Mentally Ill Misdemeanants

An Evaluation of Change In Public Safety Policy

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EXECUTIVE SUMMARY

The 1998 Legislature significantly revised public safety and treatment policies regarding mentally ill offenders charged with misdemeanor offenses. Second Substitute Senate Bill (2SSB) 6214 (Chapter 297, Laws of 1998) extended the criminal competency restoration process to misdemeanant defendants,[1] broadened the involuntary civil commitment process for both misdemeanor and felony offenders, and strengthened information sharing provisions of the law. The legislative intent was to increase public safety by:

- Requiring that a person's current behavior and mental condition, history, and likelihood of committing acts that threaten public safety should determine treatment procedure, as opposed to a felony offense category;
- Providing additional treatment opportunities for mentally ill offenders whose behavior has led to contact with the criminal justice system; and
- Improving information sharing between the mental health and criminal justice systems to allow professionals better information and easier access to records needed to make decisions affecting public safety.

The legislation directed the Washington State Institute for Public Policy (Institute) to evaluate the outcomes of competency restoration and involuntary civil commitment treatment under the new law. This study addresses whether the legislation influenced the process of competency evaluation in the state. It then focuses on learning whether the main legislative objectives have been met:

- Are misdemeanant defendants receiving treatment under the new law?
- Does this treatment reduce the population's criminal recidivism?

The research design uses a comparison group of similar individuals who received competency evaluations from 1995 to 1997. The treatment group includes misdemeanant defendants who received evaluations and treatment during the first year the new law was in place (March 1, 1999, through February 29, 2000).

Treatment and Recidivism Findings

- **Treatment under the new law significantly reduces recidivism.**
  - Treatment group defendants were significantly less likely to be convicted of a subsequent felony crime than comparison group defendants.

[1] Criminal defendants who lack capacity to understand and assist in defending themselves cannot be tried, convicted, or punished in a court of law. Competency restoration treatment usually involves inpatient psychiatric treatment ordered by the court in an attempt to restore competency to stand trial.

- Treatment group defendants were significantly less likely to be charged with a subsequent misdemeanor or misdemeanor crime against a person than comparison group defendants.
- Treatment group defendants were significantly more likely to receive outpatient community mental health treatment than those in the comparison group, contributing to a significant reduction in felony reoffending.

- **More defendants received treatment under the new law.**
  - In addition to receiving competency restoration treatment, treatment group defendants were significantly more likely than comparison group defendants to receive civil commitment treatment.

Competency Restoration and Civil Commitment Findings

- **The legislation is working as intended: 1999 misdemeanant defendants evaluated as incompetent to stand trial and determined to be a threat to public safety are receiving competency restoration treatment**.
  - Defendants with felony or misdemeanor crimes against persons, and defendants for whom the evaluator records a current or past violent offense are more likely to receive competency restoration treatment.
  - Defendants with severe mental illnesses, such as schizophrenia, bipolar, and other psychotic disorders, are more likely to receive competency restoration treatment.

- **For most individuals who are not restored to competency, the state pursues involuntary civil commitment proceedings.**
  - Approximately 90 percent of the 69 defendants who remained incompetent to stand trial after restoration treatment were detained for involuntary civil commitment proceedings, and 58 defendants received further treatment.
  - Civil commitment treatment involved fairly lengthy hospitalizations at Eastern State Hospital (ESH) and Western State Hospital (WSH): the median number of days was 57 and 97, respectively. Three defendants hospitalized at WSH were still in residence as of June 2003.
  - Defendants receiving civil commitment treatment were significantly more likely to receive community mental health services after treatment compared with defendants receiving only competency restoration treatment.

Competency Evaluation Findings

- **Courts have adopted the misdemeanor criminal competency procedures available under the new law.**
  - Competency evaluations were ordered for 561 defendants in 1999 compared with 166 in 1996, a 238 percent increase.

- The legislation had the greatest effect in King County, which accounted for 29 percent of all evaluations in 1996, rising to 48 percent in 1999.

- **The majority of defendants receiving competency evaluations have extensive involvement with the criminal justice system and a serious mental illness.**
  - About 40 percent of defendants have a felony conviction, and 75 percent have a misdemeanor conviction. Defendants average 11 misdemeanor criminal charge filings.
  - Three-quarters of defendants receiving evaluations have a major mental illness, and half have a substance disorder. Over 50 percent have prior psychiatric hospitalization.

Information Sharing and Criminal History Findings

- **Information sharing procedures have improved.**
  - Court orders, evaluations, jail transfer forms, and other documents are moving among the appropriate mental health and criminal justice system actors in a timely fashion.

- **Information on past civil commitments, violent acts, and prior insanity and incompetency findings are not consistently available to evaluators making criminal competency and civil commitment decisions.**
  - No central source maintains information on persons with prior civil commitments in Washington State.
  - Washington criminal records do not consistently report criminal insanity and incompetency findings.

Conclusions

One of the major purposes of 2SSB 6214 is to increase treatment opportunities for misdemeanor defendants identified as threats to public safety. The goal of increased treatment is to stabilize mentally ill individuals in a hospital or community setting and, ultimately, to reduce criminal reoffending, particularly violent and serious crimes.

The legislation achieved its objectives but leaves some concerns about how to best assure mentally ill offenders receive continuous treatment and services. Defendants who are returned to the courts competent to stand trial are significantly less likely to connect to the community treatment system compared with defendants whose charges are dismissed and who receive further hospitalization under involuntary civil commitment laws. This finding signals a weak link in treatment continuity between the criminal justice and mental health systems for some, particularly since outpatient treatment was an important factor in reducing felony reoffending.

2SSB 6214 influenced a key piece of the mental health and criminal justice connection, but other aspects still need to be addressed. Most mentally ill offenders enter the community directly from jails and prisons, not hospitals. Some may be competent to stand trial while others may need to be restored to competency, but there are individuals in each group—those competent to stand trial and those needing competency restoration—who have a violent background and pose some risk to public safety. In either instance, treatment continuity is an important objective.

A significant number of mentally ill persons will continue to have contact with the criminal justice system, and criminal justice involvement is a strong marker of treatment need. How to best treat mentally ill offenders and reduce the threat to public safety is an ongoing and important public policy question.

I. INTRODUCTION

The 1998 Legislature significantly revised public safety and treatment policies regarding mentally ill misdemeanants. Second Substitute Senate Bill (2SSB) 6214 (Chapter 297, Laws of 1998) extended the criminal competency restoration process to non-felony defendants, broadened the involuntary civil commitment process for non-felony and felony offenders, and strengthened information sharing provisions of the law. The legislative intent was to increase public safety by:

- Requiring that a person's current behavior and mental condition, history, and likelihood of committing acts that threaten public safety should determine treatment procedure, as opposed to a felony offense category;
- Providing additional treatment opportunities for mentally ill offenders whose behavior has led to contact with the criminal justice system; and
- Improving information sharing between the mental health and criminal justice systems to allow professionals better information and easier access to records needed to make decisions affecting public safety.

The legislation revised both criminal and civil law governing mental health issues. The first major revision transformed criminal competency laws.[2] These laws apply to persons who lack capacity to understand and assist in defending themselves in criminal proceedings due to a mental disease or defect. Prior to the legislation, defendants charged with a felony offense and found incompetent to stand trial by the court could be ordered to undergo treatment to restore competency. In contrast, defendants charged with less serious crimes, that is, misdemeanor or gross misdemeanors, had their cases dismissed when they were found incompetent to stand trial. The legislation changed the focus of criminal competency laws from whether a defendant's action constituted a felony offense to the potential public safety risk: misdemeanant defendants with a history of violent acts were required to receive competency restoration treatment.[3]

The second major revision altered involuntary civil commitment laws.[4] These laws apply to mentally disordered persons who present a likelihood of serious harm to themselves or others or are gravely disabled and refuse to accept evaluation and treatment voluntarily. The legislation expanded the definition of likelihood of serious harm to include situations where an individual threatened the physical safety of others and had a history of violent acts. It requires that the court give great weight to a history of violence, or history of civil commitments due to likelihood of serious harm, in making the determination whether to civilly commit an individual. In addition, the legislation requires that all criminal defendants who are not restored to competency under criminal laws be referred for evaluation under involuntary civil commitment laws.

[2] Criminal competency statutes are in the Revised Code of Washington (RCW) 10.77.
[3] The legislation also made competency restoration treatment mandatory for felony offenders, substituting the word "shall" for "may" in RCW 10.77.090 (1) (b).
[4] Involuntary civil commitment statutes are found in RCW 71.05.

The legislation directed the Washington State Institute for Public Policy (Institute) to determine the outcomes of competency restoration and involuntary civil commitment treatment under the new law. The evaluation questions focus on the main legislative objectives: increased treatment for high-risk, non-felony defendants and concomitant public safety.

- Are defendants receiving treatment under the revised criminal and civil statutes?
- Does treatment result in increased public safety through a reduction in criminal recidivism?

This report presents findings on the misdemeanor criminal competency process and criminal recidivism.

- Section II provides background information on the legislation and details the legislative changes to the competency restoration process.
- Section III explains the research questions and design.
- Section IV assesses whether the legislation influenced the misdemeanor competency evaluation process and describes the defendants who receive evaluations.
- Section V investigates who receives competency restoration treatment, focusing on defendants who pose a public safety threat.
- Section VI reports on the outcomes of competency restoration treatment.
- Section VII presents findings on the effectiveness of the new law in reducing criminal recidivism.
- Section VIII investigates the quality of criminal justice records used to establish an individual's criminal history.
- Section IX summarizes the findings on the misdemeanor criminal competency process.

II. LEGISLATIVE BACKGROUND

A tragic event precipitated the new legislation covered in this report. On August 24, 1997, Mr. Stanley Stevenson, a retired Seattle fire captain, was fatally stabbed by a stranger on a downtown street as he left a Seattle Mariner's baseball game. The offender, a mentally ill person with an extensive history of violent behavior, was well known to the criminal justice system. He had recently been evaluated as incompetent to stand trial for a misdemeanor theft offense. The case had been dismissed, and the offender was released from jail, even though the forensic evaluation stated he was dangerous and recommended an evaluation under involuntary civil commitment laws. The incident raised serious questions about how the state's criminal justice and mental health systems handled mentally ill offenders.

The King County Executive formed a task force in September 1997 with the goal of improving and strengthening the legal and treatment systems that handle mentally ill offenders.[5] The focus was on mentally ill offenders who pose a threat to public safety. The task force was charged with examining the adequacy of current misdemeanor criminal competency and involuntary treatment laws and the protocols for transfer of information on mentally ill offenders between the criminal justice and mental health systems. Two workgroups were formed: a process workgroup to investigate cross-system procedures and information sharing, and a legislative workgroup to review criminal and civil laws. Both groups recommended extensive changes to current systems.

The process workgroup recommended a number of changes to ensure: (1) communication between the criminal justice and mental health systems, and (2) continuity of services to mentally ill offenders. These recommendations are in Appendix A. Exhibit 1 summarizes the major procedures and programs that have been implemented,[6] including the development of protocols that provide a direct link between county designated mental health professionals (CDMHP) and municipal and district courts,[7] a crisis triage center at Harborview Medical Center, and a King County District mental health court. [8]

Exhibit 1
Procedures and Programs Implemented in King County as a Result of the Mentally Ill Offender Task Force, April 1999

Procedures	Programs
Crisis outreach and service referral protocols for municipal and district courts	Expansion of outreach and case management for homeless mentally ill
No-refusal treatment requirement in mental health service contracts	Crisis triage center for mental illness/substance abuse emergencies
Training for case managers, police, judges, and court commissioners	Locally conducted competency evaluations
New court procedures and forms for competency orders*	Mental health court
	CDMHPs assigned as jail liaisons[9]

*See Michael J. Finkle "An All-In-One Guide to Handling Competency and Insanity Issues in Courts of Limited Jurisdiction," (Seattle: City Attorney's Office Criminal Division, 1999).

