additional information about his pattern of use (e.g., frequency, severity, recency) would bolster diagnostic certainty, there is sufficient information to indicate Mr. Smith has a problematic pattern of methamphetamine use. A methamphetamine use disorder is diagnosed at this time, with the specifier in a controlled environment due to his current hospitalization.

Based on the current clinical interview, WSH records, and available collateral records, the following diagnostic impressions are offered in accordance with the *Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition – Text Revision (DSM-5-TR)*:

- Schizophrenia, currently in acute episode
- Methamphetamine use disorder, in a controlled environment

7.8 Competency to Stand Trial Impression

This section should document your evaluation of the defendant's competency to stand trial-related abilities per Washington State's version of the Dusky standard, RCW 10.77.010 (16), which states, "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."

The competency opinion is based upon a discussion of two primary considerations: (1) the nature and severity of the defendant's current mental problems and (2) the present impact of any mental disorders on the defendant's functional capacities that are important for competent performance as a defendant in criminal proceedings. The discussion of the defendant's functional capacities must include: (2.1) the defendant's capacity to understand the nature of the legal proceedings and (2.2) the defendant's capacity to assist in his or her defense. The competency discussion should also include an evaluation of the defendant's;

a) Understanding of the charges, verdicts, and penalties
b) Understanding of the trial participants and trial process
c) Ability to assist counsel in preparing and implementing a defense
d) Ability to make relevant decisions

The competency discussion is the most fundamental section of the report. A detailed description of the defendant's competency-related capacities and deficits should be provided. If a competency instrument (e.g.,

Evaluation of Competency to Stand Trial – Revised (ECST-R), Revised Competency Assessment Instrument (R-CAI), Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR)) was used to structure the evaluation or supplement related abilities or deficits, it should be summarized in this section. If all areas of the competency-related capacities are not evaluated, an explanation of what areas were evaluated and why they are relevant to the current assessment should be provided.

7.81 Competency Opinion.

This is the conclusion section or nexus, in which the evaluator offers the clinical and forensic formulation of the case. No new data should be introduced in this section. Instead, this section should reference previously documented data contained within the report and explain the implications for the conclusions offered. In the case of mental illness or defect, it is not sufficient to merely establish that it co-exists with the identified competency-related deficits; a causal connection between the two must be established and clearly described in this section.

<u>The Ultimate-Issue Issue</u>. Commenting on the ultimate legal issue (i.e., stating whether the defendant is competent or incompetent) is strongly discouraged. Offering ultimate opinions strays beyond the bounds of behavioral health professionals' expertise and impinges on the legal and moral decisions decided by the trier of fact. Conclusions on whether the defendant is competent or incompetent are the judge's responsibility, and the evaluator should resist drawing them. Instead, the evaluator should conclude whether the defendant possesses the requisite competency-related capacities and, if not, what symptoms specifically caused those deficits.

Example 1

<u>COMPETENCY TO PROCEED TO TRIAL</u>

This defendant's competency to stand trial was evaluated against Washington State's version of the *Dusky* standard; namely, whether the defendant "lacks the capacity to understand the nature of the legal proceedings against him or her or to assist in his or her own defense as a result of mental disease or defect" (RCW 10.77.010 (16)).

The competency opinion is based upon two major considerations: (1) the nature and severity of the defendant's current mental problems and (2) the present impact of any mental disorders on those of defendant's functional capacities that are important for competent performance as a defendant in criminal proceedings.

<u>Capacity to understand the nature of the legal proceedings</u>

Ms. Smith knew that she was currently charged with "DV Assault," and that this charge was a misdemeanor. She understood that a misdemeanor was less serious than a felony charge. Ms. Smith was able to provide a description of the allegations in this case that was consistent with police reports. She was aware that if found guilty of this charge she could face "up to one year in jail." Ms. Smith accurately described probation and common conditions of supervision. She was aware that a defendant found not guilty of a charge would be "released." Ms. Smith named pleas of

"guilty or not guilty" as being available to defendants in court. She provided adequate definitions of these pleas, as well as the purpose of a trial.

