

Examining the Tools in the Toolbox

A Review of Community Supervision of Dangerous Mentally Ill Offenders

As conducted by a multi-disciplinary team convened by
King County Prosecuting Attorney, Daniel T. Satterberg, and
Department of Corrections Secretary, Eldon Vail

*"I only have the tools in my toolbox, and the tools I have aren't necessarily
the right ones." - Thomas McJilton, Community Corrections Officer, to the
Seattle Post-Intelligencer, March 26, 2008*



King County

Prosecuting Attorney's Office

The efforts of this workgroup are dedicated to the memory of

Shannon Harps

April 3, 1976-December 31, 2007

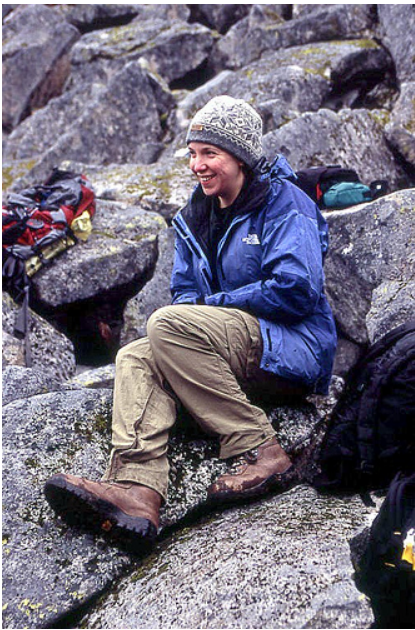


photo by Dave Schiefelbein

Shannon Harps was born on April 3, 1976, in Mentor, Ohio. She loved the outdoors and spent much of her life helping to preserve nature.

Shannon graduated from Miami University in Oxford, Ohio, in 1998. During college, she spent a summer working near Crater Lake National Park in Oregon. This experience sparked a strong desire in Shannon to move to the Pacific Northwest should she ever have the opportunity. Shannon obtained a Masters Degree in Environmental Education from Lesley College, in Massachusetts, in 2000.

Shannon was able to combine her passion for the environment with her career when she started working for the Sierra Club in June, 2000. She spent her first three years working for the Sierra Club in Ohio.

In 2003, a Sierra Club position opened up in Seattle, and Shannon was selected for it. Her new position involved long hours trying to bring together activists and volunteers from across the state in a campaign to reduce greenhouse gases. Shannon was described by her co-workers as a special person who cared both about the environment and engaging with people.

In Shannon's spare time she enjoyed biking, running, and hiking. She had studied in Europe, backpacked in Alaska, and was planning a trip to South America. Shannon Harps was 31-years old at the time of her death. In her all-too-short life, Shannon clearly gave more than she received.

Some of the factual information in this section came from a memorial published in The Cleveland Plains Dealer on January 13, 2008.

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Executive Summary

On December 31, 2007, a young woman named Shannon Harps was stabbed to death in Seattle. The person charged with her murder is James Anthony Williams. Williams has a history of prior violence (shooting a stranger in 1995) and a history of severe mental illness. He was also under supervision by the Department of Corrections (DOC) at the time of Ms. Harps' murder. Shortly after Williams was charged, King County Prosecuting Attorney Dan Satterberg and Department of Corrections Secretary Eldon Vail convened a workgroup to review Williams' interactions with the criminal justice and mental health treatment systems. This report is the product of the workgroup's efforts.

Williams was not an offender who "flew under the radar." While imprisoned after the 1995 shooting, DOC identified him as mentally ill, very resistant to treatment, and likely to be dangerous. By the time he was released from prison, he had been designated as a "Dangerous Mentally Ill Offender" (DMIO). DMIO is not just a designation, but also a program which allows for additional monies (about \$10,000 a year for five years) to be used to provide services and support for offenders designated as DMIOs as long as they engage in out-patient treatment.

After prison, Williams lived in Seattle. As a DMIO living in King County, Williams was monitored by DOC Community Corrections Officers (CCOs) who specialize in working with mentally ill persons. He was also enrolled in a special mental health treatment program run by Sound Mental Health (SMH), a private mental health treatment agency. Through SMH's program, which could access the additional \$10,000 in state monies, Williams received stable housing and medications. Williams averaged multiple contacts per week with his CCO, his out-patient treatment providers, or both. Once a week, his case was reviewed by a joint meeting of SMH, CCOs, Seattle Police Officers, and others.

After his prison release in March, 2006, Williams lived in the community for eleven months without major incident. However, from February 15, 2007, until Ms. Harps' murder on December 31st, he totaled only 38 more days in the community. On February 15th, his CCO arrested him for violating conditions of his supervision. He spent about three weeks in jail. Nine days after his release, he threatened to shoot his CCO and SMH staff and was arrested again. This incident led to criminal charges, additional jail time, and a related four month civil mental health commitment at Western State Hospital (WSH). Nineteen days after his release from WSH, he was arrested for threatening a housemate. He stayed in jail for three months. He also lost his housing.

On December 21st, just before his release from jail for threatening the roommate, he was evaluated by Designated Mental Health Professionals (DMHPs) for possible civil commitment for mental health treatment. The DMHPs decided he did not meet grounds for detention.

In the 10 days between Williams' release from jail on December 21st and Shannon Harp's murder on December 31st, his CCO or SMH case manager saw him at least four times, including several hours before the stabbing. Although the CCO was concerned about Williams, Williams had not violated his supervision conditions or committed a new

crime, so Williams could not be arrested. He had not done or said anything warranting a new referral to the DMHPs, so he was not evaluated for a civil mental health commitment. Without a mechanism to detain Williams on December 31st, his CCO had no choice but to let Williams go back to the streets.

This workgroup has reviewed Williams' interactions with the criminal justice and mental health systems since the 1995 shooting, including his participation in the DMIO program. The workgroup was a forum for discussion and ideas, and did not try to create consensus for specific proposals. Workgroup members who interact directly with offenders or the mentally ill discussed what hindered them in fulfilling their duties in the most effective manner. Members discussed the most appropriate treatment settings for mentally ill offenders and expressed their concerns that civil rights should not be infringed based upon mental illness only. As a result of discussions, the workgroup identified 16 points that must be considered as lawmakers look to reform the system. In addition to the 16 points of consideration, the workgroup identified 76 specific concepts for possible reform.

The workgroup was a forum for ideas, and did not seek consensus on which reform concepts should be implemented. However, the members of the workgroup agreed that it is imperative to address the capacity of the mental health system (both in-patient and out-patient treatment) when any proposal is examined.

Although 76 concepts for reform were identified, the workgroup's discussions centered primarily on three areas: removing mentally ill offenders off the street when they become a risk to others, the quality of the DMIO program, and communication between agencies and systems.

Taking mentally ill offenders off the street

In reviewing Williams' history, the workgroup learned that if an offender is deteriorating or not following supervision conditions, a CCO has only four tools to take the offender off the street. Two of those tools, arrest for a new crime or arrest for violation of supervision conditions, will get the offender off the street quickly, but do not directly provide for mental health treatment. The third tool, civil commitment for in-patient mental health treatment, leads to treatment, but is often not available because of strict criteria related to risk which must be met before detention will occur. The final tool, voluntary hospitalization, is not realistic for offenders resistant to treatment. What is lacking is a way to get violent offenders who are decompensating or showing other signs of risk off the streets quickly and into a treatment situation which will be long enough and secure enough for their treatment needs and the risk presented. This new tool could be part of the criminal justice system, the mental health system, or a hybrid of both.

The DMIO Program

The workgroup learned that the DMIO program has achieved positive results. Two WSIPP studies indicate that the program has had success in getting DMIOs into treatment sooner and more often, reducing felony recidivism, and creating an overall systemic savings of \$1.24 for every dollar spent on the program. However, full statewide funding

has not been provided in recent years and is threatened with budget cuts. Furthermore, many DMIOs live in counties in which Regional Support Networks (RSNs) and mental health providers will not contract with the Mental Health Division of DSHS to provide services to DMIOs, due in part to liability concerns.

Communication

The workgroup learned that communication across systems is a general problem that professionals face every day. Many professionals are prohibited from communicating with others because of confidentiality laws such as HIPAA. Sometimes it is just the perception of the coverage of confidentiality laws which inhibits communication. However, even if the communication roadblocks were lessened, there is no general database where information about the dangerous mentally ill person is kept, and the professionals in one system cannot easily access the information in another.

The workgroup agreed that there is no obvious answer on how to improve public safety, protect civil rights, and get offenders into effective treatment at minimal costs. However, one major purpose of the workgroup was to identify the questions needing answers and the points to consider for positive reform to occur. It was also a forum for proposing concepts of reform, knowing that consensus would be elusive at this stage. Whatever proposals policy makers or lawmakers choose to pursue further, they must weigh the increase in public safety against the monetary cost of new or expanded programs, and must continue to consider the liberty costs to those detained. This paper is a beginning of the conversation over reform, not the end.

Caveats

Caveat 1:

James Anthony Williams is charged in King County with Murder in the First Degree, with a Deadly Weapon sentencing enhancement. Isaac Zamora is charged in Skagit County with six counts of Aggravated Murder and fourteen counts of other felony crimes. They are presumed innocent of those charges until proven guilty. They are also presumed competent to face these charges until proven otherwise.

Caveat 2:

The focus of the workgroup and this report is on systems. While the workgroup has not seen obvious individual error on the part of the professionals working with James Williams, we do not intend to preclude the possibility that other parties may expose error via other internal review or appropriate litigation.

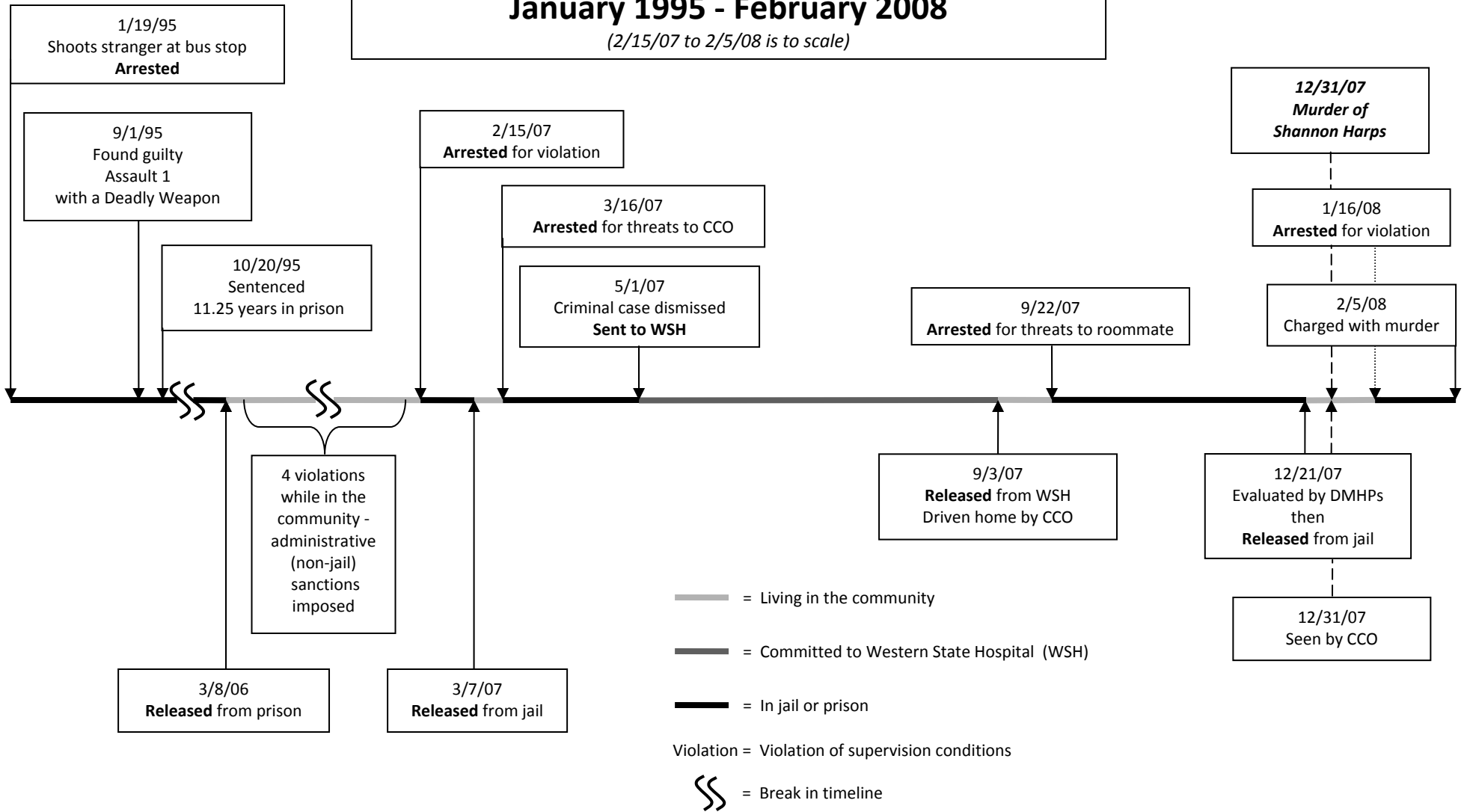
Caveat 3:

While legislative staff have been present and have been part of the discussion during workgroup meetings, no specific proposals have been endorsed by elected officials. We want to thank the staff for their involvement and ability to bring their perspective to the discussion, but we must acknowledge that they are, and must remain, neutral on specific proposals, as their job is to support the elected lawmakers in the State House and Senate.

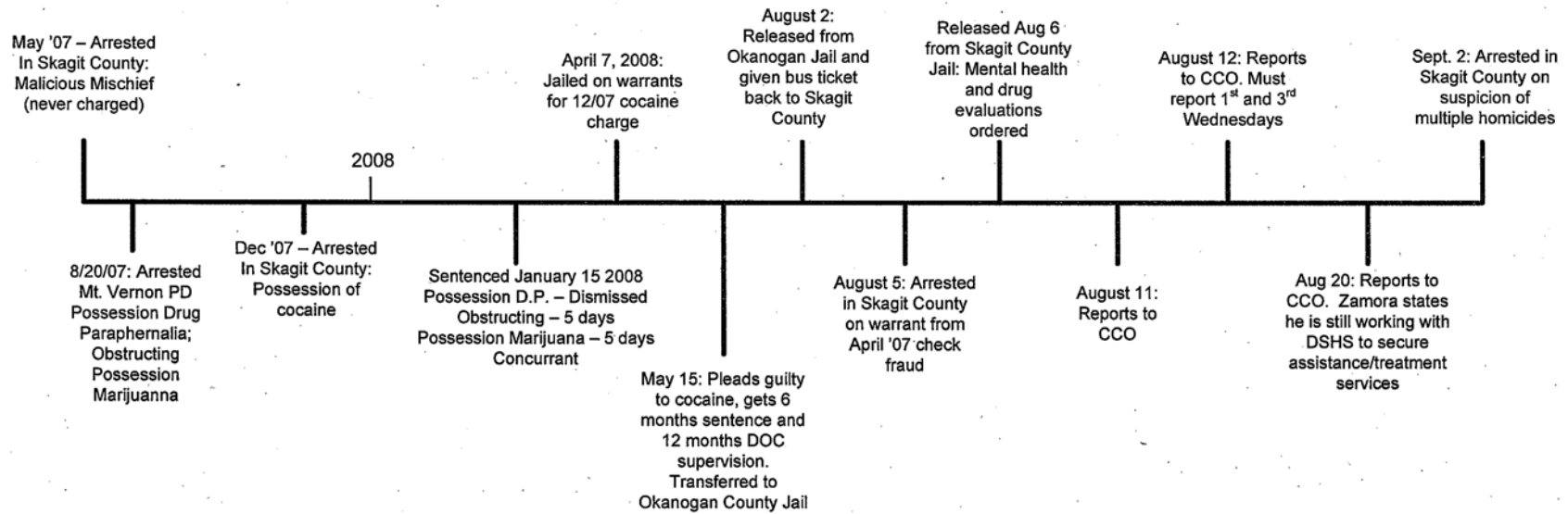
James Anthony Williams Timeline

January 1995 - February 2008

(2/15/07 to 2/5/08 is to scale)



Isaac Zamora Criminal & DOC Contacts May 2007 – September 2008



(Not to scale)

INTRODUCTION

Tools in the Toolbox: Genesis

How and why this report came to be

On December 31, 2007, Shannon Harps was brutally murdered near her apartment in the Capitol Hill neighborhood of Seattle. On January 29, 2008, the King County Prosecuting Attorney's Office charged James Anthony Williams with Murder in the First Degree, with a Deadly Weapon sentencing enhancement. Williams' culpability, if any, in causing Shannon Harps' death will be determined through the criminal justice system.

Irrespective of Williams' guilt or innocence of the crime charged, James Williams is a person with a violent criminal history and who suffers from symptoms of a major mental illness. He also was engaged in the out-patient mental health treatment system, was civilly committed for in-patient mental health treatment, and was under the strictest supervision available in the criminal justice system. In the past 13 years, including 11 years in prison and two years in the community, Williams interacted with a wide gamut of professionals from many of the organizations and systems that focus on mental illness, on criminal justice, or on both. These organizations and systems include the Department of Corrections, the criminal justice system, the civil involuntary mental health commitment system, and the out-patient mental health treatment system. All of these systems had much the same goals: to keep the community safe, to keep Williams safe, and to get Williams to accept mental health treatment.

Upon filing the murder charge stemming from the slaying of Shannon Harps, the King County Prosecuting Attorney's Office, together with the Department of Corrections, convened a workgroup to review how Williams interacted with these professionals, and, perhaps more importantly for the workgroup, how the systems interacted with each other. This workgroup consisted of medical professionals, university professors, legislators, law enforcement, prosecuting attorneys, defense attorneys, legislative staff, community mental health providers, Community Corrections Officers, advocates for the mentally ill, and others. During the course of the review of Ms. Harps' murder, another incident occurred in Skagit County in which six people, including Sheriff's Deputy Anne Jackson, were killed. The charged suspect in that shooting, Isaac Zamora, was also under DOC supervision and reportedly had a mental illness. This workgroup heard about the differences in DOC's risk assessments of James Williams and Isaac Zamora, the base of knowledge DOC had on each offender, and the different levels of supervision for each offender.

The workgroup was a forum for review of facts, for identification of issues, and for genesis of possible solutions. The presentations and discussions during workgroup meetings revealed a timeline of the events from Williams' sentencing in 1995 until his arrest in January, 2008. The presentations and discussions also came to focus on some specific points for consideration - clear questions or observations of systemic issues. The discussion often centered on proposed solutions to those issues.

This report examines the systems that Williams interacted with and attempts to ask whether improvements in those systems and their interactions might offer more to both

the public and to other offenders like Williams. This report does not contain final answers. The workgroup did not seek a consensus and did not take votes on recommendations. Rather, it presents ideas to policy makers at the state and local levels for further consideration and debate. The murder of Shannon Harps and the tragedy in Skagit County created this opportunity, and obligation, to review the interplay of our systems, and to consider all options for reform.

Here are the workgroup participants:

<p style="text-align: center;">Dan Satterberg King County Prosecuting Attorney</p>	<p style="text-align: center;">Eldon Vail Secretary Washington State Department of Corrections</p>
<p style="text-align: center;">Craig Adams Deputy Prosecuting Attorney Pierce County Prosecuting Attorney's Office</p>	<p style="text-align: center;">Jim Adams National Alliance on Mental Illness</p>
<p style="text-align: center;">The Honorable Ida Ballasiotes (retired) Washington State House of Representatives</p>	<p style="text-align: center;">Jane Beyer Senior Counsel Democratic Caucus Staff Washington State House of Representatives</p>
<p style="text-align: center;">Kevin Black Staff Counsel Human Services and Corrections Committee Washington State Senate</p>	<p style="text-align: center;">Trish Blanchard Chief Clinical Officer Sound Mental Health</p>
<p style="text-align: center;">Sarah (Sally) Coats Assistant Attorney General Section Chief, Mental Health Section Washington State Attorney General's Office</p>	<p style="text-align: center;">Dr. Christos Dagadakis, M.D. Medical Director Crisis Intervention Service Harborview Medical Center</p>
<p style="text-align: center;">Karen Daniels Assistant Secretary for Community Corrections Washington State Department of Corrections</p>	<p style="text-align: center;">Anne Deacon Division Manager Snohomish County Human Services</p>
<p style="text-align: center;">The Honorable Mary Lou Dickerson Washington State House of Representatives</p>	<p style="text-align: center;">Sergeant Liz Eddy Seattle Police Department</p>
<p style="text-align: center;">Erin Ehlert Assistant Chief Criminal Deputy King County Prosecuting Attorney's Office</p>	<p style="text-align: center;">Officer Scott Enright Seattle Police Department</p>
<p style="text-align: center;">Mike Finkle Assistant City Attorney Seattle City Attorney's Office</p>	<p style="text-align: center;">Russ Goedde Assistant Director, Operations King County Office of the Public Defender</p>

<p>Ian Goodhew Deputy Chief of Staff King County Prosecuting Attorney's Office</p>	<p>John Gower Caucus Attorney Washington State House of Representatives</p>
<p>Rashi Gupta Policy Director Human Services, Housing & ACHS Coordinator Washington State Association of Counties</p>	<p>David Hackett Senior Deputy Prosecuting Attorney King County Prosecuting Attorney's Office</p>
<p>Dr. Murray Hart, M.D. Manager-Inpatient Forensic Evaluation Program Center for Forensic Services Western State Hospital</p>	<p>V. David Hocraffer King County Public Defender King County Office of the Public Defender</p>
<p>The Honorable Christopher Hurst Washington State House of Representatives</p>	<p>Richard Kellogg Director DSHS Mental Health Division</p>
<p>John Lane Governor's Policy Office</p>	<p>Richard Lichtenstadter Felony Supervisor The Defender Agency</p>
<p>David Lord Director of Public Policy Disability Rights Washington</p>	<p>Dr. David Lovell, Ph.D. Research Associate Professor Psychosocial and Community Health University of Washington</p>
<p>Leesa Manion Chief of Staff King County Prosecuting Attorney's Office</p>	<p>Tom McBride Executive Secretary Washington Association of Prosecuting Attorneys</p>
<p>Thomas McJilton Community Corrections Officer Washington State Department of Corrections</p>	<p>Linda Merelle Staff Counsel Human Services Committee Washington State House of Representatives</p>
<p>Bonnie Muccilli Field Administrator Washington State Department of Corrections</p>	<p>The Honorable Al O'Brien Washington State House of Representatives</p>
<p>Laura Petregal Deputy Prosecuting Attorney King County Prosecuting Attorney's Office</p>	<p>Betty Pine Manager King County Jail Health Services</p>
<p>Dr. Richard Ries, M.D. Professor of Psychiatry Director, Division of Addictions University of Washington</p>	<p>Ethan Rogers Senior Deputy Prosecuting Attorney King County Prosecuting Attorney's Office</p>
<p>Bernie Ryan Policy Counsel Washington State Senate</p>	<p>Amnon Shoenfeld Director King County Mental Health, Chemical Abuse and Dependency Services Division</p>

<p>The Honorable Julie Spector Judge King County Superior Court</p>	<p>David Stewart Human Services Director Pierce County Corrections</p>
<p>Cheryl Strange Deputy Secretary Washington State Department of Corrections</p>	<p>Captain Scott Strathy King County Sheriff's Office</p>
<p>Dr. Eric Trupin, Ph.D. Professor and Vice-Chair Department of Psychiatry and Behavioral Sciences University of Washington School of Medicine</p>	<p>Jo-Ellen Watson, Ph.D. Coordinator Crisis and Commitment Services King County Mental Health, Chemical Abuse and Dependency Services Division</p>
<p>David Weston Chief Mental Health Services DSHS Mental Health Division</p>	<p>Shelley Williams Assistant Attorney General Washington State Attorney General's Office</p>
<p>Declan Wynne Program Manager Mentally Ill Offender Department Sound Mental Health</p>	

PART I
Tools in the Toolbox: Preliminary Information
Two key components of the criminal justice and mental health
treatment systems

On January 19, 1995, James Anthony Williams shot a stranger at a bus stop in Seattle. Seattle Police arrested Williams soon thereafter. He spent the next eleven years in jail or prison. On January 16, 2008, Williams was arrested for failing to follow court-imposed conditions related to the 1995 shooting. In the thirteen years between the two arrests, Williams interacted with numerous people working for the criminal justice and mental health treatment systems.

This review of Williams' contacts with the criminal justice and mental health treatment systems, and the professionals who try to carry out the systems' goals, will start with a brief overview of two components of those systems: (1) the Dangerous Mentally Ill Offender designation and program, which applies to certain offenders upon their release from prison, and (2) the civil mental health involuntary commitment system, through which persons with mental illness may be forced to do treatment if they present a risk to themselves or others. Appendix E contains full descriptions of these and many other components of the criminal justice and civil mental health treatment systems as a resource the reader of this report can refer to as needed.

A. Dangerous Mentally Ill Offenders

Most persons with mental illness are law abiding and have very little, if any, contact with the criminal justice system, except perhaps as victims. Still, a very small number of persons with mental illness do commit crimes of extreme violence. When this occurs, the system must be able to address the individual's criminal behavior and their mental illness. The system must treat the individual and also protect the public. One major approach used in Washington State is to identify, while they are in prison, offenders who have mental illness and present a likelihood of future violence, and then to engage those offenders in intense mental health services as they leave incarceration and re-enter the community. The offenders so identified are designated as Dangerously Mentally Ill Offenders (DMIOs). The unique and intensive program designed to engage a DMIO in services is the Community Integration Assistance Program (CIAP).¹

Depending on exactly how their symptoms impacted their actions, mentally ill persons who commit criminal acts of extreme violence may be found either guilty of the crime or Not Guilty by Reason of Insanity.² Those found guilty will be sentenced by a judge just like any other convicted defendant. The judge's sentence will have two components: (1) incarceration time, usually in the state prison system, and (2) a period of supervision in

¹ The term "Dangerous Mentally Ill Offender" is the term used in the Revised Code of Washington. "Community Integration Assistance Program" is what the Mental Health Division of DSHS calls the program for DMIOs. The terms are sometimes used interchangeably. CIAP is also what some out-patient mental health provider agencies call their specific program of case management and other services they directly provide to DMIOs.

²The implications of a Not Guilty by Reason of Insanity finding are described in Appendix E.

the community which starts upon the offender's release from prison and during which the offender must follow certain conditions. The state prison system is run by the Washington State Department of Corrections (DOC). The professionals assigned to monitor offenders³ on community supervision work for DOC and are known as Community Corrections Officers (CCOs). If a person does have a mental illness, one of the imposed conditions of supervision may be to follow mental health treatment recommendations. However, the mere imposition of mental health treatment as a condition of supervision is often not enough to prompt an offender to actually engage in treatment, especially for the most severely mentally ill.

The goal of the DMIO designation and associated program is to mitigate the likelihood of further violent acts by offenders with mental illness, for whom normal DOC community supervision may not be effective. The process to identify an offender as a DMIO starts during the last 12 months of the offender's period of incarceration. Per RCW 72.09.370, DOC identifies incarcerated offenders who are reasonably believed to be dangerous to themselves or others and have a mental disorder. Well in advance of the offender's scheduled release date, the offender is referred to the "DMIO Committee," a board of professionals consisting of members from DOC, DSHS, Regional Support Networks, community mental health and chemical dependency providers and others. If determined by the committee to meet the criteria for DMIO designation, the offender is then designated as a Dangerous Mentally Ill Offender.

An offender designated as a DMIO receives additional scrutiny by DOC once released. However, the offender is also offered additional mental health treatment and support services through the Mental Health Division of Washington State's Department of Social and Health Services (DSHS). The Mental Health Division (MHD) contracts with regional agencies known as Regional Support Networks (RSNs) and with community-based mental health treatment providers to provide the DMIO related services. Unfortunately, there are areas of Washington State where no RSN or provider is willing to contract to provide DMIO services, due to liability concerns. In these areas, an offender designated as DMIO will not be provided the enhanced DMIO services.

As noted, the primary goal of the DMIO program is to increase public safety. The main strategy of the DMIO program is to have DOC and DSHS work closely with community mental health providers to get DMIOs into housing and into community-based mental health treatment soon after their release. If the DMIO participates in treatment, the treatment provider has access to about \$10,000 per year (for the first five years after release) to help the DMIO receive necessary treatment, housing, or other services. This \$10,000 is provided by DSHS, and is in addition to any funding from other potential sources, such as Social Security.

Presumably, additional attention and resources will lead to the DMIO being more psychiatrically stable, reducing recidivism and creating overall savings for the system. Early studies of the DMIO program indicate some success, including a lower felony recidivism rate, earlier entry into mental health treatment, and a savings (through lower

³ "Offender" is the term most CCOs use in referring to those they supervise, and that will be the term primarily used in this paper.

incarcerations costs, prosecution costs, etc.) of \$1.24 for every \$1.00 spent on the program.

The legislation creating the DMIO designation and related program created different charges for DOC and DSHS with regard to whether a DMIO's participation in treatment is mandatory or voluntary. Under certain circumstances, DOC or a judge can order an offender to comply with treatment. If participation in mental health treatment is imposed as a condition of supervision, the offender's participation is considered mandatory by DOC because a CCO can arrest a DMIO who has not participated in treatment. However, once the period of DOC community supervision has ended, the DMIO's continued participation in the enhanced program only occurs if the DMIO voluntarily agrees to do so.⁴ DSHS has no inherent authority to mandate that a DMIO participate in treatment.⁵

In King County, DMIOs are supervised in the community by DOC's Special Needs Unit. This group of eight Community Correction Officers has smaller caseloads -- 25 to 30 defendants, rather than the approximate 40 defendants most CCOs supervise. There are approximately 45 DMIOs in King County supervised by the Special Needs Unit. The rest of the unit's caseload is made up of other offenders with mental health issues, such as those offenders found Not Guilty by Reason of Insanity (NGRI). Most Special Needs Unit CCOs have mental health backgrounds. They generally see each DMIO once or twice a week, and may see them more often if the condition of the DMIO seems to warrant it. Each CCO is often quite familiar with the DMIOs on the other CCOs' caseloads, and this fosters more of a team approach by the Special Needs Unit. For instance, when one CCO is checking in on a DMIO and is in an area where another CCO also has a DMIO, the CCO will check-up on both DMIOs if possible.

In King County, the Special Needs Unit CCOs keep in close contact with their DMIOs' out-patient mental health treatment providers. The out-patient treatment providers are the professionals who manage an offender's mental health treatment plan, including attempting to make sure that the offender is prescribed and takes medication as appropriate. Out-patient treatment providers are not considered part of the criminal justice system.

For most DMIOs in King County who engage in treatment, mental health case management is provided by Sound Mental Health (SMH), a private agency which provides a wide variety of out-patient mental health services. SMH has a program designed specifically for DMIOs, called the Community Integration Assistance Program. Besides communicating about any particular offender for which there is heightened concern, the CCOs and SMH meet once a week to review the status of all DMIOs. This meeting is also attended by other agencies, including the Seattle Police Department (SPD), housing representatives, and chemical dependency treatment providers. There are

⁴ It is important to note that in some cases, the criminal sentence does not include any period of community supervision. In these cases, DOC involvement with the DMIO ends once the DMIO is released from incarceration.

⁵ Participation can again become "mandatory" if another court, such as the ITA court discussed in the next section, obtains jurisdiction over the DMIO and orders participation in mental health treatment as part of its proceedings.

about 60 DMIOs in King County engaged in the CIAP program, including many who are not on active DOC supervision.⁶

B. Civil mental health commitment system (The Involuntary Treatment Act)

Once an individual convicted of a violent crime has completed their time of incarceration, if the individual also has a major mental illness, they may come into contact with the civil mental health commitment system. The involuntary treatment part of the civil mental health system attempts to protect the public and the mentally ill when risk can be identified but before serious harm occurs. It also provides a mechanism to treat mentally ill criminal defendants who are incompetent to stand trial.

Every state has a system for involuntary detaining and treating persons who are dangerous to themselves or others because of mental illness. In most cases, commitment can occur before a crime has been committed. Furthermore, the goal of the commitment is treatment, not punishment. Therefore, these proceedings are considered civil in nature. In Washington State, the current civil involuntary treatment system was created by legislation known as the Involuntary Treatment Act (ITA).

Even though no crime is charged, involuntary hospitalization via the ITA is considered a major imposition on a person's liberty. Therefore, many appropriate due process considerations are in place to make sure involuntary detention and treatment is warranted, even for someone previously convicted of a violent crime who clearly has a mental disorder. These considerations include a right to counsel and a right to contest the commitment in front of a judicial officer, or, at times, a jury.

Because commitment is an imposition on a person's liberty, the grounds for ITA detention are limited, and the standards for approving detention are high. A person can only be placed involuntarily in a hospital if, due to the mental disorder, the person presents a likelihood of intentional serious physical harm to themselves or others, if they have caused substantial damage to another's property, or if they cannot provide for their essential needs of health and safety.⁷ If the basis for commitment is "danger to others," the risk must be substantial, the potential harm must be serious, the risk must be specific to individuals rather than general in nature, and the person must have engaged in a "recent overt act." The patient's well-being is as much a priority of the ITA system as public safety is.

⁶ The total number of DMIOs currently living in King County is not known, because once a DMIO is no longer supervised by DOC and is not engaged in the CIAP program (either by choice or because the five years of enhanced services have concluded), the DMIO's whereabouts are not tracked. Some may be engaged in mental health treatment, even through an RSN, but since this treatment is not connected to the criminal justice system, it is not tracked by DOC or DSHS.

