

State of Washington

Forensic Evaluation Report Guidelines: Competency to Stand Trial



Washington State
Department of Social
& Health Services

Transforming lives

Office of Forensic
Mental Health Services

Acknowledgments

The following individuals contributed to the development of this manual: David D. Luxton, Ph.D., Merrill Berger, Ph.D., Richard Yocum, Ph.D., Marilyn Ronnei, PhD., Bryan Zolnikov, Ph.D., Stephen Golding, Ph.D., Thomas Kinlen, Ph.D., Jacqueline Means, Psy.D., Daniel Montaldi, Ph.D., and Randall Strandquist, Ph.D. David D. Luxton, PhD., led the development of this manual. Cover photo by Tim Hunter.

For questions and comments regarding this guidebook, please contact:

David D. Luxton, PhD., M.S.
Office of Forensic Mental Health Services
Behavioral Health Administration/ Department of Social and Health Services
P.O. Box 45050
Olympia, WA 98504-5050
(360)-725-3479
david.luxton@dshs.wa.gov

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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. The OFMHS provides forensic evaluations, competency restoration, Not Guilty by Reason of Insanity - NGRI treatment services, and liaison services to effectively coordinate efforts with system partners to meet shared goals. The office is supported by RCW 10.77.280.

The mission of this office is to lead and manage a system of forensic mental health care that assists the courts and justice system to protect both public safety and the rights of accused mentally ill persons, by providing timely, high quality, and data informed mental health services.

The vision of OFMHS is to lead the nation in innovative and quality forensic mental health services.

1. About This Manual

The objective of this manual is to provide guidance and information for writing competency to stand trial evaluations under 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 through 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. Training in forensic psychological assessment as well as a working knowledge of the relevant State of Washington competency statutes, treatment, and involuntary hospitalization of mentally ill persons in our state is all 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 such 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; or
- c) 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:

- Experience performing competency evaluations of criminal defendants;
- Knowledge of Washington state competency statutes
- Psychological testing knowledge
- Clinical assessment and diagnostic skills
- Strong report writing skills
- Have satisfactorily passed a criminal background check
- Have a Washington state license in good standing in their relevant profession

At the present time the majority of CST evaluations are conducted by evaluators employed directly by the OFMHS within the Washington State Department of Social and Health Services (DSHS). Other evaluations are conducted by clinicians contracted for their services by DSHS/OFMHS or their local county.

Employees and contractors completing forensic evaluations are expected to seek and maintain the 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 the court order. The evaluator addresses only those issues which are contained in the court order. The evaluator does not conduct evaluations on issues or populations outside his or her area of expertise. All forensic evaluations are assumed to be conducted from an impartial stance. An evaluator is neither an advocate for the defense or prosecution. The role of the forensic evaluator is to assist the trier of fact by providing impartial, well described, and quantified data and opinions. 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.

The Office of Forensic Mental Health Services Quality Team is tasked with conducting quality reviews of forensic services that fulfill statutory obligations under [RCW 10.77.280](#). 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

Washington State law requires that a defendant be mentally competent to stand trial. 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 order 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 to determine if the person is indeed competent, and if that any lack of competence is a result of a mental disease or defect. 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).

Washington State 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 (15)]

Washington State statute does not directly address the rational component of the minimum bar of the competency standard set forth in Dusky, rather, the following addition must also be considered:

"[The] test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding - and whether he has a rational as well as factual understanding of the proceedings against him." (Dusky v US; 362 U.S. 402; 1960)

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.

In the State of Washington, the burden of proof for a finding of incompetence is placed on the individual contesting competence. 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)).

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 Mental Health Professional (DMHP) 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 assessment report is to document and preserve a record of the competency evaluation and conclusions of the evaluating professional. 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, clearly explain;

1. The purpose of the evaluation and the methods used to conduct the evaluation
2. An executive summary section which appears early in the report (between the Referral Information and Nature of the Evaluation sections). This section is entitled *Summary of Opinions*, and briefly outlines key opinions;
 - a. Diagnosis or Current Mental Status
 - b. Competency
 - c. Restorability (if applicable)
 - d. DMHP 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;
 - the examiner's role
 - the purpose of the evaluation
 - that a report to the court will be made even if the defendant chooses not to participate
 - the non-confidential nature of the report and lack of privilege even if the attorney is present

- the right to participate in whole or in part with the evaluation interview
 - the right to have counsel present during interview
5. A brief relevant background of the defendant
Current mental status and diagnostic conclusions with a description of the clinical interview
 6. Documentation of competency related abilities and deficits
 7. Forensic opinions with supporting data and full forensic conceptualization regarding:
 - a. 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. An opinion as to the defendant’s effort and reliability during the evaluation
 - e. A referral for civil commitment under RCW 71.05 by a Designated Mental Health Provider

Several redacted sample reports are at the end of these guidelines (see addenda). The samples serve as examples of competency evaluations using the standards and practices in the State of Washington. There are also samples of specific sections of the report, which appear in the annotated review of the report template.