[5] Mentally Ill Offenders Task Force Final Report, November 1997. <http://www.metrokc.gov/dchs/mhd/mio/report.htm>.
[6] Mentally Ill Offenders Task Force Status Report, April 1999. <http://www.metrokc.gov/dchs/mhd/mio/aprex.htm>.
[7] The development of statewide protocols was also included in the new legislation.
[8] Seattle Municipal Court redeployed staff resources to create a mental health court in March 1999.
[9] This program ended approximately one year after implementation.

The legislative workgroup reviewed criminal and civil statutes to identify possible legislative solutions. This workgroup drafted legislation incorporating recommended changes relating to civil commitment and criminal competency statutes, including expanded treatment provisions for mentally ill offenders. The legislative proposal was submitted during the 1998 session as SB 6214 and passed by the Legislature as 2SSB 6214. Exhibit 2 summarizes the major revisions to criminal and civil legal statutes.

Exhibit 2

State Criminal and Civil Statute Changes, Chapter 297, Laws of 1998

Criminal (RCW 10.77)	Civil (RCW 71.05)
Defers bail pending sanity or competency evaluations; sets standards for bail after evaluations.	"Likelihood of serious harm" expanded to include threats to physical safety when an individual has violent history.
Requires non-felony defendants with violent history receiving competency/sanity evaluations to be referred for civil commitment evaluation. Sets requirements and timeline for civil evaluations and information sharing among courts, CDMHPs, and jails.	Requires court to give great weight to violent history or recent civil commitments involving harm when determining "likelihood of serious harm."
Requires non-felony defendants with violent history who were incompetent to stand trial to receive competency restoration treatment.	Requires CDMHP review of prior civil commitment evaluations, history of violent acts, prior incompetency, or insanity judgments.
Sets requirements and timelines for CDMHP civil commitment evaluation of persons held for treatment for the statutory maximum confinement time.	Sets timelines for CDMHP civil commitment evaluation and judicial review of CDMHP recommendation for non-felons judged incompetent to stand trial. Requires court to enter findings if it disagrees with recommendation.
Requires conditionally released persons be apprehended and returned to treatment if they present a public safety threat.	Sets conditions for review of conditional release to include decompensation, failure to adhere to treatment, and an increased likelihood of serious harm.
Authorizes sharing of relevant mental health records with law enforcement. Requires records accompany defendants transferred to a mental health or correctional facility.	Adds qualified professionals at correctional facilities to list of professionals where patient's consent is not required for communication.
Requires outpatient treatment facilities be notified of their patient's correctional facility release and receive records upon request.	Requires development of statewide protocols for use by CDMHPs.
Requires insanity acquittals and incompetency dismissals be recorded as criminal history.	

Misdemeanor Criminal Competency Before and After the Legislation

Exhibit 3 details the criminal competency process for defendants charged with misdemeanors. Prior to the passage of 2SSB 6214, a defendant charged with a misdemeanor offense could be ordered to undergo an evaluation to determine if he or she was competent to stand trial. If the defendant was judged incompetent to stand trial, either the case was dismissed and the offender released or the court could order a civil commitment evaluation.

Following 2SSB 6214's passage, competency restoration treatment is required for defendants with a history of, or current offense involving, a violent act or a previous insanity acquittal or incompetency finding that involved physical harm. Defendants can receive up to 29 days[10] of treatment at a state hospital in an attempt to restore competency, or up to 90 days mental health treatment on conditional release, or a combination of the two options.[11]

Defendants restored to competency return to court to stand trial, but prior to release they are subject to an involuntary civil commitment evaluation if recommended by the evaluator in the report to the court. If not restored to competency, defendants must be detained at an emergency and treatment facility to determine if they should be involuntarily committed for treatment under the mental health laws. Thus, 2SSB 6214 adopted procedures to assure that misdemeanant defendants who are a possible threat to public safety are not released into the community without evaluation, and, if necessary, treatment.

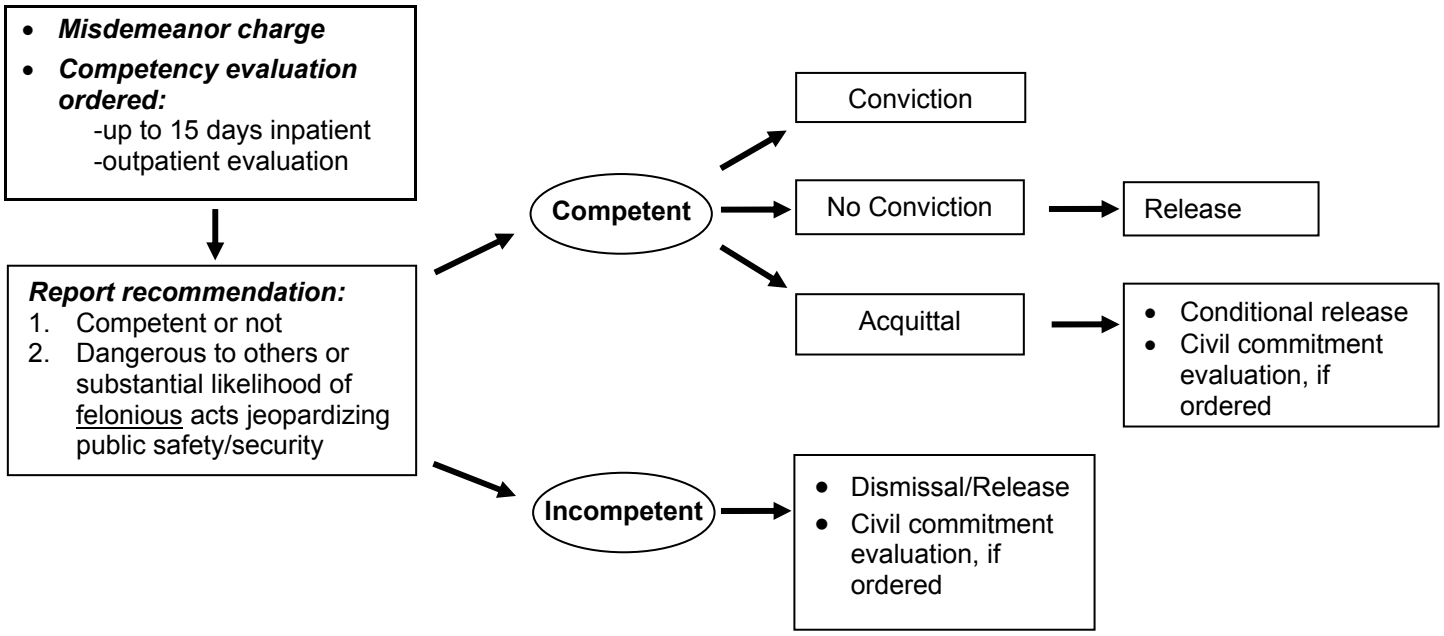
[10] 14 days plus any unused time from the 15-day evaluation. Since a majority of evaluations were conducted on an outpatient basis after 2SSB 6214, a maximum of 29 treatment days was possible in a majority of cases.

[11] Competency restoration treatment for felony offenders was not changed in the legislation. It includes up to 360 days of treatment at a state hospital.

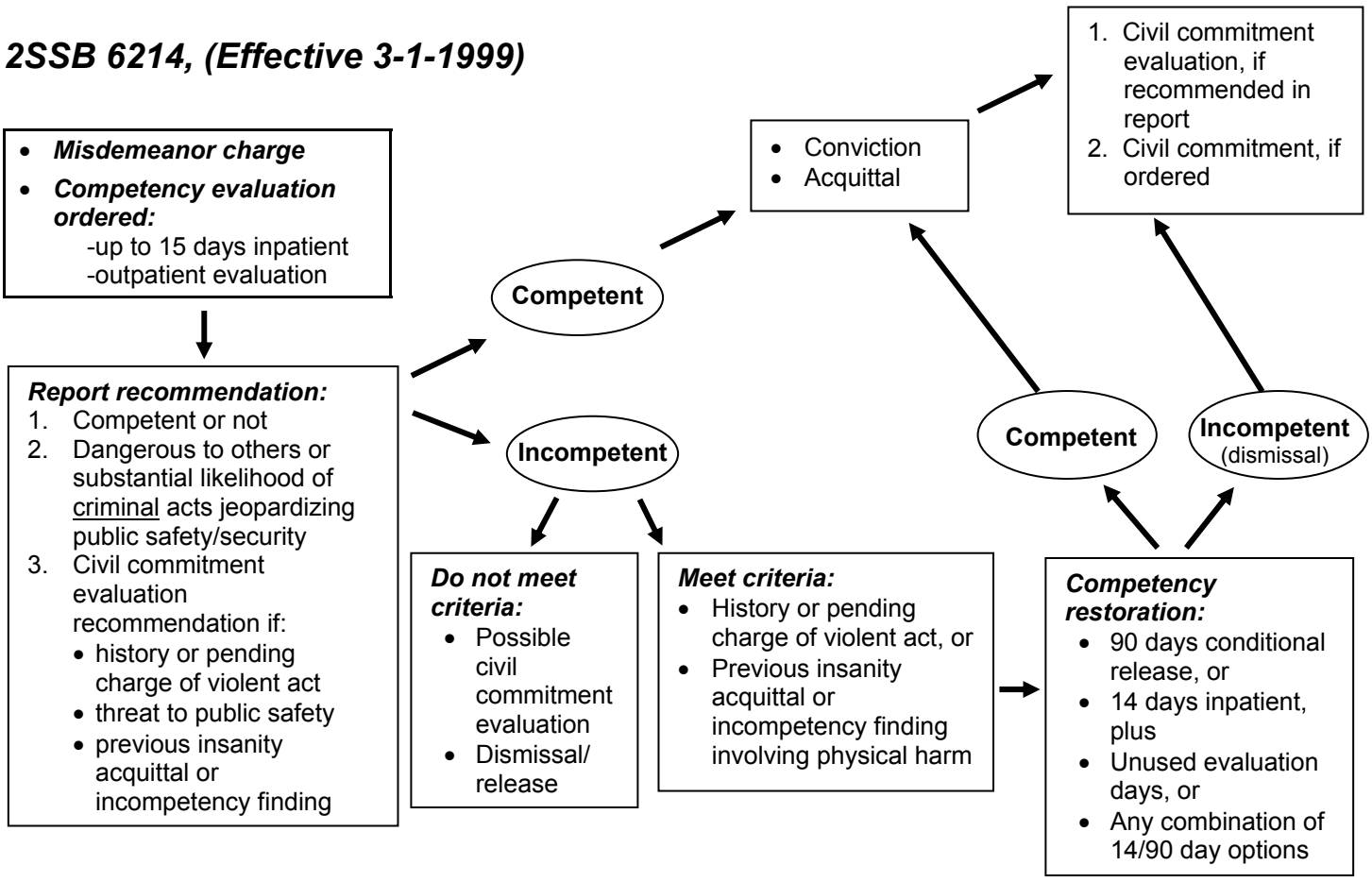
Exhibit 3

Misdemeanant Processing Before and After 2SSB 6214

Prior to 2SSB 6214



2SSB 6214, (Effective 3-1-1999)



III. RESEARCH QUESTIONS AND DESIGN

Research Questions

This study first addresses whether 2SSB 6214 altered the process of competency evaluation in Washington State. It then focuses on the main legislative objectives: Are misdemeanant defendants receiving treatment under the new law, and does this treatment reduce the population's criminal recidivism? In addition, detailed descriptive statistics on the defendants are provided, as little information previously has been available on this population, particularly their background with the mental health and criminal justice systems.

The major evaluation questions include competency evaluations, competency restoration, and criminal recidivism.

Competency Evaluations

- Did the legislation influence the misdemeanor competency evaluation process?
  - Were courts more likely to order competency evaluations after the legislation went into effect?
  - Have other changes occurred in evaluation procedures or processes?
  - What are the characteristics of defendants receiving evaluations, and have they changed from previous populations?