⁷ Courts usually require that the risk must be a near term risk, rather than one where the harm is unlikely to occur for some time, if at all. Many people refer to this as the risk needing to be "imminent," using the term "imminent" in a general sense. However, "imminent" has a specific legal definition in the ITA statutes that bears solely on whether the individual can be put immediately into a treatment facility on a DMHP's own authority or whether the DMHP must obtain judicial authorization first. If judicial authorization is obtained, the detention can occur even though the situation does not fit the legal definition of "imminent." Legally, therefore, the danger need not be "imminent" for detention to occur.

Furthermore, the design of the ITA system is to minimize the period of in-patient treatment. With some exceptions, only after a person has been in the local hospital for 72 hours and then 14 days can a local hospital seek hospitalization for 90 days and transfer to a state hospital. After that, a patient can be involuntarily detained for longer periods of time at a state hospital, but only if the case is reviewed every 180 days and the grounds upon which the detention is based can be proven to still exist each time it is reviewed. A person cannot be hospitalized merely because they would benefit from the hospitalization, and must be released once the immediate mental health crisis is resolved and out-patient treatment appears to have a legitimate chance of being successful.

Most ITA cases begin with a referral to local officials known as Designated Mental Health Professionals (DMHPs). The DMHPs gather what information they can about a person referred to them, including talking to available witnesses. They also attempt to directly talk to and evaluate the person. If the DMHPs decide the person meets grounds for detention and needs hospitalization, they detain the person for up to 72 hours and send them to a local in-patient psychiatric treatment facility, known officially as an Evaluation and Treatment Facility (E&T). If the E&T decides the person needs longer-term treatment, they file a petition with the Superior Court requesting 14 additional days of in-patient treatment. A hearing can occur over the need for additional treatment and both the E&T and the patient will be represented by attorneys. Further petitions (first for 90-days of treatment, and then for 180-days) can be filed based on the perceived risk and treatment needs of the patient. At each stage after the first 72 hours, the detained person has a right to contest the detention and force the treating facility to prove to a judicial officer (or sometimes to a jury) the grounds for detention.⁸

If the referral to the ITA system is in conjunction with a criminal case being dismissed because the defendant is not competent to stand trial, the initial request for treatment under the ITA can be for 180 days if the charged crime was a felony and 90 days if the charged crime was a serious misdemeanor. In King County, the defendant may go directly from jail to Western State Hospital, which decides whether to initiate the ITA proceeding.

⁸ See Appendix D for a flowchart of the adult ITA system in King County.

PART II

Tools in the Toolbox: The Available Tools

How a CCO can remove a defendant from the street

If a Community Corrections Officer believes an offender they are supervising has become dangerous and needs to be removed from the community, that CCO has four, and only four, "tools" to remove the person from the community. These tools are available whether or not the offender is designated a DMIO. There are no additional tools available for taking a DMIO off the street, other than these four.

A. Arrest for violation of supervision conditions

First, if an offender has violated a condition of the offender's supervision, the CCO can arrest the offender, put the offender in jail, and file a violation report. However, the maximum amount of time an offender can serve is 60 days per violation, and the offender may receive no mental health treatment or may refuse available treatment while in jail.

B. Arrest for new crime

Second, if an offender's misconduct rises to the level of a new crime, a law enforcement agency can be contacted and the offender can be arrested and charged. However, the length of detention due to the new charge and the services provided while in jail depends upon many factors, including the nature of the charge, whether an offender can make bail, and the offender's willingness to cooperate with treatment while incarcerated.

C. Voluntary hospitalization

Third, the CCO can encourage the offender to enter into a psychiatric hospital voluntarily. However, most hospitals will not accept DMIOs as voluntary patients, because the DMIOs' past history indicates that they are so resistant to treatment that they will not be successful as good-faith voluntary patients. Furthermore, any voluntary patient can request to leave the hospital at any time, making it an impractical option for the CCO in all but the rarest of circumstances.

D. Involuntary civil mental health commitment

As the fourth option, a CCO can refer an offender for involuntary mental health commitment under the Involuntary Treatment Act (ITA). However, the grounds for ITA detention are limited, and the standards for approving detention are high. If the potential ground for commitment is "danger to others," the risk must be substantial and near term, the potential harm must be serious, the risk must be specific to individuals rather than general in nature, and the person must have engaged in a "recent overt act." The design of the ITA system is to minimize the period of in-patient treatment, and the offender would have the right to contest the commitment in front of judicial officers fairly frequently. In short, for a CCO looking to take an offender off the street, the ITA system is only a hit-or-miss option, and can only rarely be considered a long-term solution.

PART III
Tools in the Toolbox: Looking Backward
A review of how "the system" interacted with James Williams

Caveat: James Anthony Williams is charged with Murder in the First Degree, with a Deadly Weapon sentencing enhancement. He is presumed innocent of those charges until proven guilty. He is also presumed competent to face these charges until proven otherwise.

James Anthony Williams was born in Arkansas on March 17, 1959. His mother died when he was eight, and he never knew his father. After his mother died, he was raised by other members of his family, mostly maternal grandparents, but his living situation never stabilized. His formal education ended in Grade 5, although he would later earn a GED while in prison. His first hospitalization for mental health issues occurred in Arkansas when he was 12 years old. By age 19, the Social Security Administration determined that he was eligible for SSI income due to his mental disability.

Williams' first commitment to a prison system occurred in Arkansas in 1976 at age 17 for a burglary and theft crime. Between 1976 and 1994, he migrated through Arkansas, Texas, Florida, and Oklahoma, and committed at least four crimes ranging from misdemeanor assault to felony forgery. He was assessed or hospitalized psychiatrically several times. He was diagnosed with a major mental disorder and with a personality disorder. Major mental disorders can often be treated with medications. Medications are less likely to successfully address the major symptoms of personality disorders.

Williams was often prescribed psychiatric medication but very rarely took the medications on his own. He also felt the need to have a weapon on him because he foresaw a need to use it in self-defense. He also had a persistent feeling of animosity towards women.

A. Arrival in Washington State and conviction for Assault in the First Degree

Williams arrived in Washington State in the first part of 1994. In March, he committed a misdemeanor assault in Kittitas County. By January, 1995, he had made his way to Seattle.

On January 19, 1995, Williams was at a bus stop in downtown Seattle. He singled out a complete stranger. He began harassing the stranger, asking the stranger whether he was "scared of a gun" and indicating that he had one. Williams then pulled out a .44 caliber handgun from his backpack. William pointed the gun at the stranger, and asked the stranger in slang terms whether the stranger wanted Williams to shoot. Williams then shot the stranger in the hand. The victim fled and Williams shot at him two more times. Williams also fled but was soon caught and confessed.

The King County Prosecuting Attorney's Office charged and tried the defendant on a charge of Assault in the First Degree, with a Deadly Weapon Sentencing Enhancement. Prior to trial, he was twice sent to Western State Hospital for competency evaluations. The evaluator at Western State Hospital determined that Williams was able to assist his attorney in his own defense and understand the nature of the charges against him and that, therefore, Williams was competent to stand trial. A Superior Court jury found Williams guilty as charged on September 1, 1995. The defendant's standard range was 105 to 135 months. This range included time added on because of the use of the deadly weapon. On October 20, 1995, the trial court judge sentenced Williams to 135 months of confinement (the top end of the standard range), to be followed by two years of supervision in the community by the Department of Corrections. As conditions of supervision, the judge ordered that the defendant obtain a mental health evaluation and follow all treatment recommendations, and that he complete anger management counseling.

In most cases, defendants are released prior to the expiration of their sentence due to good behavior while in prison, with the remainder of the potential confinement time added to the two years of community supervision. Based on the law at the time he was sentenced, Williams could have been released 20.25 months early (15% of 135 months) if he behaved appropriately in prison. However, Williams' behavior in prison was so bad that he earned less than two months off his incarceration time.

B. Williams' behavior while in prison and attempts at treatment

Williams entered the Washington State prison system in October, 1995. His first stop was at the assessment center at the DOC facility in Shelton. He began violating prison rules even before the assessment process was finished. Within a week, he ended up in 23-hours-per-day confinement because of rule infractions. This type of confinement is called segregation. While Williams did not spend his entire prison term in segregation, Williams spent most of his sentence apart from the rest of the prison population as he committed close to 250 rule infractions during his imprisonment. Williams was considered a very violent and intense prisoner and would repeatedly make very detailed and graphic threats to prison staff which accounted for many of the infractions.

During his imprisonment, he stayed at many DOC facilities. His first transfer for mental health reasons was to the mental health program at McNeil Island. He stayed in that program for two months. This did not lead to long term psychiatric stability.

DOC later moved Williams to the Special Offender Unit⁹ in the DOC facility in Monroe. This is the most intensive mental health program within DOC. DOC sought and obtained approval to place Williams on an involuntary medication regimen. Once on medications, the symptoms of his mental disorder improved. However, DOC's authority to administer medications involuntarily is limited, and Williams reached the level of functioning at which involuntary medication could not be continued. Once involuntary medication stopped, Williams refused to take medications voluntarily.

⁹ This is different from the "Special Needs Unit" consisting of CCOs supervising out-of-custody defendants in King County.

Williams' continued refusal to take his medications voluntarily created a clear pattern during his years in DOC. Once he was off his medications, he would decompensate. Initial symptoms of the decompensation were an increase in pressured speech, an increased level of agitation, and increased perseveration and delusions. He would then commit rule infractions, often by threatening or assaulting others, leading to his being placed in 23-hours-per-day confinement. This would lead to another order allowing medications to be administered involuntarily. Once on medications, some of his symptoms improved, eventually leading to the next iteration of the pattern. During periods of better behavior, he would be moved out of the Special Offender Unit or even out of the Monroe facility.

As noted earlier, Williams could have earned up 20.25 months of time off for good behavior (known as earned early release). However, Williams' overall behavior in prison was so bad that he earned only minimal time off, and ended up serving over 133 of the entire 135 month prison sentence in the various DOC prison facilities.

C. Designation of Williams as a Dangerous Mental Ill Offender

In July, 2004, the end of Williams' maximum court-ordered prison sentence was less than two years away, and with it, DOC's authority to keep the defendant in a locked facility. Once the sentence was complete, DOC had no option but to release Williams back into the community. In an effort to prepare Williams for the transition, DOC again placed him in the Special Offender Unit at Monroe.

Another round of involuntary medication improved Williams' symptoms. This particular combination of medications appeared to have the best overall effect. Williams' behavior and socialization ability reached its highest plateau of his DOC stay. Williams' rate of committing infractions lessened, but did not cease. Even at his increased level of functioning, Williams had a delusional fear of electricity and electric shock to the extent that DOC was deterred from putting him in a general population setting because he feared being in a cell which contained an electrical outlet. Eating with other inmates was a big step for him socially. He expressed nervousness about the upcoming release into the community. He showed symptoms of depression, a condition that had not been prevalent earlier. DOC worked with Williams on an 11-step "Progressive Re-Entry Program" and started to talk with him about his release.

Beyond treatment attempts while Williams was still in prison, DOC prepared for Williams' release into the community by referring him for designation as a Dangerous Mentally Ill Offender. A committee that reviews such requests agreed that Williams should be designated as a DMIO. In the last few months of his incarceration, Williams was persuaded to sign Releases of Information and to work with Sound Mental Health, the mental health treatment agency in King County which has a program specifically for DMIOs. Once SMH was on board, they arranged for Williams to live at Berkey House upon release from prison. Berkey House is clean and sober housing for the mentally ill. DOC also assigned the Community Corrections Officers of the Special Needs Unit in King County to supervise Williams after his release.

D. Williams' post-prison supervision and treatment

Williams was released from prison on March 8, 2006. Either his CCO and/or his SMH case manager would meet with him almost every day of the work week. Sometimes the visits were at Williams' residence; sometimes Williams went to the SMH or DOC office. Later, appointments would even occur at designated street corners or near police stations as concerns about Williams' behavior grew. An on-site manager of Berkey House would report on how Williams behaved during the weekend. There was a weekly meeting between CCOs and SMH staff, where all DMIO offenders were discussed. The meeting would be attended by others, including Seattle Police Officers assigned to a special unit who often deal with the mentally ill.

For a month and a half after his release from DOC, Williams maintained appropriate behavior in the community. When he was not at SMH offices doing mental health treatment such as group therapy sessions, he spent most of his time in Berkey House watching television. His first official sanction for violating the conditions of his supervision occurred in June, 2006, when he self-reported that he had missed treatment groups the previous week. He was verbally reprimanded for the violation. Throughout the rest of 2006 and into early 2007, he received three more sanctions for not following supervision conditions: once for missing treatment groups, once for missing medications (which he resumed the next day), and once for using marijuana. His sanctions were a verbal reprimand, a requirement to attend more groups, and a requirement to report to the DOC office three times a week for a month for urinalysis.

On February 15, 2007, his CCO believed Williams had stopped taking his medication. The CCO also felt Williams was deteriorating and that Williams should not be on the street. The CCO arrested Williams for violating his supervision conditions. This was Williams' first time behind bars since his release from prison. A Superior Court judge sanctioned him with 15 days in jail for the violation. He was released from jail on March 7th.

On March 16, 2007, while in the SMH office, Williams made threatening remarks to others, including a threat to shoot his CCO and all the case workers at his assigned SMH office. He was also failing to take his medication. CCOs arrested Williams immediately.

Williams would remain in a locked facility (jail or Western State Hospital) from March 16 until September 3, 2007.

Williams' actions on March 16th would result in both sanctions for violating his supervision and new criminal charges. For violating his supervision by not taking medication, a Superior Court judge imposed 60 days in jail as a sanction. This was the maximum amount of time the judge could impose.

While the defendant was sitting in jail on the sanction, the Seattle City Attorney's Office filed misdemeanor Harassment charges for the March 16th threats towards the CCO and

others. On April 21st, having never left jail, Williams was arraigned on the new charge. Bail was set at \$100,000, a very high figure for a misdemeanor.¹⁰

Seattle Municipal Court had jurisdiction over the misdemeanor case. Williams' case was referred to the Mental Health Court of Seattle Municipal Court. This is a criminal court. It is oriented towards getting its participants into mental health treatment. However, by April 24th, Williams' competency to stand trial became an issue. On May 1st, and because Williams was not competent to stand trial, the Municipal Court judge was required by statute to dismiss the criminal case. As permitted by statute, the court then sent Williams to Western State Hospital for possible civil mental health commitment under the Involuntary Treatment Act.

Western State Hospital sought civil mental health commitment through the Involuntary Treatment Act. They succeeded in their request and Williams was officially civilly committed soon after his arrival in early May, 2007. The initial commitment was for 90 days of in-patient treatment. Williams would stay in in-patient treatment at Western State Hospital until September 3, 2007. Confidentiality laws protect Williams' right to privacy as an ITA patient, so WSH cannot disclose the reasons for Williams' discharge, including whether WSH thought discharge was appropriate or whether the grounds for further detention could no longer be proved at an ITA hearing.

CCOs of the Special Needs Unit began working with social workers at Western State Hospital soon after the civil commitment started, knowing that he would eventually have to be released. The assigned CCO worked with Western State Hospital social workers for approximately a month to prepare Williams for release. When the release came on September 3rd, CCOs picked the defendant up from WSH and drove him to see his case manager at SMH, and then drove him home to Berkey House.

Less than three weeks later, on September 22nd, Williams threatened another resident of Berkey House. Seattle Police arrested him. At the time of the arrest, the defendant was armed with a knife. He told the police that it was for self defense.

This time, the defendant would remain in jail from September 22 until December 21, 2007.

Once again, Williams' actions would result in both sanctions for violating his supervision on the 1995 Assault 1 conviction and in new criminal charges. Almost immediately, the Seattle City Attorney's office filed misdemeanor Harassment charges in Seattle Municipal Court. For violating his supervision by not following mental health treatment recommendations, a Superior Court judge would later impose 60 days in jail as a sanction. This was the maximum amount of time the judge could impose.

¹⁰ In Washington State, any crime where the maximum punishment is greater than one year of confinement is classified as a felony. Non-felony crimes (i.e., where the maximum sentence is one year or less) are classified as either misdemeanors, where the maximum punishment is no more than 90 days, or gross misdemeanors, where the maximum punishment is at least 90 days but no more than one year. In this report, the term "misdemeanor" will refer to both misdemeanors and gross misdemeanors unless specifically noted. Harassment is a gross misdemeanor with a maximum punishment of one year in jail.

The misdemeanor charge was referred to the same criminal Mental Health Court of Seattle Municipal Court. This treatment-oriented court requires voluntary participation on the part of a defendant. Williams opted not to participate and his case was transferred back to regular Municipal Court. Williams' competency to stand trial was also raised again. However, this time the court found Williams competent to stand trial.

On December 18th, Williams pleaded guilty to one count of misdemeanor Harassment. He was sentenced to 120 days with credit for time served. He was also referred to the Designated Mental Health Professionals of King County (DMHPs) to see whether he should be civilly committed because of risks to himself or others caused by his mental disorders.

DMHPs met with the defendant on December 21st, his last day in jail. The DMHPs did not detain the defendant for civil commitment. Strong confidentiality statutes protect the rights of those detained or being considered for detention for civil mental health commitment under the Involuntary Treatment Act. As they would be for any person referred to them for civil commitment, DMHPs are prohibited by statute from discussing Williams' case.

Because of his threats, Williams had been evicted from Berkey House. After his release on December 21st, Williams was homeless, staying nights at a homeless shelter. There were six working days between December 21st and December 31st. The CCOs and SMH staff saw Williams at least four of those days and had extensive discussions about him at a meeting on a fifth day. His CCO saw him on December 31st. Williams' presentation that day was not much different than in previous days. There was now always a level of concern the CCOs had about him, and much of the effort of the CCOs went into making sure Williams took his medication. However, between December 21st and December 31st, Williams had not made any threats or menacing gestures, nor engaged in any suicidal or homicidal ideation. He therefore neither had done nor said anything which would have warranted a referral for civil mental health commitment. Between December 21st and December 31st, he had not committed a new crime and was compliant with his conditions of supervision. His CCO therefore had no authority to arrest him.

On December 31, 2007, hours after the meeting with DOC, Shannon Harps was stabbed to death on Capitol Hill.

DOC and SMH found housing for Williams at the Curben Hotel, which is considered housing of last resort. Williams missed a DOC appointment on January 10, 2008. On January 16th, DOC officers arrested Williams for supervision violations. These violations were never adjudicated because on February 5, 2008, the King County Prosecuting Attorney's Office filed murder charges against Williams for the death of Shannon Harps.

PART IV
Tools in the Toolbox: Even While We Worked
The September 2, 2008, shooting in Skagit County

Caveats:

Isaac Zamora is charged in Skagit County with six counts of Aggravated Murder and fourteen counts of other felony crimes. He is presumed innocent of those charges and competent to face them.

The workgroup received information about the Skagit County tragedy from DOC's perspective, via a presentation and submission. Accounts of the perception of others in this section come from media reports.

While this workgroup met over several months to examine the systems and tools that professionals use to treat and supervise mentally ill offenders in the community, another tragic incident occurred in Skagit County, Washington. On September 2, 2008, six people were killed, including Sheriff's Deputy Anne Jackson, and four more were injured in a single shooting rampage. The charged suspect, Isaac Zamora, was also a convicted felon, and while never in prison, was under Department of Corrections supervision, with probable mental health issues. Similar themes are present in both cases, but significant differences also exist. While this incident occurred near the end of the workgroup's sessions, the workgroup did have at least a discussion and partial review of this incident.

As of this writing, DOC had not completed a full internal review of their interaction with Zamora, and information regarding this incident is not as available or complete as in the Williams review.¹¹ However, Zamora's rampage merits discussion as part of this workgroup's examination of how the criminal justice system interacts with the mentally ill. It merits discussion because, like Williams, Zamora was under DOC supervision and appears to be seriously mentally ill. Unlike Williams, however, the DSHS/DOC system never identified Zamora as a potential candidate for the Dangerous Mentally Ill Offender program. Zamora was, in fact, not eligible for the DMIO program since he had never been to prison. In many respects, Zamora more accurately represents the type of offender the system must deal with every day. Both offenders moved through the same system, albeit each receiving a different level of scrutiny and supervision.

Prior to his most recent arrest, Zamora had 25 misdemeanor convictions for offenses including Theft, Obstruction of a Law Enforcement Officer, Malicious Mischief, Violation of a No-Contact Order and drug offenses. He had three felony level convictions including Theft in the Second Degree, Malicious Mischief in the Second Degree and Violation of the Uniform Controlled Substances Act--Possession of Cocaine. From the public's perspective, it is clear that Zamora has an alarming number of criminal convictions. However, Zamora's criminal history is similar to numerous others in prison

¹¹ Information about Isaac Zamora and his handling by DOC comes from the DOC offender file summary and from the presentations of Eldon Vail and Cheryl Strange at the workgroup meeting on September 22, 2008.

or on DOC supervision, and therefore unremarkable for that particular population. Unlike Williams, Zamora's potential for extreme violence is not revealed by the nature of his prior convictions because his criminal history does not include any assault convictions and certainly does not include a conviction for a felony-level violent offense.

As a result of Zamora's latest felony conviction for VUCSA in May 2008, the court sentenced Zamora to six months in jail, and 12 months of supervision in the community by DOC. As conditions of supervision, the sentencing judge ordered Zamora to participate in a mental health evaluation and a substance abuse evaluation and to follow all recommended treatment.

DOC identifies the level of risk each offender under their control presents to the public. Zamora was sentenced at a time when DOC was transitioning from one risk assessment tool to another. Zamora was assessed using both tools. While still in custody, DOC completed an intake on Zamora using the older tool, called the Level of Service Inventory Tool (LSI). Using this tool, DOC assessed Zamora as having a LSI score of 39, which resulted in a Risk Management Level B (RMB) classification. This is the second highest risk category (out of four).

DOC contracts with some county jail facilities to house inmates. Zamora therefore did his jail time in Okanogan County. Contract facilities like Okanogan are not used for severely mentally ill inmates, as these facilities will not accept persons with major mental illnesses or significant behavior problems. What can be inferred from this is that Zamora was not presenting with symptoms of mental illness while incarcerated, or the Okanogan jail would have requested that he be moved.

Zamora was released from jail in early August, but was quickly arrested for an outstanding warrant. He was released again on August 6, 2008. It appears the assigned CCO learned of his release on Friday, August 8, 2008, and left a message for Zamora telling him to report by the end of the day. Zamora did not report on Friday, but did report to the DOC office by 11:00 am on Monday, August 11th. Zamora was directed to report again the following day to meet directly with his assigned CCO. On August 12, 2008, Zamora reported as directed and spoke with his CCO. Zamora indicated that he was living with his parents and attempting to get help from DSHS. The CCO asked Zamora whether he was working with the local jail transition services in attempting to set up a mental health appointment and Zamora said, "I will do everything on my own. I don't need them." Zamora said he would not go to Compass Health (an out-patient mental health treatment agency) "because they take care of all the white trash there." He talked about relocating to Bellingham. The CCO reminded Zamora he could not move without approval and that he was to continue to report the first and the third Wednesday of each month.

On August 13, 2008, DOC reclassified Zamora using the newly adopted Static Risk Assessment. This assessment attempts to rank offenders using unchanging factors such as gender and criminal history. Using this new assessment tool, Zamora scored out as

High Risk - Non-violent. According to DOC's new tool, this assessment means that Zamora was evaluated as having a high risk to re-offend in a non-violent crime.¹²

On August 20, 2008, Zamora again reported to his CCO. He had not yet obtained a mental health or substance abuse evaluation. Despite his earlier negative statements regarding mental health treatment, he stated that he was still working with DSHS to obtain assistance and funding. He reported that he had an orientation set for the following week. He also indicated that his parents had kicked him out and he would be staying at a local shelter. Zamora also submitted a urinalysis sample, which tested negative for any controlled substance. Zamora's CCO indicated that he reported one more time after August 20, 2008. She entered lengthy notes about this contact into the computer records of DOC, but they were apparently lost when the new computer system went down. The CCO reported that Zamora had reported to her and indicated that he was back living on his parent's property. Zamora's next scheduled report date was September 3rd. Zamora never reported because on September 2, 2008, and less than a month after DOC community supervision began, he was arrested for allegedly killing six people and injuring four others in a Skagit County shooting rampage.

As noted above, Zamora appeared to DOC to be a typical supervisee, and nothing from his behavior in jail raised itself as a reason to be particularly concerned about his potential for extreme violence. His risk assessments had classified as presenting some risk, and the mental health examination requirement gave notice that there were probable mental health issues, but his CCO and other DOC staff had not seen worrisome symptoms of mental illness. There was no court-set deadline for obtaining the mental health evaluation. His progress towards obtaining the evaluation was typical, especially as he also had to arrange for the funding of the evaluation.

DOC's perception, based on the information they had first-hand and from the Okanogan jail, was in stark contrast to the perception of family and local law enforcement. Media reports indicate that Zamora had a clear and well-known history of mental illness.¹³ Zamora as an individual and his symptoms of apparent mental illness were known to the

¹² An offender's classification is used to determine some mandatory supervision targets, such as the number and type of monthly contacts between an offender and the CCO. Since the Skagit County shooting, all offenders who had been classified using the new static risk assessment tool were electronically rescored after DOC was informed by the Washington State Institute for Public Policy (WSIPP) of calculation errors. The formula received from WSIPP upon which the DOC computer application was initially constructed was in error. The new scoring went into effect on October 20, 2008. The result of this rescoring changed Zamora's classification from High Risk - Non-violent to High Risk - Violent. Regarding Zamora's actual supervision, the contacts the CCO made with Zamora in the office (since he was homeless) met the mandatory contacts guidelines for a High Risk - Violent risk level classification.

¹³ The workgroup did not hear from law enforcement or mental health officials from Skagit County. Information regarding police and family knowledge of Zamora's apparent mental illness comes from two Seattle Times articles: O'Hagan, Maureen and Berens, Michael. "Shooting-rampage Suspect Described as Deeply Troubled." Seattle Times. 4 Sept. 2008 <http://seattletimes.nwsourc.com/html/localnews/2008158190_webzamora04m.html>; and Whitely, Peyton. "Skagit County Murder Spree Suspect: 'I Kill for God.'" Seattle Times. 6 Sept. 2008 <http://seattletimes.nwsourc.com/html/localnews/2008162802_shootings06m.html>.

Skagit County's Sheriff's Department and specifically to Deputy Anne Jackson, who was killed in the rampage.

The family, friends and neighbors of Isaac Zamora have said that he was in need of psychiatric treatment for years. Family and neighbors reported that Zamora had shown increasing signs of mental illness over the years, including suicide attempts, hallucinations, overt threats and property damage. Zamora's mother reported that despite the family's urging, he would not agree to on-going mental health treatment. At one point, in 2003, Zamora's mother and his girlfriend took him to a Whatcom County hospital saying they feared for their safety. At that time, he was held for a few weeks. Upon release he told his girlfriend he wanted to go back. However, the hospital declined to re-admit him for further treatment. Later, Zamora was admitted to another hospital and during that stay, he bit a hospital employee who was restraining him. The next day, he was discharged. Zamora's mother told reporters that over the years the family tried everything they could think of to get him into treatment and nothing worked.

However, none of the information or concerns of the police and family reached DOC before the shooting, to alert DOC that Zamora had this level of potential violence. Zamora had been in the community for less than a month before the shooting, and his community supervision was therefore still in its early stage. DOC believes its local CCOs in Skagit County have a good relationship with the Sheriff's Department, but Zamora had not yet been discussed between the two agencies. There is no central database where DOC can look up what police or mental health agencies know about an individual. Zamora's mental health treatment had been spread across more than one county, so even if DOC had access to what was done in Skagit County, they may not have had access to what was known in Whatcom County. DOC will typically contact family members as part of supervision, but it had not yet occurred in the short time (in DOC's view) Zamora had been on their supervision.

PART V

Tools in the Toolbox: Observations Revealed Points of consideration for further action

Caveat:

The focus of the workgroup and this report is on systems. While the workgroup has not seen obvious individual error on the part of the professionals working with James Williams, we are not intending to preclude the possibility that other parties may expose error via other internal review or appropriate litigation.

On December 31, 2007, Williams' CCO appeared to be out of "tools" to take Williams off of the street. Williams had not committed a recent crime. He was compliant with his conditions of supervision. He was too resistant to treatment to be a good-faith voluntary patient at a psychiatric hospital. He did not make any threats or menacing gestures, nor engage in any suicidal or homicidal ideation, so he had neither done nor said anything on which his CCO could have based a referral for hospitalization under the Involuntary Treatment Act.

The review of how a DMIO such as Williams could appear to be dangerous and yet had to be left in the community led the workgroup to discussions of how the criminal justice and mental health systems interact with each other, including their ability to communicate with each other. Some of the discussion was directly related to events during the Williams' timeline; much of the discussion turned to broader issues, experiences, and concerns. Certain themes came to the fore, even if no clear answer also became apparent.

What follows are specific points to consider when a policy maker contemplates any systemic reform in this area. These are the questions and observations that became the focal points of the workgroup's attention.

Consideration point (1):

How can the capacity of the mental health treatment system, including both in-patient and out-patient treatment, be adjusted or expanded to better fit the treatment needs of persons who have mental illness, especially for the very small segment of the population who have mental illness and also have the potential to become extremely violent?

Consideration point (2):

What legal, policy, and technological roadblocks prevent the professionals who work with persons with mental illness from communicating with each other? How can the roadblocks be removed? These professionals include police, prosecutors, mental health treatment providers, Designated Mental Health Professionals (DMHPs), Community Correction Officers (CCOs), and the criminal and civil courts.

Consideration point (3):

Is there a way to expand an existing centralized database, or create a new one, so that any professional (including law enforcement, CCOs, DMHPs, or treatment providers) needing to interact with a person with mental illness and a history of violence can learn about the illness and history prior to the interaction?

Consideration point (4):

Some offenders who (A) have committed a violent crime and (B) have a mental illness are classified as Dangerous Mentally Ill Offenders (DMIO) as they are being released from prison. Which treatment or support services are most effective in reducing recidivism by DMIOs (e.g., FACT teams - Forensic Assertive Community Treatment teams, expanded use of Less Restrictive Alternatives, outpatient civil mental health commitment, or housing programs)?

Consideration point (5):

If a DMIO is living in the community and either decompensates or otherwise becomes dangerous:

- Is the civil involuntary mental health treatment system, known as the ITA system, appropriate for DMIOs?
- Are initial 72-hour or 14-day involuntary treatment periods, which are available in the ITA system, of any use for ITA cases involving DMIOs?
- Are the local in-patient treatment facilities safe and secure enough to handle a DMIO (both for the patient and for others)? As an example, King County has only 14 beds available for the most acute patients, where the staffing is highest and the ability to prevent a person from acting out physically is greatest. Those beds are often full, meaning DMIOs must either be sent to other ITA beds or be left boarding in a hospital emergency room.
- If the DMIO's behavior does not meet standards for ITA commitment, how can other professionals intervene to prevent harm to the offender or others?

Consideration point (6):

Are the practices of Designated Mental Health Professionals, who have the authority to detain people under ITA law, consistent on a statewide basis, assuming the same circumstances and facts are presented to a DMHP; or are there variances by county or region? If there are variances by county or region, are there statutory or professional revisions that can address the variations in outcomes?

Consideration point (7):

Are the practices and standards of Evaluation and Treatment facilities, prosecutors, and defense attorneys, and the interpretation of ITA law by the judiciary, consistent across the state? If not, are there ways to make them less divergent?

Consideration point (8):

Should there be less strict standards under which a person can be ordered to do mandatory out-patient mental health treatment? If so, what should be the ramifications if the person does not follow the order? Is it an infringement on civil rights if the ramifications are involuntary in-patient treatment?

Consideration point (9):

Which system is best equipped to deal with a DMIO who becomes dangerous or decompensates: the Department of Corrections, the ITA system, or a third system yet to be created?

Consideration point (10):

Do CCOs need more options (tools) in order to supervise DMIOs? What tools can be created to take DMIOs off the street when they exhibit signs of dangerousness or decompensation, but have not violated their supervision conditions or met ITA criteria? What other agencies could also benefit from having more options?

Consideration point (11):

What interventions are appropriate for offenders with mental disorders who present a threat to public safety, but have not been designated as a DMIO?

Consideration point (12):

The DMIO programs appear to have succeeded in creating a cooperative atmosphere between DSHS, Regional Support Networks, local mental health providers, and DOC. What steps can be taken to shore up or improve the DMIO program? How can counties which are reluctant to provide services to DMIO for fear of liability be made or enticed to provide those services?

Consideration point (13):

Should prosecutors have more charging options when mental illness is a contributing factor in the commission of a violent crime? If so, to what crimes should the expanded options be available? What are the types of concerns, due process or otherwise, that can be raised by giving prosecutors more options?

Consideration point (14):

Should judges have more sentencing options when mental illness is a contributing factor in the commission of a violent crime? If so, to what crimes should the expanded options be available?

Consideration point (15):

What is the best way to evaluate the costs and benefits of a lifelong supervision, commitment, or incarceration approach to segments of the DMIO population, as reflected in such suggestions as creating a "Guilty, but Mentally Ill" finding in criminal cases, an SVP-style civil commitment analog, or a "determinate plus" sentencing scheme for offenders who are violent and mentally ill?

