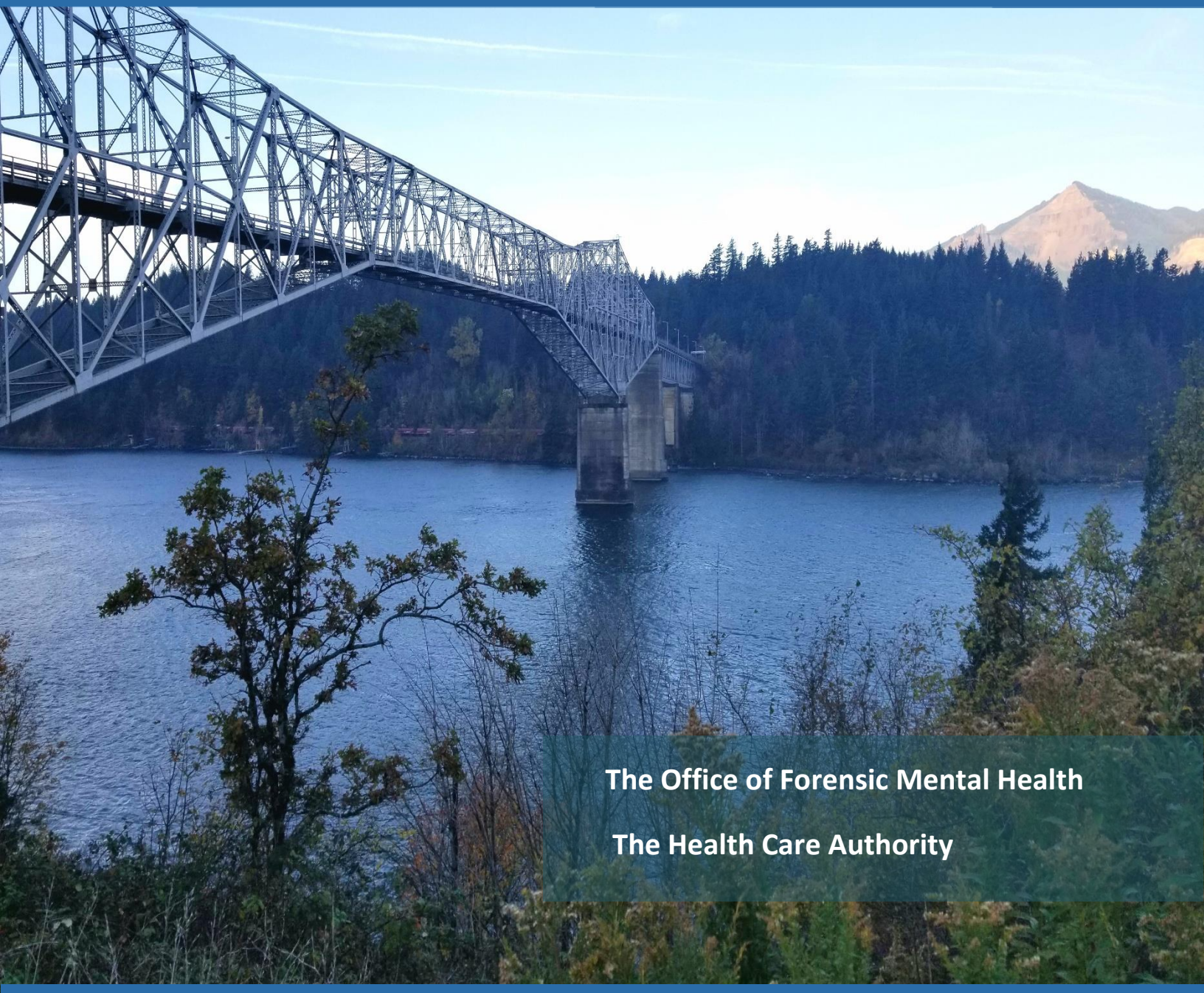
The Intersection of Behavioral Health and the Law



The Office of Forensic Mental Health

The Health Care Authority

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Washington State Health Care Authority

Washington State Department of Social & Health Services
Transforming lives

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Module 1: Introduction

This training is provided by the Washington State Health Care Authority Division of Behavioral Health and Recovery (HCA-DBHR), and the Department of Social and Health Services Office of Forensic Mental Health Services (DSHS-OFMHS). This manual is yours to keep, so feel free to take notes in it throughout the training.

What is the goal of this training?

This training provides education on a variety of topics related to working with adults who have behavioral health conditions and are involved with the Washington State criminal court system. Participants completing this two-day training will come away with a greater ability to support individuals and provide an improved quality of service.

Who will benefit from this training?

This training is beneficial for all professionals providing services to people with behavioral health conditions involved with the criminal court system.

What are the requirements to obtain a certificate of completion?

This training requires in-person participation in a two-day training workshop. Training modules include interactive activities and knowledge checks to verify understanding of the concepts presented. Upon successful completion, a certificate will be awarded.

What will you learn?

Participants will:

- Gain an understanding of Washington's forensic mental health and criminal court system and the roles of those involved.
- Understand the role of a Peer Support Specialist in the forensic mental health system and related peer support concepts.
- Be able to recognize some of the more common behavioral health conditions and information on developmental disabilities.
- Become familiar with important rules and regulations.
- Learn about diversion, forensic competency evaluation and restoration services, and civil commitment.
- Gain knowledge of person-centered, trauma-informed care, crisis de-escalation, and suicide prevention.
- Understand the importance of transition planning and continuity of care.
- Be able to define commonly used acronyms and terms.

Module 2: The Forensic Mental Health System Overview

This module provides foundational material to better understand the basic structure and functions of the forensic mental health system. It gives general guidance on strength-based practices and explains some history of the forensic mental health system.

What will you learn in this module?

Participants will:

- Understand the importance of language
- Be able to identify different components of the forensic mental health system in Washington
- Gain an understanding of different roles in the forensic mental health system in Washington
- Gain knowledge of the lawsuit Trueblood et al v. Washington State DSHS and its implications for the forensic mental health system

Why is the language we use so important?

The language we use can promote dignity and empowerment. Language can support a recovery-oriented and person-centered approach to the work we do and the people we support. By focusing on the person instead of the condition, we help to reduce stigma and negative biases.

Activity

Language

As a group, brainstorm labels you have heard used to identify people with behavioral health and/or intellectual disabilities. Create a list of these labels. As a group, using the list you have created, come up with different language for each label. Share some examples with the class.

Stigma

Stigma is a set of negative and often unfair beliefs that a society or group of people have about something. (Merriam-Webster, 2020).

- Internal, or felt, stigma is the shame and the perception of what others think about their life experiences. Felt stigma can keep a person from asking for or seeking assistance.
- External, or enacted, stigma is biased treatment from others (Davidson, 2008).

When individuals are identified by their diagnosis or disability, they are being subconsciously or consciously dehumanized or marginalized. Instead of identifying someone as their disability or diagnosis, it is preferable to describe what a person has or is experiencing. This is referred to as person or people first language. Instead of saying, “Joe is bipolar,” one could say “Joe is living with a diagnosis of bipolar disorder.” This is an example of person first language. Here are some other examples:

Not person first	Person first
"Jo is homeless."	"Jo is experiencing homelessness."
"Amy is psychotic."	"Amy is experiencing psychosis."
"He is a paranoid schizophrenic."	"He has a diagnosis of schizophrenia."
"She's slow."	"She has an intellectual disability."
"Jack is a frequent flyer."	"Jack continues looking to get their needs met."

(State of Washington DSHS, Words, 2019)

In this training we use the term "criminal court" instead of "criminal justice," which some may perceive to be a value judgement.

We also refer to "Enhanced Peer" instead of "forensic peer" to more accurately depict the additional training that a peer must complete to qualify as an Enhanced Peer.

Language is also important when talking about suicide. The phrase "committed suicide" can be associated with the commission of a crime or commitment to a hospital. The phrase "completed suicide" implies earlier attempts. The phrase "successful suicide" is discouraged due to the use of the word "success." The phrases "died by suicide" or "died of suicide" are recommended descriptors (State of Maine DHHS, 2020).

What are forensic mental health services?

Forensic mental health services are services provided to individuals with one or more behavioral health conditions and involved with the criminal court system. Generally, services are ordered by the court in a

criminal case and most often serve to address issues of competency to stand trial, not guilty by reason of insanity, and sentencing (Fitch, 2014). When people become involved with the criminal court system, they may be referred to a behavioral health professional for an assessment of competency to stand trial related to a behavioral health condition or an intellectual or developmental disability (IDD).

What is Trueblood et al v. Washington State DSHS?

Trueblood et al v. Washington State DSHS (TB v. DSHS) is a class action lawsuit challenging unconstitutional delays in competency evaluation and restoration services. It was filed on behalf of individuals who are detained in local jails awaiting competency evaluation or restoration services, and people who have previously received these services but who have been released and are at risk for re-arrest or re-institutionalization (State of Washington DSHS, Trueblood FAQs). Class members are people who are now, or will be, charged with a crime in Washington and who are waiting in jail after being ordered to receive competency evaluation or restoration services through DSHS.

In 2015 the court ruled that the constitutional rights of class members were violated, and the state was ordered to provide court-ordered competency evaluations within seven days, subsequently modified after appeal to 14 days, and competency restoration services within seven days.

Washington was unable to meet the seven and 14 day requirements, and was ruled in contempt of court. In 2018, the parties agreed to work together to come up with solutions to fix this problem, rather than pursue ongoing litigation. This collaborative effort resulted in plans to resolve the issues brought forth in the case and bring the state into compliance with the court's orders. Ultimately, it set out to reduce the number of people who become or remain class members, serve class members in a timely manner, and focus on effective outcomes of existing programs in Washington.

The resulting settlement agreement for contempt was approved by the court in December 2018 and provided DSHS with the opportunity to cure itself of its contempt status. The different elements in the agreement aim to better deliver the right care, at the right time, in the right place, for the right cost (Trueblood et al v. Washington State DSHS, 2018).

What does this mean for the forensic mental health system in Washington?

The settlement agreement for contempt outlined 14 elements to enhance the forensic mental health system. These elements include:

- An increase in state Forensic Evaluators
- The pursuit of legislative changes intended to reduce the demand for competency services
- The establishment of community outpatient competency restoration program (OCRP) services
- Establishing Forensic Navigators to assist class members in accessing services related to diversion and OCRP
- The development of additional forensic beds at the state hospitals
- Provisions for the closure of the Maple Lane and Yakima residential treatment facilities
- Increased crisis triage and diversion supports specific to residential supports
- Enhanced mobile crisis and co-responder programs
- Increased crisis triage and diversion supports for Intensive Case Management services
- Expanded crisis intervention training

- Education and technical assistance to jails and courts
- Enhanced Peer Support training
- Efforts to develop the forensic workforce

Implementation is occurring in phases. Phase 1 (2019-2021 biennium) includes the Spokane County region, the Pierce County region, and the Southwest Washington region. Phase 2 (2021-2023 biennium) includes the King County region. Phase 3 (2023-2025 biennium) will involve the opportunity to expand or modify the first two phases or look at integrating into new, high-referral regions (Trueblood et al v. Washington State DSHS, 2018).

Since the inception of the lawsuit, the State of Washington has paid more than $80 million to the federal court in fines for failing to comply with the court's orders in Trueblood. In response to a proposal jointly submitted by DSHS and the plaintiffs, the court ordered that some of this money be used to fund programs that divert class members from the criminal court system, thus creating a Trueblood Diversion Workgroup made up of plaintiff and defendant counsel, as well as representatives from DSHS and the federal court. This workgroup administered grant funding to local communities to develop diversion programs for class members (State of Washington DSHS, Trueblood, 2019).

There are 12 diversion programs funded by the Trueblood grant throughout Washington as of 2020. These programs range from co-responder teams (consisting of law enforcement and behavioral health professionals) to programs that assist people in diverting out of jail and into community-based services.

Which agencies provide forensic behavioral health services in Washington?

State of Washington DSHS

Like any complex system, Washington's forensic mental health system is made up of and influenced by a number of entities. It is managed by the Office of Forensic Mental Health Services (OFMHS), a part of the Behavioral Health Administration (BHA), which in turn is part of DSHS (State of Washington DSHS, BHA, 2020). DSHS is the state's largest agency, providing support to approximately 34 percent of the state's 7.1 million people (State of Washington DSHS, Strategic Plan, 2019). DSHS's mission is "To transform lives."

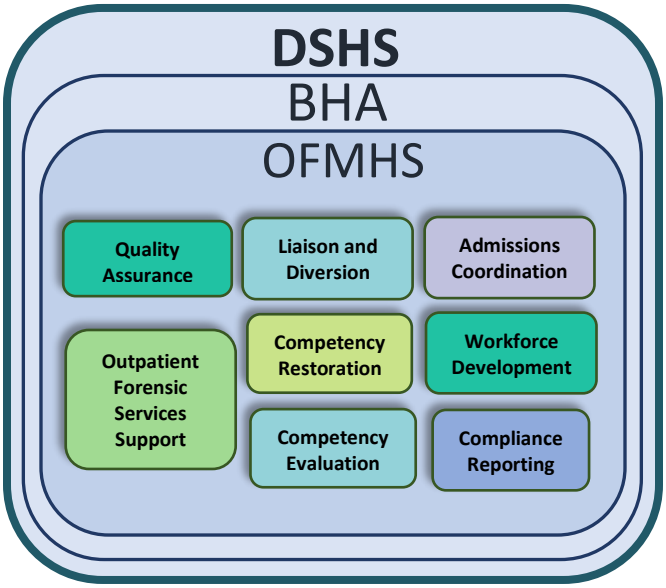
One of the six direct service administrations in DSHS, BHA supports sustainable recovery and independence and wellness through prevention and intervention services and recovery support. It operates the Child Study Treatment Center, Eastern and Western State Hospitals, and specialized mental health treatment for civilly committed sex offenders who have completed their prison sentences at the Special Commitment Center (SCC). In addition, the BHA oversees the OFMHS (State of Washington DSHS, BHA, 2020).

OFMHS is the state entity that oversees the leadership and management of the adult forensic mental health system (State of Washington DSHS, OFMHS, 2020). OFMHS provides:

- **Competency evaluation services** to determine if an individual has a sufficient ability to consult with their attorney to aid in their defense and to understand the proceedings against them due to a mental illness (Dusky v. U.S., 1960).
- **Competency restoration services** for individuals who may be able to attain competency given appropriate treatment (Danzer, Wheeler, Alexander, Wasser, 2019). DSHS provides competency

restoration treatment at Eastern and Western State Hospitals, and residential treatment facilities.

- **Not guilty by reason of insanity (NGRI) treatment services** for people determined not to be criminally responsible for their behavior due to mental illness. People found NGRI were typically experiencing severe symptoms of mental illness at the time of the offense, gravely impairing their capacity to perceive reality or think coherently.
- **Liaison services** to coordinate efforts with system partners to meet shared goals.
- **Training and technical assistance** to improve quality and timeliness of services, and to provide information and assistance pertaining to best practices.
- **Data management and resource allocation** to promote efficiency, track outcomes, and maximize effectiveness.
- **Quality monitoring and reporting** to ensure accountability and service delivery standards, quality reviews of forensic services focus on best practices, and inform improvements to the quality of forensic mental health services within Washington State.
- **Diversion efforts** to prevent citizens with mental health conditions from entering the criminal court system (State of Washington DSHS, OFMHS, 2020) (Luxton, 2019).

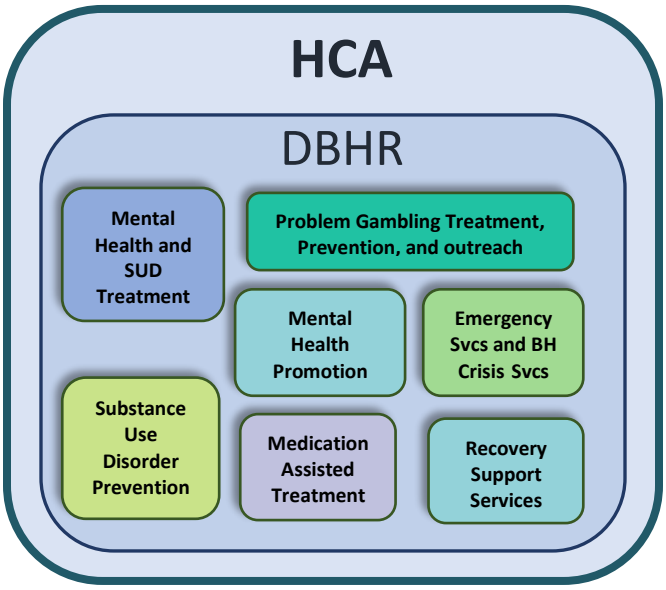


Washington State Health Care Authority

The Washington State Health Care Authority (HCA) is committed to whole person care, and integrating physical and behavioral health services for better results and healthier residents. The Division of Behavioral Health and Recovery (DBHR) is a part of HCA and provides program support for behavioral health, including:

- Mental health and substance use disorder treatment
- Substance use disorder prevention
- Problem gambling treatment, prevention, and outreach
- Mental health promotion

- Medication-assisted treatment
- Emergency services and behavioral health crisis services
- Recovery support services



What are some other components of the forensic mental health system?

Jails

When law enforcement determines there is probable cause that a person has committed a crime, the person may be placed under arrest and transported to a jail. Often, the person remains in the jail until being formally arraigned on criminal charges. After arraignment, the next steps regarding legal proceedings are established in court and include several possibilities. The person may remain incarcerated until a plea agreement is entered, a trial is set, or there is an adjudication. There are a number of other possible legal paths that may include diversion options, therapeutic court options, and/or forms of deferred prosecution. If the person's competency to stand trial comes into question at any time during legal proceedings the court may order a competency to stand trial evaluation.

If the court orders a competency evaluation while the person is in custody, the jail must accommodate a Forensic Evaluator to conduct the competency to stand trial evaluation. The Evaluator then submits a clinical opinion to the court as to the person's competency to proceed to trial.

City and county jails cooperate with Forensic Evaluators and DSHS to arrange reasonable, timely, and appropriate access to defendants for the purpose of performing competency evaluations and to accommodate the fourteen-day mark for completing evaluations for defendants in custody (RCW 10.77.078, 2015).

Trial courts

There are three types of trial courts in Washington: superior, district, and municipal courts.

Washington's superior courts are called general jurisdiction courts because there is no limit on the types of civil and criminal cases heard. They also act as a court of appeals for district and municipal courts.

Superior courts are grouped into 30 districts. Counties with large populations usually make up one district, and smaller counties are sometimes grouped together to make up one district.