Competency Restoration

- Who receives competency restoration treatment?
  - Are misdemeanants who pose a threat to public safety receiving competency restoration treatment?
- What are the outcomes of the competency restoration process?
  - What is the duration of competency restoration treatment?
  - How many defendants are restored to competency to stand trial?
  - Does the state or county pursue civil commitment for those individuals who are not restored to competency?

Criminal Recidivism

- Does treatment under the new law reduce criminal recidivism?

Research Design

To answer the Legislature's questions on this law, a comparison group design is necessary.[12] Comparing groups of defendants that received evaluations under the old and new laws allows us to determine whether defendants' characteristics or evaluation procedures have changed. A comparison group is even more important in understanding the effectiveness of treatment, as outcomes of individuals who have received treatment can be examined with an equivalent group of individuals who did not receive treatment. Since the new law applies to all misdemeanant defendants ordered for a competency evaluation on or after March 1, 1999, a comparison group must be selected from a time period prior to the law. There are limitations in using such a comparison group, for example, historical factors, including changes in the economy, crimes rates, or prosecution practices are not able to be ruled out as possible explanations for outcomes. However, since all defendants are eligible for treatment under the new law, the use of a historical comparison group is necessary. The selected study populations are described below.[13]

Historical Comparison Group Population. In selecting the time frame for the comparison group, we were aware that misdemeanor competency evaluations were not conducted as often prior to the passage of the new legislation. We needed a large pool of comparison group subjects from whom we would select individuals whose characteristics best matched the 2SSB 6214 population receiving treatment under the new law. Using state hospital records, we identified 431 misdemeanor competency evaluations (and defendants receiving the evaluations) conducted from January 1, 1995, through July 31, 1997 (prior to the August 1997 murder).[14] Using hospital records and reports, we collected defendants' demographic and clinical background data and evaluation outcomes. In addition, we collected defendants' court and public mental health system service records to ascertain criminal history and recidivism and the use of inpatient and outpatient mental health treatment services. All study data items are listed in Appendix B.

2SSB 6214 Population. Through state hospital records, we identified 561 misdemeanor competency evaluations (and defendants receiving the evaluations) conducted during the first year of the new law, from March 1, 1999, through February 29, 2000. It was necessary to use defendants receiving evaluations during the first year in order to have a sufficient time frame to measure criminal recidivism.[15] We collected the same set of data described above on the treatment group; in addition, we collected data on whether defendants received treatment under competency restoration laws.

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[12] An experimental design in which subjects are assigned randomly to a treatment and comparison group is the strongest research design. Randomization removes differences between the groups and allows the researcher to rule out all other possible causes for program outcomes. This type of design is not possible for this evaluation, as all defendants in the state are eligible for treatment under the new law.

[13] This study was approved by the Washington State Institutional Review Board.

[14] A number of key informants we interviewed suggested that courts began to order competency evaluations more frequently after the August 1997 murder, so we selected a historical time frame prior to that date to provide baseline figures. See Appendix J for a description of key informants.

[15] For legislative criminal recidivism standards, see Robert Barnoski, *Standards for Improving Research Effectiveness in Adult and Juvenile Justice* (Olympia: Washington State Institute for Public Policy, 1997).

Populations Used to Address Research Questions

To answer the questions on competency evaluations, competency restoration treatment, and criminal recidivism, we rely on different subpopulations of the treatment and comparison groups. The specific populations used to answer each topic's questions are described below.

Competency Evaluations. The questions on competency evaluations required a comparison of misdemeanant defendants ordered for evaluations before and after the implementation of the new law. From the comparison group, we selected all defendants receiving competency evaluations over a one-year time period, from March 1, 1996, through February 28, 1997, for the "before" or pre-law comparison group.[16] The "after," or post-law, population included all defendants receiving competency evaluations during the first year of the new law: March 1, 1999, to February 29, 2000. For ease of reference, we have referred to these time periods as 1996 and 1999, respectively.

Competency Restoration. For these questions, we studied only those defendants who received evaluations during the first year of the new law and, primarily, those individuals evaluated as incompetent to stand trial who received treatment.

Criminal Recidivism. The question of whether treatment under the new law reduced criminal reoffenses required a comparison group that "matched," or was equivalent to, the population of misdemeanant defendants receiving competency restoration treatment under the new law.

To develop a matched comparison group, we first constructed a statistical model using demographic, mental illness, and criminal history data. The model predicted the likelihood of receiving treatment for all defendants who were evaluated as incompetent to stand trial during the first year of the new law. Then we calculated a "propensity-to-treat" score for each defendant that summarized his or her probability of receiving treatment based on his or her demographic, mental illness, and criminal history.[17] We applied this model to the historical comparison group pool and calculated propensity-to-treat scores for each individual in that group. Then we selected comparison group members who had scores similar to the treatment group to use as our matched sample. These procedures assured a matched group highly comparable to the treatment group. Propensity-to-treat scores utilize many more matching criteria than simple matching techniques, such as only matching on age and sex, which is common in evaluation research.

[16] 1996 defendant characteristics do not differ statistically from 1995 and 1997 defendants.

[17] These scores are referred to as "propensity scores" in the statistical literature. See P.R. Rosenbaum and D.B. Rubin, "Constructing a Control Group Using Multivariate Matched Sampling Methods that Incorporate the Propensity Score," *The American Statistician* 39 (1985): 33-38.

Statistical Significance Tests

Depending on the research questions and the population size, various statistical tests allow more sensitive discernment. We utilize chi-square tests for differences between proportions and t-tests for differences in means. In assessing the significance of coefficients in regression analyses, we use chi-square and z-statistics. The strength of regression models is assessed by measures of predictive power and accuracy measures. In most cases, we use .05 as our standard for statistical significance. This result indicates that a difference would occur by chance less than five times in a hundred if the groups were not really different. For multivariate statistical models with smaller sample sizes, we include statistically significant findings up to .10.[18] Our notation for statistical significance levels is as follows: a = .05, b = .01, c = .001, and d = .0001.

[18] It is more difficult to detect statistical significance in small samples; thus, we use .10 when testing the multivariate models.

IV. CRIMINAL COMPETENCY EVALUATIONS

Did 2SSB 6214 Influence the Misdemeanor Criminal Competency Process?

2SSB 6214 substantially changed the misdemeanor criminal competency process, providing new avenues for the legal system to respond to mentally ill defendants charged with misdemeanor crimes. How did the legal and mental health systems respond to the statutory changes? To explore this question, we focus on criminal competency evaluations, the first step in the law's criminal competency process.

If a defendant's competency to stand trial is at issue, under RCW 10.77, a panel must be appointed to evaluate the defendant's mental condition. The county district or municipal court orders a misdemeanant defendant to receive a competency evaluation, which is usually conducted by state hospital staff. Each state hospital has a forensic unit, and competency evaluations are carried out by state hospital psychiatrists or psychologists on an inpatient or outpatient basis.[19] Eastern State Hospital (ESH) provides services for 21 Eastern Washington counties, has 83 beds for forensic patients, and has a forensic staff of six psychiatrists and psychologists. Western State Hospital (WSH) provides services for 18 Western Washington counties, has 240 beds for forensic patients, and employs 16 psychiatrists and psychologists whose primary responsibility is to conduct forensic evaluations.

Information on competency evaluations in the state allows us to examine a number of important questions, including the following:

- Were courts more likely to order competency evaluations after 2SSB 6214 went into effect?
- Have there been other changes in evaluation procedures or processes?
- Who receives competency evaluations, and has the population changed as a result of the new law?

To answer these questions, we compare misdemeanant defendants ordered for evaluations before and after the law's implementation. As stated earlier, the before population includes all defendants receiving competency evaluations between March 1, 1996, and February 28, 1997. The after population includes all defendants receiving competency evaluations during the first year of the new law: March 1, 1999, to February 29, 2000. We refer to these time periods as 1996 and 1999, respectively.

These comparisons also allow us to learn whether differences over time threaten the validity of our comparative historical research design. In general, differences between treatment and comparison groups can be controlled through statistical matching and controls. However, major differences between the treatment and comparison groups on a large

[19] Outpatient evaluations are typically conducted when the defendant is in jail. Defendants are admitted to the state hospital for inpatient evaluations.

number of characteristics and procedures would cast doubt on the appropriateness of the selected design.

Were Courts More Likely to Order Competency Evaluations?

Exhibit 4 shows a large increase in each state hospital's misdemeanor competency evaluations over time. The number of evaluations conducted by ESH doubled between 1996 and 1999; at WSH the number nearly quadrupled. Overall, there was a 238 percent increase in misdemeanor competency evaluations between 1996 and 1999. Thus, the new legislation set into place a process that courts adopted, as shown by this increase in competency evaluations.

Exhibit 4
Misdemeanor Competency Evaluations* by State Hospital and Year

	Number		% Change
	1996	1999	1996–99
Eastern State Hospital	48	104	117%
Western State Hospital	118	457	287%
Total	166	561	238%

* Includes competency evaluations only; does not include evaluations conducted exclusively to determine sanity or diminished capacity.

Exhibit 5 shows that the pattern of competency evaluations changed quite dramatically in some counties and very little in others. One would expect that the legislation would have the greatest effect on King County courts,[20] and the changes were substantial. King County accounted for 29 percent of all evaluations in 1996, increasing to 48 percent in 1999, a 467 percent increase.[21] The percent change from 1996–99 was even greater in Pierce County, 620 percent, where courts ordered evaluations infrequently in 1996, most likely because of an active jail diversion program for mentally ill offenders. Spokane also experienced a large change, although it accounted for about the same proportion of statewide evaluations in each time period. Courts in counties with smaller populations, grouped together in the "all other counties" category, increased their use of evaluations but accounted for a smaller proportion of evaluations over time. Ten small, mostly rural, counties did not order any evaluations during either time period: Adams, Asotin, Columbia, Garfield, Ferry, Island, Klickitat, Lincoln, San Juan, and Pend Oreille.

[20] For the reason that the crime originating the law occurred in King County and generated significant court and public awareness.
[21] King County accounts for approximately 29 percent of the state population; Pierce County, 12 percent; Snohomish County, 10 percent; Spokane County, 7 percent; Kitsap County, 4 percent; Thurston County, 4 percent; Chelan County, 1 percent; and all other counties 33 percent.

Exhibit 5
Competency Evaluations by County by Year

	1996		1999		1996–99
	N	% of All Evaluations	N	% of All Evaluations	% Change
King County	48	29%	272	48%	467%
Pierce County	10	6%	72	13%	620%
Snohomish County	14	8%	26	5%	86%
Spokane County	17	10%	61	11%	259%
Kitsap County	13	8%	15	3%	15%
Thurston County	18	11%	25	4%	39%
Chelan County	10	6%	11	2%	-60%
All Other Counties*	36	22%	79	14%	119%
Total	166	100%	561	100%	238%

* Of the 22 counties in the "all other" category, none comprised more than 3 percent of total evaluations during either time period.

Have There Been Changes in Evaluation Procedures or Processes?

Competency evaluations can be conducted in either an inpatient or outpatient setting. Exhibit 6 shows few evaluations in 1996 were conducted on an outpatient basis at either state hospital. By 1999, practices changed substantially, with WSH conducting the majority of misdemeanant competency evaluations on an outpatient basis (86 percent), and ESH increasing slightly the number of outpatient evaluations. Immediately prior to the legislation, and in response to the King County Task Force recommendations, WSH created the "Program for Forensic Evaluations in Community Corrections" to conduct outpatient evaluations in local correctional settings.[22] During 1999, over 80 percent of the WSH outpatient evaluations were conducted in jails or other correctional settings. At ESH, most outpatient evaluations were conducted at the state hospital campus. The change in the proportion of evaluations conducted on an outpatient and inpatient basis between 1996 and 1999 was statistically significant for WSH, but not for ESH.