You will note that these samples, while showing variations in writing and presentation styles all:

1. Follow a specific format. While each evaluation report is specific to the individual being evaluated; when a format is used it makes it easier for those routinely reviewing these reports to know where they are likely to find specific types of information. It also helps the writer quickly identify if something is “missing” (see Competency Evaluation template, addenda, #).
2. The reports are problem-focused. Each piece of information in the report is used as a part of the reasoning for arriving at the outcome of the evaluation.
3. The report strikes a balance on detail, providing enough detail to inform the reader and base forensic opinion while not overwhelming in irrelevant or redundant data. .
4. Reports avoid jargon. When technical terms are used, they are explained. For example; “Mr. Smith was diagnosed with schizophrenia (a thought disorder typified by a wide variety and combination of cognitive behavioral and emotional dysfunctions).”
5. Evaluators clearly differentiate between different classes of data utilized. There are three general classes of information contained in forensic reports; these include:
 - a. Clinical and historical data relevant to the assessment of competency or clinical presentation
 - b. inference or opinions
 - c. the logic explaining the relationship between the data and opinions (e.g., nexus)
6. Evaluators offer opinions only in specific sections;
 - a. Summary of Opinions section
 - b. Diagnostic Impression
 - c. Competency to Stand Trial Impression
 - d. Necessity for a DMHP 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 and Historical Data
6. Mental Status Examination
7. Diagnostic Impressions
8. Evaluation of Competency to Stand Trial
9. Designated Mental Health Professional (DMHP) Recommendation.
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; the 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 (e.g., Western or Eastern State Hospital, if applicable), 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
Office of Forensic Mental Health Services
Behavioral Health Administration
Western State Hospital Campus
9601 Steilacoom Blvd SW (C-18; W27-19)
Lakewood, WA 98498-7212

January 24, 2018

**COMMUNITY FORENSIC EVALUATION SERVICE
COMPETENCY ASSESSMENT REPORT**

RE: STATE OF WASHINGTON
vs.
Smith, John

CAUSE NO: 11-11-11111
WSH NO: 111111
DOB: 1/1/11

The forensic evaluation, as reflected in this report, was conducted by the Office of Forensic Mental Health Services of The Department of Social and Health Services pursuant to court order under the authority of RCW 10.77.060. This document has been released only to the Court and other persons legally authorized to receive it; it is intended for their use only, and any other use of this report is not authorized by the undersigned. The content and opinions herein are based upon information available within the timeframes allotted by statute, court procedure, and/or administrative guidelines. This report reflects statutory changes to RCW 10.77.060, initiated by SSB 6492, effective 5/1/12.

7.2 Referral Information

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

Example 1:

REASON FOR REFERRAL

On April 14, 2017 the Superior Court of Anywhere County ordered Mr. John L. Smith to undergo an outpatient evaluation regarding his competency to proceed to trial on his pending charges pursuant to RCW 10.77.060. The defendant is charged with one count of Assault in the Third Degree, which allegedly occurred on or about April 12, 2017.

If the opinion is that the defendant lacks such capacity, then an opinion is required as to whether he is likely to regain such capacity with further treatment as permitted under RCW 10.77.090. In addition, if the defendant is likely to regain capacity, an opinion as to whether medication is medically appropriate and necessary to help him regain or maintain such capacity, and whether less intrusive treatment methods exist. Additionally, as is mandated by RCW 10.77.060, I will address in this report Mr. Smith's mental condition and any further need for evaluation under RCW 71.05.

Example 2:

REASON FOR REFERRAL

On January 10, 2018, the Anywhere County District Court ordered Mr. John L. Smith to undergo forensic evaluation of his competency to proceed. This report will include: (1) a description of the nature of the evaluation; (2) a diagnosis or description of the current mental status of the defendant; (3) if the defendant suffers from a mental disease or defect, or has a developmental disability, an opinion regarding current competency to stand trial; (4) if it is concluded that the defendant is incompetent to proceed, an opinion whether psychotropic medications are necessary and appropriate to restore the defendant's competency, and an opinion whether the defendant is restorable; and (5) an opinion as to whether the defendant should be evaluated by a county Designated Mental Health Professional (DMHP) under RCW 71.05.

Mr. Smith was charged with Driving Under the Influence of Intoxicating Liquor or Any Drug, following an incident on or about December 28, 2015. State Toxicology Laboratory reports indicated that Mr. Smith's blood tested positive for methamphetamine. He pleaded guilty and agreed to conditions on June 1, 2016.

Example 3:

REASON FOR REFERRAL

The Anywhere County Superior Court ordered that Mr. John L. Smith remain at Western State Hospital (WSH) for up to 90 days for the second period of competency restoration and an 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 mental health professional (DMHP) under RCW 71.05 will also be addressed.

Mr. Smith is charged with Attempting to Elude a Pursuing Police Vehicle, Assault in the Third Degree, and Obstructing a Law Enforcement Officer, allegedly occurring on or about February 24, 2017.