In contrast, Washington's district and municipal courts are courts of limited jurisdiction. The district courts' jurisdiction in criminal cases includes misdemeanor and gross misdemeanor cases, while their jurisdiction in civil cases includes damages for injury to individuals or personal property and contract disputes in amounts of up to $100,000.

While district courts hear violations of state law, municipal courts have authority over violations of municipal ordinances, although municipal courts only have jurisdiction over gross misdemeanors, misdemeanors, and infractions. These courts do not accept civil or small claims cases. As with district courts, municipal courts can issue domestic violence protection orders and no-contact orders (Welcome to Washington Court Services, 2020).

Washington courts provide orders for competency to stand trial evaluations and competency restoration treatment, as well as making decisions on many other aspects of the proceedings. Within 24 hours of signing a court order for the evaluation or treatment, the court provides the order and the charging documents, including the request for bail and certification of probable cause, to the processing team. In some cases, a copy of previous court orders related to competency or criminal insanity and previous evaluation reports are also provided (RCW 10.77.075, 2015). The prosecuting attorney provides the discovery packet, including a statement of the defendant's criminal history, to the state hospital (RCW 10.77.075, 2015). After an arrest, prosecutors make decisions about whether or not to prosecute and how to prosecute, with the goal of enforcing laws, ensuring justice, and protecting the community (Hamann, K., Geisler, S., 2019).

Designated Crisis Responder

Designated Crisis Responders (DCR) typically work in partnership with crisis response teams. They also can be part of a co-responder team. DCRs are behavioral health professionals who are able to respond in the moment of crisis. In Washington, DCRs are designated by statute to evaluate individuals who are displaying signs of acute behavioral health distress. DCRs intervene when a person poses significant harm to themselves or others, or a danger to someone's property or are gravely disabled (RCW 71.05.153, 2019). They may also respond in situations when a person is in need of assisted outpatient behavioral health treatment.

When a DCR responds, they will inform the individual of their involuntary treatment rights. They will conduct interviews with the individual, available family, and friends. DCRs consider all available, less restrictive treatment options and make determinations as to whether or not the individual meets criteria for involuntary treatment. If the individual is appropriate for involuntary treatment, a petition will be submitted to the court and the DCR will work to find an available treatment bed (RCW 71.05.240, 2019). If the person is detained to a facility, they may go to court at the end of the 72-hour hold, and the court will then decide if a commitment order for up to 14 days is appropriate.

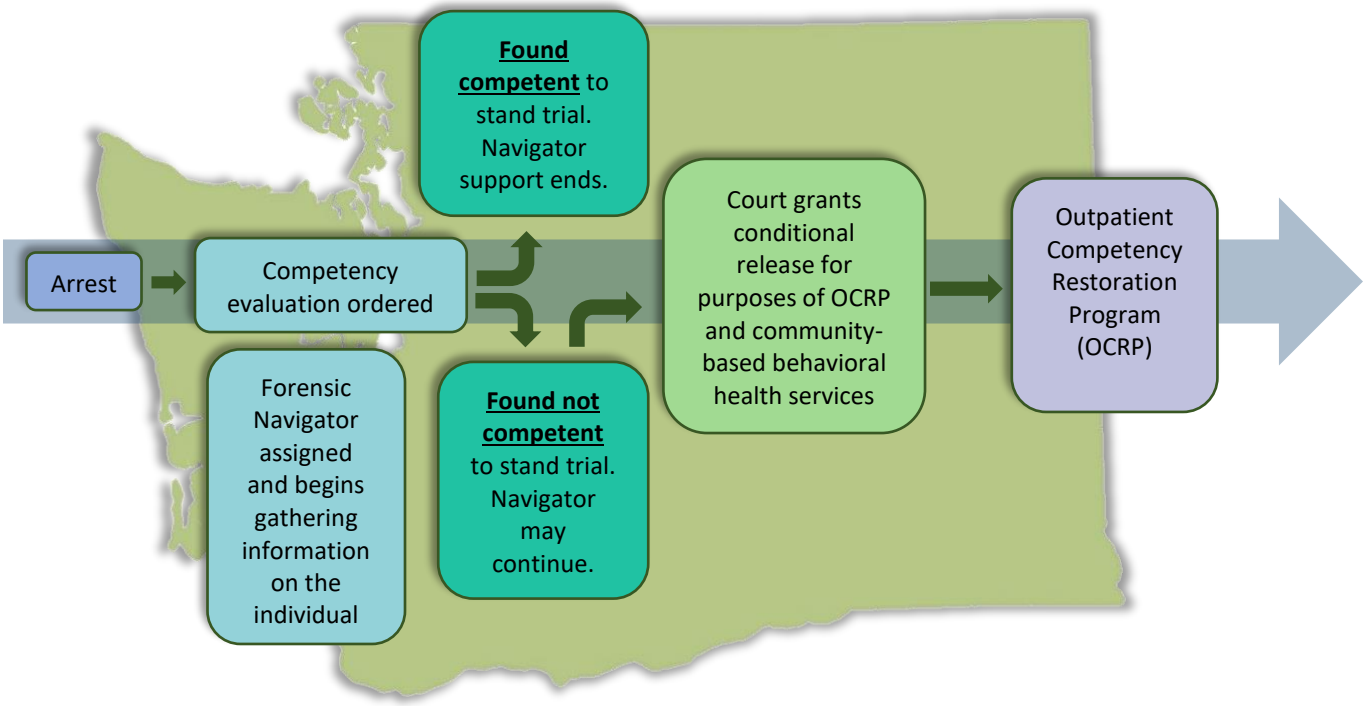
Forensic Evaluators

Forensic Evaluators complete competency to stand trial evaluations (among other forensic evaluations) and are typically OFMHS employees. Occasionally, an evaluator may be an independent external evaluator contracted with the State of Washington or the courts/defense association. Depending on the

court order, the evaluation can be completed in an inpatient setting (state hospital) or outpatient setting (in the community, jail, or attorney's office). Additionally, Forensic Evaluators conduct assessments pertaining to a person's mental state at the time of the offense (i.e., insanity), and their risk for future violent behavior (Luxton, p. 12, 2019).

Forensic Navigators

The OFMHS Forensic Navigators work to divert forensically involved defendants from both jails and inpatient treatment options, into community-based treatment settings (Karpen, 2019). A Forensic Navigator will meet with the person and assist them in understanding and accessing services related to diversion and community Outpatient Competency Restoration services. The Forensic Navigator also assists the prosecuting attorney, defense attorney, and the court in understanding the individual's available treatment options. Forensic Navigators are impartial and deemed officers of the court (RCW 10.77.074, 2019).



When an evaluation is ordered to determine competency to stand trial, a Forensic Navigator may be appointed by the court to assist an individual who has been ordered for forensic evaluation. This court order allows the Forensic Navigator to be given access to all records held by a behavioral health, educational, or law enforcement agency, or a correctional facility that relates to the individual. The order also grants the Forensic Navigators the authority to access clients in jail (RCW 10.77.074, 2019). If a person is found competent to stand trial, the Navigator provides a smooth transition for the individual's return to the facility to await trial.

For participants deemed not competent to stand trial, a determination is made about the appropriateness for the outpatient competency restoration program (OCRP). The Forensic Navigator will

collect relevant information about the individual that might support placement in the OCRP or diversion, and will present their nonclinical recommendations to the court. The court considers the collected information and the recommendations of all of the involved parties (RCW 10.77.074, 2019).

There are no qualifying or disqualifying charges for the OCRP. However, a screening process is employed, which ensures that individuals who are appropriate for community-based treatment and support are offered Forensic Navigator services (Karpen, 2019).

Courts may decide to grant conditional release so defendants can receive services in the community. If a court grants conditional release, Forensic Navigators work with clients to ensure that they comply with the conditions of their release, attend appointments and classes relating to OCRP, and adhere to prescribed medications. Navigators meet regularly with clients and provide updates to the court, which may include appearing at court hearings. They also connect clients to additional supportive services in the community, such as coordinating access to housing, community behavioral health services, substance use disorder treatment, supported employment services, and case management. Forensic Navigators also conduct regular check-ins after the person transitions to the community (RCW 10.77.074, 2019).

Forensic Projects for Assistance in Transitioning from Homelessness (F-PATH)

The Forensic Projects for Assistance in Transitioning from Homelessness (F-PATH) program provides enhanced engagement to people who are at higher risk of involvement with the criminal court system. When an individual meets specific criteria, the team will provide outreach and engagement to connect them to services and supports.

Forensic PATH teams are housed within community behavioral health agencies and include Enhanced Certified Peer Counselors who have experience working with homeless populations, and may have lived experience with the criminal court system. The counselors build relationships with people and help connect them with supports, including housing, transportation, and health care services.

Forensic Housing and Recovery through Peer Services (F-HARPS)

Homelessness is traumatic and cyclical, and can be a significant barrier to receiving services. People are connected with housing through the use of residential supports. These services include peer support and subsidies for costs such as application fees, security deposits, and vouchers for up to a few months of rent while they get help finding more permanent housing support. These teams are staffed with people who have lived experience with behavioral health challenges. This staffing model helps foster engagement with people supported by the F-HARPS team. The goal is to help participants overcome barriers, and find and maintain housing.

NOTES

Module 3: Peer Support Services

This module provides an overview Washington State's Peer Support Certification Program and Enhanced Peer, recovery definition and principles, and understanding the role of peer support within the criminal court system.

What will you learn in this module?

Participants will:

- Gain an understanding of the role of peer support in Washington State
- Understand the importance of recovery
- Become familiar with the core competencies of peer support
- Gain an understanding of the services offered by a Certified Peer Counselor
- Learn Certified Peer Counselor requirements

What are peer support services?

Peer support is a non-clinical service provided by trained individuals who are grounded in their own recovery journey from behavioral health challenges. Peer support is a complement to other services and does not replace or duplicate roles of other members on the treatment team, such as therapists or case managers. Peer support services are unique in that peer supporters draw on their recovery experience to connect, build rapport, and model what people with mental health challenges or a substance use disorder can and do recover. Peer supporters work with people to map their own defined recovery journey and walk alongside them on their path of recovery.

What are enhanced peer support services?

In 2019, HCA began the development of an Enhanced Peer program. The HCA and OFMHS partnered in the development of this specialized training which provides training regarding Washington's forensic mental health system. Enhanced peer support services are provided by Certified Peer Counselors (CPC) who have taken this specialized training in the forensic mental health system. CPCs draw from their own lived experience with criminal court involvement, leveraging it to build rapport and trust. Specific teams have been created as part of the Trueblood Settlement Agreement to support people involved in the criminal court system. Forensic HARPS, Forensic PATH, and OCRP teams are required to employ CPCs who have completed this training.

What services can peer supporters provide?

Peer supporters share their own stories of hope and overcoming challenges. Because peer supporters have personal experience navigating systems, reaching recovery goals, and maintaining wellness, they can use that experience to help others. Peer supporters work with people on meeting goals in their individual treatment plans. Below are some of the activities that peers engage in with the individuals they support:

- Identify strengths
- Build natural supports in the community
- Work with individuals to identify their goals and build plans to achieve them
- Teach self-advocacy skills

- Connect with community resources
- Help people access benefits (e.g., Supplemental Nutrition Assistance Program, Social Security)
- Facilitate peer/mutual support groups, information/skills groups, or recovery groups
- Develop daily living skills such as budgeting, meal planning, time management, or transportation
- Wellness planning such as Wellness Recovery Action Plans (WRAP)

Is peer support new?

The value of peer support goes back centuries. Peer support has its roots in the moral treatment approach, practiced by Jean-Baptiste Pussin and Philippe Pinel in France at the end of the 18th century. The quote below is in reference to a letter written by Pussin, a former hospital patient, who became the superintendent of a mental hospital in 1793, to Dr. Pinel about Pussin's management strategy (Davidson, Bellamy, Guy, and Miller, 2012).

> *"As much as possible, all servants are chosen from the category of mental patients. They are at any rate better suited to this demanding work because they are usually more gentle, honest, and humane."*
>
> *– Jean Batiste Pussin, in a 1793 letter to Philippe Pinel*

Handout

Yale article

Moral treatment diverged from other approaches to mental health that were used at the time, which focused primarily on restraint and harsh methods. Moral treatment sought to transform people through the internalization of moral standards. It promoted kindness and respect in treating people, and ushered in a patient view centered on encouragement and understanding. It was rooted in the ideas of psychology and religious or moral ideologies (Scull, 1989).

The consumer survivor movement in the United States

Deinstitutionalization of state mental hospitals began in the late 1960s when laws began to limit involuntary commitment. As a result, many ex-patients found each other and began to organize and form groups across the United States.

Darby Penney, senior research associate at Advocates for Human Potential, wrote in 2018: "The movement in the United States arose in the 1970s in reaction to negative experiences with mental health treatment and dissatisfaction with the limits of the mental patient role. Peer support among people with psychiatric histories is closely intertwined with experiences of powerlessness within the mental health system and with activism promoting human rights and alternatives to the medical model. Peer support was influenced by the human and civil rights movements of African Americans, women, and lesbians and gay men in the 1960s and '70s, and by the Independent Living (IL) movement of people

with physical, sensory, and cognitive disabilities. While peer support has political roots, it is also an interpersonal process with the goal of promoting healing and growth in the context of community" (Penney, 2018).

Handout

Gayle Bluebird, History of the Consumer/Survivor Movement

Overview of peer support in Washington State

Peer support has been a Medicaid reimbursable service available to eligible individuals living with mental health challenges in Washington State since 2005. In 2019 this service expanded to cover people who experience substance use disorders.

Although it is not required by the Department of Health, HCA provides continuing education to Certified Peer Counselors who have successfully completed the state-approved Certified Peer Counselor training. These trainings cover a wide range of topics to increase the skill set of CPCs. Below are some HCA-sponsored trainings offered to CPCs:

- Trauma Informed Peer Support
- Supporting Peers with Co-occurring Disorders
- Helping Peers in Crisis – Suicide Prevention
- Calm in the Storm – Non-violent De-escalation Skills, Knowledge & Practice for Peer Supporters
- Documentation
- Keys to Success: Ethics and Boundaries
- WRAP 1 and WRAP 2 Trainings

What are the requirements to become a Certified Peer Counselor in Washington State?

To become a CPC, a person must be at least 18 years old with a high school education or equivalent, identify as a person who is receiving or who has received either mental health or substance use services, or be the parent, legal guardian, or primary caretaker of a child who is or who has received mental health or substance use services. The individual must identify as being grounded in their own recovery. They must also demonstrate basic reading and writing comprehension.

To qualify for the training, a person needs to successfully complete the prerequisite online course and submit an application into the HCA-DBHR Peer Support Program for approval. After approval and the completion of a 36-hour in-person classroom training, the individual must pass an oral and written exam and other DBHR requirements.

Once employed by a community behavioral health agency, Certified Peer Counselors need to obtain Agency Affiliated Counselor credential (AAC) through the Washington State Department of Health. To receive this credential, a peer must pass a background check. This can be a significant barrier for some

peers who have lived experience with the criminal court system. If a person is applying for their AAC credential and has past criminal charges, they are required to submit documents obtained from all courts involved for each charge. Washington has addressed some of these barriers by passing Washington House Bill 1907 during the 2019 legislative session. This legislation, specifically section 44, lessened the restrictions for a Certified Peer Counselor to receive their AAC credential. To see these changes visit leg.wa.gov and search by bill number.

What are the core competencies of peer support?

Core competencies for peer workers reflect certain foundational principles identified by members of the mental health consumer and substance use disorder recovery communities. These are:

Recovery-oriented

Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.

Person-centered

Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individual has identified to the peer worker.

Voluntary

Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.

Relationship-focused

The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.

Trauma-informed

Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment (https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers).

What is unique about peer support services?

Certified Peer Counselors have lived experience. This means that they have experienced and live with either mental health conditions or substance use disorders, or both. The importance of lived experience cannot be over-emphasized. It is the core of peer support. Individuals with lived experience:

- Understand many of the issues people they work with face.
- Are likely to have increased empathy and compassion.
- Understand behavioral health, and often the justice system, from the inside. They know what helps and what doesn't.
- Understand what it takes to live in recovery and can share those insights.

An important part of being a Certified Peer Counselor is being willing to share parts of your story and your beliefs in recovery. Peer counselors can be called upon in any setting they feel comfortable with to provide these insights and inspiration. It can be very effective for staff to hear from people in recovery, particularly those who have overcome a history of criminal court involvement. Providers do not often see the successes, and peer supporters are great examples of success in recovery.

What is recovery and what does it look like?

Recovery can be defined many different ways. Employment, family connections, overcoming trauma, securing cultural supports are among the many possible elements of recovery. Many describe recovery as "taking back their lives." Recovery is truly self-defined.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (SAMHSA, 2012).

Activity

Defining Recovery
Work in pairs or groups to come up with a definition of recovery. Share your definition with the rest of the class.

SAMHSA identifies four major dimensions that support a life in recovery:

- **Health:** Learning to overcome, manage, or more successfully live with symptoms and making healthy choices that support one's physical and emotional wellbeing.
- **Home:** A stable and safe place to live.
- **Purpose:** Meaningful daily activities, such as a job, school, volunteer work, or creative endeavors; increased ability to lead a self-directed life; and meaningful engagement in society.
- **Community:** Relationships and social networks that provide support, friendship, love, and hope (SAMHSA, 2012).

Video

https://www.youtube.com/watch?v=jhK-7DkWaKE

Sharie McDaid, CEO of Ireland's Mental Health Reform, defines recovery as "an individual process of discovering one's own strengths, values, meaning and aspirations: a self-determined journey that can take place inside and outside the mental health system, through personal development, through partnership relationships with professionals, through peer support, or through community support" (Watts, & Higgins, 2017).

What are some barriers to recovery and how can CPCs partner to address them?

Stigma can be a significant barrier to recovery, the way an individual sees themselves, the way they perceive how others view them, and how society views them. Enhanced peer support specialists embody the potential for recovery for people who confront the dual stigmas associated with serious mental illnesses and criminal court involvement. Given the history of stigma and discrimination attributed to both mental illness and incarceration, perhaps one of the most important functions of enhanced peer support specialists is to instill hope and serve as valuable and credible models of the possibility of recovery (Davidson, 2008).

Employment

Employment not only provides a paycheck, but also a sense of purpose, opportunities to learn, and a chance to work with others. Most important, work offers hope, which is vital to recovery from mental illness and substance use disorders (NAMI, 2014).

Some barriers to employment are treatment obligations, criminal records, court obligations, lack of work history, transportation, and housing.