[22] The November 1997 Mentally Ill Offenders Task Force Final Report indicates that local evaluations would increase the available local information on mentally ill defendants, save time and effort involved in transit to and from WSH, and facilitate reduced bed space through coordination with courts to schedule hearings promptly. See <http://www.metrokc.gov/dchs/mhd/mio/report.htm>.

Exhibit 6
Evaluation Location and Length of Stay

	Eastern State Hospital		Western State Hospital	
	1996	1999	1996	1999
Total Evaluations	48	104	118	457
Number of Outpatient Evaluations	5 (10%)	23 (22%)	7 (6%)[d]	392 (86%)[d]
Number of Inpatient Evaluations	43 (90%)	81 (78%)	111 (94%)[d]	65 (14%)[d]
Inpatient Evaluation Length of Stay (days)	7.6[d]	13.0[d]	6.9[d]	11.6[d]

[d] = statistically significant at the .0001 level.

ESH increased the number of inpatient evaluations conducted between 1996 and 1999 and continued to conduct the majority of its evaluations on an inpatient basis. In both state hospitals, the average length of stay for inpatient evaluations increased by approximately five days, a statistically significant increase for each hospital. In 1999, WSH evaluators had the discretion to decide whether competency could be assessed through an outpatient evaluation or whether a defendant required a longer observation time and should be admitted to the hospital. Thus, the smaller number of defendants receiving inpatient evaluations in 1999 probably required more observation time, accounting for the longer length of stay. ESH indicated that court reports required more information over time, accounting for a longer evaluation length.

Increases in the use of (and population receiving) competency evaluations might lead one to expect that the decision on competency to stand trial changed over time. Interviews with forensic evaluators suggest that the examination and tests for determining competency did not change with the new law.[23] Exhibit 7 shows that the percentage of misdemeanant defendants evaluated as incompetent to stand trial was fairly stable, with ESH assessing about 40 percent and WSH about 60 percent of defendants incompetent to stand trial.

Exhibit 7
Hospital Determination of Competence to Stand Trial[24]

	Eastern State Hospital		Western State Hospital	
	1996	1999	1996	1999
Number Evaluated	48	104	118	457
Percent Incompetent	40%	36%	57%	59%

[23] More information on interviews with key informants can be found in Section IX and Appendix J.
[24] The differences between state hospitals in the proportion of persons evaluated as incompetent to stand trial is statistically significant in 1996 (.05) and 1999 (.0001).

Who Receives Evaluations, and Has the Population Changed as a Result of the New Law?

This section examines the demographic, criminal history, and mental illness characteristics of defendants receiving competency evaluations to provide a profile of mentally ill misdemeanants in Washington State. We also address whether the characteristics of defendants ordered for evaluations have changed. Given an increase in use of competency evaluations associated with the new law, one could assume that a different population might be receiving evaluations.

Exhibit 8 shows the most common demographic profile of a defendant receiving a competency evaluation in 1999 is a white male in his late 30s. Whites account for 73 percent of defendants in 1999, a figure slightly higher than the 67 percent white representation reported by the Washington Association of Sheriffs and Police Chiefs (WASPC) in state jails in 1999.[25] Though women comprise only 18 percent of defendants evaluated in 1999, that number is higher than the 13 percent they represent in Washington state jails in 1999. Exhibit 8 also shows that the sex and race of defendants has remained relatively stable.

Exhibit 8

Background Characteristics of Defendants Receiving Competency Evaluations

	1996		1999	
	Number	Percent	Number	Percent
Total	166		561	
Sex				
Male	137	83%	460	82%
Female	29	17%	101	18%
Race*				
White	111	72%	406	73%
Black	21	14%	107	19%
Asian	8	5%	25	4%
Other race	14	9%	20	4%
Age				
16–24	19	11%	78	14%
25–34	56	34%[a]	139	25%[a]
35–44	49	30%	180	32%
45 or over	42	25%	164	29%
Average age	37.3		38.8	

* Due to missing data, the denominator for race data is 154 in 1996 and 558 in 1999.
[a] = statistically significant at .05 level.

While 1996 defendants are slightly younger than in 1999, the only statistically significant difference between the two groups is that 1996 defendants are more likely to be in the 25-34 age group. The average age of 1999 defendants is nearly 39 years old. While a similar

[25] Statewide Average Daily Population, 1999. <http://www.waspc.org/jails/JailStats/2002/5YearADP.shtml>.

figure is not available from WASPC, their statistics indicate that 40 percent of the jail population in 1999 is between ages 18 and 29. We calculate that about 18 percent of 1999 defendants are between 18 and 29 years old, indicating defendants receiving competency evaluations are much older than the average jail population.

Defendants' past misdemeanor and felony crimes provide us with an understanding of the extent and seriousness of criminal behavior. Exhibit 9 includes both Washington criminal case filing and conviction information for defendants.[26] Misdemeanor case filings are important to this study, as many 1996 defendants would have had charges filed and dismissed if they were judged incompetent to stand trial, therefore underestimating criminal activity. Thus, compared with convictions, filings better represent misdemeanor criminal behavior.

Defendants ordered for competency evaluations in 1996 and 1999 have an extensive misdemeanor and a moderate felony history. Nearly all defendants have a misdemeanor filing, since the evaluation offense is included in criminal history. However, defendants average 11 filings, including over four filings for offenses against a person, indicating a sizeable history of misdemeanor charges. Three-quarters of defendants in each group have a misdemeanor conviction, and over a third have a prior felony conviction. Defendants with prior convictions average about two felony and seven misdemeanor convictions.

Exhibit 9
Criminal History of Defendants Receiving Competency Evaluations

	1996		1999	
	Number	**Percent**	**Number**	**Percent**
Total	166		561	
Criminal Case Filings				
Misdemeanor	164	99%	553	99%
Misdemeanor against person	125	75%	406	72%
Average Number of Filings*				
Misdemeanor	11.3		11.0	
Misdemeanor against person	4.7		4.1	
Convictions				
Felony	67	40%	201	36%
Felony against person	32	19%	98	17%
Misdemeanor	123	74%	418	74%
Misdemeanor against person	81	49%	267	46%
Average Number of Convictions*				
Felony	2.3		2.3	
Felony against person	1.4		1.3	
Misdemeanor	7.1		6.8	
Misdemeanor against person	3.1[a]		2.6[a]	

* The average number of convictions and filings are calculated only for those offenders who have received a conviction in that category. [a] = statistically significant at the .05 level.

[26] See Appendix C for definitions of felony and misdemeanor crime categories.

Exhibit 9 also indicates that defendants' criminal history is slightly more serious in 1996; however, only one difference is statistically significant. Of those defendants convicted for a misdemeanor person crime, 1996 and 1999 defendants average 3.1 and 2.6 convictions, respectively, a statistically significant difference.

Exhibit 10 shows the misdemeanor charge associated with the competency evaluation. The majority of defendants in each time period are charged with against person offenses, such as fourth degree assault and harassment. Another major charge category includes property offenses, including criminal trespass and theft. Sex and drug offenses are relatively rare. Unknown offenses are those where we were unable to make a definitive records link between the charge recorded by hospitals and the court data. Defendants in 1999 have slightly different charges that include fewer person and more property offenses, but the differences are not statistically significant.

Exhibit 10
Most Serious Misdemeanor Charge for Competency Evaluation

	1996		1999	
Misdemeanor Charge Type	**Number of Defendants**	**Percent**	**Number of Defendants**	**Percent**
Person	102	61%	314	56%
Property	33	20%	147	26%
Sex*	13	8%	14	3%
Drug	1	0%	1	0%
Other	6	4%	19	3%
Unknown	11	7%	66	12%
Total	166	100%	561	100%

* Sex crimes overlap with the "person" crime category; however, given the different nature of sex offenses, they are reported in a separate category.

In addition to significant criminal activity, defendants' Washington state mental illness history suggests a seriously mentally ill population with substantial psychiatric hospitalization and substance problems. Exhibit 11 shows approximately three-quarters of defendants are diagnosed with a major mental illness, such as schizophrenia, bipolar disorder, and other psychotic disorders.[27] Over 50 percent of defendants have a diagnosed substance disorder, and over 40 percent have a co-occurring mental illness and substance disorder. Psychiatric hospitalization is common: over half the defendants have some psychiatric hospitalization in their history, and over a quarter have previous forensic hospitalization.

[27] See Appendix D for the definition of major mental illness and substance disorder.

Exhibit 11
Mental Illness History of Defendants Receiving Competency Evaluations

	1996		1999	
	Number	Percent	Number	Percent
Total	166		561	
Major Mental Illness Diagnosis	124	75%	411	73%
Substance Disorder	90	54%	288	51%
Co-occurring Mental Illness/ Substance Disorder	48	45%	45	42%
Any Psychiatric Hospitalization	86	52%	307	55%
Any Forensic Psychiatric Hospitalization	43	26%	182	32%
Psychiatric Hospitalization in Prior Year	50	30%	204	36%
Forensic Psychiatric Hospitalization in Prior Year	27	16%	117	21%
Community Mental Health Treatment in Prior Year	74	45%[b]	320	57%[b]

[b] = statistically significant at the .01 level.

Exhibit 11 also shows that 57 percent of 1999 defendants had community mental health treatment in the year prior to their evaluation compared with 45 percent of 1996 defendants. This difference is statistically significant, but our data do not allow us to assess reasons for the differences. Possible explanations may include more mentally ill persons with criminal justice system involvement have received treatment over time, defendants with mental health system involvement in 1996 were less likely to be criminally prosecuted, and increases in competency evaluations in 1999 brought individuals with more community mental health system background into the evaluation process.

Summary

2SSB 6214 set into place a competency restoration process that courts adopted, evidenced by a large increase in the number of defendants committed for misdemeanor competency evaluations, particularly in King and Pierce Counties. The decision whether a misdemeanant defendant was incompetent to stand trial at each state hospital remained about the same over time: 40 percent at ESH and 60 percent at WSH. One evaluation practice changed substantially at WSH: local evaluations conducted in an outpatient, primarily correctional, setting replaced state hospital inpatient evaluations as the predominant evaluation location.

Defendants receiving competency evaluations are commonly white men in their late 30s; they are substantially older than average jail prisoners in Washington. The majority are charged with a misdemeanor crime against a person, such as fourth degree assault and harassment. Defendants have extensive involvement in the criminal justice system,

including an average of 11 misdemeanor criminal charge filings. Over 75 percent of defendants have a misdemeanor conviction, and over a third have a prior felony conviction.

About 75 percent of defendants are diagnosed with a serious mental illness, such as schizophrenia, bipolar disorder, and other psychotic disorders, and over half have a substance disorder diagnosis. Prior psychiatric hospitalization is common: over 50 percent of defendants have prior psychiatric hospitalization, and over 25 percent have prior forensic hospitalization.

Defendants' characteristics have remained stable over time, but there are a few significant differences. One is a greater proportion of comparison group defendants in the 25 to 34 age category; however, the average age of defendants is not significantly different. Another difference is the larger proportion of treatment group defendants who receive outpatient community mental health treatment in the year prior to the evaluation. Overall, the differences over time are modest, providing support for the use of a historical comparison group research design for this study.

V. COMPETENCY RESTORATION TREATMENT

One of the major purposes of 2SSB 6214 was to increase treatment opportunities for misdemeanor defendants identified as threats to public safety. To achieve this goal, the competency restoration process was extended to include misdemeanants with a history of violence who were determined to be incompetent to stand trial.

This section investigates the characteristics of misdemeanant defendants who receive competency treatment to learn whether the law has been implemented as intended. Our research questions include the following:

- Who receives competency restoration treatment?
- Are misdemeanants who pose a public safety threat receiving competency restoration treatment?

To address these questions, we focus on 309 misdemeanant defendants evaluated as incompetent to stand trial during the first year of the new law: March 1, 1999, to February 29, 2000.[28] Within this group, misdemeanants who received and did not receive treatment are compared to assess how criminal background and other characteristics are related to the receipt of competency restoration treatment.