Consideration point (16):

If, in connection with a conviction for a violent offense, additional mechanisms are created allowing for involuntary in-patient mental health treatment for those who become or remain a risk to public safety, should the in-patient treatment be under the auspices of DOC or of DSHS? Should any new resources made available for additional out-patient treatment or support (such as housing) be controlled by DOC or by others?

PART VI

Tools in the Toolbox: Looking Forward Concepts for Possible Reform

The Community Correction Officers and mental health professionals working with Williams appeared to have tried all viable options for improving Williams' behavior and keeping the community safe. By December 31st, there was much concern about Williams' potential for violence, but he remained in the community. However, as of December 31st, no tool in the toolbox, from the violations process, to a new criminal prosecution, to the ITA commitment process, to voluntary hospitalization, could be used to either remove Williams from the streets or to improve his behavior.

As expressed in the previous section, there are discernable issues to explore concerning the criminal justice system, the mental health treatment system (including involuntary commitment), and the way the two systems interact. Many specific ideas were brought out during workgroup discussions. Many members of this workgroup have submitted their concepts and other observations in writing. Those submissions are attached as Appendix A. Appendix A also includes a summary of three concepts which were discussed extensively during workgroup meetings, but have not appeared in the submissions of the workgroup members.

This section contains 76 concepts for possible reform drawn from the discussions and submissions. **No votes were taken on recommendations, and a consensus was not sought.** Rather, we offer these ideas to policy makers at the state and local level for further consideration and debate. Whatever concepts are pursued further, the increase in public safety must be weighed against the monetary cost of new or expanded programs and the liberty and privacy costs to those detained who present as dangerous but who would not actually be violent.

Caveat: While legislative staff have been present and have been part of the discussion during workgroup meetings, no specific proposals have been endorsed by elected officials. We want to thank the staff for their involvement and ability to bring their perspective to the discussion, but we must acknowledge that they are, and must remain, neutral on specific proposals, as their job is to support the elected lawmakers in the State House and Senate.

Concepts for Reform

System Capacity

1. Increase the capacity of the facilities that care for the mentally ill, as it is important to acknowledge that current in-patient and out-patient resources are not sufficient, and that any reform will likely result in more persons utilizing both in-patient and out-patient care. These facilities include the state hospitals run by DSHS (both forensic and civil beds), the treatment centers within DOC, and facilities working with Regional Support Networks (including local ITA Evaluation and Treatment facilities and providers who work with persons under court orders to do out-patient treatment). (From discussion in several workgroup meetings; submission of Jo-Ellen Watson)
2. Re-evaluate what is the appropriate number of in-patient wards which should be operating at Eastern and Western State Hospitals, including whether wards currently scheduled to be closed at Eastern and Western State Hospitals should remain open. (From discussion in 10/7/08 workgroup meeting)
3. Investigate whether it would be cost-effective (through reduction of demand for in-patient treatment) to expand either out-patient resources (including housing resources), the number of Program of Assertive Community Treatment (PACT) teams, and/or the placement resources for dementia patients. (From discussion in 10/7/08 workgroup meeting)

Cross-system communication and cooperation

Remove communication barriers

4. Remove regulatory and agency-policy barriers to the sharing of information across agencies who are involved in mental health crisis prevention and intervention. Some barriers are based on law and regulations, others are based on the perception of law and regulation. A workgroup approach may be needed to identify specific problems and the exact type of fix needed (e.g., education as to what laws and policies actually prohibit, change in regulatory policy, or change in statute). (DOC/DSHS submission, eighth bullet point)
5. Encourage law enforcement personnel to make inquiries into mental health history and symptoms, and not to assume that privacy laws will prevent the information from being provided. (Captain Scott Strathy submission, bullet point #2)
6. When information sharing is allowed, require that information be transmitted quickly from agency to agency when it is regarding a person in crisis. (From discussion in 10/7/08 workgroup meeting)
7. Allow civil mental health courts, prosecutors, and defense attorneys to communicate information to criminal mental health courts, prosecutors, and defense attorneys. (From discussion in 3/19/08 workgroup meeting)

8. Allow law enforcement, prosecutors and criminal courts to obtain information concerning civil mental health commitments for use in determining bail, and in making decisions concerning filing of charges and release of defendants in violent offenses. (PAO submission, point #8)
9. Expand the ability of the state hospitals to notify the prosecutors of felony charges that the person so prosecuted will be leaving the state hospital. (Coats/Williams submission, point #2)

Improve the knowledge base of law enforcement agencies and officers

10. Increase training for police officers in working with persons with mental illness, including how to identify those who are decompensating and to whom that information should be shared, and what type of information is and is not protected by privacy laws. (Captain Scott Strathy submission, bullet points # 2 and 4; From discussion in 10/7/08 workgroup meeting)
11. Create means and protocols for police to formally assess the risk posed by persons who have mental health issues and who have made recent violent threats. This could be done through the training of commissioned law enforcement personnel in the use of risk assessment tools. It could also be done by members of the behavioral science community working for or in conjunction with police. (Captain Scott Strathy submission, bullet point #1)
12. Encourage further information sharing between law enforcement agencies, including by out-of-state agencies who know of individuals with high risk potential moving to Washington State. (Captain Scott Strathy submission, bullet point #3)
13. Examine current police interagency cooperative agreements for gaps in information sharing regarding persons who present a high risk of potential violence. (Captain Scott Strathy submission, bullet point #3)

Create an accessible database

14. Develop a database, or adjust a currently existing database, to cover persons with prior convictions for violent felonies and with mental illness. The database should include a synopsis of past acts of violence and other relevant information. It should be accessible to any professional (DMHP, DOC CCO, police officer, mental health provider) who may be involved in crisis intervention. (Dr. Dagadakis submission, point #7; Captain Scott Strathy submission, bullet point #2; Discussion in 9/22/08 workgroup meeting)
15. Create lists of specific risk factors for potentially violent individuals such as DMIOs, and then make sure that all potential crisis responders have access to those lists so they can compare a person's current presentation to past times when they have actually acted violently. (From discussion in 4/30/08 workgroup meeting)

Create or enhance multi-agency teams

16. Establish interagency staffing to identify "high alert" cases, followed by communicating the gathered information to DMHPs. The information would include packets containing descriptions of past acts, behavior while in prison, and known criminal convictions. (Dr. Lovell submission, 2nd page, 1st bullet point; DOC/DSHS submission, seventh bullet point; Discussion in 4/30/08 workgroup meeting)
17. Create multi-agency teams, which include DMHPs, law enforcement, CCOs, and out-patient providers to pro-actively monitor and intercede with persons with mental illness who have a history of violence or dangerousness ("high-alert" cases). Multi-agency teams exist, but they generally do not include DMHPs. (Dr. Lovell submission, 2nd page, second bullet point; Dr. Dagadakis submission, point #5; Mike Finkle submission, point B-1-a.; DOC/DSHS submission, seventh bullet point)
18. Include a mental health professional, such as a nurse (but not necessarily a DMHP), in multi-agency teams. (From discussion in 4/2/08 workgroup meeting)
19. Develop a Rapid Response Team in King County, consisting of one representative from CCS, SMH-CIAP, DOC-Special Offenders Unit, and Seattle CIT, in order to staff specific and emerging situations with this particular sub-population of offenders. The purpose of the team would be to develop a cross-system crisis plan evaluating the needed response and determining which system best meets the community's and offender's needs: Civil Commitment, Criminal Justice (if a new crime committed), or revocation of community supervision. If successful and resources are available, the project could be expanded to other high-risk populations. (CCS/SMH submission, point #5)

Changes to the ITA system - In-Patient

Expand or clarify existing grounds for detention - general

20. Expand the definition of "likelihood of serious harm" to clarify what constitutes a "violent act." (DOC/DSHS submission, fourth bullet point)
21. Expand the definition of "likelihood of serious harm" to include other readily identifiable risk factors. (DOC/DSHS submission, fourth bullet point)
22. If a risk classification system exists, make it easier (almost automatic) to civilly commit a person who has been assigned a high violence risk level. (Dr. Dagadakis submission, point #2)
23. Work to standardize how ITA law is implemented statewide by DMHPs, E&T's, prosecutors, and the courts. (From discussion in 10/7/08 workgroup meeting)

Expand or clarify existing grounds for detention - 90 and 180-day petitions

24. In addition to all current grounds, allow ITA detentions for 90 days of treatment to be based on threats made by a person before the person's hospitalization, if the person continues to present a likelihood of serious harm due to a mental order. (Coats/Williams submission, point #1)

25. After a felony charge is dismissed due to the lack of competency of a defendant to stand trial, allow a subsequent ITA petition for 180 days of in-patient treatment to be based on any 180-day petition ground, not just on grounds related to the likelihood of felony acts being repeated. (Coats/Williams submission, point #2)
26. Change the wording of the ground for 180-day petition related to felonies from "acts constituting a felony" to "acts that threatened, attempted, or inflicted physical harm upon the person of another or substantial damage upon the property of others." (Coats/Williams submission, point #2)

Improve the use of known information in ITA proceedings

27. Amplify and specify that certain evidence is relevant to a determination of whether ITA grounds for detention exist, including correctional records, community mental health records, and hospital records. (Dr. Lovell submission, 2nd page, third bullet point)
28. Clarify that in making a decision as to whether ITA grounds for detention exist, the examiner can use established past patterns of behavior to determine what is likely to occur if there is no intervention. (Dr. Lovell submission, 2nd page, fourth bullet point)
29. In initial ITA detentions, direct DMHPs and the courts to consider evidence of a person's past involvement in the criminal justice system, including past competency determinations, past ITA commitments, and past patterns of decompensation. (Rep. Dickerson submission, ITA point #1; DOC/DSHS submission, second bullet point)
30. Make it easier to obtain admissible copies of criminal history or mental health treatment records for use in evaluating the need for 72 hours of mental health evaluation and treatment. (Rep. Dickerson submission, ITA point #2)
31. Make it easier for a judge to consider the facts leading to an earlier ITA detention when deciding issues in a current ITA proceeding. (From discussion in 4/30/08 workgroup meeting)

Changes to the ITA system - Out-Patient

Enhance and expand the ability to order mandatory out-patient treatment

32. Consider authorizing involuntary out-patient treatment using broader standards than standards used to authorize involuntary in-patient treatment. Initial steps could include either a pilot program (including an evaluation component) or development of a stakeholder workgroup to explore the viability of an involuntary out-patient program. (Rep. Dickerson submission, ITA point #3; DOC/DSHS submission, first bullet point)
33. Extend the length of ITA Less Restrictive Orders. For example, extend the length of all L.R.O.'s to 180 days, even if the in-patient hospitalization time for revocation of the L.R.O. doesn't change. (From discussion in 4/30/08 workgroup meeting)
34. If a person with a prior conviction for a violent felony is detained for at least 14 days, make any follow up Less Restrictive Order have a lifetime duration. The patient could ask for termination of the L.R.O. after ten years. A violation of the L.R.O. would result in a 180 day commitment. (Dr. Dagadakis submission, points #3,4,6)

35. If a person civilly detained has a prior conviction or has been found Not Guilty by Reason of Insanity for a violent offense, allow an ITA court to impose an L.R.O. with at least a 180 day duration. A violation of the L.R.O. would result in a 180 day commitment. (PAO submission, point #9)
36. Clarify that the criteria for revocation of a L.R.O. of a person assigned a high violence risk level is non-compliance with the L.R.O., not only whether any other ITA criteria are met. (Dr. Dagadakis submission, point #9)

Changes to the ITA system - DMIO specific

37. Eliminate short-term civil commitments (e.g. 14-day and possibly 90-day commitments) for DMIOs who need civil commitment. (From discussion in 6/25/08 workgroup meeting)
38. Do not send DMIOs to local E&T's upon initial civil commitment detentions. Send DMIOs to facilities better able to handle a DMIO's level of potential violence (probably state hospitals, with immediate priority admission provisions). (From discussion in 6/25/08 workgroup meeting)
39. Create an out-patient civil commitment program for DMIOs over whom DOC supervision has elapsed. The threshold for commitment would be lower than the present ITA commitment standards for non-offending citizens. (PAO submission, point #3)

Changes to the criminal justice system

Enhance criminal mental health courts

40. Expand criminal mental health court to include certain felonies (not just misdemeanors reduced from felonies). (Mike Finkle submission, point B-1-c.)
41. Have one regional criminal mental health court which accepts cases from all jurisdictions in that region, including all felony and misdemeanors. (From discussion in 6/25/08 workgroup meeting)

Improve competency statutes

42. Require a competency evaluation at the end of any in-patient civil commitment for any person whose civil commitment started after a violent felony charge was dismissed due to the lack of competency of the person. (From discussion in 3/19/08 workgroup meeting; PAO submission, point #6)
43. In violent felony cases where a state hospital has restored the competency of a defendant, give the courts clear discretion to have the defendant held at the state hospital pending trial, to prevent decompensation in local jails. (From PAO submission, point #6)

Alter existing NGRI statutes

44. Expand the definition of insane in NGRI pleas to the definition of insane used in the Model Penal Code § 4.01 (1) - "A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law." (David Hocraffer submission, page 4)
45. For any person found NGRI for a violent offense, impose a lifetime L.R.O. upon release from in-patient treatment. (Dr. Dagadakis submission, point #8)

Create a "Guilty, But Mentally Ill" finding

46. Create a "Guilty, But Mentally Ill" finding in criminal cases, to allow for certain defendants, in appropriate cases, to be held accountable for their acts but also allow for the initiation and continuation of mental health treatment to reduce the likelihood of future violent acts. (PAO submission, point #7)
47. As part of creating a Guilty, But Mentally Ill finding in criminal cases, expand the definition of insanity or GBMI to include a volitional impairment component. (Mike Finkle submission, point B-1-d.)

Change to "Determinate-Plus" sentencing in certain cases

48. Authorize the use of "Determinate-Plus" sentencing for violent offenders who are mentally ill. Determinate-Plus sentencing would be used as a sentencing enhancement when the initiating conditions, including a future dangerousness provision, are charged and proved. As part of this system, an offender's engagement in mental health treatment while in prison would be one of the factors considered when release is at issue. (PAO submission, point #4)
49. Create a system to classify the risk of violence for persons subject to Determinate-Plus sentencing, to be determined at time of release into the community. (PAO submission, point #4)

Increase post-supervision sanctions

50. Make the sanctions for violation of supervision conditions longer than 60 days to ensure violent offenders are off the street longer. (From discussion in 4/30/08 workgroup meeting)

Hybrid options - civil commitment/criminal justice

Pre-charging - create Jail Diversion Programs

51. Create a jail diversion program for persons with mental illness that is post-booking but pre-charging. Criteria allowing entry into the program could include whether the person has a history of at least two prior cases dismissed due to lack of competency (where the person was not detained after dismissal), the nature of the charge, or the person's criminal history. (Mike Finkle submission, point B-1-b.)
52. Encourage more communities throughout the state to create jail diversion programs and facilities. (From discussion in 10/7/08 workgroup meeting)

Create separate civil commitment systems for those with violent convictions

53. Create a system with the ability to quickly hospitalize decompensating offenders, similar to the current NGRI supervision system, for a broad category of violent offenders who are mentally ill. (From discussion in several workgroup meetings)
54. Create a separate civil commitment track for those under DOC supervision, where the grounds for commitment, the length of in-patient treatment, and the facility where the in-patient treatment occurs can be bettered tailored to the detained person's history of actual violent acts. (PAO submission, point #2)
55. Create a civil commitment model for violent or dangerous mentally ill offenders similar to SVP-type commitment, to address the likelihood that DMIOs will need longer terms of in-patient and court-ordered out-patient treatment. (PAO submission, point #5)
56. Create secure facilities for persons with mental illness who are not amenable to treatment and who continually commit criminal acts jeopardizing public safety. (From discussion in several workgroup meetings)

Create a system to classify the dangerousness of violent offenders

57. Create a classification system to assign a violence risk level to persons with mental illness who have a history of violent acts. The assigned risk level can be used in a variety of circumstances. The designation would be made by a workgroup representing a cross-section of the criminal justice and mental health systems. (Dr. Dagadakis submission, point #1; Discussion in 5/15/08 workgroup meeting)

DMIO program concepts for reform

Change the program name

58. Rename the DMIO program, probably to the Community Integration Assistance Program, as some private providers of services, such as housing, do not provide services to persons tagged as "Dangerous." (Rep. Dickerson submission, DMIO point #1)

Ensure that the existing program works as designed

59. Ensure that key stakeholders remain aware that there does not need to be a correlation between the predicate crime and mental illness in order for an offender to be designated a DMIO. (CCS/SMH submission, point #1)
60. Ensure that documentation of crimes and mental health evaluations are received by the DMIO statewide selection committee prior to their DMIO determinations. (CCS/SMH submission, point #2)
61. Require that referrals to RSNs and out-patient mental health treatment agencies occur at least three to five months prior to a DMIO's earliest possible release date so that there is adequate pre-release assessment and engagement in services of the DMIO. (CCS/SMH submission, point #3)
62. Work to ensure there is access to services for DMIOs statewide, possible by requiring RSNs to contract as a DMIO service provider as a condition of their Medicaid contract with the state. (Rep. Dickerson submission, DMIO point #4)

Expand the existing program

63. Expand the group of high-risk offenders eligible for the DMIO model of pre-release engagement, interagency cooperation, and enhanced social service support. (DOC/DSHS submission, fifth bullet point)

Ensure that known information about a DMIO is provided to DMHPs

64. Require that any pre-release assessment of a DMIO is provided to the DMHPs where the DMIO will reside. This assessment should include a psychological profile, behaviors exhibited while in prison, and a complete description and dates of each previous offense. (CCS/SMH submission, point #4)

Expand CCO options for removing DMIOs from the streets

65. Authorize CCOs to remove DMIOs from the streets upon decompensation or other signs the public is at risk, even if no new crime or supervision violation has occurred. (PAO submission, point #1)
66. Authorize CCOs to place a DMIO into a secure treatment facility rather than jail when the DMIO has authority to remove them from the street. This could be a facility run by DOC. (PAO submission, point #1)

Get DMIOs into the most intensive/appropriate out-patient programs

67. Encourage DMIOs to execute Mental Health Advance Directives. In conjunction with this, whether providers are currently willing to honor directions in MHADs should also be explored. (Rep. Dickerson submission, DMIO point #5, second bullet point)
68. Provide greater flexibility in the use of DMIO funding. An example would be authorizing DSHS to transfer funds to DOC if additional supervision is an appropriate service for a particular DMIO. (Rep. Dickerson submission, DMIO point #3, third bullet point)
69. Require that DMIOs be evaluated for eligibility for PACT programs and give DMIOs who qualify priority to receive PACT services. (Rep. Dickerson submission, DMIO point #5, first bullet point)
70. Develop a Forensic Assertive Community Treatment program for offenders under correctional supervision which is closely modeled on the PACT team program. (DOC/DSHS submission, sixth bullet point)

Funding concerns

71. Give violent offenders who are mentally ill but who do not qualify for Medicaid a non-Medicaid funding tier. (Dr. Dagadakis submission, point #10)
72. Backfill the existing funding shortfall of the DMIO program. (Rep. Dickerson submission, DMIO point #2)
73. Increase DMIO contractor rates. Means of increasing the rate could include a biennial inflationary adjustment or creating a geographic adjuster based on local housing costs. (Rep. Dickerson submission, DMIO point #3, first and second bullet points)

Miscellaneous

74. Modify the initial placement and evaluation processes in the case of high-risk offenders under correctional supervision to ensure a full review of all circumstances. (DOC/DSHS submission, third bullet point)
75. Increase the ability for medications to be administered involuntarily in local jails. (From discussion in 6/25/08 workgroup meeting)
76. Create a community awareness campaign to educate the public on who to call when they see a person in an apparent mental health crisis. (From discussion in 10/7/08 workgroup meeting)

CONCLUSION

Tools in the Toolbox: A Call to Action

Professionals within the civil and criminal systems work hard and often succeed in preventing harm due to mental illness. It is impossible to know how many violent acts are actually prevented daily because of the efforts and frequent interventions of Community Corrections Officers, DMHPs, mental health professionals, and the police. Their efforts should be praised and applauded.

Those working within the systems also remain cognizant of the rights of individuals and balance those rights with the need to protect public safety. Despite the professionals' best efforts, persons with mental illness are unpredictable and will, at times, inflict serious harm or even death. Yet, and although such a risk is always present despite the systems' best efforts, there is no such thing as an "acceptable murder." The tragedy that befell Shannon Harps is also a call to examine the tools given to those charged with preventing future tragedies.

James Williams was mentally ill. He presented a risk to others, even though no one could say exactly when or against whom he would act. The professionals dealing with Williams knew the risk he presented, and used their available tools to try to prevent it from coming to fruition. Nevertheless, the available tools were not enough. The indications, at this point, are that James Williams' presence on Capitol Hill on the evening of December 31, 2007, was due to the limits of the system, not by the lack of diligence or effort of the professionals working within it.

Therefore, the available tools must be sharpened, and new tools created. The mission of this workgroup has been to explore and suggest areas where the tools can be improved, and with it, public safety. It is now up to those hearing these suggestions to further explore them, come up with their own ideas, and implement those which are feasible.

APPENDIX A

Submissions from Workgroup Members and Discussion Summary

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Appendix A-1

Summary of session discussions on three subjects

a. Eliminating roadblocks to communication:

At some point in every workgroup meeting, the discussion turned to communications, often focusing on communication between agencies and systems, and where professionals in the mental health and criminal justice fields have come up against roadblocks in communicating with each other.

Here are some situations workgroup members have noted (either in workgroup sessions or via e-mail) where attempts to get information have been stymied, at least in King County:

1. Some persons with mental health issues find themselves charged with a misdemeanor crime and under the jurisdiction of a criminal mental health court. If that person is also civilly detained under the ITA, the ITA confidentiality statute, RCW 71.05.390, limits what professionals in the ITA system can tell those in criminal mental health court. This includes prosecutor to prosecutor, even if they work in the same office.
2. Sometimes the information concerning the prior violent history of a person being evaluated by a DMHP can only be found by examining the criminal history of the person. However, DMHPs do not have the authority or the technological capability to check criminal history. Furthermore, proof of criminal history in court, including the facts of a particular prior offense, may be difficult to substantively provide to the court because of evidentiary rules and the short timeline from detention until the first hearing.
3. Some out-patient mental health treatment agencies who are seeking extensions of ITA court orders for out-patient treatments are reluctant to provide access to and copies of the patient's records to the ITA prosecutors (who are representing the agency in court) and defense attorneys because of concerns over violating HIPAA.
4. DMHPs and King County prosecutors have had difficulty accessing mental health information DOC has on former prison inmates. Some of the information is archived with DOC, and DOC may also consider the information as protected from disclosure under HIPAA. These issues may even be preventing the offender's CCO from accessing the same information.
5. Law enforcement officers have been prevented from serving No Contact Orders on persons in E&T's, even when the officer already knows the person is a patient, because the E&T will only allow the officer on the unit if the patient agrees to be served.
6. Hospitals (non-E&T's) boarding patients have refused to provide a copy of their chart to evaluators and prosecutors for court preparation purposes without a specific court

signed subpoena. This has occurred despite the fact that the evaluator and prosecutor are representing the hospital's interests and a mental health professional from the hospital has signed the petition requesting an extension of involuntary in-patient treatment, and despite exceptions in ITA confidentiality laws. These hospitals will forward the exact same information to an E&T once the bed is available, where there is no issue as to how the information will be used for court preparation.

7. A person who is a DMIO, or who has previously been found NGRI, or who is currently on DOC supervision, may present themselves (or otherwise end up) at a hospital emergency room with mental illness symptoms. The emergency rooms, even psychiatric emergency rooms, have no way to directly find out that person's status and history of violence.

8. Because an emergency room may not know a person is on DOC supervision, the CCO will not learn of the offender's emergency room visit and potential increased risk to others.

b. Providing DMHPs with information on DMIOs in advance:

One common theme for improving public safety is to make sure that all of the professionals who may come in contact with a DMIO are aware of the DMIO's history and are prepared to react to it. For instance, DMHPs are often called to evaluate a DMIO. However, they currently have about the same amount of information for a DMIO as they do for any other person referred to them for evaluation.

This means that when the DMHP is called to do an evaluation of the DMIO they may lack the historical perspective on the DMIO's dangerousness and may only be looking at a snapshot of the DMIO's current behavior.

To assist the DMHPs, DOC at release could prepare packets of information regarding a DMIO's dangerousness and responsiveness to treatment. These packets would be given to DMHPs upon the DMIO's release from prison. The police and supervision CCOs could update this information as warranted. Then, when a DMHP is called upon to evaluate a DMIO, the historical information will be at hand. This would save the DMHP from having to scramble for the information, or do without it, during the short time frame they have to make their detention decisions.

At its most efficient, this communication could include a list of symptoms present during previous decompensations leading to violence. It could be made available to any professional who may have contact with the DMIO, not just DMHPs. Any professional aware of this list would have a better ability to compare the DMIO's current presentation to their historical risk symptoms and a better ability to gauge their current likelihood of acting out in a violent manner.

c. DMIOs and Mental Health Advanced Directives:

Currently, any person can sign what is known as a Mental Health Advanced Directive. In a MHAD, a person, while in a compensated state, indicates what type of mental health treatment they are willing to undergo should they decompensate. A valid MHAD can lead to mental health treatment in situations where the person is either not consenting or unable to give direction. MHADs were authorized by the legislature in 2003. As currently structured, it is possible for a person to revoke their MHAD fairly easily, even as their mental health deteriorates.

MHADs may be a viable tool to help CCOs and other professionals work with DMIOs after their release from prison. The key is to restrict the ability of a DMIO to revoke their MHAD. The process for encouraging DMIOs to enter into treatment and obtain the extra funding available to DMIOs begins at least three months before the DMIO's release date. Ideally, and as part of these discussions, the DMIO would also be urged to enter into a MHAD and to agree to make the MHAD non-revocable. Mandating an MHAD would not be required so as not to make the MHAD a reason for a DMIO to reject treatment. However, the current laws governing MHADs could be altered in minor ways to make clear that a DMIO's non-revocation clause would be followed in more situations than other MHADs.

Appendix A-2

Memorandum from

Michael Finkle

Seattle City Attorney's Office

MEMORANDUM

TO: Leesa Manion
FROM: Mike Finkle
SUBJECT: April 30 Meeting of DMIO Work Group
DATE: April 4, 2008

Since I won't be able to attend the next meeting, I'm sending you some of my thoughts in advance. Hopefully they will be of some use to the DMIO Work Group as a whole.

A. Overall impressions:

1. To steal a phrase from financial advisors, nickels and dimes can add up very quickly. There are a number of things we can do that have a small but definite impact. The more small-but-feasible ideas we come up with that can be implemented relatively quickly, the less we need to depend on finding one or two grand, brilliant recommendations.

2.. We should begin to look for ways for the mental health side and the criminal justice side to partner up, rather than work separately in our own "silos" on our own solutions. One example that came up at the meeting is to assign as patrol partners a law enforcement officer, someone from a community provider, and a DMHP.

3. We need to keep in mind the relatively non-aggressive, non-assaultive mentally ill as well as the fewer but highly dangerous DMIOs. The former can turn into the latter if left untreated.

4. Everyone whether mentally ill or not, has their own maximum level of functioning. We can't increase a mentally ill person's level of functioning beyond what they are capable of as a result of their illness. We therefore need to have strategies for both ends of the spectrum: those whose level of functioning cannot be raised from dangerous to non-dangerous, as well as those whose level of functioning can be raised with housing, treatment, etc.

B. Specific Impressions, some of which were voiced at the meeting and some of which were discussed at an earlier County-based work group:

1. On the criminal justice side, implement solutions at all stages of the game, from arrest through trial. Each solution will provide some benefit; all solutions together will provide greater benefit. Here are some examples:

a. Pre-arrest stage or pre-booking stage: Partnering a police or sheriff officer with someone from Sound Mental Health and a DMHP is something that strikes me as feasible and effective for a particular portion of the mentally ill who come into contact with the criminal justice system. That could include people like James Anthony Williams, who pose a severe public safety risk on the one hand, and mentally ill who, if left untreated and/or homeless could become the next James Anthony Williams.

b. Post-booking, but pre-charging diversion: There were some long-ago discussions about this one. Essentially, it would be designed to divert potential criminal defendants from jail to services. One way to screen for appropriateness is to use a bright line selection tool. For example, it could be limited to defendants who have been found incompetent and were not detained by the DMHP on two consecutive court cases. As an added safety precaution, we could always add limits as to potential charge and as to prior criminal history. That would focus the diversion resources squarely on those who could benefit from it most. It would also reduce jail usage, and would reduce the risk that a highly dangerous mentally ill offender would be diverted.

c. Post-charging but pre-trial (case disposition). Both Seattle and King County have mental health courts at the misdemeanor level. They function differently because their demographics are different, but they each provide access to housing and services to those who couldn't otherwise do without, in a manner tailored to their particular circumstances.

One area to explore is expanding the mental health court concept to felonies. The SRA creates difficulties in the sense that it ties the court's hands: a defendant who has a particular standard range would not necessarily be able to receive an "opt-in" reduced sentence that went below the standard range. What I have in mind is a Superior Court mental health court that takes on felonies, as opposed to a District or Municipal Court MHC that takes felony drop-downs.

There is a two-step legislative solution to this issue. Step one is to create a pilot project that receives funding to create a felony-level mental health court in the state, with certain mandatory criteria. King County would be a visible and logical choice. Step two is to include in that legislative package a provision that expressly authorizes diversionary-type dispositions in felony matters. It could be drafted either as form of diversion or as or as a mitigating factor in calculating a defendant's standard range.

d. Post-charging, resolved by trial. Now is a good time to re-examine how our insanity/diminished capacity statutes interact and whether they do what we want or need them to do.

Currently, we use the M'Naughten test, which limits insanity to cognitive impairment, and we have the judicially created diminished capacity defense. An insanity acquittal can result in commitment to Western (or Eastern) State Hospital; a diminished capacity acquittal does not result in any form of mental health commitment.

One suggestion was to adopt a “guilty but mentally ill” statute. While the pool of defendants who could potentially assert a GBMI defense is small compared to the pool of mentally ill defendants who opt in to MHC on a regular basis, the level of potential danger to self or others posed by the pool of potential GBMI defendants is much higher for the GBMI-eligible defendants than for MHC defendants.

It may also be worth looking at amending the insanity statute away from the more limited M'Naughten test to apply to volitional as well as cognitive impairment. That would open the insanity/GBMI options to a larger group of mentally ill defendants.

Appendix A-3

Letter from

Dr. David Lovell, Ph.D.
University of Washington Professor



April 30, 2008

TO: Dan Satterberg
King County Prosecuting Attorney

FROM: David Lovell

RE: Shannon Harps Workgroup

While our discussion has revealed systemic issues in the interface between criminal justice and mental health systems, I'm assuming that this group does not want to take on all of the issues (e.g., NGRI statute, competency restoration, sentencing). Keeping our focus on interventions to cope with the issues in the murder of Shannon Harps, I'd like to suggest two premises:

- The tragic murder of Shannon Harps on New Year's Eve was a rare event: among persons with mental illness, among persons with mental illness who have been to prison, and among persons with mental illness sent to prison for violent offenses.
- It is nevertheless the responsibility of corrections, community mental health agencies, and civil commitment authorities, working together, to prevent such tragedies whenever there is substantial reason to fear a tragic outcome.

From these premises it follows that our approach to supervision, detention, and confinement must be narrowly tailored to the individual circumstances and patterns of a dangerous person living in the community. Status as a violent offender or as a DMIO participant provides altogether too broad a brush.

A narrowly-tailored third form of civil commitment, analogous to 71.09, is also not workable. In addition to its expense, the process would be far too cumbersome to permit a nimble response to changing circumstances. Mr. Williams was less dangerous when he was released than he was after a year in the community, when his compliance began to waiver and especially when he lost his housing and treatment compliance could no longer be monitored. Furthermore, we have it on good authority that there are several other exceptional people under supervision who are equally scary but are not transitioning from prison. Since they lack the criminal history relevant to a 71.09-style commitment, they would be missed by this alternative.

If we rule out a third form of civil commitment as well as policy interventions based on criminal status, we are left with the Involuntary Treatment Act. After discussion with colleagues, I see two suggestions worth pursuing, in the spirit of not biting off more than we can chew:

1. Develop specialized “best practices” protocols for the rare cases that are a focus of concern among police, corrections, and community mental health staff. These practices would include the following:

- Interagency staffing identifies “high alert” cases and communicates information about them to designated mental health professionals, so that a review of detention or commitment does not need to begin from a blank slate.
- Delegate one of the DMHP team to join the interagency team managing “high alert” cases.

Such an approach might establish, for example, that the ability of a person like Mr. Williams to maintain a coherent and reasonable presentation during a single interview is part of a pattern of decompensation and relapse into paranoia and violence.

2. Without changing the criteria for detention of civil commitment in the ITA, add language with the following objectives:

- amplify and specify the evidence relevant to a determination: correctional records, community mental health records, hospital records.
- Clarify that the decision examines the nexus between the presumptive detainee’s current condition and history to address not only what is happening now but what is likely to happen, based on established patterns, in the absence of intervention.