7.3 Summary of Opinions

The Summary of Opinions Section needs to include the evaluators' conclusive opinions regarding the examinees;

- a. Effort and Reliability during the evaluation
- b. Diagnosis or description of symptoms
- c. Competency related abilities
- d. Restoration
- e. Necessity for a DMHP assessment

Example 1

SUMMARY OF OPINIONS

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

- **Effort and Reliability:** Mr. Smith appeared to put forth his best effort throughout the interview. There was no indication of malingering, exaggeration, or misleading responses.
- **Diagnostic Impression:** Schizophrenia
- **Competency:** Mr. Smith lacks the capacity to understand the nature of the proceedings he faces and lacks the capacity to assist in his defense.

- Restoration: Given Mr. Smith’s current psychiatric presentation, inpatient competency restoration treatment is recommended.
- DMHP Evaluation: An evaluation by a DMHP is warranted at this time.

Example 2

SUMMARY OF OPINIONS

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

Effort and Reliability: Mr. Smith appeared to be putting forth his best effort.

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.

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

Example 3

SUMMARY OF OPINIONS

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

Effort and Reliability: Due to intrusive symptoms of a currently untreated psychotic disorder, Mr. Smith had difficulty participating rationally in the evaluation. There were no indications that he was attempting to feign symptoms of mental disorder.

Diagnoses: Unspecified Psychotic Disorder, Stimulant-Induced Psychotic Disorder vs. Major Depressive Disorder, recurrent, with psychotic features; Stimulant Use Disorder.

Competency: Mr. Smith lacks the capacity to understand the nature of the proceedings against him and the capacity to assist in his own defense.

Restoration Opinion: Not applicable.

DMHP Evaluation: An evaluation by a DMHP is recommended at this time.

7.4 Nature of the Evaluation

The Nature of the Evaluation section includes notification 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. It also contains a list of all of the sources of information which formed the basis for your opinion.

Example 1

NATURE OF THE EVALUATION

Notification and Agreement to Participate

Prior to the interview, I advised Mr. Smith of the purpose and the authority for the evaluation and the non-confidential nature of the evaluation. I informed him he could end the interview at any time and could have his defense attorney or other legal representative present. I informed him of the limited confidentiality of the evaluation, including advisement that his remarks and observed behaviors may be included in this evaluation report. I told him to whom the report would be distributed. Mr. Smith agreed to participate in the evaluation without his defense counsel being present.

Sources of Information

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

1. Discovery materials provided by the prosecutor;
2. National Crime Information Center (NCIC) database information;
3. Attempted Clinical/Forensic interview with Mr. Smith at Anywhere County Jail on April 21, 2017, lasting 45-minutes;
4. Medical Records provided by Anywhere County Jail;
5. Western State Hospital records;
6. Competency Assessment by James Johnson, J.D., Ph.D., Office of Forensic Mental Health Services (OFHMS), dated March 6, 2017;
7. Competency Assessment by Jane Williams, Ph.D., ABPP, OFHMS, dated June 29, 2016;
8. Mental Health Division (MHD) Database;
9. Evaluation of Competency to Stand Trial – Revised (ECST-R).

Example 2

NATURE OF THE EVALUATION:

Notifications, Rights and Confidentiality:

Prior to beginning the interview, Mr. Smith was notified of the purpose and authority for the evaluation, who would receive copies of the report, the limits of confidentiality, the legal right not to answer questions, the right to have an attorney present during the interview, the lack of a treatment relationship, and the possibility of a recommendation for mental health treatment. Mr. Smith demonstrated an adequate understanding of the notifications and he indicated that he wished to proceed on that date with counsel present.

Database:

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

1. Prosecutor's discovery information.

2. Mental Health Division 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. Johnson, and the undersigned.
4. Mental Status Examination.
5. Criminal History Report, as provided in discovery.
6. Jail mental health records.
7. Western State Hospital (WSH)/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

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 agreed to continue the interview.

Database

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 and Historical Data

This section includes *relevant* information based on, personal interview, collateral information and criminal record. This section is not meant to be an exhaustive history of the defendant. If relevant psychosocial data has been outlined for the court on the same cause number, and no new historical data was discussed in the current forensic interview, referring the court to the specific previous evaluation with such data under the aforementioned cause number may be acceptable.

Example 1RELEVANT CLINICAL AND HISTORICAL 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.*

Mr. Smith reported he had been living on the street prior to his arrest. He had been released from Fairfax Hospital to a sober living house. However, the sober living house did not work out, and he had no place to go when he left. Mr. Smith reported he had been diagnosed with posttraumatic stress disorder and paranoid schizophrenia. He was prescribed Seroquel (antipsychotic medication) and an antidepressant medication at Fairfax, and after discharge, through Community Mental Health. The medications had served to “keep the voices down and less 24-7.” However, he had not taken those medications since leaving his sober housing. When asked why he stopped taking his medications he said, “I don’t know. Get out of treatment or jail because so stressed out. Not good with times and schedule...Stressful like when I don’t know what’s reality.” Mr. Smith had previously used methamphetamine, heroin, and marijuana, but claimed he had not used while living on the streets.