Who Receives Competency Restoration Treatment?

Exhibits 12 through 14 present the demographic, mental illness, and criminal history backgrounds of misdemeanant defendants evaluated as incompetent to stand trial in 1999. While few differences in demographic backgrounds between those receiving and not receiving treatment would be expected, there could be differences in who receives treatment associated with mental illness severity. In addition, we would expect defendants receiving treatment to have a criminal background associated with violent behavior, since the law requires competency restoration treatment for defendants who pose a public safety threat.

Exhibit 12 indicates no statistically significant differences were found in the demographics for defendants who did versus those who did not receive competency restoration treatment. Similar to defendants receiving competency evaluations, the majority of defendants evaluated as incompetent to stand trial are white and male, with an average age of approximately 40 to 42 years.

[28] For this analysis, we use state hospital evaluators' decisions on whether defendants were or were not competent to stand trial, as recorded in their reports to the court. Evaluator decisions were the most reliable data available on competency; we could not find any data source between individual courts that consistently reported the court competency decision.

Exhibit 12
Background Characteristics of Defendants Who Did and Did Not Receive Competency Restoration Treatment

	Received Competency Restoration		Did Not Receive Competency Restoration	
	Number	Percent	Number	Percent
Total	126		183	
Sex				
Male	101	80%	145	79%
Female	25	20%	38	21%
Race				
White	84	67%	132	72%
Black	30	24%	35	19%
Asian	8	6%	10	5%
Other race	4	3%	6	3%
Age				
16–24	11	9%	16	9%
25–34	32	25%	36	20%
35–44	45	36%	67	37%
45 or over	38	30%	64	35%
Average age	39.6		42.2	

The mental illness history of defendants who did and did not receive competency restoration treatment is presented in Exhibit 13. The exhibit shows that both groups had a background of very serious mental illness. Overall, defendants who received treatment had a more substantial mental illness history; however, few differences were statistically significant. Defendants receiving treatment were significantly more likely to have a major mental illness diagnosis. While a larger proportion of defendants receiving treatment had psychiatric and forensic hospitalizations and community mental health treatment, only psychiatric hospitalization in the prior year was statistically different and associated with receiving competency restoration treatment.[29]

[29] Many defendants who did not receive competency restoration treatment were hospitalized in the year after their evaluation. We found that approximately 50 percent of defendants incompetent to stand trial who did not receive competency restoration treatment had either state hospital non-forensic or community hospital days in the year after their evaluation.

Exhibit 13
Mental Illness History of Defendants Who Did and Did Not Receive Competency Restoration Treatment

	Received Competency Restoration		Did Not Receive Competency Restoration	
	Number	Percent	Number	Percent
Total	126		183	
Major Mental Illness Diagnosis	119	94%[b]	153	84%[b]
Substance Disorder	56	44%	69	38%
Any Psychiatric Hospitalization	81	64%	102	56%
Any Forensic Psychiatric Hospitalization	38	30%	38	21%
Psychiatric Hospitalization in Prior Year	55	44%[a]	59	32%[a]
Forensic Psychiatric Hospitalization in Prior Year	15	12%	17	9%
Community Mental Health Treatment in Prior Year	82	65%	108	59%

[a] = statistically significant at the .05 level; [b] = .01 level.

Are Defendants Who Pose a Threat to Public Safety Receiving Competency Restoration Treatment?

2SSB 6214 extends competency restoration to misdemeanant defendants with a history or current offense involving violence. The legislation defines violent behavior that is considered a threat to public safety. The definitions provide standards for courts to determine whether a defendant's past or current behavior mandates competency restoration treatment.

First, the law defines a *violent act* in RCW 10.77.010 (21) as:

- Behavior that resulted in, if completed would have resulted in, or was threatened to be carried out by a person with intent and opportunity and would have resulted in homicide, nonfatal injuries, or substantial damage or property; or recklessly creating an immediate risk of serious physical damage to another person.

Second, the law requires a misdemeanant defendant judged incompetent to stand trial, with any of the following behavior ordered to undergo competency restoration treatment (RCW 10.77.090 (1) (d) (i) (A)):

- A history or pending charge of one or more violent acts; or
- A previous insanity acquittal or incompetency finding where the offense involved actual, threatened, or attempted physical harm to a person.

The definitions are specific but cover a wide range of behavior and do not cross-reference a particular set of crimes. Because we did not have access to court information that indicates whether the judge determined that particular defendants met the criteria, a valid "proxy" method was needed for the evaluation.[30] We draw on two sources of criminal history as proxies for violent behavior. First, we use defendants' Washington State criminal history, with a focus on criminal convictions or filings for a crime against a person. The category of a crime against a person is most likely to meet the violence criteria defined in the law. Second, we use information recorded by state hospital evaluators on whether a defendant meets any of the legislative criteria for violence: a past or current offense involving a violent act or a previous insanity acquittal or incompetency finding involving physical harm.[31]

Exhibit 14
Criminal History of Defendants Who Did and Did Not Receive Competency Restoration Treatment

	Received Competency Restoration		Did Not Receive Competency Restoration	
	Number	Percent	Number	Percent
Total	126		183	
Convictions				
Felony	48	38%[c]	39	21%[c]
Felony against person	29	23%[c]	16	9%[c]
Misdemeanor	86	68%	113	62%
Misdemeanor against person	62	49%[c]	52	28%[c]
Average Number of Convictions*				
Felony	1.7		1.9	
Felony against person	1.4		1.4	
Misdemeanor	7.2		5.1	
Misdemeanor against person	2.7[c]		1.6[c]	
Criminal Case Filings				
Misdemeanor	126	100%	182	99%
Misdemeanor against person	108	86%[d]	116	63%[d]
Average Number of Filings*				
Misdemeanor	12.4		9.2	
Misdemeanor against person	4.6[b]		2.9[b]	

* The average number of convictions and filings are calculated only for those offenders who have a conviction in that category. [a] =statistically significant at the .05 level; [b] = .01 level; [c] = .001 level; [d] = .0001 level.

[30] Key informant interviews indicated courts have difficulty determining whether a defendant has a history or pending charge that meets the definition of a violent act. One court prosecutor suggested that actual offenses that meet the definition should be specified in the law.

[31] WSH evaluators conducting outpatient evaluations complete a form indicating whether a defendant has a past or present charge or a prior incompetency or insanity finding involving a violent act. That information was used in these analyses. For WSH inpatient evaluations and all ESH evaluations, we abstracted the same information from the evaluators' narrative reports to the court. Data on violence were fairly consistently recorded, because evaluators provide an opinion on dangerousness as required by law.

The Washington criminal history indicates that defendants who received competency restoration were more likely to meet violence criteria compared with defendants not receiving treatment. Exhibit 14 shows 23 percent of defendants receiving competency restoration had a past conviction for a felony crime against a person compared with 9 percent for those who did not receive treatment. Misdemeanor against person crimes displayed a similar pattern, with 49 percent of those receiving treatment having a conviction in that category compared with 28 percent of defendants not receiving treatment. Defendants receiving treatment also had a significantly greater *number* of convictions and filings for misdemeanor person offenses.

Defendants receiving treatment were more likely to meet each of the violence criteria recorded by evaluators than those not receiving treatment (see Exhibit 15). Evaluator reports on current or past violent offenses and past incompetency and insanity findings for violent offenses were significantly higher for defendants who received treatment. The highly significant findings from both the criminal history and evaluator reports indicate that defendants who pose a public safety threat are significantly more likely to receive treatment in accordance with the law.

Exhibit 15
Criminal History of Defendants Who Did and Did Not Receive Competency Restoration Treatment

	Received Competency Restoration		Did Not Receive Competency Restoration	
	Number	Percent	Number	Percent
Total	126		183	
Court Report/Evaluator Assessment				
Current violent offense	60	48%[b]	57	31%[b]
Past violent offense	84	67%[d]	73	40%[d]
Past incompetency, violent offense	23	18%[a]	18	10%[a]
Past insanity, violent offense	5	4%[a]	1	2%[a]

[a] =statistically significant at the .05 level; [b] = .01 level; [d] = .0001 level.

As a final step in understanding which defendants evaluated as incompetent to stand trial received competency restoration treatment, we carried out a multivariate statistical analysis. This analysis predicts the likelihood of receiving treatment based on a defendant's demographic, mental illness, and criminal history background characteristics. It allows us to learn what factors are most important in receiving treatment when all explanatory background characteristics are included and controlled for. The full statistical model is shown in Appendix E. Exhibit 16 provides a summary of the findings. Overall, the analysis shows that defendants receiving treatment are significantly more likely to have a serious major mental illness and violent offending behavior.

Exhibit 16

Factors Affecting the Likelihood of Receiving Competency Restoration Treatment

(From Logistic Regression Analyses)

Characteristics of defendants more likely to receive treatment	• Type of mental illness: schizophrenia, bipolar, other psychotic disorders • Felony and misdemeanor crimes against persons • Current or past violent offense identified by evaluator • Spokane County court case • Prior community mental health treatment
Characteristics of defendants less likely to receive treatment	• Misdemeanor property crimes • Felony drug crimes
Not a factor in receiving treatment	• Age, race, sex • Prior psychiatric hospitalization

Type of mental illness was a significant predictor of receiving competency restoration treatment. Compared with defendants without a major mental illness diagnosis, defendants with schizophrenia and other psychotic disorders had over 1 1/2 times greater odds of receiving treatment, and defendants with bipolar disorder over 2 1/2 times greater odds. Prior psychiatric hospitalization did not significantly predict receiving competency restoration treatment; however, whether a defendant received community mental health services in the year prior to the evaluation was a slightly significant factor.

Overall, the county was not a significant factor in receiving treatment with one exception. In Spokane County, all criminal competency cases were handled in the combined municipal and district mental health court, and nearly all defendants evaluated as incompetent to stand trial received treatment. The mental health court was likely the reason that defendants in Spokane County had 2 1/2 times greater odds of receiving treatment.

As one would expect, based on legislative requirements, criminal history variables were important in predicting the likelihood of treatment. Having a felony crime against a person was highly related to receiving treatment, while having a felony drug conviction was related to a lower likelihood of receiving treatment. Defendants with a greater number of misdemeanor crimes against a person were more likely to receive treatment, while those with a greater number of property offenses were less likely, fitting with the requirement for violent acts. Finally, defendants with a current or past violent offense recorded by evaluators were significantly more likely to receive treatment.

Summary

Defendants receiving competency restoration treatment are a severely mentally ill population with a history of violence, indicating the legislation is working as intended. Demographic characteristics, including age, race, and sex, are not associated with receiving treatment. While the severity of mental health diagnosis is related to receiving treatment, past mental health services for the most part are not related to receiving treatment. Defendants judged incompetent to stand trial who receive treatment have an extensive criminal background, particularly involving a crime against a person. Evaluator reports indicate that a significantly greater proportion of defendants who receive treatment meet the violent background definitions set out in law.

Multivariate analyses indicate a serious mental illness and a consistent pattern of violent offenses for defendants who receive competency restoration treatment. Defendants with felony or misdemeanor crimes against persons, and defendants for whom the evaluator records a current or past violent offense, are more likely to receive treatment. Overall, these findings indicate that defendants who pose a public safety threat are receiving treatment under the new law.

VI. COMPETENCY RESTORATION OUTCOMES

2SSB 6214 requires judges to order competency restoration treatment at state hospitals for misdemeanant defendants who pose a public safety threat and are incompetent to stand trial. If a defendant is restored to competency, he or she returns to court to stand trial. If not restored to competency, the law requires defendants be referred for an evaluation under involuntary civil commitment laws.

In this section, we continue reporting on the restoration process for misdemeanant criminal competency, concentrating on the outcomes of the competency restoration process:

- What is the duration of competency restoration treatment?
- How many defendants are restored to competency to stand trial?
- Are civil commitment proceedings pursued for those individuals who are not restored to competency?