Housing

Mental health challenges are exacerbated by unstable housing and homelessness. All people need to have safe and affordable housing to maintain wellness and recovery. There are many barriers to housing for individuals with behavioral health and criminal court involvement. Some of these barriers are financial, past evictions, lack of safe and affordable housing, and transportation issues.

Activity

Identifying barriers and strategies to overcome them

What are some important requirements for certified peer counselors?

Ethics and boundaries

The term “ethics” describes the legal and moral standards of practice. Ethics refer to decisions about right and wrong behavior. They also refer to rules and guidelines that a group agrees to.

In the article *Healthy Boundaries*, personal boundaries are defined as guidelines, rules or limits that a person creates to identify reasonable, safe, and permissible ways for other people to behave towards them and how they will respond when someone passes those limits. It is important that boundaries are set at the beginning of the peer relationship and again throughout services, as necessary. Boundaries can be difficult. Peers may need to, and are encouraged to, ask for guidance from their supervisors. Boundaries may be driven by agency policy and require the use of good judgement (Boundaries, 2020).

As with other professions that work in behavioral health, Certified Peer Counselors are guided by ethics and boundaries and are required to have clinical supervision.

The relationships peers build with those they support need to follow ethical standards and set clear and consistent boundaries. Ethics and boundaries keep the people they support safe as well as prevent problems that could result in loss of a job or certification with the Department of Health. Many agencies provide ethics training to employees. Below are some of the ethical standards Certified Peer Counselors along with other professionals who work in the behavioral health field, abide by:

Confidentiality

Certified Peer Counselors must abide by both state and federal privacy regulations. The Health Insurance Portability and Accountability Act (HIPAA) provides regulations that protect the privacy and security of certain health information.

- Any disclosure requires a signed release of information (ROI) by the individual.
- Information can only be shared with those at the providing agency who are directly involved with the person in services, or during supervision with the peer supporter supervisor.
- When CPCs cross paths with the people they support in the community, they should refrain from interacting unless acknowledged by the person.

Relationships

The relationships CPCs have with those they support are professional. CPCs are held to the same standard as other behavioral health professionals and are not allowed to have any sexual relationships with the people or the family members they work with. This includes any sort of intimate relationships such as chatting on dating sites, sexual innuendos, or talk of having a relationship when services end. Romantic relationships are allowed two years after services end, and only if services are not expected to begin again. It is best to avoid these situations.

Dual relationships can occur when a CPC knows a person who comes in for services. Dual relationships should be avoided because they could possibly do harm to the participant. In smaller or rural communities this might be challenging to navigate. CPCs will need to communicate openly and ask for guidance from their supervisors on how to proceed with these relationships.

Mandated reporters

Mandatory reporters are professionals identified by law who **must** make a report if they have reason to believe that abuse, abandonment, neglect, or financial exploitation of a child or vulnerable adult has occurred. The number to call to make a report is: 1-866-END HARM. CPCs are mandatory reporters, and they have the same obligations to report as other individuals who work in behavioral health.

Scope of practice

CPCs are not qualified to provide therapy, recommend medications, or diagnose or explain diagnoses. They work with people to take measureable steps toward goals identified on the person's individual service plan that support them in reaching their own identified recovery. If an individual has questions

about their medications, a CPC can talk to them about their concerns and work with them to develop strategies to self-advocate with their prescribers.

How are Certified Peer Counselors supervised?

CPCs are required to have clinical supervision. Clinical supervision is provided by Mental Health Professionals (MHP) or Substance Use Disorder Professionals (SUDP), depending on the peer services that are identified in their treatment plan. Clinical supervision supports peers in a professional capacity, such as developing skills, problem solving, addressing ethical dilemmas, and providing clarity around policy and procedure.

NOTES

Module 4: Common Behavioral Health Conditions

This module provides an overview of some of the most common behavioral health conditions in order to give you the opportunity to become familiar with them and to be able to recognize some typical symptoms associated with these conditions. It also provides information on cultural competence as a basis for further exploration and learning.

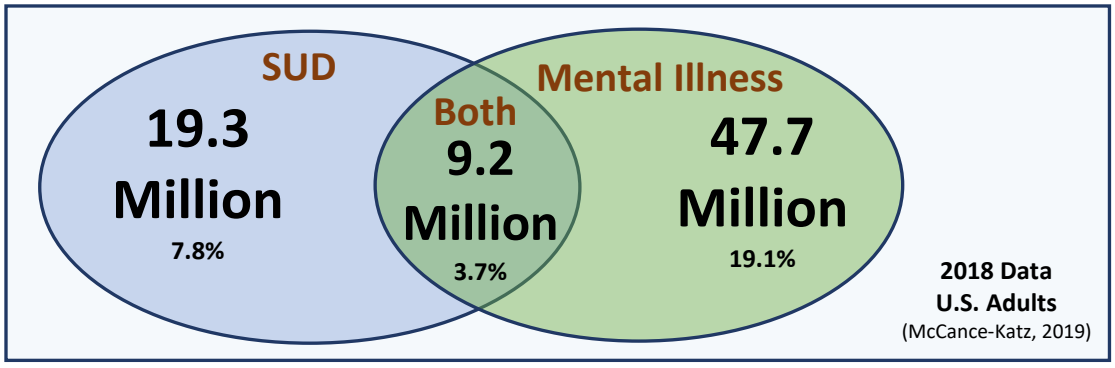
What will you learn in this module?

Participants will:

- Learn about the prevalence associated with common behavioral health conditions.
- Be able to recognize warning signs of behavioral health conditions.
- Learn how to respond and/or interact with someone experiencing symptoms.
- Gain an understanding of relevant cultural considerations.

Generally, behavioral health encompasses mental health conditions and substance use disorders that affect wellness. Developmental disabilities generally refer to specific neurological conditions, such as autism or intellectual disability, which constitute a substantial limitation to the person, occur before age 18, and are expected to continue indefinitely (RCW 71A.10.020).

In 2018, an estimated 19.1 percent of adults in the United States experienced mental illness. This can be one of many conditions which exist and range in severity. Two broad categories, any mental illness (AMI) and serious mental illness (SMI), are used to describe them. SMI represents a more severe portion of AMI. Among the 19.1 percent of adults previously mentioned, 23.9 percent experienced a serious mental illness. (McCance-Katz, 2019).



Behavioral health problems are common and treatable. People can and do recover every day. There are many misconceptions about individuals with mental illness and substance use disorders. These misunderstandings or lack of knowledge can perpetuate the stigma that surrounds people with behavioral health conditions. Stigma can also prevent people from seeking the help they need. In 2017, out of the 46.6 million individuals who experienced any mental illness, only 42.6 percent received mental health services that year (NIMH, 2019).

Myth: People with mental health problems are violent and unpredictable.

Fact: The vast majority of people with mental health problems are no more likely to be violent than anyone else. Most people with mental illness are not violent and only three to five percent of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are more than 10 times more likely to be victims of violent crime than the general population. You probably know someone with a mental health challenge and don't even realize it, because many people with mental health challenges are active, productive members of our communities (MentalHealth, 2017).

What are the most common behavioral health conditions in the United States?

Everyone experiences times in their lives when they have moments of anxiety or feelings of intense sadness. These feelings can occur around normal life experiences, like problems or deadlines at work, or the loss of a friendship or a loved one. When symptoms do not pass, increase over time, and interfere with relationships, work, and/or school, this may indicate a behavioral health condition.

Anxiety disorders

Anxiety disorders are the most common form of mental illness, with more than 40 million adults over the age of 18 affected every year. This makes up 18.1 percent of the U.S. population. Although many anxiety disorders have highly effective treatments, only 36.9 percent of people who are affected receive treatment (ADAA, 2020). Some examples of anxiety disorders are:

- **Generalized anxiety disorder:** excessive fear or worry that occurs most days for six months or longer
- **Panic disorder:** recurrent panic attacks; a sudden feeling of acute and disabling anxiety
- **Post-traumatic stress disorder:** persistent condition resulting from a traumatic experience
- **Social anxiety:** intense fear of social situations
- **Obsessive compulsive disorder:** thoughts and fears that lead to compulsive behaviors; performing something repetitively without it necessarily leading to an actual reward. This can be an attempt to make obsessions go away.
- **Specific phobias:** intense fear of a specific type of object or situation

Although every person is unique and experiences things differently, some common physical symptoms of anxiety include a racing heartbeat, sleeping difficulties (falling or staying asleep), feelings of fatigue, and muscle tension. Emotional symptoms can include feelings of irritability, dread, panic, fearfulness, and being on edge.

Mood disorders

There are many types of mood disorders. A few of the most common are:

- **Major depressive disorder:** persistent feelings of intense sadness
- **Bipolar disorder:** depression that includes times of depression and mania and can include psychosis. Mania can often be identified by extended periods of euphoria, impulsivity, and increased energy and activity.
- **Seasonal affective disorder:** associated with depressive symptoms during seasons with fewer hours of daylight

- **Persistent depressive disorder:** Chronic form of depression
- **Postpartum depression:** Occurs after childbirth and can include extreme feelings of depression and anxiety

Depression can cause a continued feeling of sadness and a loss of interest. Depression can affect how people feel, think, and behave. Depressive disorders are also common. Regarding major depressive disorders, there are approximately 3 million cases in the United States every year. This makes up about 6.8 percent of the population.

Although individual experiences can differ, common physical symptoms of mood disorders are decreased energy, chronic fatigue or feelings of sluggishness, difficulties with memory and/or concentration, changes in weight or appetite, aches and pains that do not have any apparent cause, and difficulty sleeping or oversleeping. Emotional symptoms include loss of interest or pleasure in activities or hobbies, persistent feelings of sadness, anger, irritability, or restlessness, feelings of worthlessness or hopelessness, and thoughts of death or suicide, including suicide attempts.

Psychotic disorders

Although, there seems to be an abundance of reports in the media regarding people with psychosis, psychotic disorders are represented in only 0.3 to 0.7 percent of the population. Psychotic disorders are mental disorders that cause abnormal thinking and perceptions. People experiencing psychosis can lose touch with reality in varying degrees. Some of the more common psychotic disorders include:

- **Schizophrenia:** This is the most common psychotic disorder; people with this disorder experience symptoms that last longer than six months.
- **Schizoaffective disorder:** includes both psychosis and symptoms of a mood disorder
- **Bipolar psychosis:** People with bipolar disorder can also experience psychosis.
- **Substance-induced psychosis:** can be caused by withdrawal symptoms from alcohol or other substances
- **Psychotic disorder due to a medical condition:** Some health conditions that can cause these symptoms include brain tumors, urinary tract infections, Parkinson's disease, stroke, dementia, and Alzheimer's disease.

Symptoms of psychosis include delusions, hallucinations, disorganization, and disorganized thinking. Delusions are false beliefs that are held despite strong evidence against the belief. Hallucinations are perceptions of having seen, heard, touched, tasted, or smelled something that wasn't actually there. Disorganization can be in thought, speech, or behavior, and disorganized thinking can be making strange connections between thoughts.

When working with people who are experiencing psychosis, it is important to remember that what they are experiencing is real to them. They may know that they are experiencing symptoms or they may not. It is important that you do not argue with someone about their symptoms.

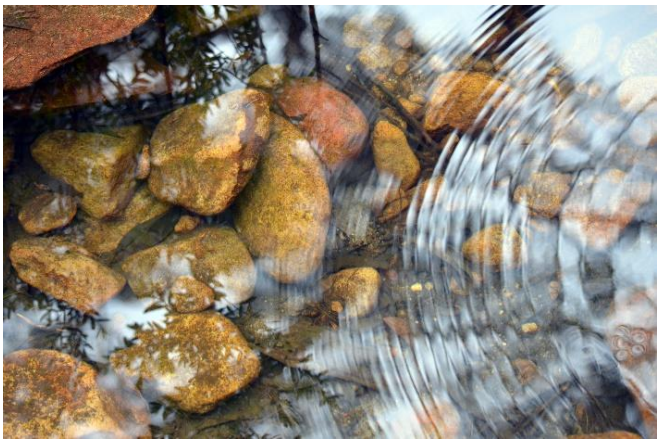
Activity

Hallucinations
Get into groups of three. Identify an individual to act out each of the following roles: a person with symptoms; a person acting as the voice; and a storekeeper. Have the storekeeper try to get the person to leave the store. The goal of this activity is to illustrate the challenges that exist when communicating with someone experiencing symptoms.

What do you do if you are working with someone who is having difficulty communicating? Sometimes people are having internal experiences and are unable to clearly communicate or they are having difficulty understanding what you are saying. Below are some tips on how to communicate when communication is difficult:

Substance use disorders

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines addictions/substance use disorders as occurring "when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. A diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria" (SAMHSA, Recovery, 2014). Substance use disorders can range from mild to severe, and diagnosis ultimately comes down to the individual.



Speak slowly
Repeat yourself if necessary
Be patient
Use short sentences
Do not assume they do not understand
Allow time for them to respond

Around 75 percent of people in a state prison or local jail who experience a mental illness also struggle with substance abuse, and the opposite is also true.[Error! Bookmark not defined.] Of the 2.3 million people in A merican prisons and jails, more than 65 percent meet the criteria for addiction. (Sack, 2014).

There are many paths to recovery for people with substance use disorders, and it is important to support people in their own identified recovery journey. Some of the more familiar options are

abstinence, mutual support groups like twelve-step programs, medication-assisted recovery, harm reduction, and peer-based recovery supports or recovery coaches.

Interventions designed to reduce the detrimental effects of substance use or other behaviors are known as harm reduction. The goal of harm reduction is to support any steps that contribute to moving in a positive direction. The phrase "meeting people where they're at" illustrates the concept of working with someone and taking into account their ability to change (Logan & Marlatt, 2010). An example is the use of vaping devices or nicotine patches to reduce the harmful effects of smoking.

Co-occurring disorders

Co-occurring disorders commonly refer to the condition in which an individual has both substance use and mental disorders, although the term can also refer to other combinations of disorders, such a mental disorder and an intellectual disability (Psychology Today, 2019).

Organic brain disorders and traumatic brain injury

An organic mental disorder refers to impaired mental function from a medical condition other than a psychiatric illness. Organic brain disorders can be acute or chronic and are caused by physical changes in the structure of a person's brain. Organic brain disorders cause impaired cognition. Causes of organic brain disorders include stroke, lack of oxygen to the brain, Alzheimer's disease, Parkinson's disease, and dementia.

Impaired mental functioning can also occur from a traumatic brain injury (TBI) which results from a bump, blow, or jolt to the head (CDC, traumatic, 2020). A TBI is usually caused by an outside force that causes dysfunction. These injuries can be a result of events such as car accidents, sports injuries, violent attacks, and other accidents. People with a TBI may have impaired language skills, mood swings, and memory loss. Symptoms of these organic brain disorders include problems with memory, changes in behavior, difficulty understanding language, trouble with performing daily activities, confusion, changes in vision, and balance issues (Healthline, 2020).

Personality disorders

"A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment " (APA, 2013, p. 645). Examples of personality disorders are paranoid personality disorder, schizoid personality disorder, antisocial personality disorder, borderline personality disorder, narcissistic personality disorder, and obsessive-compulsive personality disorder. Individuals with personality disorders can express a wide range of emotions and behaviors that may make personal relationships difficult.

Intellectual and developmental disabilities

In Washington State, a developmental disability is defined as "a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological or other condition of an individual found by the secretary [of DSHS] to be closely related to an intellectual disability… which disability originates before the individual attains age eighteen, which has continued or can be expected to continue indefinitely, and which constitutes a substantial limitation to the individual" (RCW 71A.10.020 (5))." In 2018, there were 25,082 adults in Washington State enrolled as clients of the Developmental

Disabilities Administration (DDA) (Eliason, 2018). This number, however, only reflects people that have gone through the state eligibility process to become clients of DDA. Therefore by solely using this data, the number of people in Washington State with a developmental disability is likely underrepresented.

Among the 25,082 adults in Washington with developmental disabilities, the diagnosis of intellectual disabilities (ID) applies to 7.1 percent of DDA clients (Eliason, 2018). This is significant because "people with ID experience mental illness at an increased rate that is greater than the general population. It is estimated that 30 to 35 percent of those with ID have a co-occurring mental health disorder compared with 15 to 19 percent in the general population (Diaz, Kimball, O'Neal, Shook, Devenney, 2017)."

What about cultural considerations?

According to 2014 U.S. census data, 37.9 percent of the population consists of racial or ethnic minorities (U.S. HHS 2016). Culturally competent services are those which consider distinct populations and the shared beliefs, norms, and values of the group. Cultural competence is the application of knowledge, skills, and experience, to respond respectfully and effectively to people of all cultures in a manner that recognizes, and considers the beliefs, norms and values of individuals, families, and communities (Luxton, 2019, p. 9).

Awareness of a culture's attitudes toward behavioral health, healing, and help-seeking patterns, practices, and beliefs, is important in understanding how a person may present their symptoms, their attitudes about treatment, and the influence of cultural factors in healing. Cultural mindfulness aids in developing culturally competent skills and processes to positively impact an individual's response to treatment and engagement in recovery services (SAMHSA, Tip 59, 2014, p. xix-xx). It can influence a treatment provider's diagnosis and treatment decisions, which may improve an individual's receptivity to provider recommendations (HRSA, 2005).

Four core elements of cultural competence are:

- Cultural awareness: when a person is cognizant of their own beliefs, biases, and assumptions about others and can use that information to inform their work.
- Cultural knowledge: important in developing an understanding of cultural aspects of the populations that you support, especially in terms of help-seeking, treatment, and recovery.
- Cultural knowledge of behavioral health: understanding how different cultures may interact with behavioral health issues. It helps to realize that because of our own culture, we each have at least some ethnocentric views from that culture and are shaped by our own interpretation of it.
- Cultural skill development: a commitment to ensuring continual learning and application of cultural knowledge to guarantee the delivery of culturally appropriate treatment (SAMHSA, 2014, Tip 59, p. 6-48).

Activity

Video regarding culture of institutionalism

NOTES

Module 5: Diversion Programs

This module provides an overview of what diversion is, why it is important, and how diversion can impact people who may become involved with the criminal court system.

What will you learn in this module?

Participants will:

- Understand the concept of diversion
- Understand the importance of diversion
- Become familiar with the Sequential Intercept Model
- Be able to identify different points of intercept in the Sequential Intercept Model

What are diversion programs?

Diversion programs are formal programs that divert people out of the criminal court process into treatment. Successful screening and assessment early in the criminal court process (including pretrial) are essential to diverting people into treatment programs. Diversion programs are often run by a municipal police department, county sheriff's office, tribal law enforcement, court of limited jurisdiction, or behavioral health organization. The programs are designed to enable individuals to avoid criminal charges or a criminal conviction by alternatively engaging in a treatment program (Knudson, Luxton, Peebles, Popchockhakim, DeMark, Frenchman, Mosolf, Anderson, Lookingbill, Whitney, 2020).