Anywhere County Correctional Facility mental health staff indicated that Mr. Smith had discussed delusional information briefly, including that his stepfather and brother were against him, had an affair with his wife, and had stolen from him. He had refused to meet with mental health or medical staff again. He was being held in the transfer area and was dressed in a “suicide smock.” He was not being prescribed any medications as of 1/11/18.

Western State Hospital electronic records revealed Mr. Smith had previously been evaluated for competency to stand trial on the instant offense. Dr. Jane Williams evaluated Mr. Smith on May 16, 2017. At that time he evidenced paranoid delusions (on the same themes as his current delusions), but his thought processes were organized. He was depressed. She diagnosed him with stimulant use disorder (amphetamine-type substance); stimulant-induced psychotic disorder (provisional); and unspecified depressive disorder. She opined possessed the requisite capacities for competency, noting “There was no indication that his reported beliefs would interfere with his ability to rationally understand the proceedings or to communicate with and assist his attorney.”

Dr. Williams was able to obtain the following history from Mr. Smith at that evaluation:

Mr. Smith was born and raised in the Anywhere County areas. His parents divorced when he was young. He went back and forth between his mother and father, who reside in the local area. His mother remarried. He has "four or five" siblings, which he clarified as two brothers and four sisters "maybe - I try to block it out." He has been with his wife for 12 years, and has children that he did not wish to talk about, although later referred to child support, and his sister's custody of his children. Mr. Smith has a fifth or sixth grade education, was in Special Education and described problems with speech, reading and writing. He denied recall of whether he had ever been suspended or expelled. He denied history of military service. Mr. Smith has been employed in drywall "my whole life," although he has not worked since he and his wife separated two years ago. He was receiving disability for Posttraumatic Stress Disorder, for which his sister was his payee, who "ripped me off of \$11,000." He described his medical problems as, "I can't sleep at night," and when asked about history of seizures, replied, "I twitch a lot," and referred to spasms. Mr. Smith denied history of head injuries, and volunteered that there was a time when he thought and hoped he had cancer which would be fatal, but tests were negative.

Mr. Smith denied alcohol use and history of problematic use. He endorsed cannabis use, but described his current use as "not really." When asked about synthetic cannabis use, he replied that when he was "a kid" he used "Special K - snorted it a lot." He has a history of using methamphetamine, was "clean and sober" until his wife left him, and intimated or implied more recent use as he has been living in a "trap house" occupied by substance users for the past three years. He has done his "fair share" of cocaine, heroin a few times, on which he tried to overdose, and took "70 hits of acid" when he was 16 years of age. He has used mushrooms, and denied use of inhalants and opioids. He was been in inpatient treatment at Anytown Treatment Facility at 18 years of age in order "to get away from my mom;" he has been in outpatient treatment as well. When asked about mental health treatment, he replied, "I've been trying, but I've been stuck in a house." He was admitted to Anytown Hospital pursuant to a suicide attempt via overdose on heroin. He was prescribed an antidepressant and an antipsychotic, the names of which he did not recall. When asked about his contact with Anytown Counseling Center (according to the Mental Health Division database) he denied recall. He has thought of hanging himself, jumping off of a bridge, and has thought about a gun, but has no access to a firearm. Follow-up inquiry resulted in his denial of access to firearms, although as noted in the paragraph below, he reported a plan to shoot himself with a shotgun upon release.

Mr. Smith would not discuss his arrest history, but acknowledged his booking earlier this year for a charge of Violation of a No Contact Order involving his wife; he reported, "I don't plan on talking to her, she ruined my life." He denied social support from his family, and his plans upon release are to "stay away from that house, go to community mental health facility every day and getting my stuff done," referring to visits with his children. However, he also reported another point in the interview that he planned to attempt or commit suicide after his release and completing some music that he has in progress.

State of Washington Division of Mental Health online databases showed Mr. Smith had six contacts with Anytown Counseling Center in Anywhere County in 2001, and a crisis contact on 11/29/04 (diagnosis of Alcohol/ Substance Dependence). Mr. Smith had a crisis contact at Anytown Medical Center on 11/17/99, and was admitted there from 7/22/16 to 7/29/16; no diagnosis or voluntary/involuntary status was indicated. Most recently he was hospitalized at Anytown Hospital from 8/20/17 – 8/28/17. No diagnoses were listed.

Example 2

RELEVANT CLINICAL AND HISTORICAL INFORMATION

Defendant's Self-Report:

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

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... $0 \div 1$ 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.

Collateral Sources of Information:

Mental Health Division (MHD) Database records:

Department of Corrections information within the MHD Database listed Mr. Smith as being diagnosed with Bipolar Depression – Severe with Psychosis. His incarceration date was listed as 9/22/98 and his release date as 1/18/01. No further information was listed in this portion of the database.