Ms. Smith understood that the proceedings were adversarial in nature and she provided adequate definitions of the roles of courtroom participants. For example, she indicated that the role of defense counsel was "to fight for the defendant based on the facts. Have an understanding of what the defendant is willing to agree to." She further understood that the role of the prosecutor was to prove guilt, and the judge was a neutral party in the proceedings. Ms. Smith knew that she could not be forced to be a witness in her own case, "But I have the option to." She stated that if she was to take the stand, the prosecutor would try to, "Find out what the truth is," during her cross-examination. She indicated that she may follow defense counsels advice regarding whether or not to testify "depending on what her reasons were." Ms. Smith described evidence as being, "Things that people can submit in court to prove you guilty or not guilty." Ms. Smith described a plea agreement as being, "When you decide to do certain things; in exchange you admit to a crime. It goes on your record." She knew that the defendant would forfeit the right to a trial if an agreement was accepted. Ms. Smith appropriately described circumstances where a defendant would or would not want to accept on agreement offered. Ms. Smith asserted that she wanted to be "found not guilty" in this case, and thus she did not want to consider a plea agreement.

<u>Capacity to assist in her defense</u>

Ms. Smith knew that she was currently represented by counsel, and she stated that her assigned attorney was "Jane Johnson." Ms. Smith indicated that she had met with her attorney on two occasions "five minutes before court." Ms. Smith expressed that she did not have confidence in her attorney as she felt her attorney should have fought harder for her release in this case. Ms. Smith indicated that she had wanted to be assigned a new attorney, but that she would be willing to work with assigned counsel because, "I can't keep waiting in here." She further indicated that until recently she had been unable to make telephone calls at the jail. Ms. Smith knew that what she discussed with counsel would be kept private, and she ultimately agreed to speak with her assigned attorney regarding the alleged events in this case. Ms. Smith stated that if a witness was lying about her in court she would "tell my lawyer." She believed it likely that her husband, the alleged victim in this case, would lie about her if he took the stand. She reported that this belief was due to the circumstances of the alleged offense and her previous interactions with her husband. Ms. Smith reported that if she did not understand something during the proceedings that she would "ask my lawyer." Ms. Smith understood appropriate behavior in the courtroom. She expressed the belief that her symptoms of Bipolar Disorder were well-managed at this time and she felt ready to proceed to resolution of her case.

<u>Competency Opinion</u>

In summary, Ms. Smith presented with a good understanding of the legal proceedings, her rights as a defendant, and the advocacy role of defense counsel. Her mood was dysphoric, but congruent to her current legal situation. She did not display any mood lability or current symptoms of mania. It therefore appears that her symptoms of Bipolar Disorder are currently stable with psychotropic medications. She expressed concern regarding her attorney, and wanting a new attorney, but there was no evidence that her reasoning was not reality-based. Ultimately, she stated that she was

willing to work with assigned counsel to resolve this case as she did not want to add additional time to resolution of this matter. Ms. Smith stated that she believed it likely that the alleged victim would lie about her in this case, but again there was no indication that her reasoning was delusional or influenced by thinking that was not reality-based. At the present, Ms. Smith appeared able to have reasoned and logical conversation and she was able to convey pertinent information during the interview. It is anticipated that she would likewise be capable of having productive discussions with defense counsel regarding her case and options available for resolution. Therefore, it is the professional opinion of the undersigned that Ms. Smith currently has the capacity to understand the nature of the proceedings against her, and she has the capacity to assist in her own defense.

Example 2

COMPETENCY TO PROCEED TO TRIAL

This defendant's competency to stand trial was evaluated against Washington State's version of the *Dusky* standard; namely, whether the defendant "lacks the capacity to understand the nature of the legal proceedings against him or her or to assist in his or her own defense as a result of mental disease or defect" (RCW 10.77.010 (16)).