Appendix A-4

Letter from

Dr. Christos Dagadakis, M.D.
Harborview Medical Center

To: Dan Satterberg

King County Prosecuting Attorney

5-13-08

From: Christos Dagadakis, MD, MPH

RE: Shannon Harps Workgroup

Recommendations for Change:

1. Define levels of past violence I (least intense) II (intermediate) III (Highest Level)
2. With a Level III or (possibly a lesser level depending on the definition) should substitute for the requirement for imminence in risk to others or self
3. If a person has a conviction of a felony involving violence, the person would have a life time equivalent of Less restrictive hold after release from a 14 day involuntary hold or 90 day or 180 day hold.
4. This life time LR (Less Restrictive Commitment) could be terminated after 10 years of no convictions for a violent crime or civil commitment for risk to others.
5. Continue effort to have a DMHP work with an interagency team working with violent offenders
6. Violation of LR to result in return 180 day MR, More Restrictive Hold, (could be discharged to LR earlier if stabilizes with solid outpatient plan)
7. Develop a data base on past violent felony convicted offenders especially for at least Level III so that if civil commitment is considered the information is readily available as well as a synopsis of relevant past history
8. Individuals charged with a violent felony who are found not guilty by reason of insanity would have a lifetime LR as in #4
9. The criteria for revocation of a LR for a violent offender determined as above will involve non-compliance with one of the provisions of the LR, not whether the individual currently meets the ITA criteria.
10. Violent offenders (Level III or possibly a lesser level) would get a non-Medicaid tier to qualify for mental illness care if they do not qualify for Medicaid.

Appendix A-5

Memorandum from

The Honorable Mary Lou Dickerson
Washington State House of Representatives

June 6, 2008

MEMORANDUM

To: Ethan Rogers

From: Rep. Mary Lou Dickerson

Re: Proposals for inclusion in Prosecutor Satterberg's DMIO Task Force report

At the May meeting of Prosecutor Satterberg's DMIO Task Force, task force members were invited to submit proposals for inclusion in the task force's final report, a draft of which will be discussed at the June 25th meeting of the TF. This memorandum reflects some background information and options that I would respectfully request be included in Prosecutor Satterberg's report of the task force's deliberations.

The DMIO program:

Currently, 523 offenders have been identified /designated through the DOC/DSHS process as DMIO. However, of these 550 offenders, only 212 are actually receiving services. Among those not receiving services:

- Approximately 1/3 live in a county that does not have a DMIO program contractor;
- Approximately 1/3 live in a county with a DMIO program contractor, but have chosen not to participate in services through the program.
 - Based upon a statement made by the DOC CCO at the last meeting, we would think that the offenders in this group who are under active DOC supervision are at least required to participate in mental health treatment as a condition of their supervision. However, the DMIO program provides funding and services in addition to mental health treatment, most notably, housing support.
- Approximately 1/3 are in prison, jail, inpatient psychiatric or some other institutional setting.

For those offenders served through the program, WSIPPs evaluations have been favorable. Their most recent report, issued in February 2008, using a 3 year follow-up period, found that the program:

- Has a positive return of \$1.24 for every dollar spent.
- Reduces overall felony recidivism rates by 37%, i.e. comparison group recidivism rate of 43%, versus a DMIO recidivism rate of 27%.
- Does not significantly reduce new misdemeanor offenses, and has not demonstrated a significantly significant reduction in new violent felonies, i.e. comparison group 30 new violent felonies, versus DMIO group 24 new violent felonies.

Options:

1. Amend the DMIO statute to rename the program. DSHS and DOC no longer refer to the program as the DMIO program. They call it the “Community Integration Assistance Program”.
2. As an initial step to support the program, backfill the existing funding shortfall. In the past couple of years, the program has been underfunded with respect to the ability to serve all offenders who want to participate in counties with DMIO program contractors for the full five years of the program.
 - This initial backfill step would be about \$800,000 to \$1m for the '09- '11 biennium. The DMIO budget of \$1.43m for SFY 2007 was overspent by approximately \$426,000 to serve the 229 active DMIO participants.
3. DMIO contractor rates have not increased since the program’s inception in 1999. In the context of the funding discussion, the legislature also could consider:
 - Increasing the DMIO program rates through a vendor rate increase, or by requiring biennial inflationary adjustment of the rate.
 - The majority of DMIO funds are used to secure appropriate housing for DMIO participants. Given the variability in housing costs across the state, the legislature could use a geographic adjuster for the rates, analogous to the adjusters currently used for residential long-term care services. [NOTE: A report on the adjusters currently used for these services will be submitted to the legislature in June 2008.]
 - Provide greater flexibility in the use of DMIO funding. For example, authorize DSHS to transfer funds to DOC to the extent that additional DOC supervision might be the appropriate service for a particular DMIO program participant.
4. Provide access to DMIO services on a statewide basis:
 - Currently, there are no DMIO contractors in the following counties/RSN service areas, i.e. the RSN does not contract, nor do any direct services providers in the county:
 - Chelan – Douglas RSN
 - Clark County RSN
 - Grays Harbor RSN
 - Greater Columbia RSN, in Klickitat, Benton, Franklin, Walla Walla, Columbia, Whitman, Garfield, Asotin
 - Peninsula RSN, in Jefferson
 - North Central RSN, in Okanogan, Grant, Lincoln, Adams, Ferry, Stevens, Pend Oreille
 - Spokane RSN
 - In the following counties, RSN’s have refused to contract, but direct service providers have agreed to cover some or all of the RSN service area:
 - Greater Columbia RSN:
 - Central WA Comprehensive MH serves Yakima, Kittitas and Skamania counties
 - North Sound RSN:
 - Associated Provider Network/Compass serves the entire RSN service area

- Peninsula RSN:
 - Kitsap MH Services serves Kitsap County
 - Peninsula Community MH Center serves Clallam County
 - Thurston-Mason RSN:
 - Behavioral Health Resources serves the entire RSN service area.
 - As of August 2007, 83% of active DMIO participants had been found eligible for Medicaid. Given the severity of their mental illness, it is likely that the vast majority of these individuals would meet the RSN access to care standards. In other words, whether there is an active DMIO program or not in a particular county, the likelihood is that these individuals are eligible to receive services through the RSN.
 - The DMIO program provides additional funding for services to these individuals, and has been proven to reduce recidivism rates.
 - In effect, it can reduce risk, rather than increase risk, for RSN's participating in the program.
 - Consider whether RSN's should be required to contract as a DMIO service provider as a condition of their Medicaid contract with the state. Note that current law already provides immunity from liability for simple negligence to RSN's and treatment providers serving DMIO participants.
5. Incorporate the following actions into DMIO pre-release discharge planning:
- Require that DMIO participants be evaluated to determine their need for PACT (Program for Assertive Community Treatment) services. To the extent that such services would be appropriate, give DMIO participants priority to receive PACT services through the RSN.
 - Encourage DMIO program participants to execute a mental health advance directive [MHAD] under chapter 71.32 RCW prior to release. The advance directive provides an opportunity for the individual to clearly express treatment preferences should they become incapacitated, and build a better relationship with the treatment provider. To the extent that a treatment provider is able and willing to honor an advance directive, there might be an opportunity to intervene when a DMIO participant has decompensated to the incapacity standard in the advance directive, but may not yet meet the ITA commitment standard. Concerns have been expressed regarding treatment providers' willingness to honor directions in MHAD's, so this issue should be more fully explored.

The Involuntary Treatment Act [ITA]:

1. At the initial decision to detain for 72 hour evaluation and treatment, direct the DMHP and court to consider evidence of the individual's past involvement in the criminal justice system, including competency determinations under chapter 10.77, past involuntary commitments, or past patterns of decompensation:
 - The current ITA statute specifies instances in which the DMHP or the court can consider an individual's past violent acts or treatment history. At the 14 and 90 day commitment hearings, the court must give great weight to certain information regarding an individual's prior criminal acts and/or treatment history. The statute explicitly provides that this information cannot be the sole basis for a decision to commit. RCW 71.05.245; RCW 71.05.285.

- The current statute also directs a DMHP, when conducting an evaluation under the ITA, to consider all reasonably available records and information regarding prior evaluations under chapter 10.77 RCW, the individual's history of violent acts, prior determinations of incompetency or insanity under chapter 10.77 RCW, and prior ITA commitments. RCW 71.05.212. The law is unclear regarding the extent to which this information can be relied by the DMHP in reaching his/her decision.
2. Address concerns about difficulty in accessing criminal and mental health treatment history information, and in obtaining admissible copies of criminal history or treatment records on a timely basis in the context of evaluating the need for a 72 period of evaluation and treatment.
 3. Consider authorizing involuntary **outpatient** commitment using a standard broader than that applicable to involuntary inpatient commitment:

A number of states, including Minnesota, New York and Texas, have enacted statutes that allow the court to order involuntary outpatient treatment. In Minnesota, for example, the outpatient commitment standard allows the court to base its decision upon the fact that an individual has had repeated recent hospitalizations, is exhibiting symptoms similar to those that preceded prior hospitalizations and will, without treatment, likely deteriorate to the point of meeting the criteria for involuntary inpatient treatment.

Under current law in Washington State, the court must consider whether a “less restrictive alternative” would be appropriate as an alternative to inpatient treatment. However, an individual must be found to meet the ITA standard for inpatient treatment, i.e. likelihood of serious harm or gravely disabled. The states noted above use a legal standard for involuntary outpatient civil commitment that is different, and somewhat broader, than the standard for involuntary inpatient treatment.

This is a very controversial proposal, as it results in restraints upon individual rights. In addition, to the extent that involuntary outpatient commitment results in court ordered intensive treatment, increased mental health service costs, and additional court costs could result.

A 2001 Rand Institute review of the literature did not find compelling evidence to support the use of involuntary outpatient treatment. They were unable to determine whether the involuntary treatment or the intensive services that accompanied involuntary treatment, produced the positive outcomes that have been found in some studies. The MacArthur Foundation is now funding an effort to explore more fully the use of mandated community treatment. Washington state's DMIO program, by its design, provides intensive services to program participants.

Options:

1. Authorize a limited pilot program to test the effectiveness of involuntary outpatient treatment in WA State. Any pilot implementation would include an evaluation component.
 - Geographical pilot program: For example, in New York State, the program was implemented for a pilot period only in New York City.
 - Utilize this option only in the DMIO program: The primary concern with this pilot option is that it would bring potential deprivation of rights into the program, which could significantly diminish individuals' willingness to participate in the program.
 - Allow the program to be implemented statewide, but sunset the program to allow it to operate only for 3 or 5 years.

2. Develop a stakeholder workgroup to explore the viability of, and need for, and involuntary outpatient commitment option in Washington State.

Appendix A-6

Letter from

David Hocraffer

The Public Defender of King County



King County

Office of the Public Defender

Department of
Community and Human Services

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206-296-7662 Fax 206-296-0587
TTY Relay 711

June 11, 2008

Daniel T. Satterberg
King County Prosecuting Attorney
King County Courthouse, W554
516 Third Avenue
Seattle, WA 98104

RE: Dangerous Mentally Ill Offender (DMIO) Work Group

Dear Mr. Satterberg:

This letter is to provide input on the efforts of the DMIO work group. At the onset, it should be noted, that these comments are being provided without the benefit of reviewing a draft of King County Prosecuting Attorney's Office proposals. As such, the comments will be of a more general nature, than specific comments on any proposed statutory language.

The DMIO Work Group spent considerable time reviewing the circumstances surrounding pending murder charges against James A. Williams. This individual's background was reviewed in light of current practices and procedures involving persons designated Dangerous Mentally Ill Offenders, and persons under the jurisdiction of King County Superior Court pursuant to the Involuntary Treatment Act.

The work group was provided recommendations from various sources. Included in those recommendations were outlined proposals for new sentencing legislation, changes to the "not guilty by reason of insanity" defense, and modifications to the Involuntary Treatment Act (ITA) legislation and procedures.



I. “Determinant Plus” Sentencing Enhancement

The King County Prosecutor’s Office provided an outline of proposed legislation to modify sentencing statutes to provide for a “determinant plus” sentencing enhancement. This proposal is based on the determinant plus sentencing for sex offenders. For various reasons, such extension of this concept as proposed is seriously flawed.

A. Blakely Requirements

Sex offenses with “determinant plus” sentences are sentenced based on conviction for a specific offense. Unlike sex offenses, in order to employ “determinant plus” sentencing for non-sex offense felonies committed by persons who would be classified as “dangerous mentally ill offenders” (DMIO), such persons would be convicted for offenses that others, not described as DMIO, who are likewise convicted of such charges, would not be subject to a “determinant plus” sentencing. This means two different persons convicted of the same offense would be subject to different sentencing schemes.

The distinguishing factor would be that additional findings of fact would have to be made by a jury as to an enhancement factor relating to DMIO. The requirement for such enhancement factors to be found by a jury was determined by the U.S. Supreme Court in *Blakely v. Washington*, 542 U.S. 296 (2004).

This requires a legislative determination that specific factors are enhancements which increase the sentence for DMIO defendants. Although conceptually easy to consider, this is extremely difficult, if not impossible, to set out in adequate statutory language.

B. Overbreadth

Any statutory language which sets out the enhancement factors for DMIO “determinant plus” sentencing will have to be narrow and precise. There is substantial risk that any language employed will be overbroad, i.e. including many individuals within its reach for whom the sentencing scheme was not intended. Given that mental illness is presumably part of the enhancement, it will be almost impossible to avoid such overbroad application. Given the likelihood of co-existing disorders and professional disagreements as to appropriate diagnoses, this risk is compounded.

C. Criminalizing Mental Illness

Given the *Blakely* requirements of additional findings of enhancement factors, the DMIO factors will of necessity include a requirement that a jury find some degree or diagnosis of mental illness. Such inclusion of mental illness in a sentencing scheme to increase length and severity of sentences amounts to criminalization of mental illness.

The nature of sentences contemplated, e.g. Department of Corrections (DOC) incarceration, indicates that this is not a treatment or hospitalization scheme.

To the extent that a jury is able to find beyond a reasonable doubt that a mental illness impacted a defendant's conduct sufficiently to qualify for such an enhanced sentencing scheme, then that defendant likely would or should be found not guilty by reason of insanity by the same jury.

D. Use and Abuse of Enhancements

Given the prevalence of some degree of mental illness within the defendants facing felony offenses, consideration must be made as to how the existence of such enhancements would be used by prosecutors.

It is a common practice for prosecutors to threaten to add current statutory enhancements to serious felonies, in the event that a defendant declines a pretrial offer to plead guilty, and rather proceeds to trial. It is to be presumed that this practice would continue, but expanded to include the DMIO enhancements. The effect will be that some individuals with mental illness will plead guilty and accept DOC sentences in order to avoid the risk of DMIO enhancement findings at trial. Less incentive will exist for prosecutors to consider mitigating impacts of mental illness on defendant's conduct, and indeed, some defendants will avoid disclosure of mental illness out of concern for increased punishment by DMIO enhancements.

In any event, such use or abuse, of the existence of a DMIO enhancement sentencing scheme, would be inconsistent with societal goals of treating, not punishing, mentally ill individuals, as well as reserving the most serious criminal sanctions for strictly criminal conduct.

II. Not Guilty by Reason of Insanity / Guilty but for Mental Disease or Defect

The work group was provided a brief description and comparison of Washington's not guilty by reason of insanity defense with other states' defenses of this nature.

Washington employs a restrictive application of the McNaghton Rule for determination of the defense of not guilty by reason of insanity.

A number of other states employ more expanded defenses, including a Model Penal Code defense, which requires a finding of that at the time of the offense, the defendant suffered from a mental disease or defect, and by reason of such mental disease or defect was unable to appreciate the criminality of his conduct, or to conform his conduct to the dictates of the law. Some states employ this as a "guilty but insane" or "guilty but for mental disease or defect" (GBI). See e.g. Oregon Revised Statutes 161.295 – 161.309, 161.313 – 161.400. For example in Oregon, GBI is an affirmative defense, in which the result of a finding by a jury is not a conviction for a crime, but instead results in hospitalization and jurisdiction by a Psychiatric Security Review Board, which determine release, and conditions of release.

The outline of the "determinant plus" scheme provided to the work group included a proposal to use a "guilty but mentally ill" finding by a jury, where this amounts to a conviction when mental illness exists, but is not quite enough to qualify for a not guilty by reason of insanity. When combined with the narrow definition of Not Guilty by Reason of Insanity (NGI) in Washington, the use of the guilty but mentally ill designation as outlined to the work group would amount to convictions for a large number of persons. This will happen as a practiced practical effect of compromise jury verdicts. It will also result from there being no vehicle by which the jury can consider circumstances in which, although a defendant may have appreciated the criminality of their conduct, were otherwise unable to confirm their conduct to the dictates of the law. As outlined in certain sections, this still criminalizes mental illness, and substitutes incarceration for treatment.

A better solution is to consider expanding the Washington definition of insanity for NGI purposes to include the Model Penal Code test. The potential would be that more mentally ill defendants would be able to qualify for NGI, and appropriate treatment and hospitalization.

Concerns involving the problematic intersection of the ITA and the insanity defense could be addressed by some variation of proposals such as put forth by Dr. Dagadakis and

Daniel T. Satterberg
June 11, 2008
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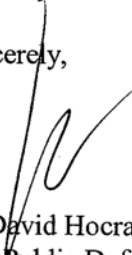
Dr. Lovell, in order to more practically address continuing treatment needs of those determined to be NGI. Such proposals can likewise address DMIO individuals. Although more modest in approach, these proposals do not run the risks of harm that a "Determinant Plus" sentencing scheme, as outlined, run.

III. Conclusion

The James A. Williams case involved extreme tragedy. However, the old saying "hard cases make bad law" is very applicable to this situation. The history and circumstances giving rise to the events involved in that specific case have a number of factors. Using this tragic event to create overbroad sentencing schemes that criminalize and penalize mentally ill individuals due to their mental illness only serves to compound the tragedy. A much more cautious approach is urged. Examination of the various proposals to modify application and requirements of the ITA statutes and procedures, especially as they relate to mentally ill individuals with a documented history of violent conduct, is a more prudent course of action.

Please contact me by e-mail at david.hocraffer@kingcounty.gov, or by phone at 206-296-7741, should you wish to discuss this further.

Sincerely,



V. David Hocraffer
The Public Defender

cc: Jackie MacLean, Director, Department of Community and Human Services

Appendix A-7

Letter from

Sarah Coats and Shelley Williams
Office of the Washington State Attorney General



Rob McKenna

ATTORNEY GENERAL OF WASHINGTON

7141 Cleanwater Dr SW • PO Box 40124 • Olympia WA 98504-0124

June 24, 2008

Dan Satterberg
King County Prosecuting Attorney
W554 King County Courthouse
516 Third Avenue
Seattle, WA 98104

RE: Proposed Changes to the Involuntary Commitment Law

Dear Mr. Satterberg:

We proposed changes to RCW 71.05.280, .290, and .320 for inclusion in the 2009 AGO legislative package. We believe that these proposed changes address situations in which a dangerous but mentally ill person could be civilly-committed but for technicalities in the current statute. We received permission Hunter Goodman, Director of Governmental Affairs in the AGO, to share our proposal with this workgroup. These changes pertain to cases in which a person is found incompetent to stand trial for either misdemeanor or felony charges, and is referred by the criminal court for civil commitment.

As noted in the Draft White Paper, civil commitments after a person is found incompetent to stand trial for misdemeanor or felony charges differ from other civil commitments. A typical civil commitment process begins with a detention for up to 72 hours for observation and evaluation, followed by a 14-day commitment, then a 90-day commitment, and then successive 180-day commitments. When a person is referred directly for civil commitment after misdemeanor charges are dismissed due to incompetency to stand trial, however, the State may directly file a petition for 90 days. When a person is referred directly for civil commitment after felony charges are dismissed due to incompetency to stand trial, the State may directly file a petition for 180 days. If a person is mentally ill and dangerous, the public will benefit from the ability to detain the person for a longer period of time for treatment.

1. RCW 71.05.280(2). When misdemeanor charges are dismissed because the defendant is incompetent to stand trial and the defendant is referred for a 90-day commitment, the State can petition under any or all of the following grounds:

- The person is “gravely disabled” – in other words, the person is unable to take care of his/her own needs of health and safety (RCW 71.05.280(4)).



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- During the current detention, the person *threatened*, attempted, or inflicted physical harm on another or substantial damage to the property of another person, and as a result of mental disorder presents a likelihood of serious harm (RCW 71.05.280(1)).
- The person was taken into custody as a result of conduct in which s/he attempted or inflicted physical harm upon the person of another or himself or herself, or substantial damage to the property of another person, and continues to present, as a result of mental disorder, a likelihood of serious harm (RCW 71.05.280(2)).

As noted above, one can be committed for making threats *while* in custody, but not if the threats were the *reason* the person was taken into custody. Thus, if a person whose misdemeanor charges were dismissed due to incompetency had been (1) taken into custody for threatening behavior that did not rise to the level of "attempting" or "inflicting" physical harm on another or substantial damage to property, and (2) does not meet any other civil commitment grounds such as grave disability, that person cannot be committed.

The need to add the word "threatened" to RCW 71.05.280(2) is illustrated by a case we handled in which Mr. C, a mentally-ill person who believed he has a "license to kill" from the United Nations, carried many weapons (including a grenade launcher) in his car. A jury refused to civilly commit Mr. C because his threatening behavior did not meet the elements of RCW 71.05.280(2). While Mr. C was stopped at a stoplight, he held a gun pointed up while staring at the driver in the next lane. The driver felt threatened and called the police. When the police took Mr. C into custody, they found a complete weapons arsenal in his car. Mr. C had legal permits for all of the weapons (including the grenade launcher).

Because Mr. C could take care of his basic needs and because he was not a behavior problem in the hospital, DSHS sought to commit Mr. C based on the ground that he was taken into custody as a result of conduct in which he attempted or inflicted physical harm upon the person of another. Because RCW 71.05.280(2) limits the conduct to "attempted or inflicted physical harm" instead of "threatened, attempted or inflicted physical harm," the jury found that Mr. C did not meet the elements for commitment, as brandishing a gun is a "threat," not an "attempt," to inflict harm.

2. RCW 71.05.280(3) and RCW 71.05.290(3). As noted above, when a person is referred directly for civil commitment after felony charges are dismissed due to incompetency to stand trial, the State may directly file a petition for one hundred and eighty days. RCW 71.05.290(3). Unlike the misdemeanor cases, the State cannot petition on any ground to obtain the longer commitment in a felony case; rather, the State *must* establish the following ground to obtain a 180-day commitment:

- (3) Such person has been determined to be incompetent and criminal charges have been dismissed pursuant to RCW 10.77.086 (4), and has committed acts constituting a felony, and as a result of a mental disorder, presents a substantial likelihood of repeating similar acts. . . .

RCW 71.05.280(3).

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This limitation presents several problems. First, establishing the RCW 71.05.280(3) ground requires that the State prove that the person committed "acts constituting a felony" by clear, cogent and convincing evidence. If witnesses refuse to cooperate or the evidence is otherwise lacking, we cannot civilly commit this person for 180-days, even if the person is gravely-disabled or meets one of the other grounds for civil commitment.

Moreover, there are cases in which we can prove the "acts constituting a felony," but we cannot prove that, "as a result of a mental disorder, [the person] presents a substantial likelihood of repeating similar acts." In other words, the person may suffer from a mental disorder and be in need of commitment, and may even be dangerous, but did not commit the "acts constituting a felony" as a result of a mental disorder. Again, we cannot civilly commit this person for 180-days even if the person is gravely-disabled or meets one of the other grounds for civil commitment. Therefore, we propose deleting the phrase "under RCW 71.05.280(3)" in RCW 71.05.290(3) to allow the State to petition on any ground for a 180-day detention.

We also propose amending RCW 71.05.280(3) to change "acts constituting a felony" to "acts that threatened, attempted, or inflicted physical harm upon the person of another, or substantial damage upon the property of others" for a couple of reasons. First, the proposed language is consistent with other commitment grounds (i.e., RCW 71.05.280(1) and proposed RCW 71.05.280(2)) that focus on public safety. Second, while civil commitments are civil proceedings, some trial courts have said that the phrase "acts constituting a felony" casts doubt on whether the proceedings are civil or criminal. Some courts have ruled that such statutory language imports the full panoply of constitutional protections for criminal trials, which is unduly burdensome for civil commitment hearings.

We also propose changes to expand prosecutor notification when a felony defendant who has been referred for civil commitment leaves the state hospital. Current law only provides for prosecutor notification when the detained person leaves the hospital if that person has first been committed under RCW 71.05.280(3). Providing this notification without statutory authorization if the evaluators determine that the detained person does not meet civil commitment criteria and must be released may violate HIPAA and the confidentiality provisions of RCW 71.05.390 and .630. Our proposed changes to RCW 71.05.280(3) require prosecutor notification in these situations, as well as prosecutor notification if an 180-day civil commitment is sought on other grounds pursuant to our proposed changes to RCW 71.05.290(3). This expanded prosecutor notification would give the prosecutors the opportunity to re-file charges and take the person into custody if the prosecutor chooses to do so, and would be more consistent with RCW 71.05.235(2), which provides for a type of notification when a petition is not filed after serious misdemeanor charges are dismissed due to incompetency and the defendant is referred for civil commitment.

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3. RCW 71.05.320. The proposed changes to RCW 71.05.320 are simply to make this section consistent with our proposed changes to RCW 71.05.280 and .290.

We welcome any comments and suggestions that you and the workgroup may have.

Thank you.

Sincerely,

A handwritten signature in black ink that reads "Sarah J. Coats". The signature is written in a cursive, flowing style.

SARAH J. COATS
SHELLEY A. WILLIAMS
Assistant Attorneys General

SJC/btc

Enclosure

RCW 71.05.280 Additional confinement — Grounds.

At the expiration of the fourteen-day period of intensive treatment, a person may be confined for further treatment pursuant to RCW 71.05.320 if:

(1) Such person after having been taken into custody for evaluation and treatment has threatened, attempted, or inflicted: (a) Physical harm upon the person of another or himself or herself, or substantial damage upon the property of another, and (b) as a result of mental disorder presents a likelihood of serious harm; or

(2) Such person was taken into custody as a result of conduct in which he or she threatened, attempted or inflicted physical harm upon the person of another or himself or herself, or substantial damage upon the property of others, and continues to present, as a result of mental disorder, a likelihood of serious harm; or

(3) Such person has been determined to be incompetent and criminal charges have been dismissed pursuant to RCW 10.77.086(4), and has committed acts ~~((constituting a felony))~~ that threatened, attempted, or inflicted physical harm upon the person of another, or substantial damage upon the property of others, and as a result of a mental disorder, presents a substantial likelihood of serious harm repeating similar acts ~~((-In any proceeding pursuant to this subsection it shall not be necessary to show intent, willfulness, or state of mind as an element of the crime))~~; or

(4) Such person is gravely disabled.

RCW 71.05.290 Petition for additional confinement — Affidavit.

(1) At any time during a person's fourteen-day intensive treatment period, the professional person in charge of a treatment facility or his or her professional designee or the designated mental health professional may petition the superior court for an order requiring such person to undergo an additional period of treatment. Such petition must be based on one or more of the grounds set forth in RCW 71.05.280.

(2) The petition shall summarize the facts which support the need for further confinement and shall be supported by affidavits signed by two examining physicians, or by one examining physician and examining mental health professional. The affidavits shall describe in detail the behavior of the detained person which supports the petition and shall explain what, if any, less restrictive treatments which are alternatives to detention are available to such person, and shall state the willingness of the affiant to testify to such facts in subsequent judicial proceedings under this chapter.

(3) If a person has been determined to be incompetent pursuant to RCW 10.77.086(4), then the professional person in charge of the treatment facility or his or her professional designee or the designated mental health professional may directly file a petition for one hundred eighty-day treatment (~~under RCW 71.05.280(3)~~). No petition for initial detention or fourteen day detention is required before such a petition may be filed. If the professional person responsible for deciding whether to file a petition decides not to file a petition, or if he or she files a petition that does not include the grounds set forth in RCW 71.05.280(3), that professional person or his or her designee shall notify the prosecuting attorney of the county in which the criminal charges against the detained person were dismissed at least three days before the detained person is released, if such notice has been requested in writing.

RCW 71.05.320 Remand for additional treatment — Duration — Developmentally disabled — Grounds — Hearing.

(1) If the court or jury finds that grounds set forth in RCW 71.05.280 have been proven and that the best interests of the person or others will not be served by a less restrictive treatment which is an alternative to detention, the court shall remand him or her to the custody of the department or to a facility certified for ninety-day treatment by the department for a further period of intensive treatment not to exceed ninety days from the date of judgment: PROVIDED, That;

(a) If (~~the grounds set forth in RCW 71.05.280(3) are the basis of commitment~~) the detained person has been determined to be incompetent pursuant to RCW 10.77.086(4), then the period of treatment may be up to but not exceed one hundred eighty-days from the date of judgment in a facility certified for one hundred eighty-day treatment by the department.

(b) If the committed person has a developmental disability and has been determined incompetent pursuant to RCW 10.77.086(4), and the best interests of the person or others will not be served by a less-restrictive treatment which is an alternative to detention, the court shall remand him or her to the custody of the department or to a facility certified for one hundred eighty-day treatment by the department. When appropriate and subject to available funds, treatment and training of such persons must be provided in a program specifically reserved for the treatment and training of persons with developmental disabilities. A person so committed shall receive habilitation services pursuant to an individualized service plan specifically developed to treat the behavior which was the subject of the criminal proceedings. The treatment program shall be administered by developmental disabilities professionals and others trained specifically in the needs of persons with developmental disabilities. The department may limit admissions to this specialized program in order to ensure that expenditures for services do not exceed amounts appropriated by the legislature and allocated by the department for such services. The department may establish admission priorities in the event that the number of eligible persons exceeds the limits set by the department. An order for treatment less restrictive than involuntary detention may include conditions, and if such conditions are not adhered to, the

designated mental health professional or developmental disabilities professional may order the person apprehended under the terms and conditions of RCW 71.05.340.

(2) If the court or jury finds that grounds set forth in RCW 71.05.280 have been proven, but finds that treatment less restrictive than detention will be in the best interest of the person or others, then the court shall remand him or her to the custody of the department or to a facility certified for ninety day treatment by the department or to a less restrictive alternative for a further period of less restrictive treatment not to exceed ninety days from the date of judgment: PROVIDED, That if ~~((the grounds set forth in RCW 71.05.280(3) are the basis of commitment))~~ the committed person has been determined to be incompetent pursuant to RCW 10.77.086(4), then the period of treatment may be up to but not exceed one hundred eighty-days from the date of judgment.

(3) The person shall be released from involuntary treatment at the expiration of the period of commitment imposed under subsection (1) or (2) of this section unless the superintendent or professional person in charge of the facility in which he or she is confined, or in the event of a less restrictive alternative, the designated mental health professional or developmental disabilities professional, files a new petition for involuntary treatment on the grounds that the committed person;

(a) During the current period of court ordered treatment: (i) Has threatened, attempted, or inflicted physical harm upon the person of another, or substantial damage upon the property of another, and (ii) as a result of mental disorder or developmental disability presents a likelihood of serious harm; or

(b) Was taken into custody as a result of conduct in which he or she threatened, attempted or inflicted serious physical harm upon the person of another, and continues to present, as a result of mental disorder or developmental disability a likelihood of serious harm; or

(c) Is in custody pursuant to RCW 71.05.280(3) and as a result of mental disorder or developmental disability presents a substantial likelihood of repeating similar acts that threaten, attempt, or inflict physical harm upon the person of another, or substantial damage upon the property of others, considering the ~~((charged criminal behavior))~~ acts committed, life history, progress in treatment, and the public safety; or

(d) Continues to be gravely disabled.

If the conduct required to be proven in (b) and (c) of this subsection was found by a judge or jury in a prior trial under this chapter, it shall not be necessary to reprove that element. Such new petition for involuntary treatment shall be filed and heard in the superior court of the county of the facility which is filing the new petition for involuntary treatment unless good cause is shown for a change of venue. The cost of the proceedings shall be borne by the state.

The hearing shall be held as provided in RCW 71.05.310, and if the court or jury finds that the grounds for additional confinement as set forth in this subsection are present, the court may order the committed person returned for an additional period of treatment not to exceed one hundred eighty days from the date of judgment. At the end of the one hundred eighty day period of commitment, the committed person shall be released unless a petition for another one hundred eighty-day period of continued treatment is filed and heard in the same manner as provided in this subsection. Successive one hundred eighty day commitments are permissible on the same grounds and pursuant to the same procedures as the original one hundred eighty-day commitment.

(4) No person committed as provided in this section may be detained unless a valid order of commitment is in effect. No order of commitment can exceed one hundred eighty-days in length.

Appendix A-8

Joint letter from

Eldon Vail

Department of Corrections

and

Robin Arnold-Williams

Department of Social and Health Services



STATE OF WASHINGTON
STATE OF WASHINGTON

September 10, 2008

Daniel Satterberg
King County Prosecuting Attorney
W400 King County Court House
516 Third Avenue
Seattle, Washington 98104

Dear Mr. Satterberg:

The sudden and violent death of Shannon Harps on New Year's Eve, 2007, and the more recent deaths of six persons in Skagit County have provided strong reason to take a critical and in-depth look at statutes, programs and policies covering offenders with mental illness. The Dangerously Mentally Ill Offender (DMIO) White Paper Draft provides a comprehensive review of issues and we would like to urge consideration of the following recommendations.