Within the Regional Support Network (RSN) portal, Mr. Smith was listed as receiving services on an outpatient basis between 1/29/01 and 12/28/01. The primary provider was the Community Psychiatric Clinic (CPC). He further received outpatient treatment through CPC between 1/2/02 and 9/17/03 on a fairly regular basis. No diagnosis was listed for these contacts. On 11/15/07, he began receiving services through the Anytown Mental Health Institute for a diagnosis of Schizoaffective Disorder Unspecified. On 8/5/08, a secondary diagnosis of Unspecified Alcohol Dependence, and a tertiary diagnosis of Cannabis Dependence Unspecified were added. His last contact with Anytown Mental Health was listed as occurring on 6/3/10. Since that time, he had crisis intervention contacts with the Anytown Provider on two occasions; 7/29/17 and 8/8/17. The diagnosis associated with these contacts was Illness, Unspecified. Mr. Smith's records listed no history of voluntary or involuntary civil commitment.

Western State Hospital (WSH)/Office of Forensic Mental Health Services (OFMHS) records:

Mr. Smith has no history of prior competency evaluation or any history of admission to WSH for treatment.

Jail mental health 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. 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 AND HISTORICAL 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. 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 stroke; 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 Mental Health Division on-line database 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.

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.

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.

7.6 Mental Status Examination

The mental status examination sections should include, minimally, 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

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 persevere 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.

Example 2

MENTAL STATUS EXAM AND BEHAVIORAL OBSERVATIONS

Staff informed the undersigned on January 23, 2018, that Mr. Smith was ill and it was uncertain whether he would be able to participate in an interview as he had been vomiting a short time before. However, he agreed to come to the interview room. Mr. Smith presented as a poorly groomed Caucasian male who appeared his chronological age. He was dressed in clean jail-issued clothing. Mr. Smith was shivering at times, and complained that he was cold and felt nauseated. His gait was slow. His eye contact was poor. He established eye contact once. He otherwise sat with his head lowered and his hair over part of his face. His appearance was most remarkable for tattoos. He had red tears tattooed under his eyes, which he said were "symbolic" of his sadness, and still-healing tattoos on his fingers, in addition to other older tattoos.

This defendant's speech was slow and monotonic. At times he was asked to repeat his mumbled responses. His thought processes were mildly disorganized and he offered no spontaneous remarks. Mr. Smith occasionally had difficulty directing his thoughts to a goal, though he was improved over his presentation two weeks ago. Mr. Smith repeatedly stated that he was uncertain what reality was on his phone. He complained that he kept losing track of reality and where he was and who he was. He evidenced paranoid ideation, believing that he was targeted for assassination, and that his brother and stepfather were part of that plan. Their motivation for wanting him dead was that they had stolen 300 of his songs online and that his stepfather had an affair with Mr. Smith's wife. Mr. Smith believed phone had been hacked and his identity stolen. He had discarded or hidden 14 phones because others had figured out how to put messages on his screen or to steal information from him. Mr. Smith reported hearing voices stating he was going to be killed.

Mr. Smith's affect was flat, and he appeared depressed and mildly anxious. However, he characterized his mood in recent days as "good." He also stated that he thought about hanging himself every day [Note: His statement was reported to Morgan Black, jail MHP]. He stated he would probably not attempt to kill himself now, because he had to get out of jail and finish his music. Once that was finished, he expected to kill himself and wait for his children to join him in heaven. When pressed, he admitted that he was depressed. He was sleeping "all the time" because he felt ill, and was not eating for the same reason. He denied assaultive ideation.

Mr. Smith had no apparent significant deficits in cognitive functioning. He was grossly oriented in all spheres. Attention and concentration were poor. He was able to follow our conversation for the most part, although he could not consistently remain on topic. He also could not perform a brief test of focus. While he could spell WORLD forward, he refused to attempt to spell it backward, stating that he could not do it. His immediate and short-term memory were intact, as he was able to register three of three items and recall three of three after two minutes of delay and distraction. His long-term memory was fair at best, as he was unable to recall details and dates of events. Expressive and receptive language skills were intact, as Mr. Smith was able to identify common object, repeat a complex phrase, follow oral directions, and

read and follow a written direction. His insight and judgment were poor with regard to his current circumstances.

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 that his last experience of auditory hallucinations was the day prior to the interview, behavioral observations indicate that 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 that the undersigned was several different people that he had had contact with in the past, as well as believing that 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.

Example 4

MENTAL STATUS EXAM AND BEHAVIORAL OBSERVATIONS

The interview was conducted in a small room at the Anytown Police Department Jail. A corrections officer remained in the room for security purposes.

Observations: Mr. Smith was a 35-year old man who reported he was of Cherokee and Comanche decent. His gait was smooth and coordinated, but while seated he showed physical agitation, as his legs bounced continuously throughout the interview. He maintained socially-appropriate eye contact.

Appearance / Hygiene: Average hygiene and grooming.

Orientation: Oriented to day of the week, exact full date, location and situation.