The competency opinion is based upon two major considerations: (1) the nature and severity of the defendant's current mental problems and (2) the present impact of any mental disorders on those of defendant's functional capacities that are important for competent performance as a defendant in criminal proceedings.

Capacity to understand the nature of the legal proceedings

Capacity to Understand Role of Key Participants: The defendant stated that the judge was in charge in the courtroom. He further described the judge's role as overseeing the courtroom and hearings. He knew the judge determined sentence. He reported his attorney represented him in court. Although he initially stated it was the role of the judge to prove he was guilty of the allegations against him when the question was repeated more slowly he easily indicated this was the prosecutor. He indicated he should not speak with the prosecutor in the absence of defense counsel because, "He could take it out of context. He'd twist it all around." He described the role of the jury as, "Oversees the case and therefore the ones find you guilty or not guilty."

Capacity to Understand Pleas: Mr. Smith reported what followed a guilty outcome was sentencing. What followed an initial not guilty plea was, "Up to the judge to find you guilty or not guilty." He indicated "released" is what occurred following a final not guilty outcome. Asked to describe the plea bargain process he responded, "It depends on what they give you." Asked for an example he indicated, "How much time you're going to get or how much fine you're going to get." He knew a guilty plea was typical in this situation and that a defendant gave up some rights, but he could not recall what they were. He knew his attorney would be the first to tell him what rights he relinquished in accepting a plea offer. He indicated he could not think of an advantage to the defendant in accepting a plea offer. However, it appeared possible this may have been more related to the ability to express himself than lack of knowledge, based on other verbal exchanges during the evaluation. When informed that 'conviction' was a disadvantage in accepting a plea offer he

appeared to recognize this, and when asked after delay and distraction he remembered that "get another conviction" was a disadvantage in this situation.

Capacity to Understand the Nature and Severity of Current Charge(s) and the Range and Nature of Possible Penalties: Mr. Smith stated that he was charged with Domestic Violence and he was reminded of the complete name of his charge. Approximately 20 minutes later he was asked again about the name of his charge. He responded that it was "Domestic Violence" but when asked for "the rest of the name" he added, "Residential Burglary." He began to say more about the offense but was stopped, at which point he grumbled that his attorney would not let him talk about it either. Mr. Smith knew his charge was a felony and therefore more serious than a misdemeanor. He did not know the maximum sentence for the offense but knew his attorney would know that information. He stated, "Drop it all," would be the best outcome for him.

Capacity to assist in his defense

Capacity to Relate to Lawyer and Plan Legal Strategy: The defendant stated Mr. Joe Jones was his attorney and described him as, "Great. I've always liked Joe." He indicated counsel had helped him in the past and he hoped Mr. Jones would get the "best deal he can get for me." He thought what counsel needed from him was his cooperation. He indicated if he disagreed with his attorney he would talk about it.

Capacity to Participate in Trial and Testify Relevantly: The defendant knew that he could not be forced to testify. As he thought the reason for this was, "Don't have to go anything you don't want to," he was informed/reminded that the "right to remain silent" continued through a case. He thought an advantage to testifying might be, "Could help, tell what happened." He did not know a disadvantage/risk in testifying. He was informed that the prosecutor would also be able to ask him questions; check of his recall of this information a few moments later showed he did not remember what he had been told. Mr. Smith indicated he would follow his attorney's advice on whether or not to testify if his case went to trial.

Capacity to Manage Courtroom Behavior: Mr. Smith described that "well-mannered" behavior was appropriate in court. He thought if he behaved inappropriately, he may be returned to jail.

Case-Specific Information: The defendant stated he did not remember any of what happened that led to his charge. He thought that a criminal case could go forward even if the defendant did not remember what had happened. He knew to tell his attorney anything he did remember and answer all of counsel's questions. He thought "probably" someone may lie about him in court, because, "Just the way they are." However, if someone said something that was not quite right, he stated he would tell the judge; he was reminded this was something he should tell his attorney. Mr. Smith indicated he expected he could get a fair trial.