To address these questions, we study misdemeanant defendants who received competency restoration treatment under the new law. Since competency restoration treatment is provided exclusively at Eastern State Hospital (ESH) and Western State Hospital (WSH), we compare treatment outcomes by hospital. There are likely to be differences, given the greater use of outpatient evaluations at WSH. The law provides for up to 29 days of inpatient treatment, which includes 14 days plus any of the 15 inpatient evaluation days not used. The law also allows a 90-day conditional release outpatient treatment option, which can be used alone or in combination with inpatient treatment. However, we did not find any defendants receiving the conditional release option. Given the violent background of the defendants receiving treatment, it may be that courts are unlikely to make use of that option. In addition, one key informant interviewed stated there is no existing structure in place within the mental health and criminal justice systems to implement the 90-day conditional release treatment option.[32]

What Is the Duration of Competency Restoration Treatment?

A total of 126 defendants judged as incompetent to stand trial between March 1999 and February 2000 were returned to the state hospitals to receive competency restoration treatment.[33] The time between evaluation and competency restoration—time spent in jail for most defendants—reflects both court processing time and state hospital admission capacity. The number of days a defendant spends waiting for treatment is shown in Exhibit 17. At ESH, all but one defendant received an inpatient evaluation. An average of 8.8 days transpired between the end of inpatient evaluations and the beginning of competency

[32] See Section IX and Appendix J for background on the key informant interviews.
[33] The DSHS fiscal note for the legislation projected 730 persons would receive competency restoration annually. The projections were based on estimates by King County that approximately 180 defendants would receive treatment, and the numbers were multiplied by four, as King County was assumed to account for one-quarter of the state cases.

restoration treatment; the actual number of days ranged from zero to 39, with a midpoint (median) of six days. At WSH, most (82) defendants received outpatient evaluations. An average of 9.8 days transpired between the outpatient evaluation date and the beginning of treatment; the actual number of days ranged from one to 29, with a midpoint of eight days.

Exhibit 17
Competency Restoration Treatment Duration, in Days

	Eastern State Hospital	Western State Hospital	Total
Received Competency Restoration Treatment	22	104	126
Average Days Between Evaluation and Competency Restoration Treatment*	9.0	10.3	10.1
Received outpatient evaluation	***	9.8	9.9
Received inpatient evaluation	8.8	13.6	10.5
Average Competency Restoration Treatment Days**	14.0	18.6	17.8
Received outpatient evaluation	14.0	19.1	19.0
Received inpatient evaluation	14.0	15.4	14.5

* The average days between evaluation and competency restoration treatment are not statistically different between the hospitals. ** The average competency restoration treatment days are statistically different between the hospitals at the .0001 level. *** One ESH defendant with 14 days between evaluation and treatment.

The duration of competency restoration treatment falls within the time frame outlined in the legislation. However, substantial differences emerged between the hospitals. Defendants at WSH received nearly five more days of treatment on average than those at ESH, due to the widespread use of outpatient evaluations at WSH. At ESH, defendants averaged 14 days of treatment, which ranged from to eight to 18 days, with a midpoint of 14 days. At WSH, defendants averaged 18.6 days of treatment, ranging from two to 30 days, with a midpoint of 18.5 days. As seen in Exhibit 17, the differences in treatment length between ESH and WSH were primarily due to the use of outpatient evaluations.

How Many Defendants Are Restored to Competency?

Overall, 45 percent of defendants were restored to competency (see Exhibit 18). Treatment at WSH restored 52 percent of defendants to competency; however, at ESH, treatment was successful for only 14 percent of defendants. The additional treatment time at WSH, with half the defendants receiving over 18.5 days treatment, probably contributed to a larger proportion of defendants being restored to competency.

Exhibit 18 also shows the number of defendants who received convictions for the offense that brought them into the competency restoration treatment process. Approximately 61 percent of defendants who were restored to competency were convicted of their offense.

Exhibit 18
Competency Restoration Treatment Outcomes

	Eastern State Hospital	Western State Hospital	Total
Received Competency Restoration Treatment	22	104	126
Competency Restoration Treatment Results			
Restored to competency	3 (14%)	54 (52%)	57 (45%)
Incompetent after treatment	19 (86%)	50 (48%)	69 (55%)
Convicted of Competency Restoration Offense			
Restored to competency	1	33	34 (61%)*

*Denominator is 55; missing adjudication data for 2 cases.

Are Civil Commitment Proceedings Pursued for Those Defendants Not Restored to Competency?

If a misdemeanant defendant is incompetent to stand trial after restoration treatment, 2SSB 6214 requires detention at an emergency and treatment facility for an evaluation to determine if involuntary commitment proceedings should be commenced under RCW 71.05.

Exhibit 19 shows the results of the involuntary civil commitment process for the 69 misdemeanant defendants who were not restored to competency. We did not find any record of involuntary civil commitment proceedings or hospitalizations for six defendants. However, over 90 percent of the defendants were detained for involuntary civil commitment proceedings, and 58 defendants were civilly committed for treatment.[34] Most defendants were committed to a state hospital immediately following competency restoration treatment, but we did find four defendants who received treatment in a community hospital setting. In addition, four defendants we include as civil commitments were detained for civil commitment proceedings but ended up as voluntary admissions to the state hospital.

[34] Two defendants who were restored to competency were involuntarily civilly committed soon after their discharge from competency restoration treatment and are not included in these statistics.

Exhibit 19
Civil Commitment Proceedings and Treatment

	Eastern State Hospital	Western State Hospital	Total
Incompetent After Competency Restoration	19	50	69
Civil Commitment			
No record of civil commitment proceedings	1 (5%)	5 (10%)	6 (9%)
Detained for civil commitment proceedings	18 (95%)	45 (90%)	63 (91%)
Civilly committed	17 (89%)	41 (82%)	58 (84%)
Civil commitment mean days	103	222	187
Civil commitment median days	57	97	87

Exhibit 19 also shows the number of days defendants were hospitalized during the civil commitment.[35] Median days are the most informative statistic on length of stay for this population because a small number of persons hospitalized for a very long periods of time inflate the average (mean). Of all defendants civilly committed, the median length of stay was 87 (approximately 3 months), indicating half the offenders had stays under and half had stays over 87 days. Few offenders had hospital stays of less than 30 days, indicating most defendants were civilly committed for at least one 90-day period at the state hospital. Since community hospitals only admit individuals with 14-day civil commitment orders, it is doubtful that most offenders receiving civil commitment treatment under this law could be hospitalized in a community inpatient setting.

Summary

Competency restoration outcomes are generally consistent with the legislation as written. Treatment length is within the range outlined in the legislation. Most defendants not restored to competency are referred for civil commitment proceedings. However, no defendant received the 90-day conditional release option available under the law.

Defendants wait an average of nine to ten days between evaluation and treatment. Treatment outcomes are substantially different for each hospital. Defendants at ESH receive approximately 14 days of competency restoration treatment, and few are judged competent to stand trial after treatment. At WSH, defendants receive 18.6 days of treatment. Over 50 percent of defendants at WSH are judged competent to stand trial after treatment, and about 60 percent of that group is convicted of their misdemeanor offense.

Both hospitals pursue civil commitment proceedings for defendants who are not restored to competency. Approximately 90 percent of defendants judged incompetent to stand trial after restoration treatment are referred for an evaluation under mental health involuntary civil commitment laws, and nearly all are civilly committed. The median length of stay for those civilly committed is 87 days, and nearly all defendants are treated at state hospital locations.

[35] The mean and median days for hospital stays are calculated through June 30, 2003 (WSH still had three persons from this population in the hospital at that time).

VII. CRIMINAL RECIDIVISM

Does Treatment Under the New Law Reduce Criminal Recidivism?

One of the major purposes of 2SSB 6214 was to increase treatment opportunities for misdemeanor defendants identified as threats to public safety. The goal of increased treatment was to stabilize mentally ill individuals in a hospital or community setting and, ultimately, to reduce criminal reoffending, particularly violent and serious crimes such as the assault and murder that precipitated the legislation.

This section compares the treatment opportunities and criminal reoffending behavior of defendants under the new and old laws. First, we compare the background characteristics of the treatment and comparison groups and assess any differences in treatment received after the competency evaluation. Then we evaluate the effect of treatment on criminal recidivism.

A total of 126 defendants judged incompetent to stand trial in 1999 were ordered to receive treatment under the new law. We excluded three defendants from the treatment group who remained in the state hospital and were not at risk to reoffend during the follow-up period; we also excluded three defendants who died during the follow-up period. We were able to select a strong match from the comparison group for 107 of the 120 remaining defendants who received treatment in 1999.[36] Thus, our final sample for the recidivism study included 214 defendants—107 each in the treatment and comparison groups.

The follow-up period for the treatment group begins at the date of discharge from the hospital after competency restoration and, for those who received it, civil commitment treatment. The follow-up period for the comparison group begins at hospital discharge after the competency evaluation or, for some comparison group defendants, hospital discharge after civil commitment treatment. The follow-up length is 24 months,[37] with an additional 12 months for the criminal justice system to process events, consistent with legislative definitions for adult criminal recidivism.[38]

[36] We had two objectives in matching treatment and comparison group members: assuring the propensity scores of matched cases were very close and maximizing the number of matched cases. Over 90 percent of cases matched within .01 of the propensity score. The standard deviation of the propensity score was .26 for both the treatment and comparison groups.

[37] We determine whether a new offense occurred within this time period, using the offense dates in the criminal charge records.

[38] Barnoski, *Standards for Improving Research Effectiveness in Adult and Juvenile Justice*.

Background Characteristics of Treatment and Comparison Groups

Exhibit 20 shows the demographic characteristics of the treatment and comparison groups; a few statistically significant differences appear between the groups. First, the treatment group has a higher proportion of black defendants than the comparison group. Second, the comparison group is several years younger on average than the treatment group, with more offenders in the 16 to 24 age category. Given the significant differences, and research that indicates younger age and male gender are associated with criminal recidivism, we use demographic items as statistical control variables in multivariate analyses described later in this section.

Exhibit 20
Demographic Characteristics of Treatment and Comparison Groups

	Treatment		Comparison	
	Number	Percent	Number	Percent
Total	107		107	
Sex				
Male	87	81%	91	85%
Female	20	19%	16	15%
Race				
White	69	64%	77	72%
Black	28	26%[a]	16	15%[a]
Asian	7	7%	5	5%
Other race	3	3%	9	8%
Age				
16–24	9	8%[a]	19	18%[a]
25–34	27	25%	32	30%
35–44	37	35%	31	29%
45 or over	34	32%	25	23%
Average age	39.7[b]		35.8[b]	

[a] = statistically significant at the .05 level; [b] = .01 level.

Exhibit 21 indicates that the treatment and comparison groups have a fairly similar criminal history: approximately one-third have a felony conviction, and over half have a misdemeanor conviction. Both groups average about two felony convictions. The treatment group has a higher proportion of defendants with a prior felony conviction for an offense against a person. Comparison group members have more convictions for misdemeanor crimes against a person, on average. Both groups have a substantial misdemeanant filing history, with between five and six misdemeanor filings and two filings for a misdemeanor crime against a person. As with background characteristics, we use criminal history variables as statistical controls in the multivariate analyses, because they have a strong relationship to criminal recidivism.

Exhibit 21
Criminal History of Treatment and Comparison Groups

	Treatment		Comparison	
	Number	Percent	Number	Percent
Total	107		107	
Convictions				
Felony	38	36%	34	32%
Felony against person	23	20%[a]	11	10%[a]
Misdemeanor	61	57%	59	55%
Misdemeanor against person	34	32%	26	24%
Average Number of Convictions*				
Felony	2.0		1.9	
Felony against person	1.4		1.6	
Misdemeanor	3.3		3.7	
Misdemeanor against person	1.6[b]		3.0[b]	
Criminal Case Filings				
Misdemeanor	106	99%	106	99%
Misdemeanor against person	85	79%	81	76%
Average Number of Filings*				
Misdemeanor	5.0		5.9	
Misdemeanor against person	1.9		2.3	

Misdemeanor offenses are standardized to include all offenses three years prior to the evaluation.
* The average number of convictions and filings are calculated only for offenders who have received a conviction in that category. [a] = statistically significant at the .05 level; [b] = statistically significant at the .01 level.