There are several diversion programs across Washington State. They range from co-responder programs where a mental health professional can respond to calls jointly with law enforcement officers in an effort to divert a person from arrest, to jail-based screening programs that help divert individuals from jail and connect them with community services. Many of these programs employ CPCs.

Diversion initiatives are focused around four main goals:

- Preventing people with behavioral health issues from recidivism and frequent involvement in the criminal court system
- Reducing the demand for competency services
- Reducing long-term incarceration for people with behavioral health issues
- Serving defendants in the least restrictive environment possible (State of Washington DSHS, OFMHS, 2020)

In 2019, the National Prosecutors' Consortium administered a nationwide survey of county prosecutors on a state-by-state basis. The survey revealed information about innovative programs and alternatives to incarceration and illustrated the increased involvement in crime prevention, creative problem solving, and community partnerships. Thirty-three percent of the prosecutors in Washington participated. Of those, most are involved with drug courts (92%) and have local drug treatment programs, half are involved with mental health courts with a large majority that have local mental health services. Examples of these programs are from King, Thurston, and Benton Counties.

King County has the Law Enforcement Assisted Diversion (LEAD) program, in which low-level offenders with behavioral health needs are diverted to services rather than prosecution. Thurston County uses a

First Look Unit to identify cases which meet the criteria for resolution through diversion or treatment. Benton County has a mental health diversion program where offenders receive treatment, and after successful program completion, can have their case dismissed (Hamann, Geisler, 2019).

DSHS contracts with three sites that operate prosecutorial diversion programs. Those sites are in Spokane, King, and Benton/Franklin counties. Through these programs, prosecutors and behavioral health professionals consider individuals for possible enrollment into a diversion program. If the prosecution, defense, behavioral health staff, and the individual all agree on program participation, then the charges can either not be filed, or (if already filed) can be dismissed without prejudice. Once enrolled into the program, individuals receive appropriate behavioral health supports, intensive case management services, housing supports, and other services. Program involvement typically lasts six to 12 months. Upon successful completion, an individual's charges can then be dismissed with prejudice, meaning the charges are gone for good and cannot be brought back up in court.

Why are diversion programs important?

In Washington there is an overrepresentation of people in jail with mental illness compared to the general population, and the demand for services exceeds the resources available (Joplin Consulting, 2016). Diversion programs can reduce the number of people in jail by providing a pathway to treatment, rather than incarceration, for those who are legally eligible. Providing an alternative to incarceration can also help prevent barriers that may impede successful transition back into the community.

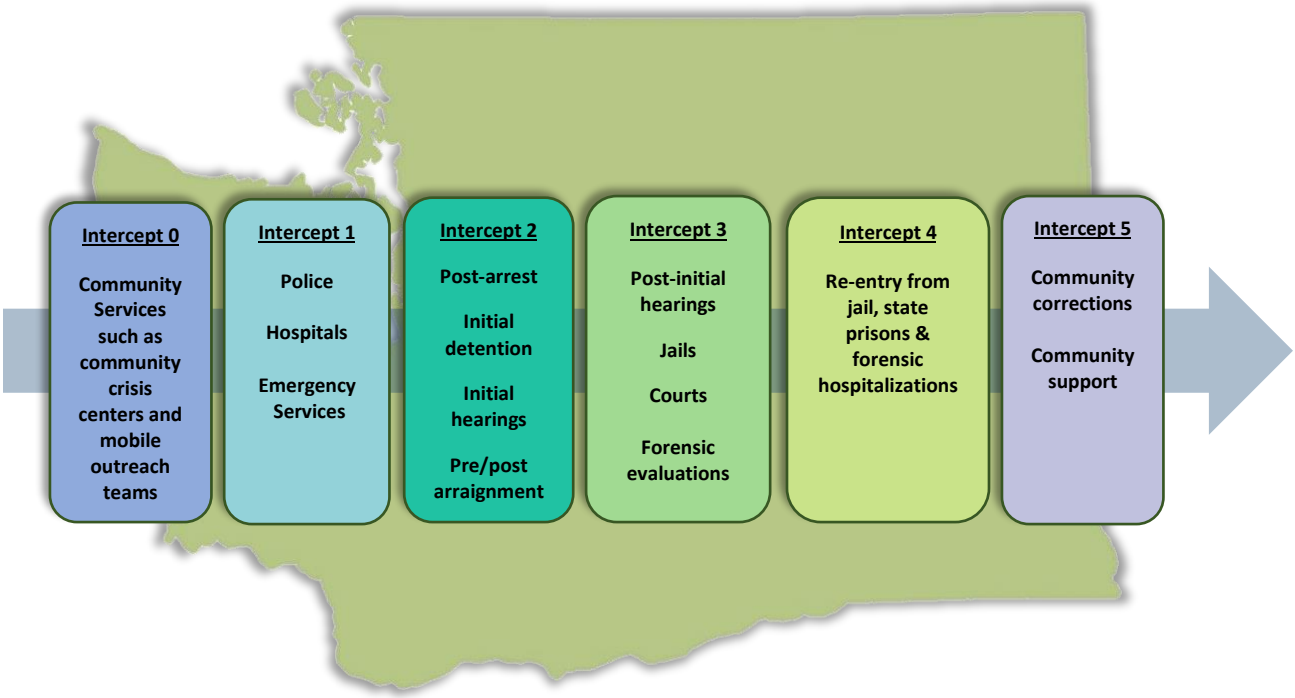
For example, a criminal record may pose challenges to obtaining employment, securing housing, accessing financial aid for higher education, and may result in an accrual of debt with court costs and restitution. Getting arrested can also affect an individual's insurance coverage and benefits, and the stigma of having a criminal record can impact interpersonal relationships.

> *"Getting to work with people who are experiencing criminal court challenges has been amazing. The mental health jail diversion program that I work in offers hope to people charged with a crime and experiencing mental health challenges. By partnering people who have navigated the court system, and also have lived experience with people who are currently going through a challenging time in their lives, it provides hope of recovery. I get to see that hope come alive in people's eyes when they realize that they are not alone and that they can overcome their challenges."*
>
> *— Sheri Reeves, Certified Peer Counselor*

What is the Sequential Intercept Model?

The Sequential Intercept Model (SIM) (Munetz & Griffin, 2006) provides a framework that helps identify points for treatment and diversion for people with behavioral health conditions who come in contact with the criminal court system. The intercept model has several key objectives, including:

- Preventing initial involvement with the criminal court system
- Decreasing admissions to jail
- Engaging individuals in treatment as soon as possible
- Minimizing time moving through the criminal court system
- Connecting people to community treatment options
- Decreasing the rate of return to the criminal court system. (Munetz & Griffin, 2006)



The Diversion (Sequential) Intercept Model

Pre-arrest diversion

Pre-arrest diversion is the first point of interception for individuals with behavioral health needs. Intercept zero is a recent addition to the Sequential Intercept Model focusing on prevention and early intervention prior to system involvement (Policy Research Associates, 2020). Examples of services in intercept zero include community crisis lines, outreach teams, and community crisis centers.

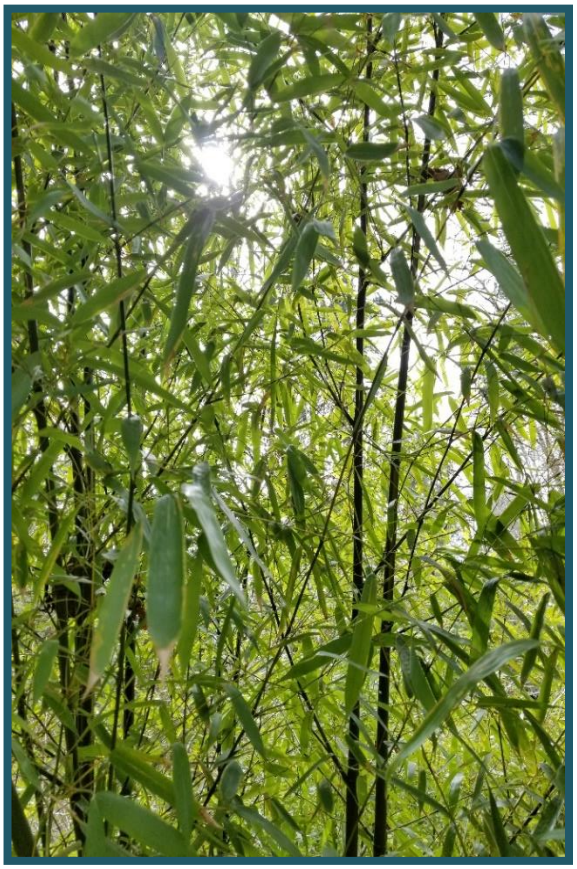
Law enforcement and emergency service professionals are often the first point of contact for people in crisis. Periodically law enforcement officers may find it difficult to immediately access behavioral health services or may be unaware of available resources. Crisis Intervention Teams (CITs) and police-mental health co-responder teams bridge the resource gap and are trained to link people with mental illnesses

to treatment without arrest. Police diversion programs are built on partnerships between mental health providers in the community and designated law enforcement entities, with the aim of identifying serious mental illness, de-escalating or not escalating situations, decreasing stigmatization, and when appropriate, linking an individual to treatment rather than booking them into jail.

Mental illness is prevalent among those incarcerated. Being diverted from the local jail into alternative and sometimes more effective options, may lead to reduced costs because of the reduced engagement with the criminal court system. It may also lead to future cost savings, as early participation in individualized treatment may improve symptoms, which could lead to a reduction in recidivism (Cowell, Hinde, Broner, Aldridge, 2013).

However, it is not just the decrease in costs that is important. The trauma a person can experience while arrested and/or incarcerated can be major, but is minimized when someone is able to be diverted from the criminal court system. Having a criminal record is also a significant cost, which impacts housing and employment opportunities that can contribute to recidivism. Diversion gives a person the opportunity to move toward recovery and wellness while not having these added barriers.

Note: Washington State RCW 10.31.110 allows for arrest diversion for any criminal charges when there is a mental health connection. It also requires local prosecutors and law enforcement to develop guidelines with the input of defense counsel and the disability community advocates on how best to utilize this arrest discretion.



Post-arrest diversion

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

Post-arrest diversion options include the use of mental health screening tools after arrest to quickly identify and refer people with behavioral health needs to appropriate services either in jail or in the community. Additionally, established diversion programs including prosecutorial diversion models exist in some jurisdictions. Finally, specialized courts, including drug, mental health, and veterans' courts, have shown to be an effective way to divert people with behavioral health needs from incarceration and into treatment

(Sarteschi, Vaughn, & Kim, 2011). These voluntary programs operate both pre- and post-adjudication, and allow participants to access treatment as an alternative to incarceration.

There will be occasions when individuals are bought to jail while experiencing symptoms of severe mental illness. Other times, a person may decompensate while in custody to the point that their safety or health is at risk and they will not agree to care. In such cases, if the person is in custody and is legally eligible, referring the individual for evaluation by a Designated Crisis Responder for involuntary civil commitment may be warranted (Knudson, Luxton, Peebles, Popchockhakim, DeMark, Frenchman, Mosolf, Anderson, Lookingbill, Whitney, 2020).

NOTES

Module 6: Competency to Stand Trial

What will you learn in this module?

Participants will:

- Gain an understanding of competency to stand trial
- Understand why determining competency is important
- Gain knowledge of the steps in the competency evaluation process
- Become familiar with relevant state statutes

What is competency to stand trial?

Competency to stand trial means that a person accused of a crime is able to consult with his or her legal representative with a rational understanding in order to assist in their own defense, and to be able to understand the nature of the proceedings against them in both a rational and factual sense (Dusky v. U.S., 1960).

Citizens have a right, when being tried for a crime, to be able to understand the legal proceedings and to aid their attorney in their own defense. At any point during a criminal trial, attorneys or the judge can raise the question of whether or not the defendant has the ability to understand the proceedings and to aid their attorney, or if a mental health condition may prevent them from being competent to stand trial. When the question of competency has been raised, the judge then orders a formal evaluation of competency to stand trial.

In Washington State, these evaluations are conducted by specially trained, licensed psychologists who are employed by the DSHS. By Washington law, a defendant is not competent if they "lack the capacity to understand the nature of the proceedings against him or her or to assist in his or her own defense as a result of mental disease or defect" (RCW 10.77.010- (15), 2020).

Why is determining competency important?

The 1966 U.S. Supreme Court case Pate v. Robinson helps to illustrate the significance of ensuring that a defendant is competent to stand trial. In this case, the defendant was charged with murdering his wife and during the trial the defense raised the issue of competence. A competency evaluation was not conducted and Robinson was convicted. The case reached the U.S. Supreme Court on appeal and the state conceded that, "the conviction of an accused person while he is legally incompetent violates due process, Bishop v. United States, 350 U.S. 961 (1956)" (id at p. 378).

Due process is a right granted by the U.S. Constitution in Amendments 5 and 14. The amendments state, "nor shall any state deprive any person of life, liberty, or property, without due process of law." Washington law states, "No incompetent individual shall be tried, convicted, or sentenced for the commission of an offense so long as such incapacity continues" (RCW 10.77.050, 1974).

Who conducts forensic evaluations in Washington?

In Washington State, Forensic Evaluators working for OFMHS, or employed by Washington State as a contractor, should have experience performing competency evaluations, knowledge of Washington State competency statutes, psychological testing knowledge, clinical assessment and diagnostic skills, and have a Washington State license in good standing in their relevant profession. Currently, the majority of competency to stand trial evaluations are conducted by OFMHS employees, and the State of Washington has a designated position for this function (https://ofm.wa.gov/state-human-resources/compensation-job-classes/ClassifiedJobListing/Specifications/4488). Washington State law RCW 10.77, does however provides defendants the right to request an independent outside expert for several services related to the question of competency.

What is the process in Washington for evaluating competency?

In Washington, the most common source of referrals to forensic mental health treatment providers are evaluations of competency to stand trial (Gowensmith, Murrie, & Packer, 2014). Once doubt about a defendant's competency to stand trial has been raised, the prosecutor may continue with the competency process or dismiss the charges without prejudice and refer the defendant for assessment by a mental health professional, substance use disorder professional, co-occurring disorder specialist, or developmental disabilities professional to determine the appropriate service needs for the defendant. This does not apply to defendants with a current charge or prior conviction for a violent or sexual offense (RCW 10.77.079, 2015). If the decision is made to initiate the competency process, a qualified expert will be designated to evaluate and report upon the mental condition of the defendant (RCW 10.77.060, 2016).

Some counties in Washington conduct in-jail screening of individuals who may be candidates for a pretrial forensic mental health evaluation. It is important to note that this type of screening assessment is not a competency evaluation, but a process to help identify and recommend to the court, appropriate referrals for competency evaluations. (Knudson, Luxton, Peebles, Popchockhakim, DeMark, Frenchman, Mosolf, Anderson, Lookingbill, Whitney, 2020).

Court order to evaluate competency to stand trial

An evaluation is initiated through a court order and a Forensic Evaluator is typically assigned. When being evaluated, the defendant is entitled to have his or her attorney present and may refuse to answer any question if they believe the answers may tend to incriminate them or form links leading to evidence of an incriminating nature (RCW 10.77.020, 2006). The forensic evaluation may be conducted in the jail, in an inpatient facility such as the state hospitals, or in community settings. In Washington, the majority of forensic evaluations are conducted by OFMHS Forensic Evaluators in a jail setting (Luxton, 2019). The state requires that the Evaluator's report include:

- A description of the nature of the evaluation
- A diagnosis of the mental status of the defendant
- An opinion as to the defendant's competency if the defendant has a mental illness, or a developmental disability

- An opinion as to the defendant's sanity and the risk to public safety (if insanity is claimed pursuant to (RCW 10.77.030) and an evaluation and report is provided by an expert)
- An opinion as to whether the defendant should be evaluated by a Designated Crisis Responder (RCW 10.77.060 (3), 2016).

The signed court order gives the Evaluator the authority to access all records held by any mental health, medical, educational, or correctional facility that relate to the present or past mental, emotional, or physical condition of the defendant. If the court is advised by any party that the defendant may have a developmental disability, the evaluation must be performed by a developmental disabilities professional (RCW 10.77.060, 2016).

If the Evaluator concludes a Designated Crisis Responder evaluation is needed, the court orders the evaluation to be conducted prior to release from confinement when the person is acquitted or convicted and sentenced to confinement for 24 months or fewer, or when charges are dismissed pursuant to a finding of incompetent to stand trial (RCW 10.77.065, 2020).

Completed evaluation submitted to the court

The competency evaluation is then submitted to the court, and if the court finds that the defendant is competent, the case proceeds to trial (Luxton, 2019). The Forensic Evaluator also provides the report and recommendation to the Designated Crisis Responder, the prosecuting attorney, the defense attorney, and the correctional facility where the defendant is being held.

If the individual is receiving inpatient services related to competency, the facility will discharge the defendant when it is determined that the defendant is competent to stand trial. If the defendant is discharged to the custody of a jail facility, they must continue the medication regimen prescribed by the facility, when clinically appropriate, unless the defendant refuses to cooperate and an involuntary medication court order has not been entered (RCW 10.77.065, 2020).

If the court concludes that the defendant is not competent, a period of treatment may be authorized to restore the defendant to competency. If the person is then restored to competency, the case proceeds to trial. It is important to note that competency to stand trial may be questioned at any time (Luxton, 2019).

What if inpatient commitment is necessary to complete an evaluation?

Sometimes an Evaluator may assess the individual and determine that a period of inpatient commitment will be necessary to complete an accurate evaluation. In these situations, a signed court order will be issued. The Evaluator then requests the jail or detention facility to transport the defendant to a hospital or secure mental health facility for a period of commitment not to exceed 15 days from the time of admission to the facility.

A defendant may also be committed for evaluation without an assessment if the defendant is charged with murder in the first or second degree, if the court finds that an evaluation in the jail will be inadequate to complete an accurate evaluation, or if it is necessary for the health, safety, or welfare of the defendant.

The court will not order an initial inpatient evaluation for any purpose other than a competency evaluation.

When a defendant is ordered to be committed for inpatient evaluation, the court may delay granting bail until the defendant has been evaluated for competency and appears before the court. In determining bail, the court considers Evaluator recommendations regarding competency, the defendant's history of violent acts, previous not guilty by reason of insanity acquittals or findings of incompetence, a likelihood of failure to appear, and consideration of a threat to public safety (RCW 10.77.060, 2016).

What if an individual has a developmental disability?