Competency Opinion

Overall, Mr. Smith demonstrated average factual knowledge of court procedures and the roles of various courtroom participants. He was aware of the adversarial nature of the criminal proceedings. He knew that criminal charges have varying levels of seriousness, and that his was a felony charge.

He understood the meanings and outcomes of basic pleas and the plea bargain process. He presented as being capable of engaging in a reasonable, rational dialogue with his attorney in weighing plea options and other defense considerations. Given that Mr. Smith was showing some difficulties with memory, repetition of information and/or written materials may be helpful to him. He was seen as being able to testify at trial, though some difficulties with memory it may require more repetition of plans than may typically be the case. Therefore, it is my opinion that Mr. Smith has the capacity to understand the nature of the proceedings and the capacity to assist in his defense.

7.82 Barriers to Competency.

The Barriers to Competency section is required in any report in which the evaluator is recommending restoration treatment. It serves as a reference for treatment providers and contains a list of the symptoms and deficits identified as currently interfering with the defendant's competency-related capacities. This section was developed at the request of treatment providers and should be separated from and located between the Competency Opinion and Restoration Opinion to help providers locate the information easily. At the request of the treatment providers, the evaluator uses bullet points to list the identified symptoms and impairments. This section does not need to be included for defendants for whom the evaluator is not recommending restoration treatment.

Example 1

<u>Barriers to Competency</u>
The following deficits interfere with Mr. Smith's ability to understand the nature of the proceedings against him or his ability to assist counsel:

- Disorganized and delusional thinking will impair his ability to rationally discuss the instant offense, plea options and other defense considerations. It will also interfere with his ability to process information in a goal-directed manner.
- Paranoid delusions, which suggest detachment from reality, and which will likely lead him to misinterpret the motivations of others, including his attorney
- Elevated, unstable affect will likely impair his ability to focus in hearings and may result in inappropriate behavior in court
- Impaired concentration will interfere with his ability to focus on relevant conversation with his attorney in discussing the alleged offenses, plea options and other defense considerations. It will also interfere with his ability to focus in court hearings to consider how the information relates to the adjudication of his charges.
- Poor judgment, as a result of these psychiatric symptoms, increases his risk of legal-related decisions that are impulsive and ill-conceived
- These symptoms would negatively impact his ability to testify coherently and rationally should such be the direction of his case.

7.83 Restoration Opinion.

Finally, the evaluator must include information in this section of the report about the defendant's prognosis for restorability, the type of treatments required and available for restoration, and the likelihood the

defendant will be restored within the timeframe statutorily defined in RCW 10.77.086 and 10.77.088. This section needs to be included for defendants eligible for restoration under the above-referenced statutes. No new data should be introduced in this section. Rather, this section should reference previously documented data contained within the report and explain the implications for the conclusions offered.

Example 1

RESTORATION OPINION

Should the Court find that Mr. Smith is not competent to stand trial, it is this examiner's opinion that there is a reasonable likelihood that inpatient psychiatric treatment will improve his mental condition and restore competency. Mr. Smith has been diagnosed with a mental illness, bipolar disorder, for which the first line of treatment is medically necessary psychotropic medications. Mr. Smith is currently taking medications in jail and expressed a willingness to continue taking them in the future. The jail medical records indicate some improvements in his irritability and communication over the last two weeks. Additionally, Mr. Smith has been opined competent following restoration treatment in the past, suggesting that more prolonged treatment period has historically improved his mental condition enough to meet requisite competency-related capacity standards. Thus, additional time on medication and attendance to psycholegal skills groups with any adjustments deemed necessary by his medical provider is likely to improve his mental condition further. Therefore, this examiner recommends a DSHS approved facility for an appropriate restoration period.