The mental illness background characteristics of the treatment and comparison groups are shown in Exhibit 22. Most defendants have a diagnosed major mental illness: nearly three-quarters have illnesses associated with psychotic behavior, including schizophrenia and other psychotic disorders. Given these diagnoses, it is clear both groups have a high need for mental health services. In addition, nearly half the defendants have a substance disorder diagnosis, a common disease among the mentally ill with criminal justice system involvement that adds to the complexity of treating this population. Several significant differences show up in the receipt of prior-year public mental health services between the treatment and comparison groups, with a larger proportion of defendants in the treatment group hospitalized in a community psychiatric hospital and receiving community mental health services.[39]

[39] These differences are controlled for in the multivariate statistical analyses.

Exhibit 22
Mental Illness Background of Treatment and Comparison Groups

	Treatment Group		Comparison Group	
	Number	Percent	Number	Percent
Total	107		107	
Major Mental Illness Diagnosis				
Schizophrenia	41	38%	45	42%
Bipolar	17	16%	25	23%
Other Psychotic Disorder	40	37%	30	28%
Organic	3	3%	1	1%
No Diagnosis	6	6%	6	6%
Substance Disorder	47	44%	52	49%
Public Mental Health Services in Year Prior to Evaluation				
Forensic State Hospitalization	14	13%	17	16%
Non-Forensic State Hospitalization	19	18%	12	11%
Community Psychiatric Hospitalization	30	28%[b]	13	12%[b]
Community Mental Health Outpatient Treatment	71	66%[c]	46	43%[c]

[b] = statistically significant at the .01 level; [c] = .001 level.

Mental Health Services Received After Treatment

While all defendants in the treatment group received competency restoration, it was not available to any members of the comparison group. However, treatment under involuntary civil commitment laws was a possibility for both groups. Exhibit 23 shows that 52 percent of the treatment group was civilly committed (after competency restoration treatment), while only 21 percent of the comparison group was civilly committed after the competency evaluation.[40] The differences are statistically significant: many more defendants are civilly committed under the new law. However, 39 percent of comparison group members evaluated at ESH were involuntarily committed. Nearly all these defendants received treatment at ESH, indicating ESH already had a practice in place to refer misdemeanant defendants incompetent to stand trial for treatment under RCW 71.05. Yet even at ESH, defendants were significantly more likely to receive civil commitment treatment under the new law.

[40] The county distribution for the 22 comparison group defendants who were civilly committed is as follows: Spokane – 6; Thurston – 5; Grant – 3; Kitsap – 2; Pierce – 2; and Chelan, Franklin, King, Snohomish – 1 each.

Exhibit 23
Post Mental Health Services of Treatment and Comparison Groups

	Treatment Group		Comparison Group	
	Number	Percent	Number	Percent
Total	107		107	
Civilly Committed Post Evaluation/Treatment	56	52%[d]	22	21%[d]
Eastern State Hospital	17 (21)	81%[b]	11 (28)	39%[b]
Western State Hospital	39 (86)	45%[d]	11 (79)	14%[d]
Public Mental Health Services in Year Post Evaluation/Treatment				
Forensic State Hospitalization	18	17%	27	25%
Non-Forensic State Hospitalization	21	20%	33	31%
Community Psychiatric Hospitalization	24	22%	24	22%
Community Mental Health Outpatient Treatment	82	77%[d]	59	55%[d]
Defendants received CR only	37 (57)	65%		
Defendants received CC	45 (50)	90%[b]	13 (22)	59%[b]
Average Service Days/Hours in Year Post Evaluation/Treatment*	Mean	Median	Mean	Median
Forensic State Hospital Days	49	29	52	16
Non-Forensic State Hospital Days	126	76	80	56
Community Psychiatric Hospital Days	34[a]	24	16[a]	15
Community Mental Health Outpatient Treatment Hours	46	23	42	11

* The average number of days and hours are calculated only for offenders who received services in that category. [a] = statistically significant at the .05 level; [b] = .01 level; [d] =.0001 level. Numbers in parentheses are denominators.

Exhibit 23 also shows that defendants in the comparison group are more likely to be hospitalized at the state hospitals after their evaluation or treatment, but most often for shorter time periods, as seen by the lower average service days and hours. In addition, treatment group defendants are hospitalized in the community for significantly longer periods of time. The fact that 20 to 30 percent of defendants in both groups were hospitalized in the year after treatment indicates the severity of this population's illnesses.

Overall, the community mental health system is serving a significantly greater proportion of treatment group defendants. The treatment group was much more likely to receive community outpatient treatment than the comparison group (77 percent compared with 55 percent), and outpatient hours were greater on average, although not statistically different. Of all treatment group defendants, 90 percent of those who received competency restoration *and* civil commitment treatment received outpatient services compared with 65 percent of defendants who received only competency restoration treatment, a statistically significant difference. Thus, the civil commitment process is more successful than competency restoration at linking defendants to community mental health services.[41]

[41] This is a fairly small sample size, and we do not have information on whether each defendant was participating in a mental health court or other program; thus, we cannot test if such programs are more likely to link defendants to community mental health services.

Criminal Reoffenses After Treatment

Exhibit 24 shows descriptive statistics on criminal reoffenses. A larger proportion of defendants in the comparison group had felony and misdemeanor convictions, including offenses against a person; the differences in misdemeanor convictions were statistically significant. Defendants in the comparison group had a 17 percent felony reoffense rate compared with 9 percent of the treatment group, statistically significant at the .10 level. Convictions for felony against person crimes were rare in both groups; the most serious crimes committed in this category were assault and robbery in the second degree. For misdemeanor offenses, convictions and charge filings are significantly different for the treatment and comparison groups: differences range from 14 to 17 percentage points higher for comparison group defendants. Thus, defendants receiving treatment under 2SSB 6214 are less likely to reoffend than comparison group defendants, an outcome investigated further in the next section.

Exhibit 24
Criminal Reoffenses for Treatment and Comparison Groups

	Treatment		Comparison	
	Number	Percent	Number	Percent
Total	107		107	
Convictions				
Felony	10	9%	18	17%
Felony against person	5	5%	7	7%
Misdemeanor	28	26%[b]	45	42%[b]
Misdemeanor against person	8	7%[b]	22	21%[b]
Average Number of Convictions*				
Felony	1.3		1.1	
Felony against person	1		1.1	
Misdemeanor	2.1		2.2	
Misdemeanor against person	1		1.2	
Criminal Case Filings				
Misdemeanor	47	44%[a]	64	61%[a]
Misdemeanor against person	23	21%[b]	41	38%[b]
Average Number of Filings*				
Misdemeanor	3.0		4.2	
Misdemeanor against person	1.6		1.9	
Convicted of Competency Evaluation Offense**	31	30%[d]	8	8%[d]

* The average number of convictions and filings are calculated only for offenders who received a conviction in that category. ** Denominator is 105 and 101 for the treatment and comparison group, respectively, due to missing adjudication data. [a] = statistically significant at the .05 level; [b] = .01 level; [d] = .001 level.

Does Treatment Reduce Criminal Recidivism?

Multivariate logistic regression analyses are used to estimate whether treatment influences criminal recidivism after controlling for other factors, including demographic, criminal history, and mental illness background. We analyze three types of criminal recidivism: felony convictions, misdemeanor against person charge filings, and misdemeanor charge filings.[42] Filings for misdemeanor offenses are a more accurate measure of reoffense than convictions, because defendants in the comparison group are likely to have misdemeanor charges filed and dismissed, underestimating their criminal activity.

Exhibit 25 displays the results of the analyses, summarizing significant factors that affect the likelihood of felony, misdemeanor against person, and misdemeanor criminal reoffending; the full statistical models are in Appendices G through I. The results indicate that, for each type of criminal recidivism, defendants who receive treatment under 2SSB 6214 are significantly less likely to reoffend than comparison group defendants.

Exhibit 25
Factors Affecting the Likelihood of Criminal Recidivism
(From Logistic Regression Analyses)

	Felony Conviction	Misdemeanor Against Person Charge	Misdemeanor Charge
Defendants significantly less likely to reoffend:	• Received treatment under 2SSB 6214 • Greater post community outpatient treatment	• Received treatment under 2SSB 6214	• Received treatment under 2SSB 6214 • Community outpatient treatment year prior to evaluation
Defendants significantly more likely to reoffend:	• Community psychiatric hospitalization in year prior to evaluation • Black race • Prior felony conviction • Greater number of prior misdemeanor convictions	• Younger age • Greater number of misdemeanor against person filings	• Younger age • Any felony conviction • Greater number of misdemeanor filings
Not a factor in reoffending:	• Age, sex • Type of mental illness	• Sex, race • Type of mental illness	• Sex, race • Type of mental illness

Defendants receiving treatment are less likely to be convicted of a felony offense. In addition, defendants receiving treatment are more likely to receive outpatient services and have higher monthly community mental health services hours than the comparison group, contributing to a lower likelihood of felony reoffending. These two factors—treatment under the new law and outpatient treatment—work together to reduce felony criminal recidivism.[43] Defendants who had community psychiatric hospitalization in the year prior to their

[42] We could not carry out logistic analyses for felony convictions against a person because there were too few.
[43] Treatment under 2SSB 6214 and outpatient treatment hours are jointly significant in the felony model. See Appendix G, Wald tests.

competency evaluation are more likely to be convicted of a felony, possibly an indicator of the acuteness of the mental illness. In addition, black defendants are more likely to be convicted of a subsequent felony offense, as are defendants with a prior felony conviction and those with a larger number of misdemeanor convictions.[44]

Defendants who received treatment under 2SSB 6214 are also significantly less likely to be charged with misdemeanor and misdemeanor against person offenses. Younger defendants are more likely to be charged with misdemeanor offenses, a finding that is common in the research literature. Defendants with a prior felony offense are more likely to be charged with a misdemeanor crime. Community outpatient treatment in the year prior to the evaluation is associated with a lower likelihood of misdemeanor reoffense. Defendants with more prior misdemeanor property and against person filings are more likely to reoffend for misdemeanor and misdemeanor against person crimes, respectively.

Summary

The background characteristics of both the treatment and comparison groups confirm a severely mentally ill population. Over 90 percent of each group has a diagnosis of schizophrenia, other psychotic disorders, or a bipolar disorder. About half have a substance disorder. State and community hospitalization in the year prior to treatment ranges from 11 to 28 percent. Eighty percent of defendants are male, and the average age is over 35 years old. The population is well known to the criminal justice system: approximately one-third have prior felony convictions and an average of five misdemeanor criminal filings. Both groups have characteristics that indicate a strong need for treatment, but are a difficult-to-treat population.[45]

2SSB 6214 is successful in providing additional treatment opportunities to mentally ill offenders. All members of the treatment group received competency restoration treatment under the law. Treatment group members are significantly more likely to receive treatment under involuntary commitment laws than the comparison group. The treatment group is significantly more likely to receive outpatient community mental health services and greater service hours after treatment than the comparison group. When re-hospitalized in the year after treatment, treatment group members receive more treatment days than the comparison group.

2SSB 6214 succeeded in achieving a major objective hoped for by the Legislature: lower criminal recidivism. Defendants who received treatment under the new law are less likely to commit felony, misdemeanor, and misdemeanor against person offenses. Outpatient treatment is also an important treatment component that reduces the likelihood of felony recidivism. As would be expected, prior criminal history, age, and other factors increase the likelihood of reoffense. However, the descriptive statistics and the statistical models indicate that treatment under the new law is a critical factor in reducing criminal recidivism.