First, revisions to the Washington State Involuntary Treatment Act (ITA) may be needed to increase its applicability to offenders with mental illness:

- Adding a mandatory outpatient commitment provision for individuals with a significant history and risk for violence.
- Allowing Designated Mental Health Professionals (DMHP) to give great weight to a prior history of violence, including records of prison behavior, when considering initial detainment, as well as, subsequent civil detainment hearings before a judge.
- Modifying initial placement and evaluation processes in the case of high-risk offenders under correctional supervision to improve safety and ensure a full review of circumstances.
- Expanding the definition of 'likelihood of serious harm' to further clarify what constitutes a violent act and to include other readily identifiable risk factors.

The following additions or enhancements to programs for offenders with mental illness are also worth considering by the Legislature:

- Applying the DMIO/CIAP model of pre-release engagement, enhanced social service support, and interagency cooperation to an expanded group of high-risk offenders



Dan Satterberg
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with mental illness leaving prison, with a need for active treatment and collaborative supervision.

- Developing a forensic assertive community treatment (FACT) program to bring the intensive services of the evidence based practice of assertive community treatment to offenders under correctional supervision.

And finally, increased collaboration among correctional, mental health, and DMHP staff may allow more effective management of risk:

- Development of “best practice models” to identify “high alert” cases and share information between interagency teams and designated mental health professionals at the community level so that recommendations and court deliberations about offenders under supervision will be better informed;
- Removal of regulatory and agency policy barriers to sharing of information across agencies to facilitate collaborative crisis prevention and intervention planning.

DOC and DSHS applaud the leadership of the King County Prosecutor’s Office in bringing the taskforce together. Although the Shannon Harps tragedy occurred in King County, and the other tragic deaths occurred in Skagit County, they could have happened anywhere in our state. We look forward to working with you to help keep communities safe.

Sincerely,



Eldon Vail
Secretary
Department of Corrections



Robin Arnold-Williams
Secretary
Department of Social & Health Services

cc: Cheryl Strange, Deputy Secretary, Department of Corrections
Richard Kellogg, Director Mental Health, Department of Social and Health Services
John Lane, Executive Policy Advisor, Office of the Governor
Kari Burrell, Executive Policy Advisor, Office of the Governor

Appendix A-9

Submission from

The King County Prosecuting Attorney's Office

DANIEL T. SATTERBERG
PROSECUTING ATTORNEY



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Proposals for Policy Maker Consideration: Mentally Ill and Violent Criminal Offenders

The interplay between the mental health system and the criminal justice system carries the potential for inherent tension. Mental health systems are primarily focused on the welfare of the patient; prosecutors think first about public safety. When the stakes are highest and criminal conduct most violent, there are often unsatisfactory resolutions of this conflict under the current system. This is an area where policy makers must set clear guidelines and create systems that provide treatment to violent and dangerous mentally ill offenders in ways that adequately protect community safety.

For non-violent mentally ill offenders, we embrace those areas where the criminal justice and mental health systems have collaborated to develop innovative programs, like Mental Health Court and Drug Court, where the justice system can be used as an effective intervention point for application of mental health treatment therapies.

Any reform of the mental illness treatment system must start with the addition of *capacity* -- in the state hospitals, the county evaluation and treatment facilities, and community resources. This critical infrastructure has not kept pace with the growth in the state's population or in response to pressing needs in the community. According to a recent presentation by the Greater Columbia Regional Service Network (RSN), the King County RSN, and the Spokane County RSN:

- Since 2000, the state population has grown 13%, but the number of available community and state psychiatric hospital beds has decreased 15%;
- In King County, between January and September 2008, 260 mentally ill patients were detained and "boarded" in unsecure hospital emergency rooms because appropriate psychiatric beds were not available;
- Washington State is 51st in the nation (including the District of Columbia) in community inpatient capacity (i.e. licensed evaluation and treatment facilities);
- Washington needs an additional 763 community-based psychiatric beds just to bring its capacity to national average;
- King County currently has only 362 psychiatric beds for children, adults, and geriatrics. Only 168 of these beds are for patients who are involuntarily detained.

The lack of capacity can drive policy and practice in ways that endanger the community in ways policymakers never intended. For instance, Washington's state psychiatric hospital capacity has been fluctuating downward over the past several years with civil capacity recently unable to meet the demands of the civil commitment process. There is a need for Western State Hospital to maintain its current capacity of 647 civil beds, and to possibly add an additional 30-bed ward to respond to heightened public safety concerns. Washington State cannot afford to fall further behind with regard to capacity. Below are nine potential reform concepts that policymakers should consider in their examination of how the State of Washington deals with violent mentally ill offenders and the current intersections of mental illness and criminal justice:

The DMIO Program and Supervision Tools

The supervision of an inmate released to the community under the DMIO (or new acronym CIAP) program ranks among the most difficult and precarious jobs given to state employees. The Community Corrections Officers (CCO) in the James Williams case were remarkable public servants, dedicated and ingenious. They appear to have used all of the tools at their disposal to both get help for Mr. Williams and to protect the community:

- Administrative sanctions for violations of sentence conditions;
- New criminal charges, for threats against a mental health caseworker;
- Attempted involuntary commitment through the civil Involuntary Treatment Act (ITA) process.

The CCOs used each of these available tools. The question is: Were the tools in their toolbox the right ones?

Our view is that a mentally ill offender who has been convicted of a violent crime, served his time in prison, and is released to the streets under the DMIO program is situated much differently than a mentally ill person with no criminal history.

If a Dangerous Mentally Ill Offender under DOC (Department of Corrections) supervision is showing symptoms of decompensation, and the CCO is concerned about a risk to public safety, there should be adequate tools that grant the CCO the authority to quickly remove the offender from the streets and into a secure setting where treatment and stabilization can occur. The current tools available to CCOs who supervise Dangerous Mentally Ill Offenders are ineffective for these reasons:

- Administrative Sanctions for Sentence Violation: The 60-day jail sentence for sentence condition violations does not provide treatment. Instead, it offers only a short period of incarceration, during which the offender often further decompensates.
- New Criminal Charges: The conduct causing concern to the supervising CCO might not constitute a new crime. For example, the concerning conduct might be general

statements of homicidal intent, for which there is often no corresponding or appropriate criminal charge. Even if the offender can be charged with new crimes, this option does not automatically result in necessary treatment or stabilization.

- The Civil ITA Option: The due process oriented system of the ITA courts stands as an important safeguard against government abuse of the involuntary commitment law. It does not, however, make sense for a violent offender already under criminal jurisdiction.

As a practical matter, "boarding" such a person in an unsecure hospital emergency room puts many people at risk, and in many cases, does not provide the environment necessary for stabilization.

The threshold for commitment, designed to protect law-abiding citizens experiencing mental health issues, may be higher than is necessary for dangerous mentally ill offenders.

Here are some proposals policymakers should consider in determining whether additional tools should be available to those dealing with Dangerous Mentally Ill Offenders:

1. One proposal is to allow DOC the authority to remove DMIO/CIAP-designated offenders the streets to a secure treatment facility within DOC jurisdiction. The CCO should be able to arrest and hold the offender and offer treatment whenever the CCO believes public safety is at risk. Additional criminal jurisdiction may be necessary in order to permit a CCO to supervise such offenders in the community, and revoke community placement quickly. These Dangerous Mentally Ill Offenders are simply not appropriate for the ITA process.
2. For other, non-DMIO/CIAP offenders who are under DOC supervision, it may be appropriate to have those individuals who are found to meet the standards for involuntary civil commitment skip the current statutorily-required 72-hour and 14-day local commitments (eliminating the need to hold them in hospital ER beds) and instead be returned to DOC or sent to a secure DSHS facility for further 90 and 180-day periods of evaluation, treatment and stabilization.
3. Another proposal is to create an outpatient civil commitment program for Dangerous Mentally Ill Offenders over whom the DOC supervision has elapsed. Under this approach, a person with a demonstrated history of criminal convictions for crimes of violence and mental illness and who is no longer on active DOC supervision, but still presents a substantial likelihood to commit further violent acts, could be civilly committed to an intensive outpatient treatment and supervision program. The threshold for commitment would be lower than the present ITA commitment standards for non-offending citizens.

Outpatient commitment could also be initiated prior to release from prison, or following commission of a recent overt act in the community. Outpatient commitment would

continue until a court determines that the person no longer presents a substantial risk of danger to the community. If outpatient commitment was not working and the person presented a risk of danger to the community, the person could then be referred for the civil commitment under the ITA process.

Determinant-Plus Sentencing Enhancement Option

4. Another proposal would be to add a *Determinant-Plus* sentencing enhancement for violent mentally ill offenders. Although most individuals with a mental illness are not violent, and most violent offenders are not mentally ill, a subset of mentally ill offenders present a continuing and persistent danger to community safety.

Under a determinant-plus sentencing enhancement approach, a person would first need to be convicted of a violent crime in accord with current criminal procedures, including the opportunity to claim insanity or diminished capacity. Following the conviction, the same jury would determine whether the offender's mental condition was a substantial factor in the commission of the crime and whether the offender presented a substantial likelihood of re-offense due to this mental condition.

If the jury agreed with this special allegation, the offender would be sentenced to both a standard range and a maximum term. Upon completion of the standard range, the offender's release prior to the maximum term would be within the discretion of the Indeterminate Sentence Review Board (ISRB), just as we do with sex offenders under current law. If the ISRB determined that the offender's mental condition allowed release consistent with community safety, the released offender would face lifetime supervision. A classification system should also be created to assign a risk level to offenders subject to this sentencing structure.

This approach would give DOC maximum flexibility over offenders under this sentence. It would be more expensive than the current system.

SVP-Type Commitment Option

5. The legislature could also create a civil commitment law for violent or dangerous mentally ill offenders that more closely resemble our state's Sexually Violent Predator (SVP) commitment laws. This approach would recognize that certain dangerous mentally ill offenders have long-term conditions that may be best addressed in an institutional setting.

A civil commitment model that focuses on dangerously mentally ill offenders could be designed to include a relatively short stay in a mental health facility, then release to a less-restrictive alternative. This approach would address the long-term need for mental health services and avoid current problems where defendants are released from prison to environments where mental health treatment and medications become voluntary or are difficult to enforce. Because it provides the most cautious approach to release, it would be the most expensive model.

Criminal Competency Changes

6. Another proposal would be to authorize and require certain defendants to remain at Western State Hospital (WSH) after their competency has been restored and while they are awaiting trial.

In State vs. Leemah Carneh, the defendant is charged with killing Josie Peterson, her boyfriend Taelor Marks, and Josie's grandparents, Richard and Jane Larson. The crime occurred in March, 2001. However, to this date, seven and a-half years later, the defendant has not been brought to trial. Mental health issues have affected the defendant's competency to stand trial. Yet, this is not a situation where the defendant can never be made competent. Mental health professionals at Western State Hospital *have* been able to make Carneh competent. However, he loses competency quickly once he has been released from WSH and returned to jail, where he refuses to take medications.

WSH believes it is not authorized to hold a defendant pending trial, even though that would be the best way to maintain the defendant's competency until a trial can be completed. This pattern of having to continually restore the defendant's competency has caused years of delay in bringing this case to trial.

In certain serious cases, it is appropriate for the defendant to remain at a state hospital in order to ensure that the defendant remains competent while awaiting trial so that justice and finality in the case can be achieved.

On a related note, when criminal charges are the impetus for finding an offender incompetent to stand trial and this finding leads to ITA commitment, state hospitals should be required to periodically re-evaluate the offender's competency. Currently, the only way to trigger a re-evaluation of the offender's competency is to re-file criminal charges. Hospitals do not currently share information with prosecutors regarding the status of these offenders. Instead, prosecutors must periodically re-file criminal charges to trigger a re-evaluation of the offender's competency.

"Guilty, But Mentally Ill"

7. Thirteen states offer a "Guilty, But Mentally Ill" (GBMI) or "Guilty, But Insane" (GBI) option to juries, in conjunction with their "Not Guilty By Reason of Insanity" standard. Various models of GBMI/GBI allow defendants to be found criminally liable for their violent acts, but be sentenced to either a psychiatric treatment facility or a specialized treatment program within a corrections institution for all or part of their criminal sentence.

GBMI/GBI findings provide offenders specialized treatment, but also protect public safety by ensuring offenders receive significant commitments in a secure facility. GBMI/GBI findings also typically impose increased supervision for offenders after their release.

Decades ago, it could be predicted that an offender found "Not Guilty By Reason of Insanity" (NGRI) would spend as long at Western State Hospital as they would in prison for their crime. However, recent advancements in the effectiveness of psychotropic drugs have allowed the mental health system to stabilize criminally insane offenders in a relatively short period of time. This has led to the community release of some offenders who have committed murder after only a few years of treatment. Here are two recent examples from King County:

In State v. Thomas Gergen, the defendant was charged with Murder in the First Degree and Manslaughter in the First Degree for fatally shooting his pregnant wife and killing their unborn child in January 2003. At the time of the crime, the defendant also shot himself in the jaw. He was found Not Guilty by Reason of Insanity, and was committed to Western State Hospital in February 25, 2004. In just over two years, in October, 2006, the defendant was allowed to leave the state hospital to work and socialize in the community. In just over five years from the murder of his wife and unborn child, the defendant, at Western State Hospital's recommendation and with the court's approval, was released from Western State Hospital and allowed to move into a residence in the Bellevue area.

In State v. Pamela Mills, the defendant was the caretaker of her elderly parents, Charles and Viola Mills, whom she stabbed to death on December 1, 2002. Mills was charged with two counts of Murder in the First Degree, and found Not Guilty by Reason of Insanity. She was committed to Western State Hospital on July 1, 2004. A little over two years later, in November, 2006, the defendant was allowed to leave the hospital to work and socialize in the community. She was released from Western State Hospital and allowed to live in the community in May, 2008, after less than four years of commitment for killing her parents. The Gergen and Mills cases are just two examples where defendants are released back into the community within a very short time after committing murder. Most members of the public would be shocked to learn that those deemed NGRI do not receive long-term, inpatient mental health treatment in a secure environment. While an increase in the types and effectiveness in psychotropic medication has led to an increase in patient functionality, it has also greatly reduced the amount of time violent offenders spend in a secure facility. It seems grossly inadequate to victims and their families that murderers are allowed to walk free so shortly after being declared criminally insane and unaccountable for their crimes. Creating a GBMI option in Washington would allow defendants to be treated for their mental illness, but would still impose a sentence commensurate with the criminal conduct. Used in conjunction with NGRI, a GBMI option would give juries a way to recognize that mental illness played a contributing factor in an offender's crime, without completely excusing accountability.

Other Proposals

8. Allow information relating to civil commitments under ITA to be used in determining bail and making release decisions in criminal cases. The potential dangerousness of a defendant is an important consideration for prosecutors in determining how much bail to seek, and for judges who determine whether bail should be

imposed or whether the defendant should be released on personal recognizance. Information relating to a defendant's civil commitment history can be highly relevant in determining risk to public safety, and this information should be allowed to be used for these purposes. Disclosure of this information would not necessarily lead to higher bail amount because this information could also potentially reveal that a defendant who suffers from mental illness does not pose a danger to the public.

9. Create a 180-Day Less-Restrictive Alternative Option in civil commitment proceedings for persons who have previously been found Not Guilty by Reason of Insanity. Some persons who have been found Not Guilty by Reason of Insanity have their supervision by the court terminated, either because the maximum term of supervision has expired, or they have demonstrated an extended period of non-symptomatic behavior and appear to have their mental illness under control. Should these persons later decompensate or otherwise become subject to a civil commitment proceeding, any less-restrictive alternative ordered during the ITA process should last 180 days, with an in-patient commitment of the remainder of the 180-days if they are unable to follow the order or decompensate. Given that they have in the past committed criminal acts due to their mental illness, a full six months of court-ordered out-patient treatment is warranted.

Reform in this arena must begin with the recognition of the complexity of the issues, and the inherent tension between mental health treatment and public safety. The success of policy changes will depend on building sufficient additional capacity for treatment beds within DOC, DSHS, local emergency and treatment facilities, and community outpatient programs. It will cost money, but to invest nothing and hope for better results from the system is not a realistic expectation.

Appendix A-10

Memorandum from

Captain Scott Strathy
King County Sheriff's Office.



Memorandum

Date: October 31, 2008

To: Dan Satterberg, King County
Prosecuting
Attorney

Via: Direct

From: Captain Scott D. Strathy, King County Sheriff's Office

Re: SHANNON HARPS WORKGROUP - RECOMMENDATIONS

"He was a walking time bomb."

- Chief Deputy Dean Byrd, Mason County Sheriff's Office, describing Shawn Roe, suspected of killing Richard Ziegler and Forest Service Officer Kristine Fairbanks.

"The cops knew him well."

"Our office is stunned... we did not see this coming."

- Comments of DMIO workgroup participants referring to Isaac Zamora, suspected of killing Skagit County Sheriff's Deputy Anne Jackson and five civilians.

"He killed his mom, threatened politicians, threatened to kill his dad, threatened officers of the law, then comes out here... it would have been nice if they would have contacted us."

- Comments of Pierce County Sheriff's Deputy Ed Troyer referring to Daniel Tavares Jr. and addressing the lack of communication between Massachusetts police, the Washington State Patrol and the Pierce County Sheriff's Office after the shooting death of Brian and Beverly Mauck in Graham

These quotes, associated with three recent Washington State tragedies, highlight the concerns shared statewide by local law enforcement professionals in dealing with violent mentally ill offenders and offenders who make serious threats to harm others. Repeatedly we see some combination of a similar scenario played out; clearly troubled individuals, often on law enforcement's radar screen, living in and moving about our communities. Family members, neighbors, friends, and work associates begin to see the individual's behavior inhibitors dissipate. Mental health issues such as delusional, controlling, or paranoid behavior become more recognizable. This is sometimes coupled with substance abuse or the discontinuance of prescribed medication. Some of these individuals become quick to anger or behave irrationally. In the cases that result in violent behavior, the same question is always asked with the benefit of 20/20 hindsight:

"Why wasn't something done to prevent this tragedy?"

As we have learned from our work group's discussions, individuals officially designated as Dangerous Mentally Ill Offenders commit a very small percentage of overall violent crime. Although not a perfect system, as evidenced by the murder of Shannon Harps, the Department of Corrections clearly understand the magnitude of its DMIO responsibility and recognizes the need to vigorously monitor the individuals in the program. In King County, most DMIOs live within the city limits of Seattle. As a result, the Seattle Police Department and the DOC have developed a close working relationship to assist each other in monitoring resident DMIO program participants. From what I have observed at the work group meetings, I have no doubt that the DOC will take the lessons learned from the Harps murder very seriously and will pursue appropriate changes to further heighten the accountability of DMIO program participants.

However, the DMIO system cannot solve the greater problem of violent mentally ill offenders and offenders who make threats to harm. What lessons have we learned by studying the Harps murder case that can assist the greater community of Washington State Law Enforcement agencies deal with these issues? Are there relationships that need to be formed, resources that need to be procured, training that must take place? How can local law enforcement be better equipped to recognize and address individuals in their own communities that might be moving towards committing a violent offense. How do we move towards preventing the violent events committed by violent mentally ill offenders and offenders who make threats to harm who fall outside the DMIO program, but whose violent behavior is escalating to the point where they pose a real threat to community safety?

Here are some of my thoughts and recommendations on these important issues:

- *Overt threats and threatening behavior must tracked and assessed.* When local law enforcement officers encounter individuals that have threatened violence, they must have the tools available to them to properly document and route pertinent information. Protocols should be established to conduct risk assessments of those making threats to harm in order to assess their dangerousness. Both Isaac Zamora (the man charged with killing Deputy Jackson in Skagit County) and Shawn Roe (the man accused of killing Forest Service Officer Kristine Fairbanks) were both apparently well known to local law enforcement. Would the routine use of a risk assessment tool by local or regional law enforcement been helpful in identifying Zamora and Roe's escalation towards violent events? It may be time for local law enforcement and the behavioral science community to join forces to share perspectives and develop an expertise that can give constructive guidance to law enforcement officers who must deal with these individuals in their communities. Law enforcement could develop sound, scientifically based risk assessment tools which would assist them in evaluating dangerousness. When a threats case came to the attention of patrol officers or detectives, they could refer the case to these law enforcement specialists for a formal assessment. In the event of arrest and charging, this information could be provided to the court for the purpose of bail recommendations and conditions of release.
- *Communication and protective intelligence sharing barriers must be broken down.* – Information must be shared in order to be useful. Our front line officers and deputies should have immediate access to risk management information when confronting potentially violent individuals in our communities. This is a matter of both public safety and officer safety. Knowing all you can about *who* you may confront in a violent event is the first step towards developing a police response strategy that minimizes risk to all our community members. There appears to be a general misunderstanding of HIPAA and other privacy protection laws among local law enforcement. Law enforcement officers fear violating the privacy rights of individuals that may have histories of substance abuse, mental illness, and competency evaluations. We are often reluctant to seek the very information that may assist us in peacefully resolving or avoiding a violent incident. There must be a clear understanding as to what information is routinely available to law enforcement for "protective intelligence." Technological information sharing systems must be developed and/or improved.

- Encourage cooperative efforts between State and Local Law Enforcement and DOC.*— There are excellent examples of State and Local Law Enforcement working together to identify and track potentially violent individuals, and there are examples of complete breakdowns in communication. Both the King County Sheriff's Office and the Seattle Police Department are engaged in on-going programs that bring state and locals agencies together to work for a common cause. These cooperative relationships must be further encouraged to promote the sharing of protective intelligence. An example of a breakdown in communication occurred with the release of Daniel Tavares Jr., an offender who killed his mother, threatened to kill law enforcement and other officials, and relocated in Pierce County. Tavares killed a young couple who lived next door in a senseless rampage. Had there been an efficient inter-agency communication process in place this terrible tragedy might have been prevented. Local law enforcement should have been informed of this offender's dangerous history and his threats to kill in order to adequately protect their community. Breaking down the communication silos that often exist between law enforcement agencies is critical to successfully monitoring threats to public safety. As a starting point, we should identify what formal and informal interagency cooperative agreements are in place now, and what gaps exist that need to be filled.
- Encourage cooperative efforts between Local Law Enforcement and the Mental Health Community.* - As first line responders, local law enforcement must be trained in a wide variety of aspects related to mental health and community safety. Our officers and deputies must be able to recognize the signs and stages of de-compensation and the potential movement towards a violent event. If signs of de-compensation are observed, what is the next step? To whom do we report? What is the proper course of action in dealing with someone who is 'off their meds?' Law Enforcement needs to be aware of and understand the sensitive and unpredictable relationship between drug and alcohol abuse and mental illness. Law enforcement needs to be given more guidance on the basics of involuntary commitment (RCW 71.05), including under what circumstances a referral needs to be made to this system, and what are the concrete steps to making a referral.

The Sheriff's Office appreciates the opportunity to participate in this workgroup. As you know, the issues discussed in this workgroup are of critical importance to law enforcement as we are on the front lines dealing with real life scenarios involving violent mentally ill offenders and threats every day. I am more than willing to continue working on these issues in the future, and I am hopeful that the efforts of this workgroup will result in some important changes on the ground.

Thank you.

Cc: Sheriff Sue Rahr
Chief Carol Cummings
Major Dave Jutilla

Appendix A-11

E-mail from

Jo-Ellen Watson

King County Crisis and Commitment Services.

Rogers, Ethan

From: Watson, Jo-Ellen - King County Crisis and Commitment Services

Sent: Friday, October 31, 2008 11:07 AM

To: Rogers, Ethan; DMIO workgroup

Subject: Inpatient Capacity for DMIO Paper

Importance: High

Attachments: Boarding Information Sheet - July 2008.doc

Since 2004, King County and other Washington State Counties have been experiencing a severe shortage of in-patient psychiatric beds (E&T beds) for detained patients. This shortage has resulted in a phenomena referred to as "boarding." When a patient is "boarded," the patient is detained by a DMHP but remains at a hospital emergency department or medical unit awaiting an in-patient bed to open up at an Evaluation and Treatment facility. DSHS grants a "one-bed certification" to the hospital boarding the patient to allow the ITA detention to continue. The patient remains the boarding hospital's responsibility.

The boarding problem has reached critical proportions. In 2008, King County Crisis and Commitment Services has boarded an average of 64 patients each month representing all age ranges. The average days from detention to appropriate placement is 1.4 days, but some patients have remained in non- E&T facilities for 14 days or longer. Every hospital emergency department and many in-patient medical units in King County have been in the position of caring for boarded patients. Emergency departments are not appropriate settings, are not secure, and are not well prepared to treat individuals who are detained and are awaiting an appropriate placement.

Any changes resulting in the expansion of our commitment laws must take into account the lack of inpatient capacity and the complexity of patient care, specifically in this sub-population of mentally ill persons with a history of violence.

For a more detailed explanation of boarding please see the attached information sheet that KC CCS leaves at a hospital each time a detained patient is boarded in a non-Evaluation and Treatment Facility in King County.



**Mental Health, Chemical Abuse
and Dependency Services Division
Crisis and Commitment Services**

Department of
Community and Human Services

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BOARDED PATIENT

Information Sheet

GENERAL INFO:

King County Crisis and Commitment Services (CCS) attempts to place involuntarily detained patients in certified Evaluation and Treatment (E&T) beds in King County. However over the past few years a variety of factors have resulted in a severe shortage of inpatient beds for both voluntary and involuntary patients. When there are no E&T beds available in King County, DMHPs have no other choice but to send an individual detained in the community to the nearest emergency room. If the individual is already in a hospital setting, (i.e. ER, voluntary psychiatric unit or medical unit) the DMHP detains and leaves the patient in the referring facility. Crisis and Commitment staff immediately begin contacting our inpatient providers to work toward transferring the individual as soon as an appropriate bed is available. When these circumstances arise, the detained individual is referred to as a “boarded patient.”

We understand that you may not have experience with the involuntary treatment process or boarding a detained person. This information sheet was prepared to help you understand your responsibilities and authority as well as how CCS can be of assistance.

FREQUENTLY ASKED QUESTIONS:

Q: IF SOMEONE IS BOARDING IN MY FACILITY, WHAT KIND OF CARE CAN I PROVIDE ?

A: If you have a boarding, involuntarily detained person, you are authorized to provide psychiatric care as you deem necessary.

Q: CAN A PATIENT BE MADE TO TAKE MEDICATION?

A: Antipsychotic medication can be given to a patient against their will, though an attempt must be made to obtain their consent (RCW 71.05.215). If informed consent cannot be obtained, it should be documented in the patient record and then antipsychotic meds can be given under the following circumstances:

- The physician determines an emergency exists in which the patient presents an imminent likelihood of serious harm to self or others and there are no other medically acceptable or available alternatives.
- The physician must get a second opinion within 24 hours to justify the use of antipsychotic medication.
- Antipsychotic medication is designed for short-term treatment—if a failure to treat may result in a likelihood of serious harm or substantial deterioration or prolong the length of the hospitalization and there is no less intrusive treatment option.
- The patient has the right to refuse all psychiatric medications in the 24-hour period prior to the probable-cause hearing unless the criteria for involuntary antipsychotic administration are met. (See below). (RCW71.05.210).

- Documenting that the patient was informed of their right to refuse all psychiatric medications and whether or not that right was exercised. If a patient has indicated a refusal to accept medication and later agrees to take medication, there must be documentation in the patient medical record as to what was given and the time noted when the patient accepted the medication.

Q: WHAT ABOUT PHYSICAL RESTRAINTS?

A: Physical restraints and seclusion may be used according to your own policies to ensure safety of the patient and others in the facility (WAC 388-865-0845).

Q: CAN I GIVE MEDICAL TREATMENT?

A: You are expected to provide necessary medical care, although patients are assumed to be competent and have the right to refuse medical treatment for non-life threatening conditions.

Q: WHAT KIND OF ADDITIONAL DOCUMENTATION MUST I PROVIDE?

A: The patient must be seen daily and charted on by a mental health professional as defined in RCW 71.05.020(25). If you do not have one on staff, please let us know, and we will have our staff assist.

Q: CAN I DISCHARGE A PATIENT WHO IS ON A 72-HOUR MENTAL HEALTH HOLD?

A: If the patient's condition improves prior to the 72-hour hearing and your professional staff believes they no longer present a substantial risk or are not gravely disabled, you may discharge the patient (RCW 71.05.210). You may also choose to transfer the patient to a voluntary inpatient unit. If you choose to exercise these options, please notify our office of the changes.

Q: WHAT SUPPORT CAN WE EXPECT FROM CRISIS AND COMMITMENT SERVICES?

A: We will try to move the person as soon as an appropriate bed opens in a certified Evaluation and Treatment facility.

- It is our practice to have a supervisor or designee stay in close contact with you until the patient is transferred. This begins the morning of the first business day after the person is boarded and will occur at least once daily until the patient is moved. We will be asking questions to learn about the patient's level of control and any care needs that may have a bearing on the most appropriate placement.
- A Crisis and Commitment Services supervisor is available by phone or pager to assist with any issues or concerns that arise. Please call (206) 384-5805 Monday - Friday, between 8:30 am and 4:30 pm if you wish to speak with the supervisor.

Q: WILL THE PATIENT'S ATTORNEY VISIT THEM?

A: When your hospital is boarding an ITA patient, expect to have a public defender visit the patient. The attorney will need to have a confidential conversation with the patient and will want access to the patient's chart to read and possibly copy it.

Q: WHAT IF THE PATIENT CAN'T BE PLACED IN 72 HOURS?

A: There are times when a placement is not available for the entire 72-hour hold. Within twenty four hours prior to the end of the 72 hour, a court evaluator or DMHP acting as a court evaluator, will see the patient in preparation for the patient's probable-cause court hearing. If a petition for further treatment is written by a court evaluator, the statute requires a physician's signature on the petition. This means that one of your physicians will be asked to meet with the patient, review and co-sign the petition. The court evaluator will act as the witness in court. At the probable-cause hearing there will be a review of the circumstances leading up to the initial detention of the person and whether the individual requires further court-ordered mental health treatment. In most cases, your staff would not be testify, **however, a copy of the patient's chart must go with the patient to the probable-cause hearing.** You also have access to advice or counsel from the ITA Prosecuting Attorney, who will act as the hospital representative at court. If you would like to talk to a Prosecutor about the probable-cause hearing, please call 206-296-8936.

At the probable-cause hearing, if the person is committed for up to an additional 14 days of inpatient treatment, the patient will come back to your facility if there is not an appropriate E&T bed available to transfer. We will continue to make every effort to get the patient transferred as quickly as possible.

Appendix A-12

E-mail from

Trish Blanchard and Declan Wynne
Sound Mental Health

and

Jo-Ellen Watson and Michael Leake
King County Crisis and Commitment Services.

Rogers, Ethan

From: Blanchard, Trish; Wynne Declan - Sound Mental Health; Watson, Jo-Ellen; Leake, Mike - King County Crisis and Commitment Services

Sent: Friday, October 31, 2008 12:01 PM

To: Rogers, Ethan; DMIO workgroup

Subject: DMIO Workgroup Recommendations

Importance: High

The following recommendations were developed during a meeting involving representatives from Sound Mental Health's Community Integration Assistance Program (CIAP, formerly called DMIO), King County Crisis and Commitment Services, the Seattle Police Department's Crisis Intervention Team, and the Department of Correction's Special Needs Unit. The purpose of the meeting was to staff a specific problematic individual, but also resulted in the identification of recommendations that could be made to this workgroup.

These recommendations have been made in collaboration between Trish Blanchard and Jo-Ellen Watson and additional members of these groups.

1. There should be a consistent reminder to key stakeholders that there does not need to be a correlation between the predicate crime and mental illness for an offender to be designated a DMIO. This is unlike the similar "MIO Community Treatment Program (CTP)," created by SSB 6002.
2. For the DMIO statewide selection committee (which gives final approval of which inmates will be designated as DMIO) to make decisions, there needs to be validated documentation of crimes and mental health evaluations.
3. Referrals of DMIOs to RSNs and out-patient treatment agencies need to occur no less than 3-5 months prior to the earliest release date in order to provide adequate pre-release assessment and engagement services.
4. A pre-release assessment completed by CIAP/DMIO team should be made available to the office of the Designated Mental Health Professionals where the DMIO offender will reside. This assessment would include a psychological profile, behaviors exhibited while in prison, as well as a complete description and dates of each previous offense.
5. A Rapid Response Team should be developed in King County, consisting of one representative from CCS, SMH-CIAP, DOC-Special Offenders Unit, and Seattle CIT, in order to staff specific and emerging situations with this particular

sub-population of offenders. The purpose of the team would be to develop a cross-system crisis plan evaluating the needed response and determining which system best meets the community's and offender's needs: Civil Commitment, Criminal Justice (if a new crime committed), or revocation of community supervision. If successful and resources are available, the project could be expanded to other high-risk populations.

APPENDIX B

Glossary and Acronyms

Boarding – A patient detained for involuntary mental health treatment should receive that treatment at an Evaluation and Treatment facility. However, when a Designated Mental Health Professional takes the patient into custody to start that evaluation and treatment, the beds in the local E&T's are often full. When this occurs, the patient must be "boarded" in a hospital emergency room (psychiatric emergency room or otherwise) until a bed becomes available at an E&T. The boarding of a patient at an emergency room can last several days, even beyond the initial 72 hour detention period.

Case manager - An employee of an out-patient mental health treatment agency who helps a mental ill person arrange for their treatment and other needs, such as housing.

CCO - "Community Corrections Officer" - An employee of the Department of Corrections assigned to supervise offenders in the community, during the offender's period of post-incarceration supervision.