Example 2

RESTORATION OPINION

Should the Court find that Mr. Smith is incompetent to proceed to trial, this examiner believes that there is not a reasonable likelihood that additional restoration will be successful. Mr. Smith has a severe psychotic illness, schizophrenia, for which the first line of treatment is medically necessary psychotropic medications. Although Mr. Smith is currently taking prescribed medicines, they have been ineffective throughout his restoration. Namely, Mr. Smith has not demonstrated any improvements in his severely delusional and disorganized thinking over the 90 days of restoration treatment. During the restoration, the psychiatrist has trialed Mr. Smith on three antipsychotics and a combination thereof, without noticeable improvements in his mental condition. As previously mentioned, the psychiatrist documented on March 3, 2021,

> I do not see indications that the patient is improving in competency restoration despite adequate antipsychotic trials of Risperdal, a combination of Risperdal and Abilify, and now a combination of clozapine and Abilify. The Patient's delusions and disorganized thought process also did not improve with an adequate trial of Zyprexa in jail. Historical and family information indicates that the patient has chronically impaired functioning due to schizophrenia. He is functioning at baseline.

Of additional concern, collateral records suggest possible cognitive impairment or a neurodevelopmental disorder (see *Collateral Records* section for details). These records note

lifelong learning difficulties and possible memory impairments. Even if Mr. Smith's psychotic symptoms were to remit, it is not clear that he could learn the pertinent legal information to assist defense counsel. Taken together, there is very little evidence suggesting that additional time on medications and psychosocial treatment will produce the needed improvements in Mr. Smith's mental condition to restore his competency-related capacities. As a result, the undersigned's opinion is that Mr. Smith is not likely to be restored to competency as defined in RCW 10.77.088.

7.84 Involuntary Administration of Medications.

If restoration treatment is recommended and the defendant (1) is refusing medications or (2) has a pattern of inadequate medication compliance and has been diagnosed with a mental illness for which the first line of treatment is medically necessary medications (e.g., schizophrenia spectrum and other psychotic disorder), authorization for involuntary administration of psychiatric mediation may be deemed medically necessary for treatment. In such cases, the evaluator must address the following factors:

- *If the defendant is diagnosed with a mental illness, for which the first line of treatment is psychotropic medication;*
- *The defendant's history of response to treatment*
- *The defendant's history of medication adherence or noncompliance;*
- *If the defendant is currently refusing treatment or has stated a plan to refuse medication;*
- *If prognosis is poor in the absence of psychotropic medication; and*
- *If side effects should develop, if they will be addressed by a psychiatrist to minimize their effect.*

Example 1

The following information describes factors related to the possible need for an order authorizing the involuntary administration of medication:

	Yes	No	Unknown
Diagnosed with a mental illness for which the first line treatment is psychotropic medication	X		
History of response to treatment	X		
History of medication noncompliance	X		
Current refusal/stated plan to refuse	X		
Poor prognosis in absence of psychotropic medication	X		
Should side effects develop, they will be addressed by the psychiatrist in such a manner as to minimize their effect	X		

Based on these factors, it is the undersigned's professional opinion the probability of restoration would be improved, and the length of time to restoration would be reduced, if the Court granted judicial authority for the involuntary administration of medication, and Mr. Smith's treating psychiatrist opined it clinically necessary.

Example 2

The following information describes factors related to the possible need for an order authorizing the involuntary administration of medication:

- Diagnosed with a mental illness for which the first line of treatment is psychotropic medication: **Yes**
- History of response to treatment: **Unknown**
- History of medication noncompliance: **Unknown, but would likely refuse medications due to lack of insight into mental illness**
- Current refusal/stated plan to refuse: **He stated he would refuse medications due to denying presence of mental illness**
- Poor prognosis in absence of psychotropic medication: **Yes**
- Should side effects develop, they will be addressed by the psychiatrist in such a manner as to minimize their effect: **Yes**

Based on these factors, it is the undersigned's professional opinion the probability of restoration would be improved, and the length of time to restoration would be reduced, if the Court granted judicial authority for the involuntary administration of medication, and Mr. Smith's treating psychiatrist opined it clinically necessary.