A defendant found not competent by the court must have a determination made as to whether they have a developmental disability. If so, they may be placed in a specialized habilitative program for people with developmental disabilities. Security is provided, appropriate to the charged criminal behavior, and as necessary to protect public safety (RCW 10.77.0845, 2012).

The habilitative model supports the development of new skills and competencies that nurture a person's growth and assist with living a safe and fulfilling life. Eastern and Western State Hospitals' specialized program is the Habilitative Mental Health (HMH) program. Western serves up to 30 clients and Eastern up to 12 with specialized treatment needs that could not be adequately addressed or supported in a community setting (BHA, 2020).

What are the timeframes for evaluations?

For adult criminal defendants, the Washington State Legislature established performance targets for the timely completion of competency evaluations and inpatient restoration services related to competency to stand trial. Although these targets may not be achievable in all cases, they are met whenever possible without sacrificing the accuracy and quality of competency evaluations and restorations.

For a defendant in pretrial custody, the shortest of the following deadlines:

- For in-jail competency evaluations: 14 days from receipt of order (if the order was received within 0 to 7 days from order signature date) or 21 days from order signature date (if the order was received more than 7 days from order signature date).
- For inpatient competency evaluations and restorations: 7 days from receipt of order (if the order was received within 0 to 7 days from order signature date) or 14 days from order signature date (if the order was received more than 7 days from order signature date).
- Using the shortest of the above deadlines, the time periods begin the date DSHS receives a signed order for competency services (if received within 7 days of court order signature) or the date the court signs an order for competency services (if the court order is received by DSHS more than 7 days from the court order signature (RCW 10.77.68, 2012 and Trueblood, et al. v. DSHS).

For a defendant who is released from custody and makes a reasonable effort to cooperate with the evaluation process, to receive a completed competency evaluation in the community, the performance target is 21 days or less (RCW 10.77.68, 2012). If the evaluation cannot be conducted due to a lack of cooperation by the defendant, the Evaluator notifies the court (RCW 10.77.065, 2020).

Activity

Completing the intake assessment of barriers to competency

NOTES

Module 7: Competency Restoration Services

What will you learn in this module?

Participants will:

- Be able to explain what competency restoration is
- Understand the importance of competency restoration
- Gain an understanding of the competency restoration process
- Learn about Sell orders and Harper hearings
- Become familiar with some of the state facilities that provide competency restoration services
- Become familiar with relevant state statutes

What are competency restoration services?

When someone has a competency evaluation and is then found by the court to be not competent to stand trial, the court may order the person to participate in competency restoration treatment services. The goal of competency restoration services is to assist the individual overcome the factors that limit their ability to understand the proceedings and aid their attorney in their own defense.

Competency restoration services typically include appropriate psychiatric medications when indicated, education about court procedures, education about management of mental health symptoms, and other supportive services. The process is typically referred to as competency restoration. This evidence-based program is designed to be a multimodal experience, providing individualized treatment tailored to deficits in competency (Breaking Barriers Training module). At the end of the competency restoration period or at any time a professional determines competency has been, or is unlikely to be, restored, the defendant will be returned to court for a hearing. If the court finds that competency has been restored, the court will lift the stay entered (RCW 10.77.084, 2016).

Why is competency restoration important?

When a person is found incompetent to stand trial, they lack the capacity to understand the nature of the proceedings against them or to assist in their own defense as a result of mental disease or defect. (RCW 10.77.010 (15), 2020). Washington State law provides that “no incompetent person shall be tried, convicted, or sentenced for the commission of an offense so long as such incapacity continues” (RCW 10.77.050, 1974).

How is the process different for a non-felony and a felony?

Competency restoration procedure in non-felony charge

If the defendant is charged with a non-felony crime that is not a serious offense, the court may stay or dismiss proceedings and allow a Designated Crisis Responder to evaluate the defendant and consider initial detention proceedings. However, the prosecutor can object to the dismissal and ask for competency restoration, in which case the court will schedule a hearing. The prosecution must establish that there is a compelling state interest to order competency restoration treatment. The court may consider prior criminal history, history in treatment, history of violence, the quality and severity of the pending charges, and previous competency restoration treatment outcomes. If there is a compelling state interest, the court may order inpatient or outpatient competency restoration. The placement can

be up to 29 days for inpatient, and up to 90 days for outpatient restoration. If it is determined that the defendant is unlikely to regain competency, the court may dismiss the charges without prejudice and order that the defendant be referred for evaluation for civil commitment. If the proceedings are dismissed and the defendant was on conditional release, the court will order a DCR evaluation. If the defendant was in custody at the time of dismissal, the defendant is detained and sent to an evaluation and treatment facility for up to 72 hours (RCW 10.77.088, 2019).

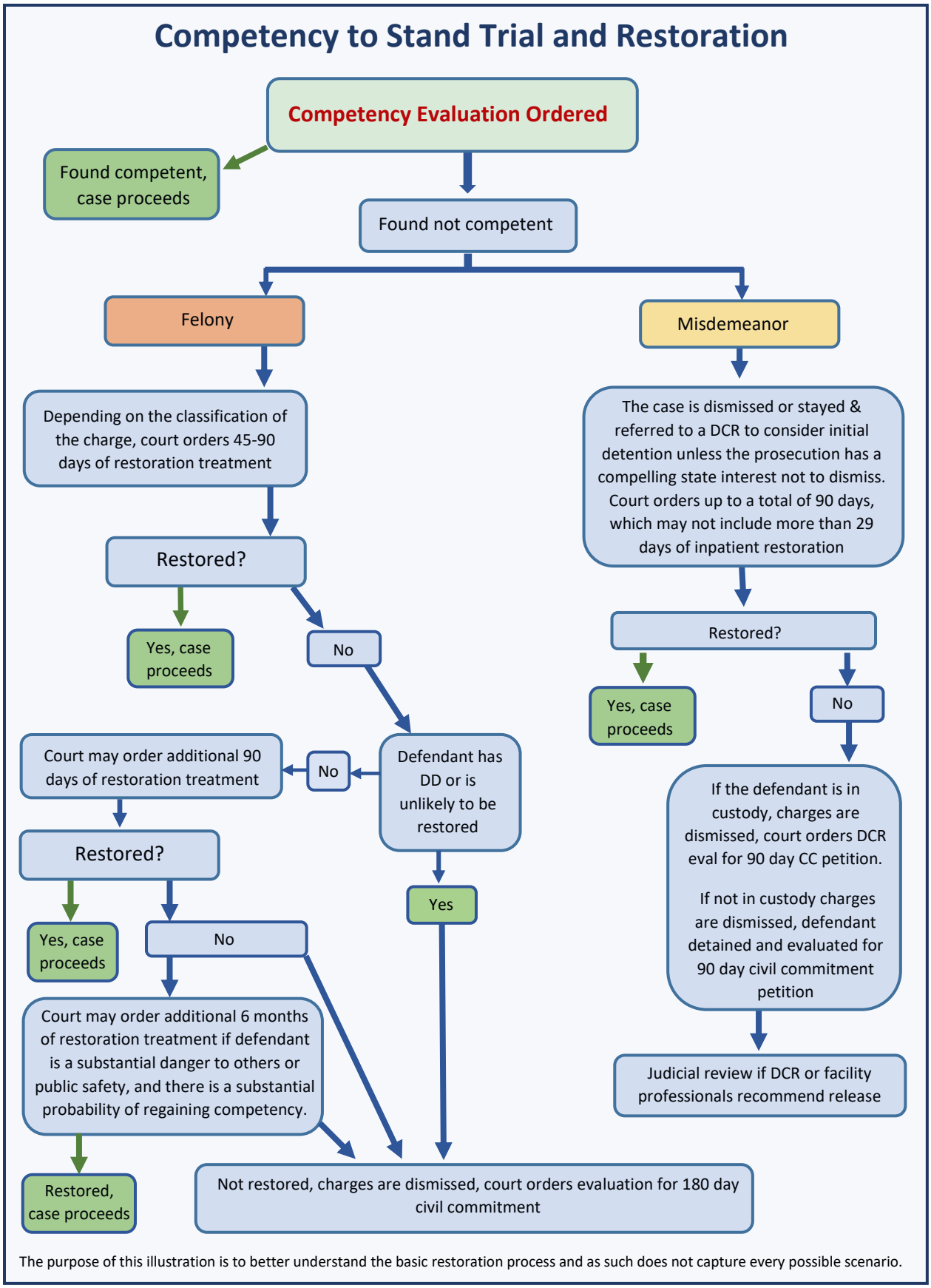
Competency restoration procedure in a felony charge

If the defendant is charged with a felony and found not competent to stand trial until regaining competency (no longer than 90 days total), the defendant will receive inpatient or outpatient competency restoration. If the court orders a defendant into the Outpatient Competency Restoration Program, it modifies the conditions of release as needed to accommodate approved housing.

The OCRP will monitor the defendant and report any noncompliance or significant changes. The 90-day period for competency restoration includes the time at the facility and transportation time to or from the facility. For a defendant whose highest charge is a class C felony, or a class B felony that is not classified as violent, the maximum time allowed for the initial period of commitment for competency restoration is 45 days. If the court determines that the defendant is unlikely to regain competency, the court may dismiss the charges without prejudice without ordering restoration treatment, in which case the court will order that the defendant be referred for evaluation for civil commitment. On or before expiration of the initial period of commitment, the court will conduct a hearing to determine whether or not the defendant is competent to stand trial.

If the court finds that a defendant charged with a felony is not competent, the court will have the option of extending the order of commitment or alternative treatment for an additional 90 days, but the court must, at the time of extension, set a date for a prompt hearing to determine the defendant's competency before the expiration of the second restoration period. No extension shall be ordered for a second or third restoration period if the defendant's incompetence has been determined to be the result of a developmental disability where competence is not likely to be regained with an extension.

For people charged with a felony, at the hearing upon the expiration of the second restoration period (or at the end of the first restoration period in the case of a developmental disability), or at any stage, if the defendant is found not competent, and it is determined that the defendant is unlikely to regain competency, the charges will be dismissed without prejudice. The court will then order the defendant be committed to a state hospital for up to 72 hours starting from admission to the facility, for evaluation for the purpose of filing a civil commitment petition. The criminal charges will not be dismissed if it is found that the defendant is a substantial danger to other people or is likely to commit criminal acts jeopardizing public safety or security, and it is likely that the defendant will regain competency within a reasonable period of time. In this situation, the court may extend the period of commitment for up to six months (RCW 10.77.086, 2012).


Competency to Stand Trial and Restoration
Competency Evaluation Ordered
Found competent, case proceeds
Found not competent
Felony
Misdemeanor
Depending on the classification of the charge, court orders 45-90 days of restoration treatment
The case is dismissed or stayed & referred to a DCR to consider initial detention unless the prosecution has a compelling state interest not to dismiss. Court orders up to a total of 90 days, which may not include more than 29 days of inpatient restoration
Restored?
Yes, case proceeds
No
Restored?
Yes, case proceeds
No
Court may order additional 90 days of restoration treatment
No
Defendant has DD or is unlikely to be restored
If the defendant is in custody, charges are dismissed, court orders DCR eval for 90 day CC petition.
If not in custody charges are dismissed, defendant detained and evaluated for 90 day civil commitment petition
Restored?
Yes, case proceeds
No
Yes
Court may order additional 6 months of restoration treatment if defendant is a substantial danger to others or public safety, and there is a substantial probability of regaining competency.
Judicial review if DCR or facility professionals recommend release
Restored, case proceeds
Not restored, charges are dismissed, court orders evaluation for 180 day civil commitment
The purpose of this illustration is to better understand the basic restoration process and as such does not capture every possible scenario.

What are the competency restoration facilities in Washington?

Eastern State Hospital

Eastern State Hospital is located in Medical Lake, Washington. This 317-bed inpatient psychiatric hospital is accredited by the Joint Commission and certified by the federal Centers for Medicare and Medicaid Services (CMS). Eastern State Hospital is one of two state-owned psychiatric hospitals for adults in the state.

Eastern State Hospital partners with individuals, families, advocates, community health care providers, behavioral health organizations, employee organizations, educational organizations, and local and state government systems to provide services to individuals in eastern Washington counties. The hospital provides evaluation and inpatient treatment for people with serious or long-term mental illness who have been referred to the hospital through a behavioral health administrative service organization (BH-ASO), managed care organization (MCO), or the civil court system for people who receive a civil court order for involuntary treatment, or through the criminal court system (BHA, 2020).

Western State Hospital

Western State Hospital is located on the site of historic Fort Steilacoom in Lakewood, Washington. It opened in 1871 and has a capacity of more than 800 beds. The hospital provides evaluation and inpatient treatment to individuals with serious or long-term mental illness. Patients are referred to the hospital through their BH-ASO, MCO, or the civil court system when they meet the criteria for involuntary treatment or through the criminal court system (BHA, 2020).

The Center for Forensic Services (CFS) is located on the Western State Hospital campus and has eight treatment units which house about 30 to 31 clients each. The center serves adults who have been committed to the hospital under RCW 10.77. Services include competency evaluations, competency restoration treatment, and treatment for people who have been found not guilty by reason of insanity. Individuals work with a multidisciplinary team and participate in daily active psychiatric treatment. While at the center, clients progress through a level privilege system in which they are able to earn increased incentives and privileges.

The Center for Forensic Services also has a Community Program which serves NGRI clients who are ready for conditional release from the Court. NGRI clients seeking conditional release or receiving unconditional release/final discharge are reviewed by the center's Risk Review Board. The board then provides its recommendations to the court. The Community Program provides case management services for a number of NGRI clients living in the community after being conditionally released. Community Program staff also work with behavioral health organizations in the community to assist CFS clients with outpatient treatment and housing upon their discharge from Western State Hospital (BHA, 2020).

Competency restoration residential treatment facilities (RTF)

Washington currently has three inpatient competency restoration facilities. Maple Lane is a 30-bed competency restoration program in Centralia, Washington, serving pretrial adults, and has an anticipated closure date of 2024. Yakima is a 24-bed competency restoration center in Yakima, Washington, serving pretrial adults, and is scheduled for closure in 2021. Fort Steilacoom Restoration and Treatment facility is in Lakewood, Washington, on the Western State Hospital grounds and serves

pretrial adults. It has a 30 bed capacity. RTFs serve patients who are assessed to be relatively low in risk to harm themselves or others. Candidates for admission are screened by clinical staff to determine their appropriateness for the program.

Both WSH and ESH continue to be options for patients. Defendants ordered into competency restoration services are assessed through a centralized screening process to determine which location best matches their needs. State law gives the Secretary of DSHS the discretion for placement for competency restoration. (See RCW 10.77.084(1)(b), 10.77.086(1)(a)(i) and 10.77.088(1)(a).)

Outpatient Competency Restoration

Washington's OCRP began services in July 2020 through contracted behavioral health agencies, and managed by HCA in collaboration with OFMHS. The program is intended to reduce the number of people waiting to receive competency restoration services and to provide services in the least restrictive setting possible. The program provides competency restoration services to individuals determined by the court as not competent to stand trial and appropriate for community treatment.

OCRP eligibility criteria

Defendants in a state hospital, a jail, or in the community may be ordered to OCRP. To be considered for OCRP several factors are reviewed:

- Clinical appropriateness
- Willingness to adhere to medications
- Willingness to abstain from drugs and alcohol or participate in substance use treatment
- Need for restoration treatment in a secure facility
- Appropriateness for civil commitment
- Likelihood of adhering to community based services
- Risk of elopement

Clinical appropriateness for OCRP is assessed by DSHS. Factors considering clinical appropriateness include medical stability, current severe psychiatric symptoms, risk of harming oneself or others, recent history of assaultive behaviors, history of elopement, and history of compliance with community behavioral health.

In addition, individuals must be willing to adhere to medications, and abstain from alcohol and un-prescribed drugs (RCW 10.77.088, 2019). Based on those factors and information gathered by the Navigator (with clinical recommendations from the OFMHS Forensic Admissions Coordinator), the Navigator will make a non-clinical recommendation to the court regarding the suitability of the defendant for the program. If the court approves the individual for OCRP, it will order a conditional release. The Navigator will then make a formal referral to the OCRP, assist in the transition to services, meet with the person on a regular basis, and provide status information to the court. The court may not issue an order for OCRP unless there is an available appropriate outpatient restoration program or the

court places the defendant under the control of an identified professional person (RCW 10.77.086, 2012).

OCRP program delivery

The OCRP utilizes the Breaking Barriers Competency Restoration Program, used in Washington State inpatient settings with individualized assessments and treatment. Services include intake assessment of barriers to competency, monitoring barriers to competency, making adjustments to interventions as needed, standardized psychosocial and psychoeducational treatment, and early referral, if appropriate, to forensic evaluation. This standardized psychosocial and psychoeducational treatment includes the following modules:

- Courtroom Knowledge and Understanding
- Optimal Symptom Management
- Relaxation and Coping Skills
- Effective Communication (with attorneys and others in the court system)

OCRP approaches may vary among individual defendants and within and across regions. Contractors may utilize individual and group in-person treatment, telehealth, and mobile treatment approaches, depending on the person's needs, the range of service area coverage, and the competency restoration period.

Program completion

The OCRP will provide documentation regarding the client activity at least weekly to the assigned Forensic Navigator. If a client fails to comply with the program requirements and restoration is no longer appropriate in the community setting, or the client is no longer clinically appropriate based on the treatment team recommendation, the client may be transferred to an inpatient restoration facility to serve the rest of their restoration order. The subsequent inpatient stay cannot exceed 29 days regardless of any time spent in outpatient competency restoration (RCW 10.77.088, 2019).

A competency evaluation will be scheduled near the end of the ordered restoration period or when the client may have achieved competency. The evaluation will be coordinated among the Forensic Evaluator, the Forensic Navigator, the defense attorney, and the OCRP contractor. If the Forensic Evaluator determines that an individual remains not competent to stand trial at the end of a restoration period, the court may order an additional period of restoration consistent with legal requirements. If the client is at the end of legal authority and is not-likely-restorable, the court may dismiss the charges and refer for civil commitment evaluation.

Involuntary medications

In the United States Supreme Court case *Sell v. United States*, an individual with a history of mental illness was found not competent to stand trial and was undergoing restoration treatment. The staff recommended he take psychiatric medications, but he refused and challenged the requirement to take it involuntarily. The court held that the U.S. Constitution allows the government to administer psychiatric medications involuntarily to a criminal defendant with mental illness in order to render that defendant competent to stand trial for serious but nonviolent crimes (Sell v. United States, 2003). The case established that four conditions must be met in order to administer psychiatric medications involuntarily in the case of competency restoration:

- Important government interests are at stake
- The medication is likely to render the defendant competent and unlikely to interfere significantly with the defendant's ability to assist in their defense
- Alternative, less intrusive treatments are unlikely to achieve the same results
- The administration of the drugs is medically appropriate (Etheridge, Chamberlain, 2006).