Attention / Concentration: Attention intact. Concentration variable. When Mr. Smith gave brief responses to questions his concentration was intact. However, he often provided extraneous information that was not directly relevant to the topic under discussion. He interrupted and talked over the undersigned. He needed to be interrupted and directed back to reciprocal dialogue, and at times could not recall the original topic under consideration.

Memory: Intact for short-term, recent and remote.

Cognitive / Intellectual Functioning: Mr. Smith's intellectual functioning likely fell no lower than the average range, based on his vocabulary, abstract reasoning skills, and fund of information.

Speech / Ability to Communicate: Speech was normal for volume but quick-paced and mildly to moderately pressured throughout the interview. Tone variable, at times normal but mostly irritable.

Thought Process / Thought Content: The defendant's thought process was variable and included logical, linear and organized thoughts but often circumstantial and tangential thoughts. He was excessively detailed in the information he offered. Approximately 20 minutes into the interview he was asked to provide fewer details and stay closer to the main topic under discussion. He agreed, though noted all of the information he was offering was important; he thereafter continued to provide many details. Mr. Smith consistently externalized responsibility and blame. For example, during discussion of his history he reported a daughter and step-daughter. Much later in the interview he referenced his young son, and when it was noted he had not mentioned him earlier he objected, "You didn't really ask in my mind." On another occasion when the undersigned noted he presented as angry he countered, "There's a lot going on. You don't want to know the details." Mr. Smith presented as grandiose. Although he complained about alleged treatment by Grays Harbor County police and other county corrections officers, his statements did not appear to be delusional in nature.

Affect / Mood: Mr. Smith's affect (range of emotional expressiveness) was constricted and mildly elevated. He presented as angry. He described his mood as, "I'm going through a lot right now, a lot to deal with," and when asked to describe further he indicated he was "fine," "upset," and "irritated." The defendant stated he was getting six to seven hours of sleep a night and felt rested. He described his appetite and energy level as "fine."

Suicidal Ideation / Homicidal Ideation: Mr. Smith denied any thoughts of harming himself or others.

7.7 Diagnostic Impression

This section should 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.

Example 1

DIAGNOSTIC IMPRESSION

In summary, this 34-year-old man presented with a history of chronic substance abuse which had led to an inpatient hospitalization at Anytown. While he denied recent use of illicit substances, it appears unlikely based on his history and his current presentation. I concur with Dr. Jones' observation in her report of May 2017 that "his report of paranoid beliefs strike the undersigned as consistent with stimulant use, but cannot be confirmed as solely attributable to its use." In any case, substance abuse would exacerbate any underlying mental disorder. Mr. Smith has a history of depression and suicidal ideation, which had previously been successfully treated with antidepressant medication.

At the time of this evaluation, Mr. Smith presented with symptoms of both major affective disorder and psychosis, including paranoid ideation, disorganized thought processes, and monotonic and impoverished speech, poor concentration and attention, poor self-care, flat affect, low energy, and auditory hallucinations. He reported that he visualizes killing himself every day, and expects to suicide after getting out of jail. He also expects to be killed by assassination by "the end of the summer." He has refused to see jail mental health and medical staff, and was not being prescribed any medications at the time of our interview.

Given the detail, consistency and complexity of Mr. Smith's described symptoms it is unlikely that he was attempting to exaggerate or malingering potential psychotic symptoms. For purposes of this evaluation, based on the available information my diagnostic impressions are:

- Unspecified Psychotic Disorder
- Provisional: Major Depressive Disorder, recurrent, with psychotic features
- Stimulant Use Disorder
- Hallucinogen Use Disorder by history

Example 2

DIAGNOSTIC IMPRESSION

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 my clinical interview and review of records, my DSM-5 diagnostic impressions are:

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

Example 3

DIAGNOSTIC IMPRESSION

Mr. Smith has a documented history of mental illness with diagnoses primarily denoting symptoms of psychosis and behavioral dysregulation. Records indicate that he has experienced mood lability, attention to internal stimuli, disorganized thought processes, delusional ideation, and poor insight and judgment. Mr. Smith has been prescribed antipsychotic medications for the aforementioned symptoms of mental illness and chart notes indicate significant decreases in overt indications of psychosis as well as drastic reductions in behavioral dysregulation.

Additionally, Mr. Smith's records indicate that he likely experiences deficits in his cognitive functioning congruent with an Intellectual Disability of mild severity. Testing results reviewed from the previous evaluation indicate that he performed within the borderline range of intellectual functioning, with associated difficulties in abstract reasoning and quick verbal production of language.

It should be noted that there are indications in available documentation that Mr. Smith has engaged in significant substance use. His use of substances may have an impact on the expression of the symptoms of his mental illness and the influence of substance use on the etiology, course, and presentation of Mr. Smith's mental health symptoms is unknown at this time. As such his diagnoses are listed as *provisional* until such data regarding his substance use is available.