CIAP - "Community Integration Assistance Program" - The term DSHS uses to describe the general DMIO enhanced services program. It is also the name of a specific program of services provided to DMIOs living in King County. The program in King County is run by Sound Mental Health, an out-patient mental health service provider. If a DMIO living in King County participates in this program, up to \$10,000 in additional funding per year may be available to assist the DMIO's integration into the community. Currently, the funding is available for the first five years after a DMIO's release from prison.

Competency to stand trial - Relates to a person's ability to be tried in criminal courts. If, due to a mental illness, a person is unable to assist their attorney or is unable to understand the basics of the court process, they are not competent to stand trial.

District Court - A court of limited jurisdiction. District Courts are part of county government. Among other duties, District Courts handle most misdemeanor cases occurring in unincorporated parts of a county.

DMHP - "Designated Mental Health Professional" - This is a social worker, nurse, or other mental health professional who has been designated by a county government to investigate, evaluate, and determine whether a person in the community should be detained because the symptoms of a mental illness make the person a risk to themselves, others, or other's property. DMHPs have the authority to detain a person and are the only officials able to initiate a civil mental health commitment of a person in the community. In some counties, the DMHP is a county employee; in others, the DMHP works for a mental health treatment provider agency and has other duties. Up until a few years ago, the acronym was "CDMHP," with the "C" standing for "County."

DMIO - "Dangerously Mentally Ill Offender" - A designation applied to certain persons upon their release from prison, due to the existence of a mental disorder and a perceived risk for reoffending. The designation occurs when the Department of Corrections identifies and recommends that an inmate be so designated, and then a board consisting of representatives from DOC, DSHS, the Department of Developmental Disabilities, community mental health treatment providers, the Regional Support Network, law enforcement, and chemical dependency treatment providers approves the recommendation.

DOC - "Department of Corrections" - The part of Washington State government which oversees the state prison system. DOC also oversees the post-release supervision of offenders.

DSHS - "Department of Social and Health Services" - The part of Washington State government that, among many other duties, oversees mental health treatment at the state level. This includes managing many of the funding options for those with mental health issues who need public assistance. It also includes running the two state mental health hospitals, Western State Hospital and Eastern State Hospital.

E&T - "Evaluation and Treatment Facility" - A local mental health facility which can provide involuntary in-patient treatment at the local level under the Involuntary Treatment Act. An E&T can be part of a larger medical facility and consists of locked units. The statutory definition of Evaluation and Treatment Facility is found in RCW 71.05.020(16).

ESH - "Eastern State Hospital" - One of two state-run, long term, in-patient mental health treatment facilities for adults. It is located in Spokane County.

FACT - "Forensic Assertive Community Treatment" - This is a mental health services program which is usually a variation of a "PACT" team, and is targeted for clients who are often repeatedly jailed for reasons related to mental illness. The strategies used are similar to PACT teams, although CCOs or other professionals of the criminal justice system may be considered part of the team. The only FACT team of this type in Washington State is run by Sound Mental Health in King County.

Felony - In Washington State, a crime where the maximum punishment is greater than one year of confinement. Felony crimes are prosecuted in Superior Court.

Gross Misdemeanor - In Washington State, a crime where the maximum amount of jail time is over 90 days but no more than one year. Gross misdemeanors are usually prosecuted in Municipal or District Court, but can be heard in Superior Court. When used in a general sense, including in most instances in this report, the term "misdemeanor" is used to denote both Gross Misdemeanors and Misdemeanors.

HIPAA - "Health Insurance Portability and Accountability Act" - This is a federal law which, among other things, prohibits disclosure of a person's health information to others. While there are exceptions which allow for the providing of the information, there are also stiff fines if the information is disclosed improperly.

ITA - "Involuntary Treatment Act" - The set of Washington State laws through which a person may be civilly detained for involuntary mental health treatment, if they present a risk to themselves or others. For adults, the ITA is found in RCW 71.05. For juveniles, the ITA is found in RCW 71.34. Involuntary treatment under the ITA can include court-ordered out-patient treatment.

KC CCS - "King County Crisis and Commitment Services" - The agency in King County which employs DMHPs. It is part of the King County government and DMHPs in King County are county employees.

L.R.O. - "Less Restrictive Order" - Also known as a "Less Restrictive Alternative" (L.R.A.). This is an order issued by a judge in an ITA proceeding which requires a person to do out-patient mental health treatment. Failure to follow the order, or decompensation, can lead to DMHPs recommitting the person to an E&T.

MHAD - "Mental Health Advanced Directive" - This is a document by which a person, while in a compensated state of mental health, attempts to direct what mental health treatment they will receive should they decompensate.

MHC - "Mental Health Court" - This usually refers to a program offered by either a Municipal or District Court for people charged with misdemeanors who have mental health issues. This is part of criminal proceedings. By "opting-in" to the program and following its treatment requirements, the defendant receives a break in regards to the criminal charges. Less frequently in King County, it refers to the civil ITA proceedings in Superior Court.

MHD - "Mental Health Division" - This is a Division of DSHS. It oversees many components of mental health treatment and programs in Washington State, including the DMIO program (called CIAP by the Mental Health Division) and Eastern and Western State Hospitals.

MHP - "Mental Health Professional" - Generally, any psychiatrist, psychologist, ARNP, social worker, therapist or other professional who works with people with mental illness. An "MHP" should not be confused with a "DMHP."

Misdemeanor - When used in a general sense, including in most instances in this report, the term "misdemeanor" is used to denote all non-felony crimes, where the maximum amount of jail time is one year or less. Misdemeanors are further classified into Gross Misdemeanors and Misdemeanors. In Washington State, a crime is classified as a Misdemeanor if the maximum punishment is 90 days in jail or less. If the maximum punishment is more than 90 days but no more than one year, the crime is classified by statute as a Gross Misdemeanor. Most misdemeanor crimes are prosecuted in Municipal or District Court, but can be heard in Superior Court.

Municipal Court - A court of limited jurisdiction. It is part of city government. Among other duties, Municipal Courts handle most misdemeanor cases occurring within the city's boundaries.

NGRI - "Not Guilty by Reason of Insanity" - A plea in criminal cases where a person admits doing the acts constituting a crime, but claims that the effects of a mental disease or defect means they should not be held criminally responsible for their acts.

Offender - A person who commits acts constituting a crime and who are being held legally, if not criminally, responsible for it. Offenders include those found guilty of a crime and those found Not Guilty by Reason of Insanity.

OAA - "Offender Accountability Act" - The Offender Accountability Act is legislation which gives CCOs latitude in imposing conditions on those they supervise, and also allows certain violations of conditions to be handled administratively, rather than in a court proceeding.

PACT - "Program of Assertive Community Treatment" - This is an out-patient mental health service program designed to work with the highest users of mental health treatment services. The clients of PACT teams usually have the hardest time maintaining stability and are often incapable or unwilling to engage in treatment with more typical providers. PACT teams attempt to engage their clients in the clients' community settings, with some of the features of in-patient treatment brought to the client. There are ten PACT teams statewide, including two in King County. In some states, a "PACT" team is known as an "ACT" team.

PES - "Psychiatric Evaluation Specialist" - This is an employee who works at the King County Jail and evaluates inmates who appear to be showing symptoms of mental illness. While they work at the jail, Psychiatric Evaluation Specialists are employed by the Public Health Division of King County government. (n.B., while not used in this report, "PES" is also the acronym used for Harborview Medical Center's psychiatric emergency room - known as Psychiatric Emergency Services)

RSN - "Regional Support Network" - a single or multi-county based entity responsible for arranging mental health services for adults and children with mental illness who are eligible for public-assistance through programs such as Medicaid.

SMH - "Sound Mental Health" - An out-patient mental health treatment agency. It is one of 16 agencies in King County which contract with the Regional Support Network of King County to provide most of out-patient mental health treatment and case management in King County.

SOU - "Special Offender Unit" - This is a special residential center within the Department of Corrections. Inmates with the most severe symptoms of mental disorder are housed and treated at the SOU. The SOU is located at the DOC facility in Monroe, and houses about 400 inmates.

Special Needs Unit - A unit of Community Corrections Officers in King County assigned to supervise offenders with mental health issues. There are normally eight members on the unit. The caseload of a CCO on the Special Needs Unit consists of offenders who have been designated DMIO, offenders who have plead NGRI, and other offenders who have no special designation but have been referred to the unit due to the existence of mental illness.

SPD - "Seattle Police Department"

Superior Court - A court of general jurisdiction. Superior Courts are part of county government and are authorized to handle all criminal cases, including all felonies. Superior Courts also have jurisdiction over all civil mental health commitment cases under the ITA.

WSH - "Western State Hospital" - One of two state-run, long term, in-patient mental health treatment facilities for adults. It is located in Pierce County.

WSIPP - "Washington State Institute for Public Policy" - A state-sponsored, non-partisan research institute created by the state legislature to examine issues as directed by the legislature.

APPENDIX C

Legal Standards Related to Mental Illness

The extent to which a mental illness affects a person's actions and ability to understand what is going on around them can impact what happens to the person in court. Legal standards have been created to determine when the impact should occur. Some standards were created by the legislature, others by the courts. Here are some of those legal standards applicable in Washington State, and the impact they have in court when it is found that the standards are met.

1. Standards used in criminal prosecutions:

Competency:

Competency relates to the ability of the State to bring a defendant to trial.

Definition:

A defendant is incompetent to stand trial if, at the time the defendant is at court, and due to a mental illness, a person:

(1) is unable to understand the nature of the charges (also described as unable to have a rational as well as factual understanding of the court proceedings);

or

(2) is unable to assist in his defense.

Impact:

If a defendant is incompetent to stand trial *at the time they are before the court*, the criminal prosecution cannot proceed. The State may be allowed to treat a defendant to make them competent. If the defendant remains incompetent, the criminal case must be dismissed.

Diminished capacity:

Diminished capacity is a defense to criminal charges.

Definition:

Diminished capacity is an assertion that *at the time of the criminal acts*, and due to a mental condition (not amounting to insanity), the defendant did not possess the requisite mental state necessary to commit the crime charged. An example of a mental state is "intent," such as whether a person had the intent to cause the death of the victim.

Impact:

Once a defendant has exerted a diminished capacity defense, the State must prove beyond a reasonable doubt that the defendant did have the capacity to possess the mental state. If the defendant is successful in exerting a diminished capacity defense, the defendant is found Not Guilty of the charged crime.

Insanity:

Insanity is a defense to criminal charges.

Definition:

The definition of insanity is known as the M'Naughten rule. A person is legally insane if, at the time of the commission of the offense, and as a result of mental disease or defect, the mind of the defendant was affected to such an extent that:

(1) the defendant was unable to perceive the nature and quality of the act with which the defendant is charged;

or

(2) the defendant was unable to tell right from wrong with reference to the particular act charged.

Impact:

A defendant may assert as a defense to a crime that they were legally insane *at the time of the criminal acts*. Once asserted, the defendant has the burden to prove by a preponderance of the evidence that they were legally insane. If successful, the defendant is found Not Guilty by Reason of Insanity. A defendant found NGRI may be subject to hospitalization and supervision if the court believes that the defendant remains a risk in the community.

2. **Standards used in civil mental health commitment proceedings:**

Legal standards for civil detention:

Civil detention due to a mental disorder is based on the severity of the risk presented. These are the legal standards used during the initial stages of a civil mental health commitment. These standards are found in RCW 71.05.020, which is part of the Involuntary Treatment Act.

Definitions:

Likelihood of serious harm: A person presents a likelihood of serious harm if:

(a) they present a substantial risk that:

(i) Physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; or

(ii) physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm, and the behavior includes a "recent overt act"; or

(iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others;

OR

(b) the person has threatened the physical safety of another and has a history of one or more violent acts ("violent act" means behavior that resulted in homicide, attempted suicide, nonfatal injuries, or substantial damage to property);

Grave disability:

"Gravely disabled" means a condition in which a person, as a result of a mental disorder:

(a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or

(b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety;

Impact:

A Designated Mental Health Professional can place a person into a locked psychiatric treatment facility for up to 72 hours if, *at the time the DMHP sees the person*, that person either presents a likelihood of serious harm or is gravely disabled due to a mental disorder. If, *at the time of a court hearing* within those 72 hours, the person continues to presents a likelihood of serious harm or is gravely disabled due to a mental disorder, the court can order up to 14 more days of in-patient treatment. Detention beyond the 14 days can continue, first for 90 more days and then for successive periods of 180 more days, if the person meets legal standards different but closely related to the standards listed above. Two significant differences in the legal standards for longer detentions are that a person cannot be hospitalized for more than 14 days if they have only made threats prior to their hospitalization, and a person cannot be hospitalized for 180 days if they are only at risk for intentionally hurting themselves.

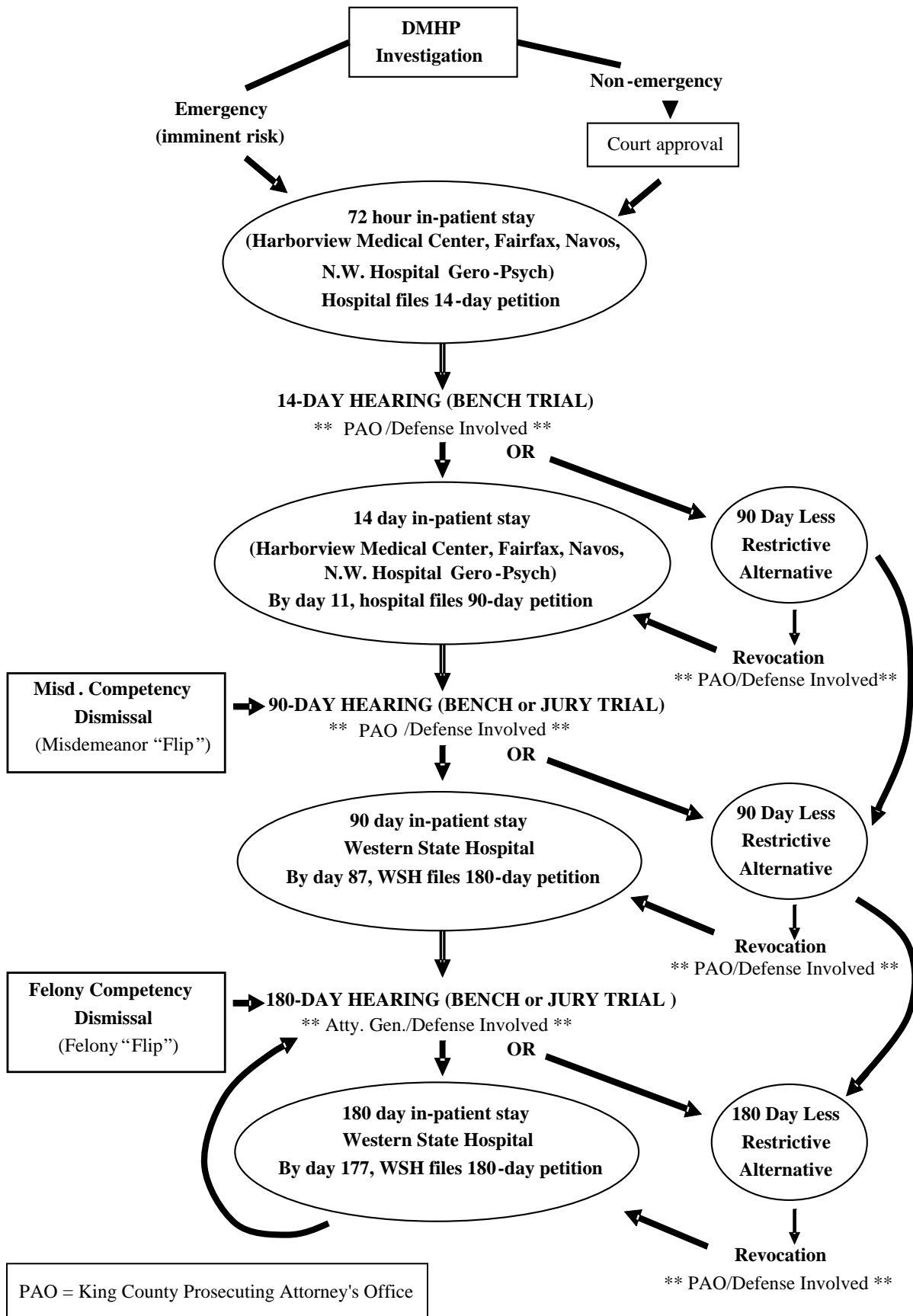
APPENDIX D

Involuntary Civil Mental Health Commitment (ITA) Caseflow in King County - Adults

FROM DMHP INVESTIGATION

TO

**LONG TERM (180-DAY) COMMITMENT
AT WESTERN STATE HOSPITAL**



APPENDIX E

A Primer of Mental Health System Components

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A. CIVIL MENTAL HEALTH SYSTEMS

1. The Involuntary Treatment Act and civil mental health court

The Involuntary Treatment Act is the set of laws which allow a person to be detained for mental health treatment through a civil legal action. The ITA is found in RCW 71.05 for adults and RCW 71.34 for juveniles.

Under the ITA, the existence of a mental disorder alone is not sufficient to justify an involuntary detention. The mental disorder must be having a substantial and adverse effect on a person's ability to control their actions, to the extent that the person presents a risk to themselves or others. These are the specific circumstances by which a person can be considered for involuntary hospitalization, assuming that the mental disorder led to the existence of the circumstance:

- if the person attempted to or actually harmed another person;
- if the person has committed a recent overt act which causes another person to be reasonably concerned for their safety;
- if the person has threatened another and has a provable history of violent acts;
- if the person has threatened or attempted to harm themselves or has actually harmed themselves;
- if the person has substantially damaged someone else's property;
- if the person is endangered because they are not caring for their basic needs such as eating, sleeping, clothing and shelter due to their mental disorder; or the person shows severe deterioration in functioning ability and is not receiving such essential care.

Under RCW 71.05, local officials known as Designated Mental Health Professionals, are assigned to conduct the investigation into whether someone should be involuntarily detained for mental health treatment. DMHPs are the only ones authorized to involuntarily detain individuals from the community who are a risk to themselves or others due to a mental disorder.

If the person evaluated appears appropriate for involuntary treatment, one of the following will happen:

1. If imminent risk exists, the DMHP will immediately detain the person.
2. If the risk is not imminent, the DMHP will petition the Superior Court for an order to detain the person. In this situation a judge reviews the evidence provided by the DMHP, and decides whether the person should be involuntarily hospitalized. If the court agrees with the DMHP, the judicial officer signs an order authorizing the DMHP to detain and hospitalize the individual.

Once the DMHP detains an individual, the DMHP places that person into local mental health hospitals defined as Evaluation and Treatment Facilities (E&T's). If the E&T

wishes to treat a patient for more than 72 hours, the E&T must file a petition with the Superior Court before the 72 hours expire. This petition requests fourteen days of additional treatment. By statute, the Prosecutor's Office is charged with representing the E&T's. The patient also is represented by an attorney, and a full evidentiary hearing can occur over whether the patient should remain hospitalized. The rules of evidence, including the rule prohibiting the introduction of hearsay as substantive evidence, apply. The E&T has the burden to prove by a preponderance of evidence that the patient presents a risk to themselves or others and that treatment cannot safely occur in an out-patient setting.

If a patient is detained, the E&T can later petition for 90 days of additional treatment. The grounds for a 90-day petition differ somewhat from the grounds for the initial or 14-day detention, and the burden of proof rises to a clear, cogent, and convincing evidence standard. A patient can contest a 90-day petition and can even request a jury trial on the issue. If a patient is detained as a result of a 90-day petition, the patient will be transferred to Western or Eastern State Hospitals, the long term in-patient mental health facilities in Washington State. If the state hospital believes detention beyond the 90 days is necessary, the hospital can petition for 180 days of further in-patient treatment. The Attorney General's Office represents the state hospital at the hearing for the 180 days of additional treatment. The state hospital can petition for additional 180 day periods of treatment, and can do so whenever the current period of treatment is about to expire, but 180 days is the longest period of treatment that can be sought in any one petition.

Throughout the ITA process, courts also have the authority to order a patient into out-patient mental health treatment, through what is known as a Less Restrictive Order. L.R.O.'s are used to compel a patient to remain in out-patient treatment and take their medication while in the community. Case managers with local out-patient mental health providers, such as Sound Mental Health, usually monitor patients on L.R.O.'s. Patients who are alleged to have violated the L.R.O. or to have decompensated can be placed back in an E&T by the DMHPs on a revocation petition, and that can also be the subject of litigation.

Treatment facilities, whether a local E&T or a state hospital, have the ability to administratively discharge a patient before the court-ordered treatment period expires. If a facility discharges a patient outright, the facility automatically ends the civil commitment proceedings without further court action. The facility can also decide to conditionally release a patient administratively, which has the same effect and ramifications of an L.R.O. The discharges and releases described in this paragraph occur solely at the treatment facility's discretion.

In King County, there are four adult Evaluation and Treatment Facilities that treat involuntary patients and file ITA petitions into King County Superior Court. The E&T's are Fairfax Hospital, Navos In-Patient Services (formally known as West Seattle Psychiatric Hospital), Harborview Medical Center, and the Gero-psychiatric Unit of Northwest Hospital. The E&T's in King County file about 2200 14-day petitions per year. There are 16 primary out-patient service provider agencies operating in King

County. These are the agencies which contract with the Regional Service Network to provide out-patient services. Most persons designated as DMIOs work with Sound Mental Health for out-patient services.

a. The interface between criminal competency and civil commitment

Referrals for civil commitment can also come through the criminal justice system. When a defendant is not competent to stand trial and they cannot be made competent, their criminal case will be dismissed. At that point, the criminal court will usually refer a defendant for civil commitment. Just because a defendant is incompetent to stand trial does not mean the defendant will necessarily be civilly committed, because, with one exception, the grounds for civil commitment are not legally connected to the grounds for determining competency to stand trial.

If the criminal charge was a felony, the defendant is sent directly to a state hospital, which has the ability to file a 180-day petition, avoiding the 72-hour, 14-day, and 90-day stages. The grounds on which a defendant can be committed in this manner include the defendant is incompetent to stand trial and may commit similar criminal acts (this is the one exception where criminal competency and the grounds for civil commitment are legally connected). In King County, if the criminal charge was a misdemeanor and the crime was serious enough, the defendant will also be sent to WSH where WSH has the ability to file a 90-day petition, avoiding the 72-hour and 14-day stages. If the criminal charge was a misdemeanor and not as serious, the misdemeanor court will make a referral to the King County DMHPs, who will evaluate the defendant and decide whether there are grounds to detain to an E&T for an initial 72-hour hold.

WSH professionals and DMHPs must do their evaluations using the legal grounds for civil commitment, and cannot commit just based on the competency dismissal. For example, a defendant may not be competent to stand trial on a criminal trespass charge and it is clear they have a mental disorder. However, if it cannot be shown that they are not providing for food, clothing, and shelter, they are neither gravely disabled nor presenting a likelihood of serious harm, and would not be detained.

2. Designated Mental Health Professionals

In King County, all Designated Mental Health Professionals work for the county and are part of an agency known as King County Crisis and Commitment Services (KC CCS). KC CCS is a part of the Mental Health, Chemical Abuse and Dependency Services Division of the King County Department of Community and Human Services. The work of KC CCS is a component of the King County Regional Support Network. The duties of KC CCS include evaluating people with mental disorders for possible involuntary detention in psychiatric facilities according to the Involuntary Treatment Act. In addition to detaining persons under the ITA, DMHPs are responsible for all initial crisis outreach services for persons in King County who are not currently enrolled with an out-patient service provider. The services of KC CCS are available 24 hours a day.

KC CCS DMHPs usually first try to guide a person they contact to voluntary programs. DMHPs do not detain due to mental disorder alone, and must explore less restrictive options to detention first. If a person refuses all voluntary help, the person may be appropriate for involuntary treatment. If a DMHP determines that the person evaluated is appropriate for involuntary treatment, they will either detain immediately or petition the court for an order to detain, depending on whether the existing risk is imminent or not.

Once the person is detained, the DMHP will arrange for the person to be sent to a certified Evaluation and Treatment Facility. As noted earlier, the facilities in King County for adults are Harborview Medical Center, Navos In-Patient Services (formally West Seattle Psychiatric Hospital), Northwest Hospital Geriatric-psychiatric Unit, and Fairfax Hospital. The inpatient care is for an initial period of 72 hours.

3. The Regional Support Network and out-patient services providers

Washington State's current civil mental health system structure originated out of a reform effort which began in 1989. Legislation enacted in 1989 shifted responsibility and accountability for services from state agencies to county-based entities called Regional Support Networks (RSNs). Through legislative mandate and/or a contractual agreement with the State of Washington, an RSN is responsible for arranging services and supports for adults with severe and persistent mental illness and children with severe emotional disturbances who are eligible for services through public-assistance programs such as Medicaid. Most RSNs consist of several counties. King County is populous enough to be an RSN in and of itself. The King County RSN was established in 1990 and is managed by the Mental Health, Chemical Abuse and Dependency Services Division of the King County Department of Community and Human Services.

A second phase of mental health reform occurred in 1995 with the implementation of the Medicaid managed care system for outpatient health services. The King County RSN began to deliver Medicaid services under this new structure in response to a federal waiver granted to the state to establish regionalized administration of the Medicaid program. This managed care structure is designed to increase access to care, client satisfaction, administrative efficiency, and create greater accountability for outcomes and quality. To receive Medicaid services through an RSN, a person must have a covered mental illness diagnosis, have a functional impairment measured by a standard functioning protocol, and in some cases have additional risk factors.

King County, through the RSN, offers a wide variety of mental health services to clients based on their individual needs. Mental health services are provided through a network of community mental health agencies that contract with the RSN. There are currently 16 agencies with whom the RSN primarily contracts with, and many other sub-contracting agencies. The network includes providers who specialize in certain areas of care. Services offered vary by provider but can include the following: 24-hour crisis response, interpreter services, brief interventions, case management, psychiatric and medical services, in-home services, employment/vocational services, homeless outreach and engagement, housing/residential services, day treatment, individual and group therapy, family therapy, psychiatric consultation to schools, medication management, cultural

consultations and culturally appropriate care, education and training opportunities, and consumer/advocate run services.

a. Sound Mental Health's CIAP program for DMIOs

One of the community mental health agencies is Sound Mental Health. Sound Mental Health has a specific program designed for defendants who are being released from prison and have been designated as Dangerous Mentally Ill Offenders. Although this program is for those convicted of felonies, the program is civil in nature and not part of the actual criminal system. The services that Sound Mental Health provides to DMIOs are part of the Regional Support Network's civil treatment structure. Sound Mental Health's program for DMIOs is known as the Community Integration Assistance Program (CIAP). The SMH staff assigned to this program only work with DMIOs, and they begin working with the DMIO three months before the DMIO's release from prison. The case manager to DMIO ratio is one to ten, which is a much smaller case manager to client ratio than most other programs. It is also a multi-disciplinary team approach, with chemical dependency treatment providers, Community Corrections Officers, and a Seattle Police liaison all considered part of the team. The medication prescriber, an ARNP, also works with far fewer patients than prescribers in other programs. The CIAP program is based on an intensive service model, with most DMIOs being seen at least once a day and sometimes multiple times per day as the client's condition warrants. The contacts occur both in the SMH office and at the DMIO's residence. The CIAP program also has easier to access housing options for the DMIOs, as SMH has agreements or partnerships with several housing providers, and SMH staff begins working on the housing issue even while the DMIO is still in prison.

B. CRIMINAL JUSTICE AND THE MENTALLY ILL - PRE-ADJUDICATION

1. The criminal courts and the basics of prosecution

A person who commits a crime will be prosecuted in Superior Court, District Court or Municipal Court. Felony crimes are prosecuted in Superior Court. Misdemeanor crimes are prosecuted in District or Municipal Court. Most criminal cases progress through the court system in the same manner. First, a case is investigated and put together by a law enforcement agency. Depending on the severity and location of the crime, the law enforcement agency will then refer the case to either the Prosecutor's Office (a county agency) or a City Attorney's office. Once a case has been referred, a county or city prosecutor will review the case for legal sufficiency and, following filing standards, will file the case into the appropriate court.

Once a case is filed, the defendant is arraigned. A defendant must plead guilty or not guilty at the initial arraignment, and most plead not guilty. If the defendant pleads not guilty, the case is set for a pre-trial hearing, and eventually may be set for a trial. While a case is in the pre-trial stage the prosecutor and defense attorney negotiate the case, review

the evidence, and discuss possible defenses the defendant may raise to the crime. At any point a defendant may decide to plead guilty. In doing so, the defendant is agreeing to admit guilt, or at least accept punishment, for the crime, usually in exchange for a specific recommendation from the prosecutor at sentencing.

If the case is not resolved before trial, the case is either tried before a jury of citizens (jury trial) or before a judge (bench trial). If a case goes to trial, a defendant may be found guilty or not guilty. If found not guilty the case is over and the court has no jurisdiction over the defendant. If found guilty, a judge will impose a sentence on the defendant. Punishment may involve imposition of some combination of incarceration (prison, jail, or a jail alternative such as work release or electronic home detention), community service, a fine, restitution, a period of supervision by the state Department of Corrections or county probation services, and certain affirmative treatment conditions such as substance abuse, mental health, anger management, or domestic violence treatment.

Below is a description of the courts in King County.

a. Superior Court

An adult defendant who is charged with a felony criminal offense as defined by the Revised Code of Washington will have his case prosecuted in King County Superior Court by the King County Prosecutor's Office. A felony offense is defined as any offense that carries a maximum of more than one year in jail. Felonies are divided into classes. A class A felony is punishable by up to life in prison, a class B felony is punishable by up to 10 years in prison, and a class C felony is punishable by up to 5 years in prison. The length of confinement time in a defendant's specific sentence on a felony case is determined by looking at the seriousness of the crime and the defendant's criminal history and locating the combination of those factors on a "sentencing grid" created by the Sentencing Reform Act. The judge in many cases also will impose a period of post-incarceration supervision. When under supervision, the defendant is in the community but must abide by certain conditions. A Community Corrections Officer from the Department of Corrections is assigned to monitor the defendant to make sure the defendant complies with the imposed conditions.

A defendant who violates the conditions of supervision can be put back in jail or prison. Depending upon when the original crime occurred, the violation will be reviewed either by a Superior Court judge or a DOC administrative officer. For each violation, a defendant could receive an additional sixty days of incarceration.

b. District and Municipal Courts

Misdemeanors and gross misdemeanors are crimes that carry lesser maximum punishment (up to one year in jail) than felonies. The term "misdemeanor" is often used to refer to both gross misdemeanors and misdemeanors, and that will be the practice here. Superior Courts have jurisdiction to hear misdemeanor cases. However, most

misdemeanors are filed in District and Municipal Courts. District and Municipal Courts cannot hear felony cases, and they are therefore called courts of "limited jurisdiction." A misdemeanor crime occurring in unincorporated King County will be filed into King County District Court, and the prosecution will be handled by the District Court Unit of the King County Prosecutor's office. A misdemeanor occurring within city limits will be filed into Municipal Court, and that city's City Attorney's office will prosecute the case. The City Attorney's office will also prosecute violations of that city's Municipal Code. No matter whether the misdemeanor is filed in District or Municipal court, the procedure from the commission of the crime through the finding of guilt is similar to the felony process described above.

The sentencing phase for a misdemeanor is quite different than for felonies. The District or Municipal Court Judge has complete discretion to impose as much confinement time as the judge feels appropriate, up to the maximum of one year (ninety days for some of the least serious crimes). The judge can also suspend part or all of a sentence or defer sentencing. If the judge suspends or defers the sentence, the judge can impose supervision and conditions of supervision for up to two years.

A defendant who violates the conditions of supervision on a misdemeanor charge can be brought back before a District or Municipal Court judge. As a sanction for violating supervision conditions, the judge can impose more jail time. The length of the sanction can be up to the time remaining from the original sentence.

2. Specialty criminal mental health courts for misdemeanors

Both King County District Court and Seattle Municipal Court have special divisions which are designed to handle misdemeanor defendants with mental illness. These criminal Mental Health Courts represent an effort to increase effective cooperation between two systems that have traditionally not worked closely together - the mental health treatment system and the criminal justice system. The primary goal of these courts is to improve public safety. In order to improve public safety, the mission of these courts is to achieve the following outcomes for the mentally ill misdemeanant population: faster case processing time, improved access to public mental health treatment services, improved well-being, and reduced recidivism.

Mental Health Courts are "opt-in" courts, which means the defendant can choose to "opt-in" and agree to the mental health court program, or the defendant can choose to "opt-out" and have their case prosecuted in regular criminal court. Mental Health Court offers misdemeanor defendants with mental illnesses a single point of contact with the court system. A team approach is used for each case, with the team including the judge, prosecutor, defender, treatment court liaison, and probation officers. The hallmarks of the program include:

- Defendants may be referred to the Mental Health Court from a variety of different sources. In-custody defendants are often referred by jail psychiatric staff who have screened for mental health issues. Defendants may also be

referred for consideration by police, attorneys, family members, or probation officers. A defendant may be referred by another District Court at any point during regular legal proceedings if the judge feels the defendant could be better served by the Mental Health Court. Some cases originally filed as felonies in Superior Court can, at the discretion of the King County Prosecutor's Office, be reduced or "dropped down" to misdemeanor charges and referred to the Mental Health Court of the District Court.