In reference to this case, an authorization to administer medications involuntarily as part of treatment pertaining to competency to stand trial, may be referred to as a Sell order. In Washington State, the treating psychiatrist or Advanced Registered Nurse Practitioner (ARNP) is responsible for initiating Sell hearing proceedings. Typically, if medication is refused for three consecutive days or there is a pattern of inadequate medication compliance for at least a week, and the psychiatrist or ARNP believes that the defendant cannot be restored without medication, a Sell hearing will be requested. If the Evaluator believes that competence will not be restored without medication compliance but an order for the involuntary administration of medication is not granted, and the medication refusal continues, a report will be submitted to the court providing an opinion on the defendant's capacity to stand trial (Luxton, 2019).

Another important court case involving involuntary medications is *Washington v. Harper*. In this case Harper challenged the prison policy regarding the administration of antipsychotic medication, citing a violation of due process. The court held that medication could be involuntarily administered to a prisoner with a mental illness who posed a danger to themselves or others, provided it is in the individual's best medical interest (494 U.S. 210 (1990)). A Harper hearing is specific to reducing dangerousness or grave disability. When the court must make a determination whether to order involuntary medications for the purpose of restoring or maintaining competency to stand trial, the court asks whether the defendant is the subject of a pending civil commitment proceeding or has been ordered into involuntary treatment pursuant to a civil commitment proceeding (RCW 10.77.093). For the purpose of restoring and maintaining competency to stand trial in the case of a serious offense, the court may authorize involuntary medication. Some examples of charges that are serious offenses in this context are violent offenses, sex offenses, serious traffic offenses, those involving firearms and dangerous weapons, domestic violence, and class B felonies. In determining a serious offense in terms of competency restoration, some court considerations are bodily or emotional harm inflicted, the impact on community security, related charges pending, the length of potential confinement, and the number of victims (RCW 10.77.092, 2014).

NOTES

Module 8: Civil Commitment and NGRI

What will you learn in this module?

Participants will:

- Gain an understanding of civil commitment
- Be able to identify what a felony conversion is
- Become familiar with not guilty by reason of insanity (NGRI)
- Become familiar with *Ross, et al. v. Lashway* et al
- Understand the function of a Public Safety Review Panel

What is civil commitment?

Civil commitment means the determination by a court that a person should be detained for a period of evaluation, treatment, or both, in an inpatient or a less restrictive setting (RCW 10.77.010, 2020). The presence of a mental disorder is a prerequisite for civil commitment. Other criteria frequently include dangerous behavior toward oneself or others, grave disability, and the need for treatment (Luxton, 2019).

In Washington, a civil commitment begins with an evaluation by a Designated Crisis Responder (DCR). The DCR can then detain a patient to a hospital for a 72-hour evaluation if they are dangerous to themselves or others due to a mental disorder or substance use disorder (RCW 71.05.150, 2019). Additional commitments of up to 180 days may be ordered by the court if needed. The hospital evaluates and treats patients with the most complicated mental illnesses, with the goal of stabilizing the patient so that they can return to the community as quickly as possible. Discharge planning begins at the time of admission. The treatment team, consisting of psychiatrists, psychologists, nurses, social workers and others, develops an individualized treatment plan with strategies and goals. To ensure a smooth transition, social workers and others work with community liaisons to find a placement appropriate to the individual's needs. Once it is identified, the patient is then discharged from the hospital or given a less restrictive alternative (LRA) placement in the community (BHA, 2020).

What is a felony conversion or "felony flip"

A "felony flip" is when a defendant's felony charges are dismissed and a civil commitment is pursued. A court may dismiss criminal charges due to the lack of competence to stand trial. The individual is then sent to the state psychiatric hospital for evaluation to determine if the individual meets criteria under Washington State law, RCW 71.05 for civil commitment, due to their mental illness. Pursuant to RCW 10.77.086(4), charges are dismissed without prejudice, allowing the court to re-charge the individual in the future, if the individual is determined to have become competent (Luxton, 2019).

What are some relevant court cases?

During the era of institutionalization in the United States, it was widely believed that people with mental illness lacked the capacity to make decisions and inpatient care was beneficial. Many people were involuntarily admitted to psychiatric hospitals and if they did get released, they often found that they had lost their property and custody rights. A gradual shift occurred in response to abuses of civil

commitment, and states began to change laws to protect the rights of people considered for civil commitment.

By 1960, Medicare and Medicaid were established, new medications entered the market, and the civil rights movement had begun. These events helped to bring about change. In 1963, the Community Mental Health Center Act was signed into law, which led to the reduction of psychiatric institutions and the establishment of community mental health centers in the United States.

The 1966 court case *Lake v. Cameron*, looked at involuntary hospitalization of psychiatric patients that were not considered to be dangerous to themselves or others (1967). The court ruled that for individuals who meet this criteria, alternative treatment that is less restrictive, but still meets the treatment needs of the patient is available (Testa, West, 2010).

In 1975, the Supreme Court decision in *O'Conner v. Donaldson* established that states cannot confine an individual who has been determined not to be dangerous and who can live safely either independently or with the support of family and friends. To do so violates the constitutional right to liberty under the Fourteenth Amendment (O'Connor v. Donaldson, 1975).

What is not guilty by reason of insanity (NGRI)?

When a defendant pleads not guilty by reason of insanity, they are admitting that they committed an offense but were either not able to perceive the nature and quality of the act or were not able to tell right from wrong in regard to the charged offense due to a mental illness that satisfies the definition of legal insanity. A criminally insane person means someone who has been acquitted of a crime by reason of insanity, and found to be a substantial danger to others or presents a likelihood of committing criminal acts jeopardizing public safety or security unless kept under further control by the court or other people or institutions (RCW 10.77.010, 2020).

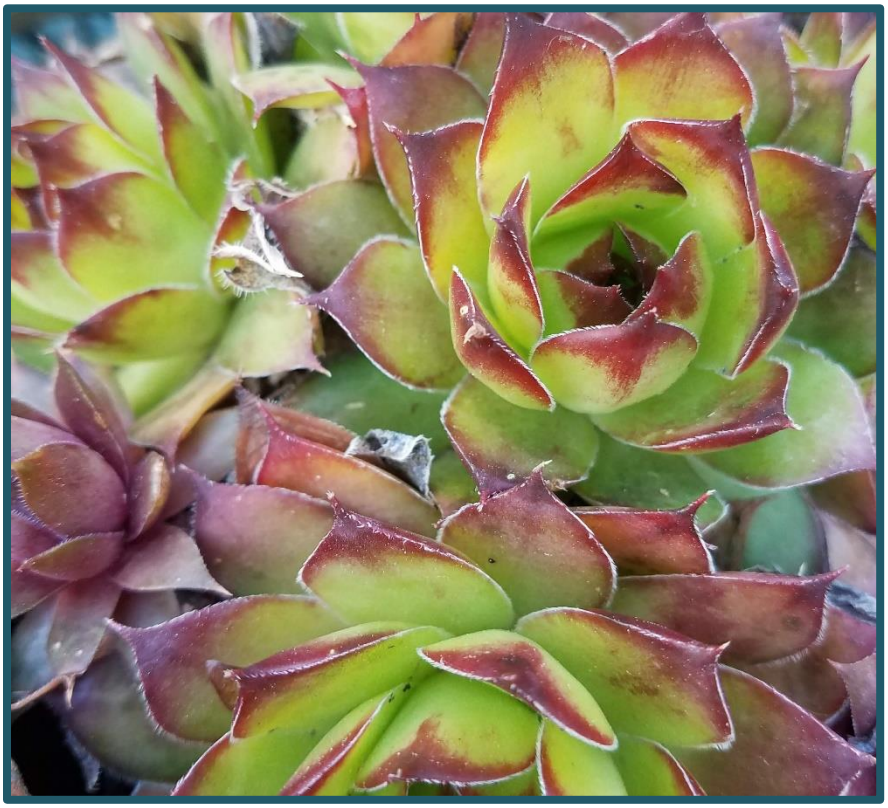
In this case, the defendant will be evaluated to determine if they have a developmental disability. If so, the defendant may then be committed to a program specifically reserved for the treatment and habilitation of individuals with developmental disabilities. If they do not, the court will order their hospitalization, or any appropriate alternative treatment less restrictive than detention in a state psychiatric hospital (RCW 10.77.110, 1998).

If a defendant is acquitted of a crime by reason of insanity, and it is found that they are not a danger to others, nor present a likelihood of committing criminal acts jeopardizing public safety or security, the court will direct the defendant's conditional release (RCW 10.77.110, 1998).

When a person has been committed following their NGRI acquittal, the commitment or treatment can't exceed the maximum possible sentence for the offense. The maximum possible sentence for the offense charged is determined and a maximum release date is computed. If the person hasn't been released by six months prior to this date, the court and prosecuting attorney are notified of the required release date, which stands unless civil proceedings are instituted or the court determines that the computation of maximum release date is incorrect (WAC 388-875-0050, 2019). If the individual has not been released within seven days of the maximum possible sentence, and the facility believes that the person presents a likelihood of serious harm or is gravely disabled due to a mental disorder, the facility will notify the DCR of the impending expiration and provide a copy of all relevant information, including the likely

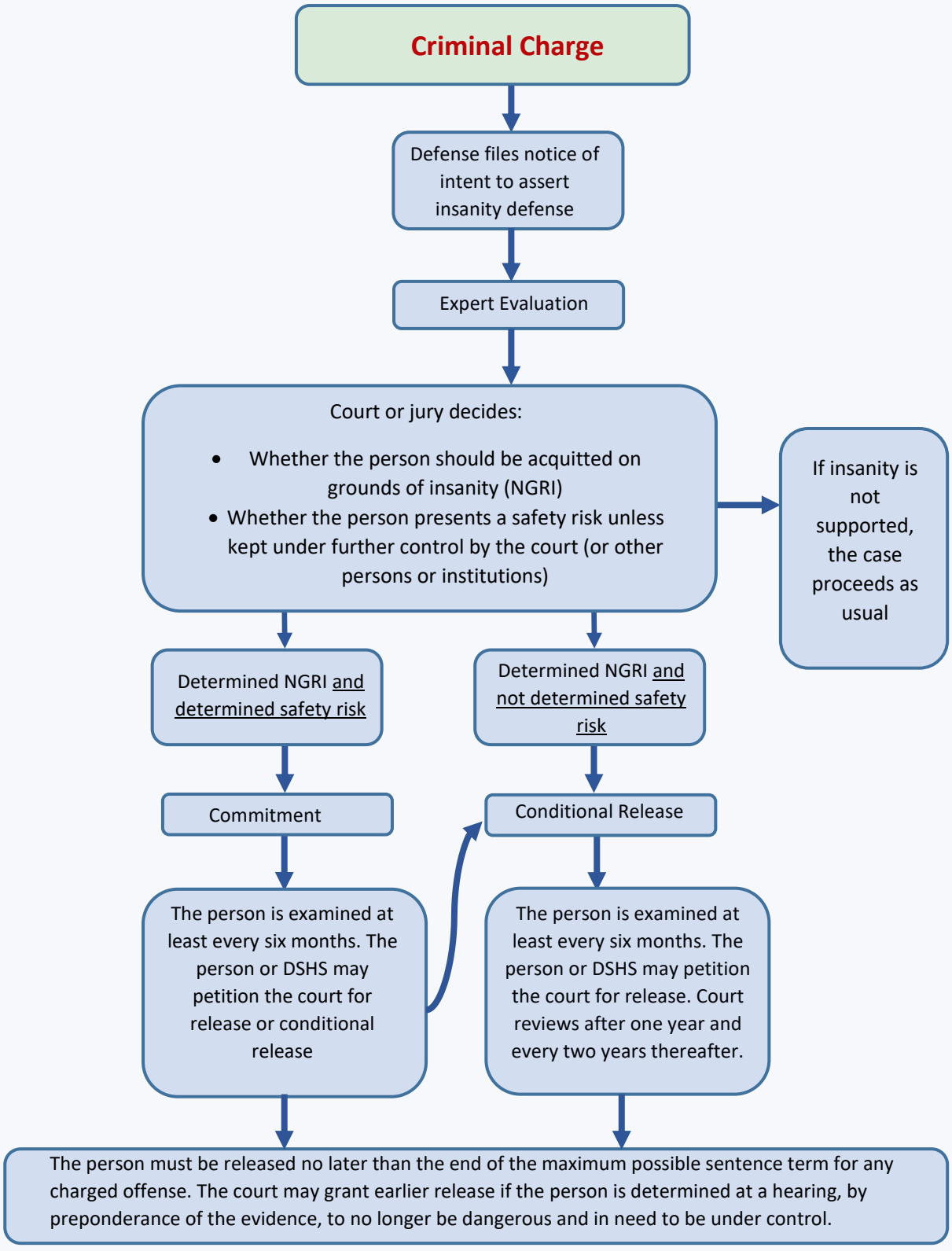
release date and an indication of why the person should not be released. The DCR will then determine whether to initiate proceedings under chapter 71.05 RCW. (RCW 10.77.025, 2016).

Individuals who have been found NGRI require attention for clinical and legal needs as a result of their connection to both the mental health and criminal court systems. Some NGRI acquittees may also be discharged into community treatment programs (Luxton, 2019). When a person is committed under NGRI in Washington, the treatment facility evaluates and diagnoses the person to develop an individualized treatment program. This happens within 15 days of admission. The person's treatment team develops the individualized treatment plan which must include the person's specific challenges and needs, a description of the physical setting necessary, the treatment goals and how and when they will be reached, staffing plans for goal attainment, and criteria for recommendation to the court for release.



The treatment plan must be reviewed at least every six months and be made available to the court, and other authorized people or entities, upon request (WAC 388-875-0060, 2019). NGRI treatment services are targeted to help reduce an individual's risk to re-offend and help individuals progress toward safely returning to the community, with appropriate supports, when the court approves such a return.

Not Guilty By Reason of Insanity Process



What is Ross, et al. v. Lashway et al?

In 2014, patients found to be NGRI and sent to the state hospitals for treatment, brought a lawsuit against DSHS. The lawsuit sought to improve services to NGRI patients and ensure that conditional and unconditional release/final discharge processes required by 10.77 RCW were pursued per clinical indication and public safety (DSHS, Ross, 2020).

Prior to 2010, patients received treatment that gradually reintegrated them into the community through supervised trips. This deliberate release planning provided a balance between patient recovery and public safety and resulted in the streamlined release of patients who no longer needed to stay at the hospital.

In 2010, a series of new state laws added restrictions to the release process for patients committed under NGRI. Patients were generally required to obtain a court order to leave the hospital, even if doctors recommend this for treatment and recovery. The Public Safety Review Panel was also created to provide an additional layer of review before patients committed under NGRI or civilly committed for a violent offense and found not competent to stand trial are permitted to leave the secure areas of the state psychiatric hospitals. Because changes in the law delayed the treatment and recovery process, plaintiffs brought the lawsuit to ensure timely clinical decision-making while respecting the safety of patients and the public (DSHS, Ross, 2020).

What is the Ross Settlement Project?

The parties involved in the lawsuit agreed that there were several steps hospitals could take to improve the treatment and release process despite the new laws. These changes would significantly benefit patients without having to involve the court. The settlement agreement anticipated that by September 2018, both state hospitals would have modified their policies and put into place all of the stipulations in the agreement, including ensuring individualized treatment plans, increasing the patient's role in treatment and discharge planning, streamlining the grounds privileges and release processes, new requirements for strip searches and restraints used during transport, and the creation of a more uniform NGRI patient-level system policy (levels are used to increase patient privileges as they make progress in their treatment). In August 2019, a U.S. Federal Court dismissed the *Ross, et al. v. Lashway et al* case after DSHS demonstrated that it has greatly improved policies and provided patients found not guilty by reason of insanity a better chance of success once they are approved to leave the state psychiatric hospital (DSHS, Ross, 2020).

NOTES

Module 9: Trauma Informed Care

What will you learn in this module?

Participants will:

- Gain a better understanding of trauma
- Understand the impact of trauma on behavior
- Understand the importance of the trauma informed care approach
- Be able to identify key principles of the trauma informed care approach
- Learn about post-traumatic growth

Prevalence

In the National Epidemiologic Survey on Alcohol and Related Conditions, 71.6 percent of people reported witnessing trauma; 30.7 percent experienced a trauma that resulted in injury; and 17.3 percent experienced psychological trauma (SAMHSA, tip 57, 2014).

Definition of trauma

Trauma encompasses "experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual wellbeing" (SAMHSA, tip 57, p xix, 2014).

The main components of this definition are:

- **Event:** The event or set of circumstances that induces trauma.
- **Experience:** Two people can experience the same event differently. One may be traumatized by the event and the other may not. Factors including the person's cultural beliefs, social connections and supports, and age may impact how an individual experiences events.
- **Effect**: These are long-lasting and can happen immediately or later on. At times a person may not connect the traumatic event with the effects it has on them. Some examples of traumatic effects are hypervigilance, a constant state of arousal, numbing or avoidance (SAMHSA, Concepts P 7, 2014).

The significance of trauma in behavioral health services

Recently there has been increased focus on the ways in which trauma, psychological distress, quality of life, and health are linked. Integrating trauma informed care into behavioral health services highlights the view that trauma can significantly affect an individual's well-being, including physical and mental health. It recognizes that people may be affected by trauma even though they may not acknowledge it

and is based on an understanding that individuals accessing behavioral health services are likely to have experienced trauma.

Trauma informed care emphasizes a person-centered approach and provides individuals with increased opportunities to engage in services that reflect a compassionate perspective. It may also provide a greater sense of security for people who have histories of trauma and reduce more serious consequences of traumatic stress (as cited in SAMHSA, tip 57, p. 8, 2014). It offers people the opportunity to explore the impact of trauma, and the relationship to substance use and psychological symptoms, even though some people may chose not to. It also offers the opportunity to recognize and utilize strengths, adaptability, and resilience, found in managing past trauma (SAMHSA, tip 57, 2014).