Example 3

The following information describes factors related to the need for a forced medication order:

- Mr. Smith is diagnosed with a mental illness for which the first line treatment is psychotropic medication
- Mr. Smith has a history of responding to treatment
- Mr. Smith has a history of medication noncompliance
- It is unknown if Mr. Smith has a stated plan to refuse or is currently refusing medications
- The prognosis is poor in the absence of psychotropic medications.
- Should side effects develop, they will be addressed by the psychiatrist in such a manner as to minimize their effect.

7.85 Opinion Regarding Dangerousness.

As directed in RCW 10.77.086, a discussion of risk factors related to future dangerousness is required for (1) all second and third restoration period evaluations regardless of the evaluator's competency opinion, and (2) all reports in which the evaluator's opinion is that the defendant is not restorable. Consistent with best practices in risk assessment, it is strongly recommended that evaluators use a structured professional judgment risk assessment tool, such as the HCR-20 v3, to guide this discussion. This section is based solely upon the information gathered and relied upon in the competency evaluation. Other factors may exist that increase or decrease the examinee's risk but fall outside the evaluation's purview.

Example 1

Opinion Regarding Dangerousness

This section concerning dangerousness was court-ordered and conducted within the scope of the competency evaluation to aid the court's determination as to whether the defendant (1) is a substantial danger to other persons; or (2) presents a substantial likelihood of committing criminal acts jeopardizing public safety or security. The following is based solely upon information known and relied upon in the above evaluation. Other reasons may exist that increase or decrease the defendant's relative risk but fall outside the purview of this evaluation. The dangerousness section focuses on factors empirically linked to violent reoffending.

Current practice in violence risk assessment involves the consideration of factors frequently associated with future violence. The Historical, Clinical, Risk Management-20 version 3 (HCR-20 v3) is an instrument that organizes such known risk factors, dividing them into three categories: Historical, Clinical, and Risk Management.

Historical risk factors (i.e., static factors) are relatively stable elements of the individual's life and are unlikely to change. The following historical risk factors, as discussed by the HCR-20 v3, were present: a history of a major mental illness, poor treatment supervision and response, problems maintaining and establishing stable personal relationships, and problems with employment. Specifically, Mr. Smith has a severe and persistent mental illness, schizophrenia, and a lengthy history of refusing psychotropic medications. During the interview, Mr. Smith described himself as a "loner" and preferring to keep to himself. He ran away around age 15 and has been homeless since. In addition, Mr. Smith has not maintained any relationships with friends or family. His social isolation is likely related to the persistent paranoia that characterizes his illness. Regardless, he has a lack of positive social or emotional support. Otherwise, Mr. Smith does not have a known history of actual, attempted, or threatening behaviors outside of the alleged events. Available records do not indicate significant problems with substance abuse. There were no indications that Mr. Smith has maladaptive personality characteristics or personality disorder behavioral problems, such as antisocial behavior. Mr. Smith does not appear to have issues of violence or a belief of violent attitudes. Furthermore, he does not report a history of traumatic experiences and records do not reflect any.

Clinical risk factors describe the individual's current mental state and are considered to be more changeable or amenable to treatment. Mr. Smith is acutely psychotic and has little insight into his mental illness. While he has been taking psychotropic medications recently, he has routinely refused to meet with treatment providers suggesting poor treatment supervision and response. At present, he does not appear to have problems with violent ideation or intent. Further, he does not appear to have recent problems with affective, behavioral, or cognitive instability; that is, over the last three months of restoration treatment.

Finally, risk management factors are those likely to influence the individual in the future and are also considered to be changeable. Mr. Smith's risk might be elevated regarding future problems with obtaining professional services, adequate housing, substance use, and future problems with stress and coping. He reported having little to no personal support and a lengthy history of

homelessness. Important factors in Mr. Smith's case will be obtaining adequate housing and engaging in treatment.