In accordance with the *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5)*, Mr. Smith appears to meet diagnostic criteria for the following mental disorders:

Bipolar Disorder

Intellectual Disability (mild)

Unspecified Substance Use Disorder (Provisional)

Example 4

DIAGNOSTIC IMPRESSION

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 a 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 5

DIAGNOSTIC IMPRESSION

Per the MHD, Mr. Smith has a history of being diagnosed by KMH with Bipolar Disorder, Alcohol Abuse, Schizoaffective Disorder, and Major Depressive Disorder. Notably, he has no history of involuntary civil commitment due to psychiatric symptoms. Also, Mr. Smith indicated he served three terms with the WDOC, all at the Washington State Penitentiary (WSP) Walla Walla. Typically, the WDOC does not house inmates with significant psychiatric disorders at WSP Walla Walla. Additionally, the defendant reported an "18- year history of taking, Prozac, Ritalin, Strattera, and Effexor." Prozac, Strattera and Effexor are anti-depressants, while Ritalin is a stimulant primarily used to treat Attention Deficit Hyperactivity Disorder (ADHD).

As noted above, during this evaluation the defendant endorsed all psychiatric symptoms the evaluator inquired about. Noticeably, the defendant reported symptoms prior to the evaluator inquiring about them. However, the defendant's thought processes were logical/linear/connected and he did not appear to be responding to internal stimuli, which is consistent with observations from KCJ mental health staff. Mr. Smith presented as expressly concerned about being sent back to WSP should he be convicted of his present charges. His apparent, rather naïve, presentation of symptoms consistent with psychosis, which is inconsistent with legitimate psychosis, combined with the expressed anxiety about being returned to prison are indicative of Mr. Smith exaggerating psychiatric symptoms.

Additionally, the defendant stated, "I self-medicated. I don't do meth. I used to do meth." He also endorsed a history of using Cannabis and Alcohol.

Finally, the defendant has a significant history of interaction with legal authorities beginning prior to his 15th birthday and resulting in an arrest for "theft/burglary." Mr. Smith also reported multiple suspensions

during his primary school years for his involvement in psychical altercations. Mr. Smith's pattern of behavior consistently deviates from societal norms and expectations. He has demonstrated a pervasive pattern of disregard for the rights of others. His NCIC report indicates 17 prior convictions for criminal offenses. Of the 17 prior convictions listed on his NCIC printout, 9 are for violence, or a violence related offense. His pattern of criminal convictions in total demonstrates a reckless disregard for the safety of others.

7. 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 (DSM-5):

- Alcohol Use Disorder
- Stimulant Use Disorder (Methamphetamine)
- Exaggerating symptoms of psychosis
- Antisocial Personality Disorder
- Unspecified Mood Disorder

7.8 Competency to Stand Trial Impression

This section should document your evaluation of competency to stand trial related abilities and can include;

- 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 decision

An opinion regarding CST is provided at the end of this section. If all areas of CST related abilities are not evaluated, an explanation of what areas were evaluated and why they are relevant to the current assessment should be provided.

Example 1

COMPETENCY TO STAND TRIAL

1. Ms. Smith's competency to proceed to trial was evaluated by Dr. AAA on January 19, 2018, at (insert location).

The defendant's competency to stand trial was evaluated against Washington State's version of the *Dusky* standard. Per RCW 10.77.010 (15), "Incompetency" means a person lacks the capacity to understand the nature of the proceedings against him or her or to assist in his or her own defense as a result of mental disease or defect."

2. 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

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.

Capacity to assist in his defense

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.

Competency Opinion

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 STAND TRIAL

Ms. Smith's competency to proceed to trial was evaluated by Dr. AAA on January 19, 2018, at (insert location).

The defendant's competency to stand trial was evaluated against Washington State's version of the *Dusky* standard. Per RCW 10.77.010 (15), "Incompetency" means a person lacks the capacity to understand the nature of the proceedings against him or her or to assist in his or her own defense as a result of mental disease or defect."

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.

Example 3

COMPETENCY TO STAND TRIAL

Competency Discussion

Mr. Smith's competency to stand trial was evaluated against Washington State's version of the *Dusky* standard; namely, whether as a result of a mental disease or defect the defendant "[l]acks the capacity to understand the nature of the legal proceedings against him or her or to assist in his or her own defense". (RCW 10.77.010 (15)).

This 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.

Mr. Smith identified his charge as "Assault 4." "I want them to just drop it." He was uncertain who his attorney was, saying, "They told me it was Jack, but I'm pretty sure it was a girl. I'm not trying to sell any algorithms now, so they're trying to gain citizenship through a female identity. If it's a sister, it doesn't matter." When asked what he meant by a sister, Mr. Smith stated, "We enroll with the king. One king, who's in charge and what he says goes." At another point he stated "I'm practicing as my own attorney."