Characteristics of trauma

Traumatic experiences can vary tremendously, but certain characteristics may impact the intensity and duration of the trauma. Some key characteristics are:

- **Occurrence:** Single, repeated, or sustained trauma. Everyone is different; a single traumatic event can cause significant disruption in a person's life, and repeated trauma can have a cumulative effect.
- **Condition:** The traumatic event is expected or unexpected. Most traumatic events don't occur with warning; however, the opportunity to prepare may allow a person to equip themselves and thereby diffuse some of the traumatic effects.
- **Intensity:** The trauma has isolated or pervasive effects on the person's life. If the event is isolated, the individual may have a greater ability to leave the traumatic event in the past and embrace the present.
- **Responsibility and intent:** Unintentional or intentional event, and responsible party. Understanding why something has happened can be healing and cathartic.
- **Time:** The time and degree of disruption after the initial trauma. The amount of disruption a traumatic event causes and the time it takes to get back to normalcy can have a significant impact on a person's wellness and resilience.
- **Belief system:** Core assumptions and beliefs challenged. These are traumatic events which can rock our core beliefs and throw us off center.

Forms and types of trauma

There are many different kinds of trauma. Examples of traumatic events that have a natural basis are tornados, earthquakes, or other natural disasters. Events that have a human basis are a car accident, a shooting, a home invasion, or other violent acts perpetrated by people.

Although trauma is individually defined, experiences can also depend on the degree of devastation, the extent of loss, and the time it takes for things to get back to normal. Trauma can affect people individually, such as a mugging, or as a group, a community, or on a large scale such as a terrorist attack.

Historical and or generational trauma are events with such lasting effects that they are passed to future generations. An example of historical trauma is the internment of people with Japanese ancestry in the United States during World War II.

Secondary trauma occurs when a person is empathetically engaged in reports of traumatic experience by others. This indirect exposure to these events is sometimes referred to as compassion fatigue.

Another way in which people experience trauma can occur through conscious or unconscious reminders of past trauma, this is known as re-traumatization. For example, certain sights, smells and/or environments can trigger past traumatic experiences (SAMHSA, tip 57, 2014).

The trauma informed care approach

Trauma informed care (TIC) is "a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p.82)

"TIC is an intervention and organizational approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health services from prevention through treatment" (SAMHSA, tip 57, 2014).

SAMHSA identifies three key elements which a trauma-informed approach incorporates: being aware of the prevalence of trauma, recognizing how it affects all individuals involved, and responding by putting this knowledge into practice" (SAMHSA, tip 57, 2014).

Principles of a trauma informed approach are safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical and gender issues (SAMHSA, concept, 2014).

Steps to build a trauma informed environment

- Meeting the client's needs in a safe collaborative and compassionate manner
- Preventing treatment practices that re-traumatize people with histories of trauma who are seeking help or receiving services
- Building on the strengths and resilience of clients in the context of their environments and communities, and endorsing trauma informed principles in agencies through support consultation and supervision of staff" (SAMHSA, tip 57, 2014)

Post traumatic growth

Some people who experience trauma develop a resiliency and learn and grow from their experiences. This is referred to as post traumatic growth. It can result in new possibilities, growth in personal relationships, and increased confidence and personal strength. It may also prompt a spiritual change or growth and create a new appreciation of life. Living through trauma provides a great deal of information about self-reliance, affecting not only self-evaluations of competence in difficult situations, but also the likelihood one will choose to address difficulties with assertiveness.

People coping with a traumatic event often draw the conclusion that they are stronger, a confidence which may generalize to all kinds of situations, including future trauma (The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma, Tedeschi, Calhoun, 1996). Adverse experiences can

be the impetus for self-discovery, and can exponentially increase a person's capacity for compassion, understanding, and empathy. It can result in the emergence of new skills, confidence, and a sense of purpose.

Activity

ACEs, Individually answer the 10 Adverse Childhood Experiences questions

NOTES

Module 10: Crisis De-escalation

This module provides an overview of de-escalation, why it's important, and how the application of de-escalation concepts can impact the outcomes of tense situations.

Because this module offers a high-level view, following specific techniques and training by your organization should provide you with the focused knowledge and skills needed in your particular area of expertise.

What will you learn in this module?

Participants will:

- Understand what a crisis is and some indicators and triggers.
- Become familiar with concepts of crisis de-escalation, and crisis intervention.
- Learn about different types of interactions.

What is a psychiatric crisis?

When a person is in crisis, what they are experiencing exceeds their ability to cope. A psychiatric crisis is when a person has any or all of the following:

- Thoughts/actions of self-directed violence (or suicide) or physical harm to others
- Acute psychotic symptoms
- Deterioration in mental status

Any or all of these result in the person's behaviors putting them at risk of harming themselves or others (Luxton, Prisco, Zolnikov, 2019).

What are signs that may indicate a looming crisis?

When a person is experiencing a crisis, they may have difficulty communicating their thoughts, feelings, or needs. They may also have difficulty listening to what others are saying. Aggressive behavior may occur due to this inability to express feelings or get needs met (Luxton, Prisco, Zolnikov, 2019). Other signs that a person may be nearing a crisis are an inability to perform daily tasks like showering or changing clothes, rapid mood swings, increased agitation, unpredictable outbursts, abusive behavior, isolation, paranoia, losing touch with reality (psychosis), increased hostility, or angry staring (NAMI, 2018).

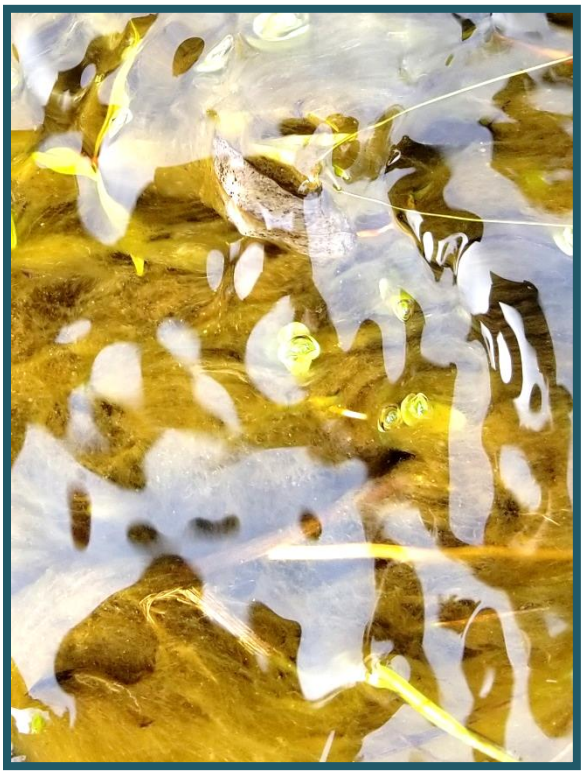
What are possible triggers or things that could lead to escalation?

Everyone is unique and has had numerous varied experiences throughout their lives; therefore, triggers can be different for each person. However, by focusing on our actions, we may contribute to diffusing a situation (although some situations may escalate despite your best efforts). We can avoid triggering pre-existing trauma by being aware of postures that may suggest dominance, like our proximity, distance, tone and volume of voice, and our use of command statements.

Individuals who are already agitated may also react by mirroring agitation or frustration causing them to react (Luxton, Prisco, Zolnikov, 2019). Conversely, by using neutral facial expressions, relaxed non-defensive body language, and a calm demeanor and tone of voice, we can convey a feeling of safety and

a non-rushed space in which to communicate. Feeling unsafe or powerless, feeling a loss of control, or having an inability to communicate unmet needs, can all be triggers.

The surrounding environment might also be a contributing factor. A new environment or a change to the environment may elicit anxiety, agitation, or fear. There may be jarring or different noises, unfamiliar rules or people, a lack of personal space, or someone new who reminds them of past trauma. Individual factors such as anxiety, trauma history, psychotic symptoms, organic brain disorders, medications, substance use, or a lack of coping skills may also contribute to heightened stress (Luxton, Prisco, Zolnikov, 2019).



What is de-escalation and crisis intervention?

De-escalation is the process of reducing the intensity of a conflict or potentially volatile situation. Crisis intervention is immediate and short-term psychological care aimed at assisting someone in a crisis situation (Luxton, Prisco, Zolnikov, 2019).

Why is crisis de-escalation important?

De-escalating a crisis situation can contribute to a safer, healthier environment for everyone involved. In psychiatric settings, injury and illness rates due to violence in the workplace by patients are 69 times higher for psychiatric aides than the national rate of workplace violence, and 38 times higher for psychiatric technicians (Longton, 2015). Law enforcement and corrections officers also experience high rates of violence. Between 2005 and 2009, they were two of the four professions with the highest rates of nonfatal workplace violence (Harrell, 2011). Direct experience with violence can also contribute to a higher risk of suicide and increased trauma exposure (Luxton, Prisco, Zolnikov, 2019).

Being aware of de-escalation techniques and being able to respond in the most effective way can help reduce incidents and contribute to an environment of workplace safety. When working in human service organizations, it is essential to develop and maintain the skills to reduce conflict before it reaches crisis-level intensity and to de-escalate conflict when it occurs.

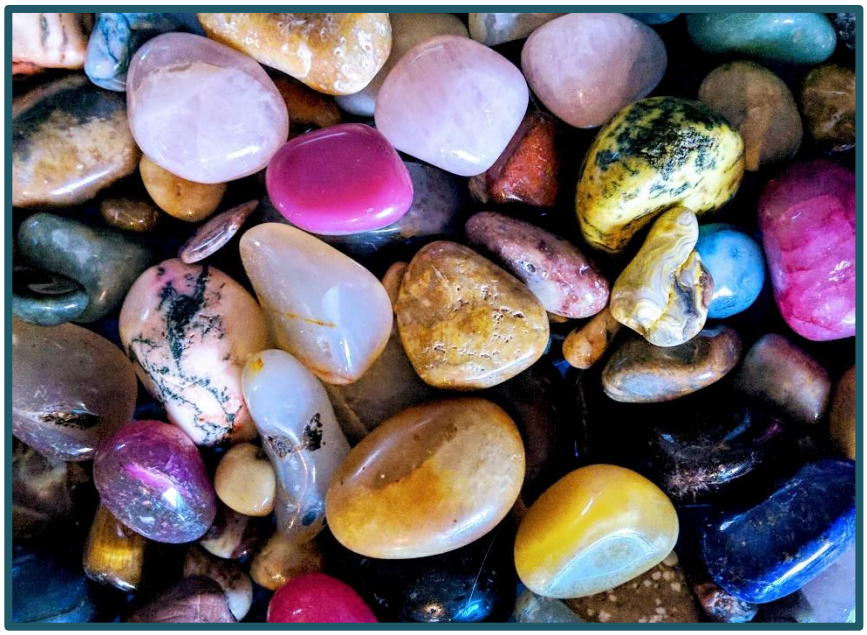
What are some different types of interactions?

Some interactions used in crisis de-escalation are listening, validation, positive dialogue and body language, explaining consequences of behavior, and maintaining boundaries. Listening to what a person says, and observing how they feel and act, can help us understand their point of view and where they are in the moment. It involves active engagement in the conversation. Some examples of phrases which demonstrate this are, “Tell me more,” or “Can you explain that?”

By providing validation, you let the person know that you see them, are listening to them, and are trying to understand their concerns. You let them know that you are invested in connecting with them. Validation involves accurately reflecting or recapping what the person has said, while remaining nonjudgmental. A phrase that can be helpful in letting a person know that they have been understood is, “In other words…” Validation can also be provided for actions. In this situation, phrases such as, “It sounds like you were very upset,” or “This must be really difficult for you” are helpful.

Using positive dialog involves speaking moderately, with a calm tone, and using clear language. This is through your body language as well as through what you say and how you say it. Explaining the consequences of behaviors and maintaining boundaries helps provide a framework to move toward resolution while preserving accepted options or alternatives (Luxton, Prisco, Zolnikov, 2019).

In a crisis, maintaining a calm demeanor, using non-threatening postures and voice, and striving to ensure that you understand the individual’s needs are helpful interactions that can make a significant difference.



NOTES

Module 11: Suicide Prevention

What will you learn in this module?

Participants will:

- Understand the impact suicide has on both Washington State and the nation.
- Be able to identify risk factors, warning signs, and other circumstances of suicidal ideation.
- Know how to appropriately ask the question.
- Be able to support people at risk of suicide with appropriate responses, including resources and connecting people to effective health care.

This section provides general suicide prevention and awareness information from local and national best-practice programs and sources. For your workplace, please ensure you work with your supervisor for specific protocols and policies pertaining to suicide prevention.

Suicide prevention and awareness

Suicide is a serious public health problem in Washington State and is a leading cause of death both nationally and statewide. Suicide prevention involves everyone in the community, including schools, employers, health care systems, and the media. By offering suicide prevention education and awareness, our communities can work together to decrease stigma, increase awareness of resources, and promote safer and more supportive environments.

It is important to understand that suicide is rarely caused by a single factor, but rather a combination of stressors, life circumstances, and feelings of hopelessness. These problems, or risk factors, that lead people to consider suicide may include problematic relationships, substance use, physical health, employment problems, money, legal, or housing stress (CDC, suicide, 2020).

What are the statistics?

- Suicide rates went up more than 30 percent in half of states since 1999 and increased in nearly every state from 1999 to 2016.
- From 2011 to 2015, 5,263 Washington residents died from suicide. They ranged from 11 to 101 years old. On average, three Washington residents died by suicide each day in 2016 (CDC, suicide, 2020).

What are the risk factors and warning signs?

It is important to understand every person reacts differently to stress and specific situations. For example, the end of a relationship may affect one person more strongly than another. With that being said, one person's negative experience may be another person's positive one, or vice versa. There is an abundance of risk factors and types of situations that can affect a person. There are many types of categories of risk factors, such as personal, social, legal, or historical events.

The CDC has identified the top 12 warning signs for suicidal ideation:

- Feeling like a burden
- Being isolated, withdrawing
- Increased anxiety, or agitated; behaving recklessly

- Feeling trapped or in unbearable pain
- Increased substance use
- Looking for a way to access lethal means
- Increased anger or rage
- Extreme mood swings
- Expressing hopelessness
- Sleeping too little or too much
- Talking or posting about wanting to die
- Making plans for suicide

(MentalHealth, 2018).

Activity

Work in groups and come up with two potential risk factors for each category:

- Personal (example: substance abuse)
- Social (example: bullying)
- Legal (example: bankruptcy)
- Historical (example: anniversary date of a tragedy)

The Centers for Disease Control's Five Steps to Help Someone at Risk

1. Ask someone you are worried about if they're thinking about suicide.
2. Keep them safe. Reduce access to lethal means for those at risk.
3. Be there with them. Listen to what they need.
4. Help them connect with ongoing support like the Lifeline (1-800-273-8255).
5. Follow up to see how they're doing. (CDC, suicide, 2020).

How do you ask the question?

Asking someone you are worried about if they are having thoughts of suicide can be difficult. It is essential this question is asked in a direct and unbiased manner in order to communicate that you're open to talking about suicide.

"We often worry about offending the person, or 'giving them the idea of suicide,' but research actually shows that asking someone about suicide does not increase risk, but rather gives individuals a sense of relief to talk freely about their pain" (NIMH, Suicide, 2019).

Here are some examples of a direct question. Remember, the way you say it matters.

- Are you having thoughts of suicide?
- Have you ever struggled with thoughts of ending your life?
- Are you thinking about ending your life?

Ask yourself, how would you ask the question?

What is the Be the One to Save a Life campaign?

Be the One to Save a Life, or, BETHE1TO, is a resource provided by the National Suicide Prevention Lifeline. It is their message for National Suicide Prevention Month and beyond. Their goal is to spread the word about actions we can all take to prevent suicide. Their message includes:

Be the one to ask.

Ask the tough question. When somebody you know shows warning signs, ask them directly: "Are you thinking about killing yourself?" Encourage them to take an online screening.

Be the one to keep them safe.

Do they have access to medications, firearms, or other means of suicide? Ask if they've thought about how they would do it and separate them from anything they could use to hurt themselves. Learn more from Washington's Safer Homes Coalition.

Be the one to be there.

People thinking about suicide can feel like a burden to their loved ones.

If someone you know is thinking about suicide, listen to their reasons for feeling hopeless and in pain. Listen with compassion and empathy, without judgement.

Be the one to help them connect.

Help connect them to a support system, whether it's 800-273-TALK (8255), the crisis text line (text "HEAL" to 741741), family, friends, faith-based leaders, coaches, co-workers, health care professionals or therapists, so they have a network to reach out to for help. There is also an online database of local resources at 211.org.

Be the one to follow up.

Check in with the person you care about on a regular basis.

Making contact with a friend in the days and weeks after a crisis can make a difference in keeping them alive. Send a caring contact. This could be a phone call, text, email, or letter (https://www.bethe1to.com).

Activity

Work in groups and discuss one of the above categories of BETHE1TO. Brainstorm additional ways to support someone in the category specific to your job and the people you work with.

Where can I go for additional resources and information?

- Centers for Disease Control and Prevention: https://www.cdc.gov/violenceprevention/suicide/index.html
- National Suicide Prevention Lifeline: https://suicidepreventionlifeline.org/
- Preventing Suicide: A Technical Package of Policy, Programs, and Practices: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf
- Washington State Department of Health: https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/SuicidePrevention

If you or someone you know is experiencing a crisis help is available via text or phone at the following numbers:

Text “HEAL” to 741741 Crisis Text Line

Call 1-800-273-TALK (1-800-273-8255)

NOTES

Module 12: Transition Planning and Continuity of Care

This module provides an overview of what transition planning is, why it is important, and how transition planning can impact mental health as well as recidivism.

What will you learn in this module?

Participants will:

- Increase understanding of transition planning and continuity of care.
- Understand the importance of transition planning and continuity of care.
- Be able to identify best practices related to transition planning and continuity of care.
- Become familiar with the APIC model.

What are transition planning and continuity of care?

Connecting or (in many cases) re-connecting people with community care providers after release from jail, a transition facility, or as part of a diversion program, requires significant planning. The amount of transition planning to ensure continuity depends on several factors, including the severity of mental illness, the intensity of transition provided at the facility, and the person's level of functioning upon release (Metzner, 2002). It is important to begin this process as soon as possible so that staff can develop a transition plan that ensures stability upon release.

A transition plan is a map to guide transition providers in addressing the strengths and barriers to recovery for people with mental illness who are transitioning into the community. A comprehensive transition plan will support stability and examine risk factors that may lead to further involvement in the criminal court system. The areas addressed are cognitive skills, health and safety, employment, education/literacy, housing, finances, family/social supports, barriers to transition, use of leisure time, and building pro-social attitudes (Fd.org, 2019). By identifying an individual's barriers to success, transition providers are able to address and mitigate some of the risk areas, ultimately increasing stability and decreasing the person's potential to re-enter the criminal court system.

Continuity of care involves collaboration with all treatment providers to reduce repetition of services. This is often best achieved when working with external providers, prior to release from jail, and when there is a "warm handoff" upon release. Warm handoffs can occur when a person is not released to the streets to navigate the system alone. An example of a warm handoff would be when a staff member from a connected community health provider is sent to pick up an individual and take them directly to the services identified in their transition plan. Warm handoffs also can occur between service providers.