- The Mental Health Court reserves the right not to accept cases into its jurisdiction if a person does not meet eligibility criteria. Likewise, participation in the program is voluntary, as defendants will be asked to waive their rights to a trial on the merits of the case and enter into a diversion or plea agreement with a community-based treatment emphasis.
- A court liaison to the treatment community is present at all hearings and is responsible for linking the defendant with appropriate services developing an initial treatment plan with the treating agency.
- Defendants participate in court ordered treatment plans and successful participation may result in dismissed charges, early case closure, or reduced sentencing.
- Defendants are placed on probation and the case is assigned to a Mental Health Court Mental Health Specialist Probation Officer. These officers have mental health backgrounds and carry substantially reduced caseloads in order to be able to provide a more intensive level of supervision and expertise to this traditionally high-needs population.
- The Seattle Municipal Court has jurisdiction over all misdemeanor and gross misdemeanor offenses allegedly committed by adults within Seattle City limits that are referred by a City agency. The referring city agency is usually the Seattle Police Department, but other city agencies (e.g. Animal Control, Health, Revenue, etc.) refer cases, too. It also has jurisdiction over criminal traffic misdemeanor and gross misdemeanor offenses allegedly committed by teenagers 16 and older.

Any misdemeanor case where the competency of the defendant is raised is also filed into or transferred to Mental Health Court. If a person is treated and "restored" following a competency proceeding they then have the right to "opt-out" of the court.

3. Mental health services in the King County Jail

Most defendants who are arrested on either a new charge or detained on a probation violation will be booked into the King County Jail. Once booked, all defendants go through an extensive intake process. During the intake process, inmates are interviewed by corrections officers and a nurse. Inmates also complete an initial medical screening

form on which they may list any medical or mental health concerns. All health services provided in the jail, whether medical or psychiatric, are administered through King County Public Health, not the King County Department of Adult and Juvenile Detention. Nurses check inmates to make sure they have no outstanding medical concerns which are more serious than the jail's medical facilities can address. If an inmate's medical condition is such that they cannot be admitted to the jail, they are sent to a hospital until they are medically cleared for return to the jail.

Inmates with severe mental health issues, unlike those with strictly physical medical issues, are not sent anywhere for care but are admitted to jail. As a result, the King County Correctional Facility has developed a detailed mental health evaluation and triage process for inmates with possible mental health issues. Any inmate with possible mental health issues are evaluated by staff of Jail Health Services, Psychiatric Services, which is part of King County Public Health. This process usually starts when an inmate is sent to an area of the jail known as Psychiatric Receiving for evaluation. Through this triage process, the correctional staff attempts to identify, within 24 hours, those inmates that are mentally ill and in need of specialized services. Psychiatric Services staff also attempt, whenever possible, to gather mental health information on inmates from as many collateral sources as possible. Inmates sent to the jail psychiatric unit are seen within 24 hours by a Psychiatric Evaluation Specialist (PES). Once those inmates are identified, the PES makes a decision on the severity of the inmate's mental health condition and makes a recommendation about where an inmate should be housed within the jail. Then a treatment team reviews the housing decision after seeing the inmate the next day and makes a final housing recommendation.

A mentally ill inmate might go into one of four housing settings: (1) the Acute Unit; (2) the Sub-Acute Unit; (3) the Sheltered Housing Unit; or (4) General Population.¹⁴ Two themes are always present in the jail's housing process for inmates. First, universal suicide precautions are in place while the inmate's psychiatric needs are being assessed and any inmate who appears to be suicidal is closely watched and can be housed in isolation or group suicide prevention cells. In either setting, these inmates are on 15 minute watch to prevent any harm. Second, the jail always attempts to shift inmates to the least restrictive housing option possible. If an inmate's mental illness symptoms improve, the inmate will be moved to a lesser restrictive unit. When an inmate is in general population, if any mental health issue arises, the inmate will be referred or re-referred to psychiatric services for an evaluation and to redetermine appropriate housing status based upon the inmate's condition.

As part of caring for mentally ill inmates, the jail must not only decide how to house and protect these inmates but must also attempt to administer appropriate treatment to them. The goal is to improve the mentally ill inmate's symptoms, not just to warehouse the inmate or prevent harm. Mental health treatment in the jail focuses primarily on the administration of medications to the mentally ill. Psychiatric Services staff are able to convince well over 50% of inmates to take medications voluntarily. However, treatment

¹⁴ For a detailed description of these units please see the King County Correctional Facility-Jail Health Services Mental Health Evaluation and Triage Process flow chart at the end of this appendix.

can become limited because jail staff cannot force an inmate to take medication except in extremely rare circumstances.

Staff attempt to learn as much information about a mentally ill inmate as they can, including current courses of psychiatric medication. Staff works with the inmate to ensure the continuation of medications while the inmate is detained and also work on encouraging the inmate to take their medications. The jail treatment teams will evaluate each mentally ill inmate to determine the best regiment of medication for each individual. The treatment teams may change medications as medically indicated but they never attempt to move an inmate to less expensive medication. Instead, they will keep each inmate on the most appropriate medication even if that medication happens to be the most expensive. The other focus of the treatment team is helping mentally ill inmates with discharge planning once released. This includes trying to help the inmate with obtaining out-patient mental health services.

Psychiatric Services staff does what they can to treat mentally ill defendants while they are detained. Most would probably agree that jail is not a therapeutic setting for those with severe mental illness and ideally they would like to see more resources to treat these inmates elsewhere in the community. There is a strong sentiment that the jail should not be a de facto housing placement for the mentally ill. Psychiatric Services staff try to remain neutral on issues of guilt and innocence when treating inmates and prefer to see themselves as administering much-needed medical care to patients rather than administering criminal justice to inmates.

The jail staff will also make referrals to the DMHPs for civil commitment when they feel there are grounds. However, they mostly make these referrals on misdemeanor cases, or felony cases where the case is over, because the local psychiatric facilities are unlikely to accept inmates who are charged with felonies.

4. Defendants not competent to stand trial due to mental illness

A defendant must be competent to stand trial before they can be criminally prosecuted. A defendant is not competent to stand trial if the symptoms of their mental illness make the defendant unable to assist his attorney, or if the defendant is unable to understand the basics of court, such as the roles of the judge, prosecutor, their attorney, etc. It is a violation of the defendant's Constitutional rights to force the defendant to stand trial while incompetent. However, the State may be allowed to try to restore a defendant's competency so that they may stand trial. The process for restoration of competency includes providing the defendant with mental health treatment. If a defendant becomes competent through treatment, the case continues and the defendant must stand trial for the charges against him. If a defendant is not restored to competency, the criminal case will be dismissed and further mental health treatment may follow through the civil involuntary treatment process.

The issue of a defendant's competency is raised when a defendant's attorney, the prosecutor, or the judge articulates a reason to doubt the defendant's competency. Once a

question over the defendant's competency has been raised, the proceedings are suspended while the defendant is evaluated by a mental health expert, usually a psychologist from Western State Hospital. If the psychologist determines in their professional opinion that the defendant is incompetent, the criminal proceedings remain suspended while the issue of whether the defendant can be made to competent is explored. What happens to the criminal case of an incompetent defendant varies whether the charge is a felony or a misdemeanor.

If the criminal charge is a felony, the judge will send an incompetent defendant to Western State Hospital so that the mental health professionals there can treat the defendant and attempt to restore the defendant's competency. The initial period of in-patient treatment is 90 days. Depending upon the likelihood of success for restoration, the State can seek an additional 90 days and then an additional six months of treatment at WSH. This can include forced medications if the charge is serious enough. If competency is restored, the criminal prosecution will resume. If the defendant cannot be made competent, the judge must dismiss the case. When a felony case is dismissed because the defendant is not competent to stand trial, the defendant will be returned to WSH, where WSH can petition to initiate a civil mental health commitment under the civil Involuntary Treatment Act.

If the criminal charge is a misdemeanor, and the charge is defined by statute as "serious," an incompetent defendant will be sent to WSH to see if competency can be restored. However, on a misdemeanor charge, the period for restoration is significantly shorter and the maximum time for this commitment is 29 days. If competency is restored, the criminal prosecution will resume. If competency cannot be restored, the judge must dismiss the case. In this situation in King County, the defendant will be returned to WSH, where WSH can petition to initiate a civil mental health commitment under the ITA.

If the criminal charge is a misdemeanor, but the allegations do not rise to the level allowing for competency restoration, the criminal case must be dismissed. Contemporaneous with the dismissal, the judge may order the defendant to be detained for up to 72 hours to allow the local Designated Mental Health Professionals to examine the defendant for possible civil mental health commitment under the ITA.

Once a criminal case is dismissed because a defendant is not competent to stand trial, the judge no longer has any ability to supervise or impose conditions on the defendant. However, the dismissal is "without prejudice," meaning that the Prosecuting Attorney or City Attorney has the ability to refile charges when they deem it necessary and appropriate. Competency can still be an issue in any subsequent filing, and the same procedures for determining and restoring competency will be used.

C. **CRIMINAL JUSTICE AND THE MENTALLY ILL -
POST-ADJUDICATION**

1. **The Department of Corrections and the prison system**

When a defendant receives a sentence longer than 12 months, even if it is 12 months and one day, the defendant is committed to the custody of the Department of Corrections. DOC is Washington State's prison system, as well as the department which provides post-prison supervision of offenders. Each offender entering the DOC system starts their commitment by going through the reception center at Shelton Corrections Center. During the initial stop at Shelton's reception center, offenders are screened for both medical and mental health issues. Mental health professionals evaluate each offender to determine who has a need for mental health services. Once a mental health professional identifies an offender who is in need of mental health services, they look at the offender's diagnosis and whether the offender can be treated for his mental illness within the general population of DOC.

DOC must handle and treat all of its mentally ill offenders within the prison system. DOC does not contract with outside agencies for those services and may not rely on the services and facilities of any other system such as Western State or Eastern State Hospitals. Therefore, all mentally ill offenders are treated and managed exclusively by DOC staff and qualified mental health professionals who are part of the DOC staff. All in-patient and residential treatment programs for DOC offenders are operated solely by DOC.

As part of the initial evaluation, the mental health professionals determine whether an offender needs to be put on medication or whether the offender's current mental health medications must be continued. DOC also must determine whether an offender is so ill that he needs to be hospitalized.

If an offender is so ill that he must be hospitalized, DOC will transfer him to an acute in-patient setting within DOC. This setting is similar to a hospital setting for the mentally ill, but it is contained solely within DOC. The acute in-patient setting is staffed with medical professionals who have the credentials to assess and treat the mentally ill. Offenders are sent to the acute in-patient setting for stabilization of their condition and will remain there until their condition is stabilized. Once an individual is stabilized, he is evaluated to determine whether he is well enough to maintain appropriate behavior within the general population of the prison.

A number of mentally offenders within the DOC system can function fine within the normal prison population. If it is determined that an individual can return to the general population, he is returned there and referred to one of many "out-patient" mental health programs within DOC. Out-patient programs at the different DOC facilities offer defendants help with medication management and provide psycho-educational groups in which the defendant may participate. Psycho-educational groups help offenders learn to manage their mental illness and provide information on a host of issues relating to mental

illness including information on how to recognize and control things that triggers their mental illness.

If DOC mental health professionals determine that an offender is not stabilized enough to maintain appropriate behavior in the general prison population, that offender will be referred to a "residential" setting within the prison system. Residential settings provide more services and more protection for the most mentally ill offenders. There are three residential treatment centers within the DOC system. First is the Special Offender Unit (SOU) at Monroe Prison. The SOU is a self-contained residential treatment center and the largest within DOC. The SOU at Monroe houses about 400 offenders. Generally, the most severe mentally ill are housed within this center.

Second is the residential center at Walla Walla Prison. This unit resembles a cross between an in-patient setting and a residential setting because it is very small and contains only 14 to 16 beds. The unit is not self-contained. Finally, there is the residential center at McNeil Island Prison. This unit contains about 78 beds.

When DOC is attempting to place mentally ill offenders within the system, it must continuously balance the desire to place an offender in the least restrictive environment possible while at the same time ensuring the protection of the most vulnerable mentally ill offenders. Prison can be a very dangerous place for a mentally ill offender because of the high number of dangerous and predatory offenders within the system. These predatory offenders will often target the mentally ill within DOC, perhaps watching for times when a mentally ill offender receives a package or money from home and then taking advantage of the situation.

Likewise, mentally ill offenders can also present an extreme threat to the general population. Due to their significant mental illness, mentally ill offenders can be violent and unpredictable. It is exactly this unpredictability which causes concern and management issues for DOC. At times, offenders are paranoid and operating under delusions known only to the offender. Therefore, an offender could strike out at any time and for a reason known only to the offender. The reasons are most often not based in reality, but are merely products of the offender's mental illness. Because of the unpredictability of some mentally ill offenders within DOC, it is impossible to predict when they might act out. DOC must also consider this factor when deciding where to place a mentally ill offender.

Therefore, the three residential programs within DOC are structured to be better equipped for both protecting the mentally ill from other inmates in the general population and also for dealing with the often violent and unpredictable nature of a mentally ill offender. Residential programs have more staff and more resources to address and manage these issues.

Mental health professionals at DOC can seek to involuntarily medicate an inmate through an administrative process. They can do so on an emergency basis for up to 72 hours. If they wish to involuntarily medicate for a longer period of time, the treating psychiatrist

must make a written request and submit it to a special administrative committee. The initial request is for 14 days. The treating psychiatrist can then request an additional 180 days of involuntary medication, and repeat the request every 180 days. Each time a treating psychiatrist requests authorization or an extension of authorization for forced medication, the special administrative committee will hold a hearing and review the request. The inmate can contest whether involuntary medications are necessary and call or cross-examine witnesses. If a majority of the committee, including a psychiatrist who is not part of the treatment team, decides that the inmate is gravely disabled or constitutes a likelihood of serious harm to themselves, others, or property (these are terms which come from the civil Involuntary Treatment Act laws), medications can be administered involuntarily by the treatment team.

It is important to note that an offender's mental illness and placement in a mental health program at DOC, whether it is in-patient, residential treatment or outpatient, is independent of that offender's overall risk classification. All prison inmates, whether mentally ill or not, are assigned a classification based on their perceived level of risk. The risk level of an offender also dictates the type of facility in which he will be placed. Risk levels at DOC range from a 1 (lowest risk) to a 5 (highest risk). DOC must not only take into account an offender's mental illness when deciding where to place him but must also work with the offender's classification level. This complicates where an offender is placed because certain facilities only service offenders of certain risk levels. The highest risk level 5 is also known as Intensive Management Status. The SOU unit at Monroe serves offenders up to levels 3, 4 and 5 and is the largest in the system so it receives many of the most dangerous and difficult to manage of the mentally ill offenders.

The Washington State prison system tries to be progressive in managing and treating mentally ill offenders. All mentally ill offenders are given a continuum of care throughout their stay at DOC, and DOC always engages in very purposeful release plans for each and every mentally ill offender approaching their release dates. In fact, the release plans for mentally ill offenders are similar to discharge summaries for patients from hospitals. These release plans may do even more to help offenders plan for their release into the community. The release plans involve DOC staff, the offender, and community members. The plans are aimed at helping offenders transition to the community outside DOC. DOC helps set up appointments for treatment and care, sets up housing for offenders if possible, and helps offenders obtain all needed medication upon release.¹⁵

All mentally ill offenders, even those not designated as Dangerously Mentally Ill Offenders, are given detailed release plans. Offenders designated as DMIO may have additional funding to help pay for the DMIO's treatment and housing upon release. Unlike DMIO offenders who may receive some funding, other mentally ill offenders do not receive these funds and must rely on DSHS benefits and possibly housing or other resources provided by family or friends.

¹⁵ Williams went through this release planning phase, with DOC successfully cajoling Williams to go along with their plans, at least when he was first released.

Finally, DOC keeps very detailed logs of an offender's placement, classification, behavior and infractions while in the prison system. Because the offender is confined to a public prison, all information is public and there are no confidentiality restrictions on disclosure of that information. Therefore, anyone who requests such information is entitled to receive it. This includes information about whether an offender had been placed in SOU while in DOC custody. All DOC Community Corrections Officers have immediate access to the system which maintains logs of offender information and prison behavior.¹⁶ That access includes the ability to read narratives about each of an offender's infractions while in prison. While DOC does not specifically send this information to the State, the Court, the CCO, or the defendant's treatment providers upon release, anyone can get that information if they ask.

2. The Department of Corrections and community supervision

Whether, and under what conditions, an offender will be supervised in the community after they are released from prison has been a frequent subject of legislation over the years. As a result, while many offenders are subject to supervision in the community upon release, the official name of the supervision varies depending on when the defendant was sentenced and when the defendant is released. Official names include Community Custody, Community Placement, and Community Supervision, and the name can even change during the period of supervision. A bill, HB 2719, passed by the legislature this year acknowledges the resultant confusion and attempts to provide some clarity.

Most defendants who leave prison after serving time for violent offenses will be on some version of supervision while in the community. The length of supervision is determined by the nature of the crime, and if a defendant was released early, the amount of earned release time is added to the original amount of community supervision. Specific conditions of supervision may have been imposed by a judge. Since 2000, when the Offender Accountability Act (OAA) became effective, the Department of Correction decides most supervision conditions.

Every offender undergoing supervision is assigned a Community Corrections Officer. The CCO is a DOC employee responsible for monitoring the defendant while on supervision. The CCO has the ability to arrest and jail an offender who does not comply with conditions. The standard conditions of supervision include reporting to the CCO as directed, obtaining CCO approval of residence, engaging in work or schooling, no possession or use of alcohol, street drugs, or firearms, and no contact with the victim. Crime specific conditions, such as anger management or mental health treatment, can be imposed when connected to the crime. DOC also monitors whether the defendant is paying court ordered fees, fines, and restitution.

¹⁶ Specific treatment information may be considered confidential under HIPAA, and some information may be archived, impacting the speed with which information could be obtained.

When a defendant violates a condition of supervision, the defendant could be subjected to up to 60 days confinement per violation. A defendant has a right to a hearing before a sanction is imposed. If the defendant was sentenced pre-OAA, the hearing will be before a judge. If the sentence was post-OAA, the hearing will be an administrative hearing before a DOC hearing officer. Rather than arrest and a jail, a CCO may allow the defendant to enter into a stipulated agreement, wherein the defendant avoids jail by agreeing to additional conditions, such as going through in-patient chemical dependency treatment.

3. Dangerous Mentally Ill Offenders

In 1999, the Legislature attempted to address the issue of prison inmates who were both dangerous and mentally ill, but whose release into the community was unavoidable. To do so, the Legislature created the designation "Dangerous Mentally Ill Offender." The process to have an inmate designated DMIO begins about two years before the anticipated release date. A computer program uses an algorithm to identify all inmates who have mental illness. The case of every inmate identified by the computer program is then analyzed by DOC staff. When the staff decides that an inmate presents such a high risk to others due to mental illness so as to warrant a DMIO designation, they present the inmate to a board for further consideration and final approval of the DMIO designation. The board is made of professionals and includes representation from DOC, DSHS, the Department of Developmental Disabilities, community mental health treatment providers, the Regional Support Network, law enforcement, and chemical dependency treatment providers.

If the board approves of the DMIO designation, DSHS representatives begin to work with the defendant at least three months before the defendant's release. Their goal is to convince the DMIO to engage in out-patient treatment. The DMIO will also be assigned to a special unit for DOC supervision, if such a unit exists in the area where the DMIO will live. The DMIO will also be examined by DMHPs for possible civil commitment in the days before the DMIO's scheduled release into the community.

If the DMIO engages in out-patient mental health treatment after their prison release, their out-patient provider has the ability to tap into a source of extra funding. This funding averages about \$10,000 per year per engaged DMIO, and is in addition to any funding from other sources, such as Social Security. The extra funding is often used for housing, but has enough flexibility that it can be used for almost anything which will help keep a DMIO mentally stable, such as education or to help the DMIO remain employed.

Only those DMIOs who are engaged in mental health treatment are eligible for the extra funding. DSHS cannot obligate a person to engage in treatment, and therefore from the DSHS perspective, the extra funding is a voluntary program. However, DOC often has the ability to impose engaging in mental health treatment as a condition of supervision. This makes a DMIO's participation in the program mandatory from DOC's perspective, because a DMIO who does not participate can be arrested and subject to sanctions, including jail.

Presumably, additional attention and resources will lead to the DMIO being more psychiatrically stable, reducing recidivism and creating overall savings for the system. Early studies of the DMIO program, by David Lovell of the University of Washington and by Gregg Gagliardi and Polly Phipps of the Washington State Institute for Public Policy (WSIPP), bear this out.

These studies indicate that the DMIO program is successful in several areas. Over the first 18 months of release, DMIOs committed new crimes at a rate 19% lower than a similar group released before the program started. They also got into treatment sooner, (two weeks on average rather than six months), and stayed in treatment longer, with a 60% higher rate of defendants staying in treatment for at least nine months. DMIOs also tapped into additional funding sources sooner (in 26 days rather than 54 days), and more often (72% of DMIOs versus 41% of non-DMIOs). DMIOs were also in substance abuse treatment more often than the other group, 53% to 19%. The WSIPP study found that for every \$1.00 spent on DMIOs, \$1.24 is saved through reduced incarceration costs, prosecution costs, etc.

The extra funding for DMIOs is not a continuing resource. Currently, the extra funding is available for the first five years after the DMIOs release from prison. However, there has been discussion among officials to cut back the number of years the funding would be provided. Furthermore, in many parts of Washington State, the extra funding is not utilized, either because there is not an out-patient provider with a program for DMIOs, or the Regional Support Network does not contract with providers because of liability concerns.

4. DOC's Special Needs Unit in King County

King County is large enough that DOC has created a unit dedicated to supervising offenders with mental health issues. The unit is called the Special Needs Unit. This group of eight Community Corrections Officers has smaller caseloads - 25 to 30 defendants, rather than the approximate 40 defendants most CCOs supervise. The Special Needs Unit is assigned to supervise all DMIOs living in King County. There are about 45 DMIO designated offenders in King County supervised by the Special Needs Unit. The unit also supervises all offenders who are under supervision due to a finding of Not Guilty by Reason of Insanity. Currently about 15 persons living in King County and found NGRI are supervised by the Special Needs Unit. The remainder of the Special Needs Unit's caseload is offenders whose mental illness is so prevalent that they have been referred by other units specifically for supervision by the Special Needs Unit.

Most Special Needs Unit CCOs have mental health backgrounds. They will usually see each offender once or twice per week, and often much more if the condition of the defendant seems to warrant it. Their teamwork within the unit is more overlapping than in most units, with each member becoming quite familiar with the offenders on the other CCOs' caseloads. For instance, if a CCO is checking in on an offender and is in an area where another CCO also has an offender, the CCO will check-up on both offenders if possible.

The Special Needs Unit CCOs keep in close contact with their defendants' out-patient treatment providers. For DMIOs, mental health case management in King County is provided by Sound Mental Health, which has a program dedicated to case managing DMIOs. Besides communicating about any particular offender for which there is heightened concern, the CCOs and SMH meet once a week to review the status of all DMIOs. This meeting is also attended by other agencies, including the Seattle Police Department, housing representatives, and chemical dependency treatment providers.

Other than their pre-CCO training, their experience, and their wits, a Special Needs Unit CCO has no more tools to work with a mentally ill offender than any other CCO working with an offender, mentally ill or not. This means that a Special Needs Unit has only four ways to take a defendant off of the streets (this does not include NGRI offenders). First, a CCO can use the violation hearing process. If there has been a violation of conditions of supervision, the CCO can put the defendant in jail and file a violation report. The maximum amount of time a defendant can serve is 60 days per violation. Second, if a defendant's new conduct rises to a criminal level, a law enforcement agency can be contacted and the defendant can be arrested and charged. Third, the CCO can encourage the defendant to enter into a psychiatric hospital voluntarily, although most DMIOs will not qualify as good-faith voluntary patients. Finally, a CCO may make a referral to the Designated Mental Health Professionals for civil involuntary mental health commitment under the Involuntary Treatment Act.

5. Defendants found Not Guilty by Reason of Insanity

If the symptoms of a defendant's mental illness impacted a defendant's ability to think and act (or not act) at the time the defendant engaged in felony criminal behavior, the defendant could be found Not Guilty by Reason of Insanity (NGRI). In Washington State, the issue of whether a defendant was insane at the time the defendant committed the criminal acts is governed by the M'Naughten standard of insanity. Under the M'Naughten standard, there is a presumption of sanity, unless the defense proves by a preponderance of the evidence that as a result of mental disease or defect, the mind of the defendant was affected to such an extent that (1) the defendant was unable to perceive the nature and quality of the act with which the defendant is charged; or (2) the defendant was unable to tell right from wrong with reference to the particular act charged. The defendant has the right to have the issue of insanity tried before a jury. Often, a defendant will decide to waive the right to a jury and have a judge alone decide the issue, or the prosecution agrees an NGRI finding is appropriate and an "agreed" finding is entered by a judge. An NGRI finding means the defendant is not criminally responsible for their acts; however, it can still lead to in-patient mental health treatment and/or close supervision of a defendant living in the community.

Once a defendant has been found NGRI by a judge or jury, the judge or jury also decides whether the defendant remains a risk to community safety and security. If so, the court retains jurisdiction over the defendant. The court can order the defendant to a state psychiatric hospital for in-patient treatment. The court can also order the defendant to be released into the community but on conditions which usually include supervision and out-

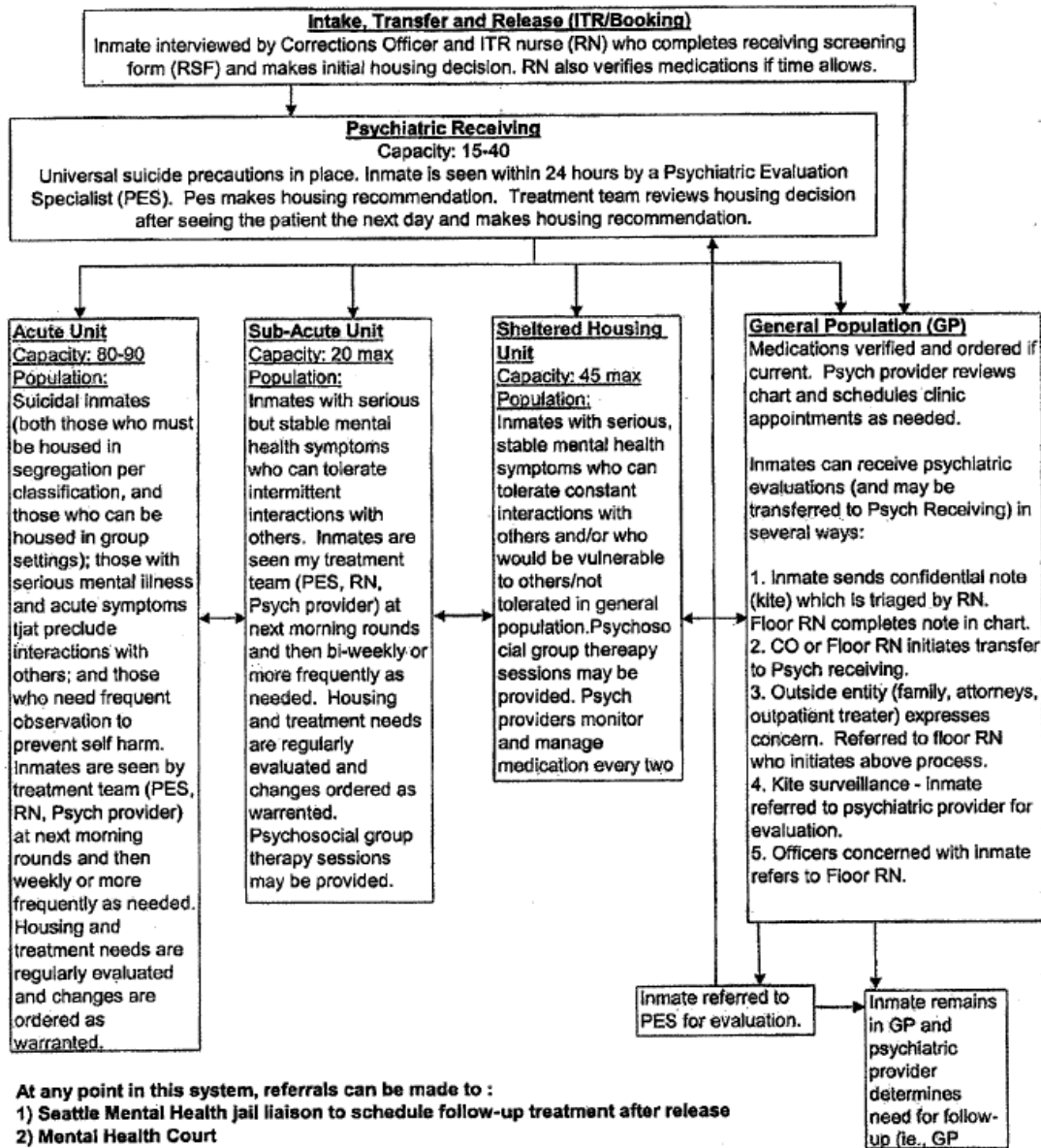
patient treatment. The court's jurisdiction can be up to the maximum possible sentence of the crime charged, including life, and therefore, some defendants are under the court's jurisdiction for decades, with the court's authority only ceasing with the defendant's death.

At any one time in King County, there are between 125 and 140 defendants who have been found NGRI on criminal charges and who are either in in-patient treatment at Western State Hospital (WSH) or are on conditional release and must comply with court-ordered treatment and other conditions, including supervision. Community supervision is done either by the Department of Corrections (even though the defendant was not actually found guilty of the offense and placed on traditional supervision) or by Western State Hospital. When DOC is the supervising agency, the defendant is usually assigned to the Special Needs Unit, the unit which also supervises DMIOs. The Special Needs Units supervise NGRI and DMIO defendants in very similar manners, but the officers of the Special Needs Unit have the ability to place an NGRI defendant into WSH rather than just jail if the officers see a need to remove the defendant from the community.

The status of NGRI defendants can change, either because WSH believes the defendant's mental health is improving and they can safely transition into the community, or because the defendant decompensates or violates their conditional release and DOC or WSH believes they need to return to in-patient treatment at WSH. When a defendant is returned to WSH, the treatment needs of the defendant usually determine how long the defendant will remain in in-patient treatment. The statutory scheme requires WSH or DOC to periodically file written reports with Superior Court and the Prosecuting Attorney's Office for all NGRI defendants and also requires periodic reviews for those on conditional release. WSH has developed a program called the Community Program. This program helps a defendant to transition slowly and successfully from an in-patient ward to living in the community.

The NGRI statutory scheme allows defendants to petition for conditional release or to petition for court supervision to end permanently. The defendant is afforded an attorney for all hearings. When the defendant is requesting conditional release, the defendant usually has the burden to prove that they can be safe in the community.

King County Correctional Facility - Jail Health Services Mental Health Evaluation and Triage Process



Rev. 1/24/08

APPENDIX F

The Charging Documents Filed in
State v. James Anthony Williams,
King County Cause Number 08-1-01211-1 SEA

CAUSE NO. 08-1701211-1 SEA



**CERTIFICATION FOR DETERMINATION
OF PROBABLE CAUSE**

GENERAL OFFENSE #	07-520581
UNIT FILE NUMBER	H07-470

That Cloyd Steiger is a Detective with the Seattle Police Department and has reviewed the investigation conducted in Seattle Police Department Case Number 07-520581;

There is probable cause to believe that James Anthony Williams committed the crime(s) of Murder within the City of Seattle, County of King, State of Washington.

This belief is predicated on the following facts and circumstances:

Shannon Harps lived alone in an apartment at 1532 E. Howell St. #2 in Seattle, King County Washington.

On New Years Eve, 2007, Harps planned to attend dinner with friends. She made a phone call to that friend at 5:19PM. She left a voice mail message asking what she should bring to the dinner, and saying that she was going to take a shower and go to the store.

Harps went to the Safeway store near 15th and E. John St., checking out at 6:44PM. She returned to her daylight basement apartment briefly, then went to the Madison Co-op, another grocery store located near 16th and E. Madison St. She checked out at that store at 7:09PM.

She was walking back to her apartment and had gone into a stairwell that leads to a side door to her lock out building when she was attacked.

Joseph Mirabella was walking north on 15th Ave. He was near E. Howell St. when he heard a woman scream. He couldn't see anything, but knew it was coming from the east of where he stood. He heard the female voice call for help. He yelled out that he was calling 911. A moment later, he saw a woman, (later identified as Shannon Harps) come out of the stairwell on the north side of the building (1632 E. Howell), stagger a few feet and fall to the planting strip. He called 911. The call was registered at the 911 Center at 7:15PM.

A moment later, Mirabella saw a white male emerge from the same stairwell, look briefly at him, then walk casually eastbound on E. Howell St.

Other witnesses saw other aspects of the crime.

Beth Kirschbaum was walking west on E. Howell St. She heard a woman scream. She at first thought it just a drunken brawl of some sort. As she walked west, she passed a transient looking man. She didn't make eye contact. She saw a woman lying on the planting strip. When she got closer she heard the woman moan. She saw another man with the woman. She knelt to help the woman and saw that she was bleeding profusely.

A neighbor across E. Howell heard screaming, and heard a woman's voice yell, "Get off me, you maniac!" When she looked out her window, which faces south, she saw a man walk east on Howell. When he got to 16th Ave. he started running southbound.

Police and Fire Department units arrived and found Harps unconscious. She was taken to Harborview Medical Center, where she was pronounced dead.