Based upon observations contained in Mr. Smith's medical record, information obtained through clinical interviews, and a review of risk factors, it is the undersigned's opinion that Mr. Smith's most salient risk factors include his severe and persistent mental illness, tendency to refuse medications and interactions with treatment providers, his limited insight into his illness, and obtaining prosocial supports and adequate housing in the community. Mr. Smith's risk for both future dangerous behavior and reoffending would increase should he discontinue his medications, experience an increase in psychiatric symptoms, or return to a houseless environment upon returning to the community. Should Mr. Smith be placed into secure or monitored housing environment with ongoing psychiatric medication management, his recidivism risk would significantly decrease.

7.9 Necessity for a DCR evaluation.

Per 10.77, an opinion as to whether or not the defendant should be evaluated to see if they meet the criteria for involuntary psychiatric commitment (i.e., RCW 71.05) is required. This section should address if the defendant is or is not a danger to themselves or others, and if they can or cannot meet their basic needs of health and safety.

Example 1

DESIGNATED CRISIS RESPONDER (DCR) REFERRAL

An opinion is required as to whether the defendant should receive an RCW 71.05 civil commitment evaluation by a DCR. This opinion is based upon the information referred to in this report. Other reasons may exist to require such an evaluation but fall outside this evaluation's purview.

Based upon the information referred to in this report, it does not appear Mr./Mrs. Defendant represents an *imminent* risk of danger to himself/herself or others. The defendant did not meet criteria for grave disability at the time of the evaluation. As such, an evaluation by a DCR pursuant to RCW 71.05 ***is not recommended*** prior to change in his/her custodial situation.

Example 2

DESIGNATED CRISIS RESPONDER (DCR) REFERRAL

An opinion is required as to whether the defendant should receive an RCW 71.05 civil commitment evaluation by a DCR. This opinion is based upon the information referred to in this report. Other reasons may exist to require such an evaluation but fall outside this evaluation's purview.

Based upon the information referred to in this report, Mr. Johnson does not appear to present as an *imminent* risk of danger to self or others. He appears to possess the *current* capacity to meet his basic needs of health and safety. As such, an evaluation by a DCR, pursuant to RCW 71.05, is ***not recommended*** at this time should his custodial situation change in the future. However, this evaluation took place at time Mr. Johnson was housed in a secure setting, taking psychotropic

medication, and likely abstinent from illicit substances. If he were to discontinue medication and/or use substances, he may decompensate and an evaluation by a DCR would possibly be warranted.

7.10 Signature and Report Copies

Your signature should appear above your typed name, degree, credentials, and contact information. **.** *Copies of the report are to be filed with the court first and then simultaneously with parties to the matter. It is not appropriate to discuss the results of your evaluation with either defense or prosecution prior to release to the court.* *Preview drafts of your report should not be released*. *All copies which are sent via email need to be done via secure e-mail.*

Example 1

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Licensed Psychologist (#1111)
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bf.skinner@dshs.wa.gov
Phone: 253-111-1111

cc: Presiding Judge, Any County Superior Court
Eliot Ness, Prosecutor
C. Darrow, Defense Counsel
Name, Any County Designated Crisis Responder
Designated Recipient, Appropriate Jail

8. Available Resources and References

Case Law

Cooper v. Oklahoma, 517 U.S. 348 (1996).

Dusky v. United States, 362 U.S. 402 (1960).

Guidebooks:

Washington State Guide to Forensic Mental Health Services. Department of Social and Health Services. Available at: https://www.dshs.wa.gov/bha/office-service-integration/office-forensic-mental-health-services

Textbooks and Articles:

Allan, A., & Grisso, T. (2014). Ethical principles and the communication of forensic mental health assessments. *Ethics & Behavior*, *24*(6), 467-477.

Golding, S. L. (2016). Learning forensic examinations of adjudicative competency. In R. A. Jackson & R. Roesch (Eds.), *Learning forensic assessment: Research and practice* (pp. 65–96). New York: Routledge.

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Stafford, K. P., & Sellbom, M. O. (2013). Assessment of Competence to Stand Trial. In I. B. Weiner, & R. K. Otto, (Eds). *Handbook of Psychology*, *Forensic Psychology*. Hoboken, NJ: Wiley.

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