Why are transition planning and continuity of care important?

There is a disproportionate number of people living with mental illness and substance use who are incarcerated, verses living in the community. Upon release, some people lack access to basic needs and services, which may contribute to cyclical criminal court system involvement (Pew Center on States, 2011). Developing transition plans and maintaining continuity of care help to foster recovery and proves to be successful in the reduction of individuals re-entering the criminal court system.

Introduction to APIC: assess, plan, identify, coordinate

According to SAMHSA, best practices for transition planning is a model called APIC: assess, plan, identify, and coordinate (SAMHSA, 2017). The APIC model is a framework for behavioral health, the criminal court system, and community providers to work collaboratively.

Assess

It is recommended to develop a universal screening and assessment process, for everyone booked into a correctional setting. The purpose is to assess a person's clinical needs, social needs, and community risk.

Plan

Planning takes place both during incarceration and in preparation for release. The plan should address the person's level of need determined during the assessment phase. Planning should involve the person that will be transitioning to ensure they have a role and say in their transition options.

Identify

It is important to identify community connections and programs that can assist with post-release services. If the person is connected with a community provider prior to incarceration, there should be communication to facilitate a warm handoff at release. If the person does not have established community care, attempts should be made to connect them with a community provider prior to release.

Coordinate

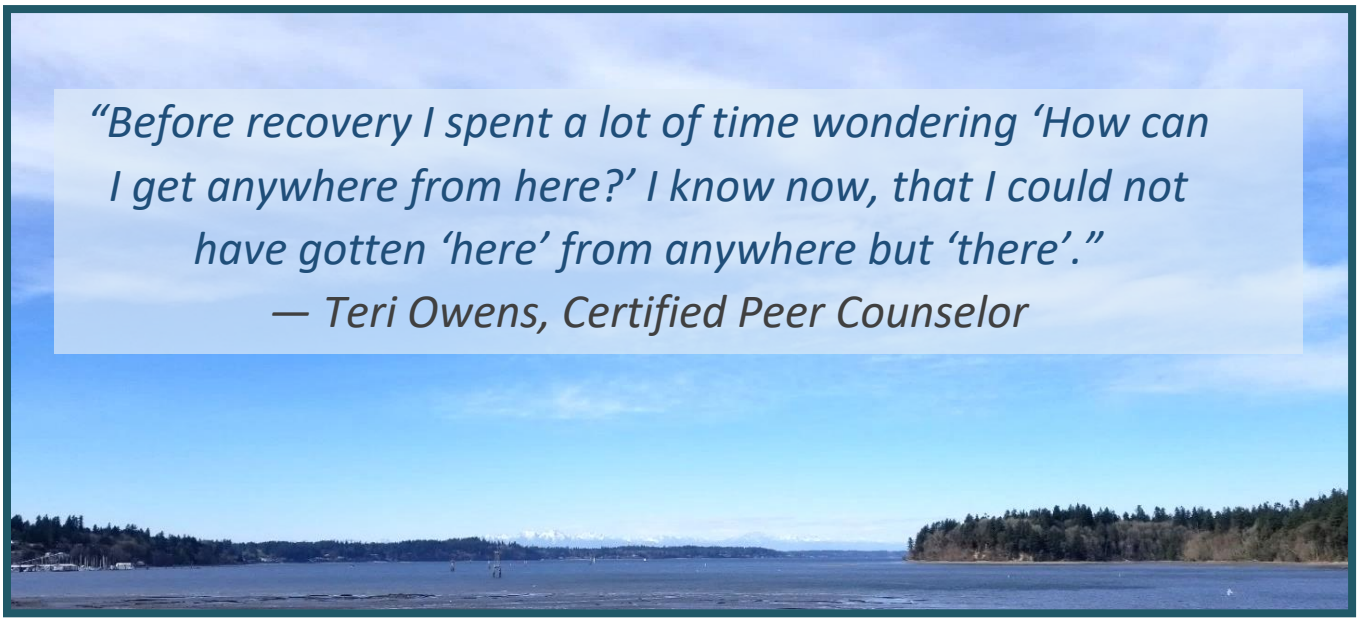
Coordinate the services outlined in the Transition plan. To avoid gaps upon release, coordination with receiving services should be ongoing.

(Blanford & Osher, 2019)

Activity

Break into small groups and discuss lived experience, or perceived feelings or challenges to transitioning from discharge from a facility, either or jail.
Discussion points.

1. Transition planning with no supports, e.g. family, community health, or resources.
2. Transitioning with family support only, may or may not have housing with family support
3. Transitioning with community connections to treatment, being picked up from the discharging facility, and being transported to needed resources. E.g. housing, food, clothing, medications
4. How can transition planning reduce mental health crises or repeat crimes?


"Before recovery I spent a lot of time wondering 'How can I get anywhere from here?' I know now, that I could not have gotten 'here' from anywhere but 'there'."
— Teri Owens, Certified Peer Counselor

NOTES

Glossary

Affidavit	A written or printed statement made under oath
Arraignment	A proceeding in which a criminal defendant is brought into court, told of the charges in an indictment or information, and asked to plead guilty or not guilty
Assessment	The gathering and appraisal of information in order to identify a person's needs and strengths
BH-ASO	Behavioral Health Administrative Service Organization that is regionally based and provides crisis services to anyone who is experiencing a mental health or substance use disorder crisis, as well as other support services to individuals who are not eligible for Medicaid services
Behavioral health	Behavioral health refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders (SAMHSA 2014)
Bias	A belief a person has about a thing, person, or group of people. Biases can be conscious or unconscious, positive or negative, but are often considered unfair
Bench trial	A trial without a jury, in which the judge serves as the fact-finder
Case management	A service that helps people arrange for appropriate services and supports. A case manager coordinates mental health, social work, educational, health, vocational, transportation, advocacy, respite care, and recreational services, as needed
Certified Peer Counselor (CPC)	A person who has completed state approved training passed a state test, and is credentialed by the Department of Health as an Agency Affiliated Counselor. The CPC designation is also often used by people who are not credentialed as well
Charge	A formal accusation or indictment filed by the prosecutor's office that a person has committed a specific crime. Also known as pressing charges
Class member	All people who are now, or will be in the future, charged with a crime in the State of Washington and: (a) who are ordered by a court to receive competency evaluation or restoration services through DSHS; (b) who are waiting in jail for those services; and (c) for whom DSHS receives the court order.[Error! Bookmark not defined.] (Trueblood et al v. Washington State DSHS, 2018)
Collaboration	Professionals and/or agencies with working effectively together on common issues, including the provision of care to an individual

Community care	The provision of services and support for people who are affected by a range of problems, including mental health challenges, to enable them to live as independently as possible in their own homes or in other home-like settings
Community mental health agencies (CMHAs)	Groups of professionals providing local mental health services
Competency restoration	The process of assisting a person accused of a crime to regain or achieve the capacity to understand the proceedings and to assist an attorney in their own defense. Treatment typically includes educational, therapeutic and recreational activities. It also may include administration of psychotropic medications (https://www.dshs.wa.gov/bha/office-service-integration/ofmhs-faqs)
Conditional release	Release from incarceration contingent upon obeying the conditions of release under threat of revocation (return to prison) under reduced due process protections
Confidentiality	The protection and proper use of patient information. Information given or received for one purpose may not be used for a different purpose or passed to anyone else without the consent of the provider of the information.
Continuance	The postponement of a hearing, trial, or other scheduled court proceeding at the request of either or both parties in the dispute, or by the judge
Continuum of care	A term that implies a progression of services that a person moves through, usually one service at a time. More recently, it has come to mean comprehensive services. Also see system of care and wraparound services
Co-occurring disorder	Commonly used to refer to the condition in which an individual has both substance use and mental disorders, although the term can also refer to other combinations of disorders, such a mental disorder and an intellectual disability. (2020 Psychology Today)
Co-responder program	The Mental Health Field Response Teams Program, currently administered by the Washington Association of Sheriffs and Police Chiefs, (WASPC) as a grant program, pursuant to Washington Revised Code § 36.28A.440
Counseling	Assistance and guidance to assist people in developing insight into their problems and identifying resources within themselves that they can use to cope more effectively with their situation
Credential	The approval by the Department of Health to work in the counseling field. The credential may vary by level of education; however, most CPCs apply for an Agency Affiliated Counselor credential. A credential is required to work in a Medicaid setting, except for the first 60 days after applying to DOH

Criminal court system	Includes all agencies involved in criminal court, including the police, probation service, courts, and prisons
Crisis	A time of extreme trouble and an opportunity for growth
Crisis intervention teams (CITs)	A model for community policing that brings together law enforcement, mental health providers, hospital emergency departments and individuals with mental illness and their families to improve responses to people in crisis
Crisis residential treatment services	Short-term, around-the-clock help provided in a non-hospital setting during a crisis
Culture	The integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith, or social group
DCR	Designated Crisis Responder. A DCR determines if a person presents a harm to self/others/property, or is gravely disabled and is at imminent risk, or if there is a non-emergent risk due to a substance use disorder or mental disorder, or is in need of assisted outpatient behavioral health treatment(www.hca.wa.gov)
De-escalate	Lowering the intensity of a situation; often refers to a way of communicating with a person when they are upset or in crisis
Defendant	Entity accused of a crime, in a court of law
Deferred sentence	Postponement or delay of a sentence to a future date
Deinstitutionalization	The process of releasing individuals from psychiatric institutions
Deposition	An oral statement made before an officer authorized by law to administer oaths. Such statements are often taken to examine potential witnesses, to obtain discovery, or to be used later in trial
Disability	A physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities
Discrimination	Treating a person differently, usually in a negative way, based on differences in culture, beliefs, or other characteristics
Discovery	The pre-trial devices that can be used by one party to obtain facts and information about the case from the other party in order to assist the party's preparation for trial
Diversion	Programs that implement strategies which seek to avoid the formal processing of an offender by the criminal court system

DRW	Disability Rights Washington, a private nonprofit organization that protects the rights of people with disabilities statewidehttps://www.disabilityrightswa.org/
DSM	The Diagnostic and Statistical Manual of Mental Disorders, containing criteria for diagnosing and codes required for billing
Dusky standard	"The defendant must have a rational and factual understanding of the charges and the penalties associated with the charges against them." The Dusky Standard has been adopted by Washingtonhttps://www.dshs.wa.gov/bha/office-forensic-mental-health-services
Duty to warn	Mental health professionals licensed in Washington State, including others, have a duty to protect and warn potential victims of violence by patients under their care
E & T	Evaluation and Treatment
Early intervention	A process used to recognize warning signs for mental health challenges and to take early action against factors that put individuals at risk
Emergency and crisis services	A group of services available 24 hours a day, seven days a week, to help during a mental health emergency. Examples include telephone crisis hotlines, suicide hotlines, crisis counseling, crisis residential treatment services, crisis outreach teams, and crisis respite care
Ethics	Refers to principles of right and wrong as well as rules an organization or group agrees to
Evidence-based practices (EBP)	Activities or programs that have been shown to be effective through scientific testing and reproduction of practices. Various organizations have lists of these practices
Felony	A crime that is considered to be more serious in nature. Felonies can be either violent or nonviolent
Forensic Evaluator	A mental health professional that conducts assessments pertaining to a person's mental state at time of the offense, and their risk for future violent behavior (Washington State Legal System Guide to Forensic Mental Health Services Pg. 12)
Forensic HARPS (F-HARPS	Forensic Housing and Recovery through Peer Services, or Forensic HARPS Teams that provide housing supports and subsidies to qualifying individuals. Supports are provided by housing specialists and Certified Peer Counselors who have completed this training.

Forensic mental health system	The forensic mental health system is comprised of various entities that have a touchpoint to people who are involved with the criminal court system (e.g., jails, courts, evaluation and treatment services, and corrections) and may have a behavioral health condition
Forensic Navigator	An agent of the court who works to divert forensically involved defendants from jails and inpatient treatment settings into community-based alternatives
Forensic PATH (F-PATH)	Forensic Projects for Assistance in Transitioning from Homelessness, or Forensic PATH. Teams that provide outreach and engagement to individuals identified as at risk of future criminal court involvement. Services are provided by Certified Peer Counselors who have completed this forensic systems training
Gross misdemeanor	A crime that is more serious than a regular misdemeanor, but is still classified as a minor crime, as opposed to a serious crime
Habilitative services	Services that assist people with acquiring, maintaining, or improving skills for daily living and raising their levels of physical, mental, social, and vocational functioning
Hallucination	A false or distorted perception of objects or events, including sensations of sight, sound, taste, smell, or touch, typically accompanied by a powerful sense of their reality
Health Care Authority	A government agency that oversees Washington Apple Health (Medicaid), the Public Employees Benefits Board (PEBB), and the School Employees Benefits Board (SEBB) program, as well as other programs.
Homelessness	Describes people living in a broad spectrum of unsatisfactory housing conditions ranging from cardboard boxes and park benches through night shelters and direct access hostels to bed and breakfast accommodation or even sleeping on a friend's floor
Internalized stigma	Negative beliefs about a condition, held by a person having the condition
IDD	Intellectual or developmental disability
Integration	Refers to treatment that approaches multiple challenges, such as substance use and mental health, or behavioral health and physical health.
ITA	Involuntary Treatment Act, enacted in 1973, allowing people to be detained if they are found to be gravely disabled, a danger to self, or danger to others and experience mental illness. In 2018, Ricky's Law was enacted which also allows DCRs to detain for substance use disorders

Less Restrictive alternative (LRA)	A living arrangement that is less restrictive than total confinement
Managed Care Organization (MCO)	A private health organization that provides comprehensive health care. These organizations may contract with the state to provide public services
Mental Health Professional MHP	An MHP designation in the State of Washington indicates a person that is qualified to assess and diagnose people with mental health conditions
Mental health services	Services that are specially designed for the care and treatment of people with mental health challenges, including those with co-occurring substance use disorders
Misdemeanor	A criminal offense that is less serious than a felony and more serious than an infraction. Misdemeanors are generally punishable by a fine and incarceration in a local county jail
Not guilty by reason of insanity	People found, as a result of mental illness, unable to perceive the nature of the crime they are charged with, and unable to tell right from wrong in reference to the particular act they are charged with and adjudicated as such
OFMHS	The Office of Forensic Mental Health Services, part of DSHS
Outpatient Competency Restoration Program (OCRP)	A community-based program that helps defendants achieve the ability to fully participate in their own defense
Peer	An individual (typically an adult) who receives or has received services. Parents may be referred to as peers when they are in a peer relationship with another parent
Peer Support Services	An evidence-based practice designed and delivered by people in recovery with a focus on supporting others in their recovery journey. In Washington State, certification is provided per WA Admin. Code § 182-538D-0200
Plaintiff	A person who brings a case against another in a court of law, such as a prosecutor or the state seeking charges
Plea bargain	A negotiation between the defense and prosecution for a fair disposition of the case and must be approved by the court
PR	Personal recognizance. A person who promises to appear in court to answer criminal charges can sometimes be released from jail without having to pay bail. This person is said to be released on his or her personal recognizance.
Prevention	A strategy or approach that delays or reduces the likelihood of onset mental health problems

Provider	Any organization, agency, group of people, or individual who supplies a service in the community, home, or hospital in return for payment
Public Safety Review panel PSRP	An advisory panel composed of a psychiatrist, a psychologist, a prosecutor, a law enforcement representative, a consumer and family advocate representative, and a public defender. This panel independently assesses and provides advice to DSHS and the courts, regarding potential risk to public safety related to the proposed conditional release or unconditional release/final discharge from Western or Eastern State Hospital of patients found not guilty by reason of insanity or civilly committed for a violent offense after found not competent to stand trial
Recovery	The process in which people are living, working, learning, and participating fully in their communities (RCW 71.24)
Revised Codes of Washington (RCW's)	Laws that the Washington State government creates; see also Washington Administrative Codes (WAC). RCWs are the highest form of state legislation
RTF	Residential treatment facility
Screening	The administration of an assessment tool to identify people in need of more in-depth evaluation or treatment. Screening tools are instruments and techniques (questionnaires, checklists, self-assessments forms) used to evaluate people for increased risk of certain health problems
Self-advocacy	Action taken by a person to get their needs and wants met
Sentence	The punishment ordered by a court for a defendant convicted of a crime
Speedy trial	The right to a speedy trial is a human right under which it is asserted that a government prosecutor may not delay the trial of a criminal suspect arbitrarily and indefinitely
Social support	Assistance that may include companionship, emotional backing, cognitive guidance, material aid, and special services
Social worker	A graduate of an accredited school who holds a master's degree and who is trained in effective ways of helping people living with mental health challenges, and other groups in need of assistance
Strengths	Personal skills, abilities, qualities, and values that are used or can be used to support recovery
Strengths-based	The practice of focusing on a person's strengths, not deficits
Statutory	Organizations set up by law, statute, or regulation (e.g. county council, local authority)

Stigma	A general term for the widespread fear and misunderstanding of behavioral health challenges or substance use disorder, together with the stereotyping and negative attitudes toward those who experience them.
Stipulation	An agreement made by parties or by their attorneys in a judicial proceeding before the court
Substance Abuse Mental Health Services Administration (SAMHSA)	The agency within the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental and substance use disorders, and their families. https://www.samhsa.gov/about-us/who-we-are
Subpoena	A command to a witness to appear and give testimony
Substance use disorder	A cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems
Symptom	A reported feeling or specific observable physical sign of a person's condition
System of care	A coordinated network of agencies and providers that make a full range of services available to people with mental health challenges and their families
Trauma	An event, series of events, or circumstances experienced by an individual as physically or emotionally harmful or life threatening and that have lasting negative effects on the individual's functioning and mental physical, social, emotional, or spiritual well-being. Trauma is a normal response to extreme events
Treatment	A medical or psychological therapeutic intervention.
Treatment plan	Person centered plan for recovery, services and supports.
Treatment team	A group of professionals, service providers, family members and/or support people who meet to develop, implement, and review a comprehensive service plan for an individual
Vulnerable adult	Someone who is physically or economically dependent on another and unable to leave a situation without assistance, or a person who has a paid aide or home service provider
Warrant	Court authorization, most often for law enforcement officers, to conduct a search or make an arrest
Washington Administrative Codes (WACs)	Washington administrative codes. Specific guidance on the operation of legislation. These rules are derived from the Revised codes of Washington (RCW), the laws that the state legislature has created

With and without prejudice	A dismissal of a case WITH prejudice is a final judgment barring any further action on the case. A dismissal WITHOUT prejudice allows for prosecutions to refile charges at a later date

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