After additional nonsensical statements, Mr. Smith terminated the interview. During the course of this evaluation Mr. Smith was not able to express himself in a rational manner, and did not communicate his interests effectively. It is unlikely that he would be able to do so with defense counsel. At the time of this evaluation his symptoms of mental disorder impaired his perception, reasoning, motivation to defend himself, and ability to communicate. It is my opinion that Mr. Smith, due to a mental disorder, lacks the capacity to understand the proceedings against him and to assist in his own defense.

Barriers to Competency

The following deficits would 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.

Restoration Opinion

The defendant is charged with a non-felony crime. The Court expressly ruled that Mr. Smith's charge of Assault was a "serious offense" as defined in RCW 10.77.092. Therefore, Mr. Smith met the criteria under RCW 10.77.092 for competency restoration treatment. **Should the Court find that Mr. Smith is not competent to stand trial, inpatient psychiatric treatment is recommended for 14 days (plus any**

unused time of inpatient evaluation up to 15 days) toward improving his condition so his competency can be restored.

It should be noted that while Mr. Smith's competency was not restored during his most recent restoration treatment period this fall, he had twice previously been restored following periods of approximately one month of treatment. Prior to one of those successful restoration periods, he had taken antipsychotic medications in the jail beginning before his admission and continued on clinically indicated medications in the hospital. He is not currently prescribed anything but Ibuprofen in the jail. The likelihood of successful restoration would be improved if he started taking psychotropic medications prior to admission. Mr. Smith indicated he was willing to do so. He also stated he would take medications at WSH.

7.9 Necessity for a DMHP evaluation.

An opinion as to whether or not the defendant should be evaluated to see if they meets the criteria for involuntary psychiatric commitment is required.

Example 1

DMHP RECOMMENDATION

An opinion is required as to whether or not the defendant should receive an RCW 71.05 civil commitment evaluation by a DMHP. This opinion is based solely upon the above evaluation under RCW 10.77.060. Other reasons may exist to require a civil commitment evaluation, which fall within the scope of other standards outside the purview of this evaluation.

Mr. Smith is depressed and acutely psychotic. He stated that he visualizes hanging himself every day and stated that he would suicide or be assassinated after leaving jail. It is my recommendation that should the Court elect to release Mr. Smith, the Court first order an evaluation by a DMHP for civil commitment under RCW 71.05.

Example 2

DMHP RECOMMENDATION

An opinion is required as to whether or not the defendant should receive an RCW 71.05 civil commitment evaluation by a DMHP. This opinion is based solely upon the above evaluation under RCW 10.77.060. Other reasons may exist to require a civil commitment evaluation, which fall within the scope of other standards outside the purview of this evaluation.

Based upon the information referred to in this report, there is no evidence to indicate Mr. Smith presents an *imminent* risk of danger to self and others as he directly denied a current plan to harm himself or others. He currently appears to have the ability to carry out activities of daily living and provide for his basic needs of health and safety. Therefore, an evaluation by a DMHP *does not* appear warranted should Mr. Smith's custodial situation change.

Example 3

DMHP RECOMMENDATION

An opinion is required as to whether or not the defendant should receive an RCW 71.05 civil commitment evaluation by a DMHP. This opinion is based solely upon the above evaluation under RCW 10.77.060.

Other reasons may exist to require a civil commitment evaluation, which fall within the scope of other standards outside the purview of this evaluation.

It is my recommendation that if Court elects to release Mr. Smith, an evaluation by a DMHP for civil commitment under RCW 71.05 should be completed prior to his release from custody.

7.10 Signature and Report Copies

Your signature should appear above your 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

B. F. Skinner, Ph.D.,
 ABPP Board Certified in Forensic Psychology (#1111)
 Licensed Psychologist (#1111)
 Office of Forensic Mental Health Services
bf.skinner@dshs.wa.gov
 Phone: 253-111-1111
 Fax: 253-111-1111

Mailing Address

Community Forensic Evaluation Service
 Western State Hospital (C-18; W27-19)
 9601 Steilacoom Boulevard SW
 Lakewood, WA 98498-7213

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

8. Available Resources

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>

Text books:

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.

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.

9. Glossary

BHO – Behavioral Health Organization

CFS – Center for Forensic Services

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

CSTC – Child Study and Treatment Center

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

ESH – Eastern State Hospital

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

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

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

Involuntary Civil Commitment – Involuntary civil commitment is the involuntary placement of an adult person for the purpose of treating a mental illness that renders the person dangerous or at risk of self-neglect.

NGRI – Not Guilty for Reason of Insanity

NRO – Northern Regional Office

OFMHS – Office of Forensic Mental Health Services

Trier of fact – (or finder of fact), is a person, or group of persons, who determines facts in a legal proceeding.

WATCH – Washington State Patrol’s criminal history database.

WSH - Western State Hospital

10. References

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

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

Golding, S. L., & Roesch, R. (1988). Competency for adjudication: An international analysis. In D. N. Weisstub (Ed.), *Law and mental health: International perspectives* (Vol. 4, pp. 73–109). New York: Pergamon

Zapf, P. A. & Roesch, R., (2008). *Evaluation of Competence to Stand Trial*, Oxford University Press. New York, NY.