SEATTLE
POLICE
DEPARTMENT

**CERTIFICATION FOR DETERMINATION
OF PROBABLE CAUSE**

INCIDENT NUMBER	07-520581
UNIT FILE NUMBER	H07-470

Multiple patrol units converged on the scene immediately after the call was received, and a K9 track was initiated from the scene.

Patrol unit 3H3, Officer Peter Leutz was in the area of 17th and E. Madison at about 8:42 PM. He saw two males in a bus shelter. He turned around to talk to them. By the time he pulled up, one of the males had walked off. The remaining male was wearing a blue coat. He stopped to talk to that person.

The man was drinking Pabst Blue Ribbon beer, which was the same brand of beer found around the corner from the murder scene on the steps of Seattle Mental Health. (One witness had walked by that location just before the murder and had been "creeped out" by a man sitting there drinking beer. She thought at the time that the man may have been the killer and told officers that). The man that was stopped was identified as James Anthony Williams, W/M 3/17/59.

Leutz asked that officers at the scene bring the witnesses to his location to look at the person he had stopped to see if he was the man they saw walking from the murder scene.

Patrol Unit 3E3, Officer William Campbell took Joseph Mirabella and Beth Kirschbaum, (both of whom had seen the suspect walk out of the stairwell where Harps was stabbed) to Leutz' location. They looked at James Williams. Both said he was not the person they saw walk from the scene.

Because of his proximity to the scene, and the fact that he was drinking Pabst beer at the time of the stop, which was the same brand as the beer near the scene, and since Pabst, though not unheard of, is a somewhat less common beer than many other brands, we asked Officer Leutz to take Williams to the Homicide office for further questioning.

In the early morning hours of January 1, 2008, Detective Jason Kasner and I interviewed Williams. (The interview was video recorded).

During our interview, Williams told us that he had been sitting on the steps of the Seattle Mental Health drinking beer prior to this event. We asked if he had been "flicking" his beer caps into the street, (which is what Kirschbaum said the "creepy" guy was doing). He said that he had been doing that. He denied seeing any other people following women down that street or any other suspicious people. He didn't hear any screaming.

He said he didn't know who the other guy at the bus stop with him was.

We photographed him and asked if he would voluntarily submit to a buccal swab for DNA. He agreed, and we took the sample.

An autopsy was conducted on Shannon Harps by the King County Medical Examiner's Office. The cause of death was ruled as stabbing. The manner of death was ruled Homicide. During the autopsy, among other evidence collected, fingernail clippings were recovered from Harps' body.

A kitchen knife with a bent blade was found a few feet from the stairwell where Harps was attacked. There were what appeared to be traces of blood on the handle. This, along with the nail clippings and other evidence, was submitted to the Washington State Patrol Crime Lab for testing.

Forensic Scientist Amy Jagmin was assigned the DNA aspect of the case. Jagmin and I kept in constant contact and communication.



**CERTIFICATION FOR DETERMINATION
OF PROBABLE CAUSE**

INCIDENT NUMBER	07-520581
UNIT FILE NUMBER	H07-470

Jagmin processed the fingernail clippings, and found what appeared to be minute traces of male DNA on the clippings. These traces were too small for the processes of the State Crime Lab to test further. They were eventually sent out of state to a private lab for YSTR DNA testing.

Jagmin reported to me that she had processed the knife. The blade of the knife had blood on it from which DNA was extracted. This DNA was female, and was matched to Shannon Harps. The handle of the knife produced a mixed sample of male and female DNA. The female DNA was isolated and matched that of Shannon Harps. The male DNA was isolated from the female markers and the remaining profile was run through the state DNA databank. There were no matches in the state databank to the male DNA on the handle.

On Tuesday, January 22nd, I submitted the buccal swabs from James Williams to the crime lab.

On Friday, January 25th at about noon, Jagmin called me with another report. She told me that she had extracted the DNA from the buccal swabs we had submitted from James A. Williams. The DNA on the buccal swabs was a match to the unknown male DNA on the knife handle.

Kasner and myself immediately attempted to locate Williams. We discovered that he was currently an inmate in the King County Jail.

We brought Williams from the jail to the Homicide office. We started another interview with him. (This interview was also video recorded). We advised Williams of his rights and he said he understood. We talked to him at length and eventually told him we matched his DNA to the murder weapon. At first he denied any involvement in this murder. We continued to talk to him about the evidence against him. He started crying. He then admitted that he'd killed Shannon Harps. He described in detail seeing her walk on 16th Ave. and he started following her. He said he had no reason to pick her. (He did not know her prior to this event, and later said that Harps had just been in the wrong place at the wrong time). He followed her into the stairwell and just started stabbing her multiple times. He said that he had no sexual motive, no robbery motive, or any other motive. He just wanted to kill her.

Our interview lasted more than four hours, on and off. We eventually transported him to the jail. En route to the jail, he told us that he was distraught that he'd killed Harps after reading about her in the paper, about what a nice person she was. He said that he'd convinced himself she wasn't really dead. He said that when he stabbed her, the knife blade bent, and he hoped that he had just superficially wounded her. He thought the news was just saying she was dead to get him to confess.

The knife recovered did, in fact, have a severely bent blade. This fact was not publicized or known outside our unit and a few other police officers.

Under penalty of perjury under the laws of the State of Washington, I certify that the foregoing is true and correct to best of my knowledge and belief. Signed and dated by me this 26th day of JANUARY, 2008, at Seattle, Washington.

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CAUSE NO. 08-1-01211-1 SEA

PROSECUTING ATTORNEY CASE SUMMARY AND REQUEST FOR BAIL AND/OR
CONDITIONS OF RELEASE

The Certification for Determination of Probable Cause prepared by Seattle Police Detective Cloyd Steiger, dated January 26, 2008, is hereby incorporated by reference.

REQUEST FOR BAIL

The State requests bail in the amount of \$1,000,000. As set forth in the Certification for Determination of Probable Cause, the defendant poses an extreme risk to the public in general. In the present case, it is alleged that the murder of the victim, Shannon Harps, was a random act of homicidal violence.

The concern of law enforcement regarding the defendant's potential for violence is based on his actions in this case, his mental health history and his extensive criminal history. The defendant's criminal history extends over a period of 30 years and at least four different states. In addition to felony convictions for Burglary (in Arkansas) and Forgery (Texas), the defendant has an extensive violent misdemeanor history, including convictions for Assault and Battery in 1990 (Oklahoma), Battery in 1992 (Florida), Assault in 1993 (Florida) and Assault/Carrying a Concealed Weapon in 1994 (Florida).

The defendant's Washington criminal history includes a conviction in October 1995 for Assault in the First Degree for the unprovoked shooting of another man on the streets of Seattle. He was sentenced to 135 months in prison for that offense, the maximum sentence allowed under the law.

In addition, the defendant was arrested in March 2007 for Harassment and was deferred for evaluation to Western State Hospital. His most recent arrest also was for Harassment in September 2007, when he threatened a female resident of a group home in Seattle. At the time of his arrest, the defendant was armed with an 8" butcher knife, which he stated to officers, was

Prosecuting Attorney Case
Summary and Request for Bail
and/or Conditions of Release - 1

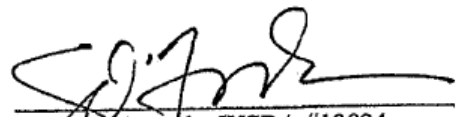
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for "self-protection." He was convicted of the Harassment charge in Seattle Municipal court in December 2007.

Finally, the defendant should be ordered to have no contact with any of the witnesses in this case.

Signed this 29 day of January, 2008.



Scott M. O'Toole, WSBA #13024

APPENDIX G

Recent Media Articles on DOC's Special Needs Unit in King County

Seattle Post-Intelligencer

http://seattlepi.nwsourc.com/local/356469_dangerside26.html



Randy Vanzandt, left, a Department of Corrections community corrections officer, visits with Parish Cockett at his independent living residence in West Seattle last month. Cockett, who has a history of assault, has done well on medication since Vanzandt's supervision began in 2001. Vanzandt is one of seven officers supervising more than 200 criminal offenders with a history of mental or developmental troubles. (Dan DeLong / P-I)

Corrections officers face daily struggle to keep offenders, public safe

Wednesday, March 26, 2008

Last updated 7:59 a.m. PT

By **CAROL SMITH**
P-I REPORTER

Just before first light, Randy Vanzandt pedaled downtown, past the Seattle Emergency Center, where some of his offenders hang out, and left down Yesler Way. Throughout the city, the eight-to-five office crowd queued up for its first caffeine hits of the day. Ahead of him, he could make out a young woman, buzz cut, all edges, angular bone and harsh words -- someone he knew.

The woman had a warrant out for failing to show up for supervision. "I rolled up on her and invited her to take a walk," he said. Then he strolled both her and his bike the remaining 1 1/2 miles to the Department of Corrections' special needs unit south of the stadiums.

Vanzandt, lanky and affable, chuckles at the recounting of his commute.

His shift hasn't started yet, and he's already made his first arrest of the day.

Invisible dangers

Vanzandt is one of seven corrections officers in charge of supervising more than 200 offenders who have severe mental illness, personality disorders or developmental disabilities along with histories of petty crime, drug addiction, assault, robbery or murder. Their caseload also includes the state's "Dangerous Mentally Ill Offenders" -- people coming out of prison who have psychiatric histories that warrant extra supervision and support.

James A. Williams, charged in the random stabbing death of a young Seattle woman on New Year's Eve, was one of theirs. So was Daniel Culotti, who was shot dead after attacking a stranger in Westlake Plaza in 2006. So was Paul Pearson, who threw lighter fluid on three pedestrians in downtown Seattle in January 2007, setting a woman's hair on fire.

The dangerous mentally ill who wander the streets of Seattle go unseen by most of us. Some blend with the office crowd. Others are the homeless we hurry past, avoiding eye contact until we cease to notice them at all.

The special needs corrections staff does see them -- in alleys, and hospital waiting rooms, and needle-littered parks. They spy them on MySpace or Internet dating sites.

It's a job few take, or want. They get spit on, sworn at, and are paid less than corrections staff for other jurisdictions on top of it. They've learned not to bring up their occupation at parties.

"When people find out what you do," said Patty McGuinness, another of the corrections officers. "It's a conversation stopper."

'Word salad'

Mornings in the office resemble an improv skit with overnight messages providing the scenario. The police called -- one of their offenders passed out in the library with a needle in his arm and insists he wasn't using. Sound Mental Health called -- someone was a no-show for the third time. An apartment manager called -- "There's been a bit of an incident. ... "

Occasionally the offenders leave messages, too -- threatening, pleading or on a good day, just checking in. Sometimes, it's hard to tell what they're saying.

"It's just total word salad," Vanzandt said.

The corrections crew scrambles to fish their offenders out of jails and emergency rooms, arrest those with warrants out, drive some to appointments and knock on the doors of others. Sometimes a quick eyeballing is enough to assess whether someone is at "baseline" or beginning to fall down the rabbit hole of their disease.

"We try to plan things, but in this business you never know," Dan Weiss said, adjusting the geek-cool glasses that suit his mellow manner. Weiss is prepping for the morning sweep with fellow officers Kathy Woik, "the queen of structure," and McGuinness, who projects an unflappable maternal compassion no matter what chaos unfolds.

Woik's morning, too, has started with a jolt.

"Can you believe it, Brett Favre is retiring?" Woik, an avid Green Bay Packers fan, shakes her head and chews over the news. "I've seen him block. He's a guy who would do whatever it takes, you know?"

The corridor

The corrections officers usually hit the field in groups of three. They go out armed with handcuffs, fast reflexes and a dark sense of humor. "Got pepper spray?" one asks as they head out.

Their unmarked van, painted drizzle gray, is unnoticeable to most of us, but well known to the city's street people. For many, it's their only touchstone with reality. "In a weird way, they start to think of us like family," Weiss says.

With its battered laptop docking stations and its Happy Meal hula girl mascot mounted to the dash, the van functions as part mobile office, part holding cell and full-time command center.

On this morning, the van rolls down Western Avenue, slowing as it passes the Millionair Club. As soon as the van appears, a stringy-looking man ducks his head and edges backward through the clump of day laborers gathered in front.



 ZOOM

Dan DeLong / P-I

Community Corrections Officer Patty McGuinness talks with a woman inside the King County Jail in Seattle after the woman was arrested for violations of supervision earlier this month. Officers work to keep their offender stable and out of trouble through jail, treatment or housing.

"Hey, there's one of ours," said Thomas McJilton, the driver, his watch cap pulled down against the chill. McJilton, a former roofer, is the only one of the crew who doesn't come from a mental health background. Among the rest of them, they have 60 years as counselors and case workers. His colleagues rag him about that to his face, but call him "a natural" behind his back.

Weiss, riding shotgun, peered at the guy moving opposite the crowd and shook his head. "Not anymore," he said. "He's done."

McJilton turned left, looping through "the corridor," a territory bounded by South Jackson and Wall streets and Sixth Avenue and the waterfront, where their offenders like to hang out. They clatter past a disheveled woman in purple, who waves at them. She, too, is designated dangerous, and mentally ill, but they have no business with her today.

That makes two offenders in as many blocks. Before the next few hours are up, they will have spotted, stopped or spoken with a dozen more.

Missing tools

In between stops, their phones ring constantly. They duck in and out of conversations on their Nextels the way stunt drivers weave through traffic, trying to get their offenders into treatment, or housing or jail, manipulating the system to try to keep them stable and out of trouble.

McGuiness hunches over her phone in the back of the van, waging a verbal chess match with a young man under her supervision for robbing a bank. He doesn't believe he's schizophrenic. He's stopped checking in, and hasn't been taking his meds. She's trying to get him to come back to see her so she doesn't have to arrest him for violating his supervision.

"No," she says patiently. She's been over this with him many times already. "You can't hire yourself to give a second opinion on yourself." A long pause. "I understand that, but you're not qualified to give a second opinion."

The officers have to make judgment calls within a system that seems as irrational as the offenders they supervise.

They can put their offenders in jail, but not a mental hospital. They can order them to take their meds, but they can't force them. If they manage to convince the county mental health professionals their offenders need emergency mental treatment for their own safety, or the public's, the odds are the offender will bounce back after 72 hours because



 ZOOM

Dan DeLong / P-I

Community Corrections Officer Thomas McJilton looks for offenders in Victor Steinbrueck Park in Seattle. Corrections officers and their gray van are well known to Seattle street people. "In a weird way, they start to think of us like family," one officer said.

of lack of beds in specialized psychiatric care. They know housing is critical for a mentally ill offender's stability -- but there is almost none.

"I have only the tools in my toolbox," McJilton said. "And the tools I have aren't necessarily the right ones."

Night sweep

Just before quitting time, the group crams into supervisor David Aiken's office for an emergency meeting. The staff has just gotten word the Dangerous Mentally Ill Offender program may have to cut services for participants from five years to 2 1/2. That would mean 40 of their offenders could lose their housing by April 1.

"Homeless DMIOs (Dangerous Mentally Ill Offenders) are a huge concern," Aiken said. "We don't want that to happen."

With no solution in sight, the meeting breaks up so the late crew can do a night sweep.

McGuinness, McJilton and Weiss grab bulletproof vests and climb back into the van.

The colors have nearly bled out of the day, but it's not long before they land on a skinny guy in a familiar red jacket on a Pioneer Square street corner. McJilton throws the van in reverse and screeches backwards.

"Drop it, Omar," Weiss yells. Omar's bag of Cheetos lands on the ground, and he leans against the van while they pat him down. He's been designated dangerous by the state and has a warrant out for going AWOL on his supervision. His supervisor has been trying to get him into inpatient treatment for months. He has a habit of slicing himself open and putting chicken bones and other foreign objects inside. He's also homeless.

Before this shift is up, they will arrest one more -- a chronic alcoholic woman whose belongings are crammed into a plastic bag from Harborview, along with her discharge instructions.

Weiss reads it through. The instructions say, "Do not drink alcohol."

It's dark by the time the team drives into the tunnel entrance to the jail to unload the pair for booking.

Omar cooperated, McJilton said a few minutes later as he drove the emptied van back into the rain. "It's cold out, and he knew he had a bed for the night."

P-I reporter Carol Smith can be reached at 206-448-8070 or carolsmith@seattlepi.com.

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http://seattlepi.nwsourc.com/local/356465_dangerousmain26.html



Dan Weiss, one of seven Department of Corrections special needs unit officers, scans the street for mentally ill offenders under their supervision who are in violation or have outstanding warrants. Many offenders are homeless or live on the street. About once a month officers patrol at night checking to see if offenders are where they're supposed to be. A computer in the van allows them to check the warrant status of offenders. (Dan DeLong / P-I)

Dangerous and mentally ill: A system in restraints

Wednesday, March 26, 2008

Last updated 7:59 a.m. PT

By CAROL SMITH
P-I REPORTER

Before James A. Williams was charged with stabbing a young Seattle woman to death, he stood before a King County Superior Court on a different occasion, accused of assaulting a different stranger, and asked to speak in his own defense.

In the midst of a passionate and rambling argument explaining why he shot a stranger at a Seattle bus stop, he paused to deliver this judgment:

"I didn't even ask to be born," he told the judge. "If I had my way I would never have been born, but unfortunately, I was."

In some sense, it is a wish echoed by a mental health system that failed to predict the emergence in the last few decades of a class of violent, mentally ill offenders, such as Williams.

The year Williams, 48, was born, the United States was on the cusp of a grand experiment to free the mentally ill from insane asylums, a shift that would eventually and disastrously claim him as a casualty and, if what he is accused of is true, cost Shannon Harps, 31, her life. Harps, a Sierra Club worker, was walking outside her Capitol Hill condominium at about 7 p.m. on New Year's Eve when a man attacked her with a butcher knife and commanded her to die. Williams' DNA was found on the knife.

That such a tragedy occurred in King County, which offers a comprehensive and progressive system for dealing with mentally ill parolees, has both the public and the mental health community asking what went wrong.

It's a question underscored by a spate of gruesome killings linked to mental illness around the country, from the most recent campus shooting in Illinois, to the psychiatrist who was hacked to death in her New York office last month.

Since April 2000, 512 Washington inmates have been designated as dangerous and mentally ill, the same designation Williams received when he got out of prison in 2006 for the bus stop shooting. Of those, 466 are living in the community. Those who volunteer to enroll in a special supervision program receive extra help with housing and mental health care in addition to being closely monitored by the Department of Corrections.

But about half of the "dangerous mentally ill" either can't or don't participate. Only 222 actually receive services through the program -- some because they live in areas of the state where no mental health counselors will take such patients on, or where no housing will accept them. Others simply reject the help.

Williams' case, like the nearly identical case 10 years ago when a psychotic man stabbed a Seattle firefighter to death outside the Kingdome after a Mariners game, has once again forced the issue of how society deals with those who are severely mentally ill and have criminal histories -- a population that has been exploding even as the resources to deal with it have dwindled. At the same time, laws intended to safeguard the rights of the mentally ill seem instead at cross-purposes with keeping the public safe. To be committed to a mental hospital today, even for a brief period, an individual must be in imminent, provable danger of harming himself or others.



Shannon Harps, a Sierra Club worker who lived on Capitol Hill, was murdered with a butcher knife outside her home on New Year's Eve. James Williams (below) has pleaded not guilty



Nervous breakdown

Williams should have been a success story. He was one of 70 dangerous mentally ill offenders living in King County, which does provide services and has some housing that takes psychiatric patients with violent histories. Despite getting intensive intervention, supervision and financial help, he slipped the grasp of the medication that kept him somewhat stabilized, and the efforts of a dozen caseworkers, corrections officers, counselors and others who struggled to keep him from exploding.

The reasons have their roots in the history of psychiatric care in the last half of the last century. Williams' own story, pieced together from psychiatric records included in public filings, and court records obtained by the Seattle P-I, is a case history of the dark side of deinstitutionalization.

Williams was born in 1959 in Camden, Ark., at the tail end of the decade that also produced Thorazine, the first "miracle" anti-psychotic medication. For the first time, doctors had a medicine to treat delusional symptoms, opening the door for treatment outside the restraints of a hospital. Like the social change it helped instigate, however, the medicine also had nasty side effects that made many patients refuse to take it. Neither deinstitutionalization, nor the medicines that spawned it, worked as intended.

Williams was only 8 when his mother died under mysterious circumstances. He never knew his father. After his mother's death, he was shuffled among households, living with various aunts and grandparents.

At age 12, he had his first "nervous breakdown" and was admitted to Arkansas State Hospital for about a month for treatment of "obsessive, psychosomatic thoughts." After his release, he dropped out of seventh grade and started doing drugs. Eventually, he graduated from huffing lighter fluid off rags to shooting methamphetamine.

At 17, he was convicted of burglary and landed in an Arkansas penitentiary for the first time. Meanwhile, his mental health continued to deteriorate, and signs of a virulent anti-social personality disorder began to emerge in a foreshadowing of his future.

In 1982, after breaking up with a girlfriend, he told doctors he had "such hatred for her that he has serious thoughts about taking a knife and going and cutting her up." According to his treatment notes, "He spends a great deal of time thinking about how he would like to get even with people whom he believes to be the blame for what has happened to him." Doctors diagnosed him with schizophrenia. He was 22.

The conclusion doctors made 25 years ago: "Prognosis is considered poor at this time because of apparent lack of motivation to follow through with any treatment recommendations"

That prognosis would prove prophetic.

Missing pieces

Over the next decade, a series of progress notes from Arkansas mental hospitals and prisons traces Williams' dizzying circuit among hospitals, jail and the streets, a loop that mimicked that of countless other psychiatric patients. Hospitals, gutted by budget cuts after deinstitutionalization, had neither the beds nor legal grounds for keeping them. Prisons and jails were not equipped to treat them. And landlords didn't want them.

This was not the intended consequence of the push for community care of the mentally ill. Three decades ago, it was far too easy to warehouse patients for abnormal social behavior, a loose criterion that let families offload their more difficult or embarrassing relatives.

"People in state hospitals in the early '60s did not get there based on imminent danger," said Richard Kellogg, director of the Mental Health Division of the state Department of Social and Health Services.

In 1963, when President Kennedy signed the Community Mental Health Centers Act, the vision was to provide prevention, intervention and treatment outside of institutions for all ages and incomes based on ability to pay.

"But when patients were deinstitutionalized, no one envisioned such a subset (of patients) with this degree of violence," Kellogg said.

The visionaries missed other pieces necessary to help psychiatric patients succeed in the community, in particular the need for affordable housing.

"The 1963 act didn't envision the relationship (of outcomes) to housing, and mental health service is not housing," Kellogg said. "That major point got lost."

Nor did the reformers foresee the effects of a rising street drug culture on crime and a growing consumer appetite for violent entertainment.

"Our culture changed. We have a more violent culture today," he said. The right infrastructure wasn't in place to safeguard either them, or the public.

Instead they went to jail, in droves.

"The census of mentally ill in King County Jail is second only to that at Western State Hospital," said David Aiken, supervisor of the Special Needs Unit, the section of the Department of Corrections that oversees dangerously mentally ill offenders after release from prison. A 2006 Department of Justice report says 45 percent of federal prisoners have symptoms of serious mental illness. The percentages are even higher in local jails -- 64 percent -- and state prisons --56 percent.

The population of people with mental illness in jails in turn jammed up what was left of the state hospital system. The number of beds nationwide, which peaked at about 565,000 beds in the 1970s, is now down to about one-tenth of that, which some argue is no longer sufficient to meet demand.

Before 1990, Western State Hospital did about 300 evaluations for "competency restoration" a year, said Mark Allen, a mental health counselor in the forensics unit at Western. Today, the hospital does about 3,000 outpatient admissions a year to determine whether a person is competent to stand trial.

Western, which is at capacity, has a current patient census of about 1,000 patients, including 300 criminal offenders. In addition, there are about 230 beds sprinkled around King County that will take psych patients who are committed involuntarily.

But that isn't enough. At any given time, an estimated 20 percent of those who have been identified as qualifying for involuntary commitment under the state's strict committal laws still can't get beds and wait out their 72-hour "holds" in ERs or other nonpsychiatric facilities. When the holds are up, they walk.

To qualify for a longer stay in the hospital, a patient has to do something extreme. Allen recalls a mother who pleaded with the mental health community for six months to try to have her mentally ill son hospitalized. Finally, he stabbed her.

Then he was committed.

"The majority of people with mental illness in the community are not violent and in fact are not more likely to commit violent crimes than nonmentally ill people," Kellogg said. "But there is a subset, that we have growing knowledge of, coalescing around co-substance abuse, multiple admissions, including jail time, and a history of social inadequacy."

That was Williams' subset.

Clear and present danger

By the turn of the '90s, Williams was a 31-year-old vagrant described in records as "unkempt, very dirty, agitated, loud and cursing." Now labeled a "chronic paranoid schizophrenic" he had already cycled on and off powerful anti-psychotics multiple times, typically abandoning them as soon as he was out of prison or the hospital. Psychiatrists



 zoom

Dan DeLong / P-I

A security officer walks the hall in the Center for Forensic Services at Western State Hospital in Lakewood on Monday. The hospital is at capacity with about 1,000 patients, including 300 criminal offenders.

say going on and off meds multiple times can erode their effectiveness, creating a class of patients who become untreatable over time.

In the previous 10 years, he had been committed for "terroristic threatening" of his grandfather, then jailed for assaulting an elderly woman. He'd been in prison for writing hot checks, and back in treatment for delusions that his grandmother was trying to kill him with the TV remote control.

He claimed that medicine was destroying his brain. He was known to carry a knife and said he slept with a loaded gun. "If people try to mess with me," he told a counselor in 1990. "I will get pleasure in killing them."

Throughout, notes from repeated mental evaluations show Williams' grounding in reality morphing to quicksand.

"He believed that he was an FBI and CIA agent, and that he also worked for the U.S. Army, God and the devil," said one such note.

Doctors in Arkansas called him a "clear and present danger" to himself and others.

Then he vanished, and the mental health facility where he was periodically seen throughout the 1980s "terminated" his chart.

In a disturbing prelude to events to come, Williams popped up in a new city, this time in Florida, where he racked up three convictions on separate occasions for assaulting a man with a knife, for bashing another man's face into a fire extinguisher and, ominously, for terrorizing a woman.

According to the 1993 police report from that incident, "As the defendant rubbed on her leg (victim), the defendant was talking about 'killing women' and 'cutting women from their eyes to their throat.' "

Stranger violence

It's not clear when, how, or why Williams arrived in Seattle, but this chapter of his life starts on another prophetic note.

In 1995, he was arrested for shooting a stranger at a downtown bus stop. In the police report of that initial incident, there is this bold-face warning: "DO NOT RELEASE!!! SUSPECT SHOT A STRANGER WITH A LARGE CALIBER PISTOL. THE SUSPECT IS A DANGER TO ALL CITIZENS ..."

Despite his record, prosecutors determined Williams' prior offenses in other states didn't qualify him to be prosecuted under the state's three-strikes criteria that would have put him in prison for life. Instead, Williams was convicted and sentenced to 11 years for the shooting. In prison, his behavior continued to spiral out of control. He was put in

restraints for fits of rage, forced to take medication and racked up 248 violations for damaging property and assaults. When his release date came up in 2006, he was a textbook case for the Dangerous Mentally Ill Offender program. A judge ordered him to 24 months of community supervision, and Williams agreed to take part in the program.

Although he became increasingly difficult to handle, he was checking in with his corrections officer as he was supposed to, said those who were responsible for tracking him.

"Assuming he didn't commit a murder," Kellogg said, "the system worked."

Degree of imminence

The case raises a host of disturbing and complicated issues that come down to how much risk is too much for society to bear. For sexually violent predators, the state has decided there is a class of offenders -- Level 4 -- that should remain locked up for mental health treatment even after serving their prison time because of their danger to the public.

Should a similar risk category be created for violent offenders with certain combinations of personality disorders, mental health diagnoses and track records with treatment compliance? Should the public be notified -- as it is with sex offenders -- when offenders with violent and serious mental health histories are released? Is the bar too high for getting people committed? And should the three-strikes law be applied differently for those who have severe mental illnesses?

David Weston, chief of mental health services for the state, said he knew of no other states that had tried such measures. Washington would be setting precedents.

"I don't think the public mental health system was ever designed to guarantee 100 percent safety," Kellogg said. "Whether it should be or not, is an open question."

Earlier this month, King County Prosecutor Dan Satterberg convened a task force to examine the Williams case. It is still in the fact-gathering stage and has yet to draw any conclusions or propose solutions.

Many of the issues boil down to money -- more money for housing, for treatment centers, for supervision, say those who are closely watching this case.

The program that monitored Williams is already under financial strain. In 2007, it overspent its budget by \$400,000, and in response may have to slash the number of years it will provide mental health help to those enrolled from five years to 2 1/2 years. Weston said he is trying to find other funds to keep services available for the full length of time, but hasn't found them yet.

And that won't help the many others who corrections officers say are equally likely to be dangerous, but who don't fit the eligibility requirements for the mentally ill offender program and receive no such coordinated assistance at all.

The high thresholds for commitment also frustrate those who track mentally ill offenders.

To be hospitalized, the person must be a danger to self or others, or gravely disabled. And there must be a trail of evidence, including witnesses, to persuade a court. The threat must be imminent, not based on hearsay, and specifically related to a serious mental illness. A threat made by a mentally ill person because he or she is angry or frustrated wouldn't qualify. In addition, the county, which evaluates people for involuntary commitment, is also bound by law to ensure they are treated in the "least restrictive" setting, which usually means in community clinics and housing.

Only "designated mental health professionals," who work for King County Mental Health, can decide to commit someone against their will. In 2006, these evaluators, most of whom are not psychiatrists, but do have master's-level degrees in psychology-related fields, did 5,500 such crisis assessments. Of those, 2,169 patients were hospitalized.

Critics say that isn't enough, and that of those who do get hospitalized, too few get held long enough. To hold someone for more than 72 hours requires an additional court order.

"We need to change the degree of imminence," said Randy Vanzandt, a community corrections officer who tracks dangerous mentally ill offenders for a living.

That, however, would cost more. State hospitals are expensive to run. Filling a bed in a state psychiatric hospital costs \$145,000 to \$190,000 a year.

Making commitments easier also raises constitutional issues. In our society, you can't lock people away just because they might do something, or say they're going to do something.

"There is no perfect way of predicting dangerousness is the bottom line," said Weston, who also heads the mentally ill offender program in Olympia. "It remains an inexact science."

Losing it

Reading the "chronos"-- a history of Williams' supervision -- is like watching a man self-destruct in slow motion.

The community corrections officers, nurses, counselors and social workers assigned to his case reached out repeatedly to help him. They got him clean-and-sober housing. He lost it for drinking and drugging. They got him an apartment. He got himself evicted for threatening residents with a butcher knife. They drove him to appointments at his mental health clinic and ordered him to take his meds. He flung the medicine in their faces. They

arrested him multiple times for breaking his supervision requirements in the hopes of getting him back on meds, or committed to a hospital for treatment. Each time he eventually was released back to them. His primary supervisor kept at it even after Williams said he would lay in wait and shoot him with a sawed-off shotgun as he reported to work

The day Shannon Harps was killed, Williams checked in with his community corrections officer, who noted he was "barely holding it together."

"But that was his baseline," said Dan Weiss, who saw him that day. "That's how James was every day."

In September 2007, Williams went to jail for threatening a woman at his housing facility. He pleaded guilty and received a psych evaluation on his release. How or whether he was treated in a psychiatric facility after that evaluation is not known because laws keep those records private.

What is known is that Shannon Harps, an adventuresome traveler, who loved to backpack and was working to improve the environment, a young woman who impressed her friends with her grace and integrity, was killed 10 days after Williams' release from King County Jail.

Williams has pleaded not guilty to the crime.

TRYING TO LIMIT THE RISK

Washington's Dangerous Mentally Ill Offender program helps identify those inmates in state prisons who suffer from major mental disorders and based on their histories could pose a risk to public safety on their release. The program provides for up to five years of housing assistance and intensive mental health treatment to aid their transition into the community. Two challenges facing those who work with dangerous mentally ill offenders are finding housing for them, and finding hospital beds to take them when their mental states deteriorate.

Dangerous mentally ill offenders

In Washington as of February 2008

512 people have been designated DMIO since April 2000



Of those, **466** have been released from prison

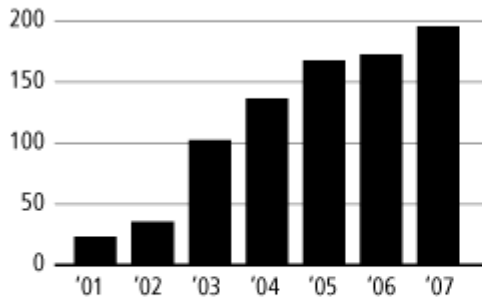


Of the 466, **222** have received mental health services and housing funding through program



DMIO receiving state services

Statewide per fiscal year



Inmates with symptoms of serious mental illness



Program costs

\$9,000

Amount the state spends each year per offender to provide housing and mental health services after their release from prison

37 percent

Reduction in recidivism attributed to the program

\$1.24

Amount the public gets back in cost savings for every dollar spent

Hospitalization options

365

Psychiatric beds available at King County hospitals including voluntary, involuntary, children and geriatrics

1,000

Psychiatric beds available at Western State Hospital

\$145,000 to \$190,000

Cost of filling one bed in a psychiatric facility per year

Sources: DSHS, Mental Health Division, 2006 Department of Justice report, Washington State Institute for Public Policy, Western State Hospital and King County Public Health

P-I reporter Carol Smith can be reached at 206-448-8070 or carolsmith@seattlepi.com.

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