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[44] We tested county in all three models but excluded it in final models because no single county was significant, and counties as a group were not jointly significant. See Appendices G through I, Wald tests.

[45] A substantial proportion of mentally ill offenders are highly resistant to treatment. In addition, severe mental illness and substance abuse are associated with medication non-compliance. See H. Richard Lamb and Linda E. Weinberger, "Persons With Severe Mental Illness in Jails and Prisons: A Review," *Psychiatric Services* 49 (1998): 483-492.

VIII. INFORMATION SHARING AND CRIMINAL HISTORY

Background

Throughout criminal competency and civil commitment proceedings, the criminal justice and mental health systems must have access to certain information to make decisions that ensure the best outcomes for defendants and public safety. One of the evaluation tasks assigned to the Institute includes assessing whether the information sharing procedures set out by the new law are adequate. This section focuses on both the availability and sharing of information, with special attention to the violence history that is critical to this legislation.

Many pieces of information are required by the legislation, and sharing needs to occur at several points. The information includes court orders, criminal history records, past civil commitments, results of forensic and civil evaluations, and court dismissal hearings. The information moves among the criminal and civil courts, state hospital examiners, county designated mental health professionals (CDMHP), correctional facilities, evaluation and treatment facilities, and mental health treatment providers. The legislation adds new requirements to the content of criminal justice records, specifies who should be receiving certain information, and sets deadlines for the receipt of orders, notices, and reports in order to facilitate information sharing among the mental health and criminal justice systems (RCW 71.05; RCW 10.77).

To investigate this topic area, we interviewed key informants from professional groups and organizations involved in the criminal competency and civil commitment processes. Our informants included representatives from state and community hospitals, civil and criminal courts, jails, and mental health organizations (see Appendix J). Our interview questions focused on two areas. First, do key actors have access to the information they need to implement the law? Second, are they able to get the information in a timely fashion? Interviews were conducted from July 1999 through March 2000.

Informant Interviews

Most persons involved in the information sharing process were satisfied that court orders, evaluations, jail transfer forms, and other documents moved through the various systems as required, and moved in a timely manner. As one informant stated, the law intended information sharing, and that seemed to be well understood by everyone. Most informants indicated they were not seeing major gaps in this process. In addition, the courts and agencies work with the legislature to refine timelines and information sharing: SSB 6375 passed by the Legislature in 2000 addressed a number of early problems in the process.

Informants voiced many concerns about inadequate timeliness, as well as uneven quality regarding information on past civil commitments, violent acts, and incompetency and insanity findings. State hospital evaluators and CDMHPs indicated that finding information on civil commitments up to ten years in the past, as required by the legislation, was difficult. While past civil commitments might be available for the evaluation county (particularly in large counties), no statewide information could be accessed from one place. Evaluators

used multiple sources to obtain information, such as prior hospital records, court documents, and self-reports, as well as calls to agencies, hospitals, and families. They indicated that finding this information within a 72-hour time period was often difficult.

Violent acts and incompetency/insanity findings were also difficult to find within a short time period. Several evaluators mentioned the difficulty of obtaining information on violent acts in hospitals. One evaluator suggested that a threshold definition for violence be created and that all psychiatric hospitals and outpatient facilities be required to report this information to some type of central authority.

Forensic evaluators at the state hospitals have access to state and national criminal history records, including arrests, through the National Crime Information Center (NCIC). However, evaluators voiced concerns with the quality of this information, particularly missing disposition information, including dispositions from Washington State. Evaluators on the non-forensic side of the state hospitals and CDMHPs do not have access to the NCIC system. Within a very short time frame, they attempt to utilize a number of sources to obtain criminal and violent background information. These include prior state hospital reports and records, the police, jails, prosecution and defense lawyers, the Washington State Patrol (WSP) Watch system, and self and family reports. Non-forensic state evaluators and CDMHPs noted that arrest information was not available to them and that incompetency and insanity findings were not recorded in WSP's Watch system.

Criminal History Records

The new law amended the Criminal Records Privacy Act (RCW 10.97.030), requiring that criminal case dismissals, based on lack of competency and acquittals by reason of insanity, be included as an adverse disposition on an individual's criminal conviction record. Both incompetency and insanity findings are necessary for civil and forensic evaluation decisions under the new law. For civil evaluations, the legislation requires CDMHPs to consult all reasonably available information and records for history of violent acts and criminal incompetency and insanity findings.

CDMHP protocols developed as a result of this legislation recommend the use of the WSP Watch system as a source of information for violent and criminal behavior, including incompetency and insanity findings. Watch is also used as an initial source of criminal history information for forensic evaluations and is later supplemented by NCIC records. The Watch system is the official internet source for Washington criminal history conviction records; it includes conviction records sent by courts and criminal justice agencies. For non-law enforcement agencies, the system costs users $10 per record.

Interviewees suggested that incompetency and insanity findings were difficult to access in court and criminal history records, including the Watch system. To examine the ease or difficulty of finding this information, we used Watch to investigate 58 misdemeanant defendants who were judged incompetent to stand trial after restoration treatment and were civilly committed. By law, these 1999 and 2000 cases should have received a dismissal due to a finding of incompetency, and this finding should have been recorded on an individual's criminal record. We found only five persons with a recorded incompetency

finding. In the remaining cases, the offense and disposition were not recorded. Those offenders without a recorded finding were located in counties across the state, in both municipal and district courts, and in courts that had large and small numbers of competency proceedings, indicating a system-wide problem. Therefore, as interviewees suggested, there appears to be a lack of incompetency findings in criminal records.

Summary

Overall, key informants indicated that information sharing procedures are working between the mental health and criminal justice systems. Information, such as court orders and evaluation reports, are moving among the appropriate actors in a timely manner.

Many informants voiced concerns about the availability of prior civil commitment and criminal history information required for civil and forensic evaluations. While evaluators indicated they use every available source, many could not access reliable information on past civil commitments, violent acts, and incompetency and insanity findings.

Since Washington State criminal records, by statute, should have information on incompetency and insanity findings, it would be useful for the courts and the WSP to determine the particular problems recording or receiving insanity and incompetency information and discuss means to assure that past and future findings are included. It would also be useful to have the agencies assess other weak points in the system that could be improved, such as the recording of case dispositions.

IX. CONCLUSION

2SSB 6214 accomplished most of its objectives. Courts have readily adopted the misdemeanant criminal competency procedures required. A significantly greater number of misdemeanant defendants are receiving treatment, and the treatment shows significant reductions in criminal reoffending by its recipients. In addition, information sharing procedures between the criminal justice and mental health systems have been improved.

Yet, as much as the new legislation succeeded, it also leaves some concerns about what works in treating mentally ill offenders. The law clearly identifies a group of misdemeanant defendants with violent backgrounds who can benefit from treatment. Competency restoration treatment provides defendants with short-term treatment, returning about half to the criminal justice system competent to stand trial. However, defendants who return to the criminal justice system are significantly less likely to receive further treatment in the community mental health system compared with those who receive involuntary treatment under civil commitment laws and are significantly more likely to receive community outpatient treatment. This finding signals a weak link in treatment continuity for some, particularly considering that outpatient services in the year after treatment are an important factor in reducing felony reoffending.

While this study did not allow us to assess the particulars of this weak link, evidence suggests that hospitals provide a greater connection to the community treatment system than the criminal justice system, which is not surprising. However, the reality is that significant numbers of mentally ill persons will continue to have contact with the criminal justice system, so efforts to strengthen the connection between the mental health and criminal justice systems are important policy objectives.

Most defendants who are returned as competent to stand trial receive short sentences for their misdemeanor conviction; some are probably good candidates for immediate diversion out of the criminal justice system and into the community mental health system. Other individuals may be appropriate for combined inpatient and outpatient competency restoration treatment, if such an option existed. Mental health courts that combine court supervision with community treatment may benefit a number of defendants.

In addition, some defendants are likely candidates for immediate civil commitment in a community hospital rather than competency restoration. While civil commitment did not occur in the case of the individual who precipitated this legislation, strong connections between county designated mental health professionals and the criminal justice system would increase the success of this option.

A recent U.S. Supreme Court case ruling on whether a court may authorize involuntary medication for competency restoration may make civil commitment in lieu of competency restoration a more likely option for misdemeanants, as offense seriousness must be considered.[46] Senate Bill 6274, introduced in Washington's 2004 legislative session,

[46] Sell v. U.S., 539 U.S. ____ (2003).

proposes to clarify state law by (1) defining offenses that are to be considered as serious for *every* case, and (2) setting standards for other offenses that may be considered as serious.

Some mentally ill offenders may be best placed in a highly supervised or secure treatment setting, such as a state hospital. However, pressure to cut costs and reduce state hospital spending is a constant fixture in state policymaking, and community alternatives are sparse for offenders who are likely to be serious, continual public safety threats.

Overall, criminal justice involvement is a strong marker of treatment need for the mentally ill. How to best treat mentally ill offenders and reduce the threat to public safety is an ongoing and important public policy issue.

APPENDIX A: RECOMMENDATIONS OF THE KING COUNTY TASK FORCE, 1997[47]

1. Establish a program that provides aggressive outreach to mentally ill individuals at large in the community.
2. Create a "no refusal" triage center to serve individuals with mental illness and/or substance abuse emergencies.
3. Review the application of "standards" used for 72 hour detention under RCW 71.05.
4. Perform misdemeanant competency and sanity evaluations locally.
5. Create crisis outreach and service referral protocols to ensure responsiveness to district and municipal courts.
6. Pilot a Mental Health Court in King County.
7. Assign a liaison from the voluntary and involuntary treatment systems to the King County Jail.
8. Redesign the King County Jail Alternative Services Program (JAS) to broaden eligibility and improve the diversion capabilities by strengthening post release connections to the long term care system including residential options.
9. Develop a "no refusal" procedure to ensure that mentally ill defendants remain engaged, or become immediately re-engaged, or are authorized to receive service with an appropriate community service provider.
10. Develop a discharge planning program for mentally ill individuals released from Washington State Department of Corrections (DOC) and Juvenile Rehabilitation Administration (JRA) facilities to ensure that they are engaged by community resources appropriate to their need including, but not limited to, mental health, financial aid and involuntary treatment screening.
11. Improve the monitoring of Least Restrictive Alternative court orders (LRA) by community providers; ensure that providers follow clients through the entire period of the order. Develop a range of options to employ when less restrictive orders are violated including standards for revocation.
12. Revise the standard form of the competency evaluation court order to specify that Western State Hospital should provide the report required by RCW 10.77 directly to Jail Health Staff as well as the court, prosecutor and defense.
13. Develop continuing education curriculum and information resources to increase interested professionals' understanding of the Mentally Ill Offender Network. The Internet and electronic technology should be used whenever possible to provide ease of access to critical information.

[47] Mentally Ill Offenders Task Force Final Report, November 1997. <http://www.metrokc.gov/dchs/mhd/mio/report.htm>.

APPENDIX B: STUDY DATA ITEMS

Demographic
Date of birth
Sex
Race/ethnicity

Competency Evaluation
County
Court
Criminal charges
Criminal charge outcomes
WSH or ESH evaluation
Inpatient or outpatient evaluation type
Evaluation location
Evaluation date/hospitalization dates
Competency to stand trial
Past violent offense
Current violent offense
Prior incompetency finding
Prior insanity finding
DSM IV diagnoses

Competency Restoration
Hospitalization dates
Competency to stand trial

Civil Commitment
Civilly committed
Civil hospitalization dates

Public Mental Health Monthly Services (1994 forward)
Forensic state hospital days
Non-forensic state hospital days
Community hospital days
Community outpatient treatment hours

Criminal Charges
Misdemeanor charges (1992 forward)
Felony charges
Offense type (see Appendix C)
Dates of offense
Adjudication type
Adjudication date

Mortality
Date of death

APPENDIX C: CRIMINAL OFFENSE CATEGORIES

OFFENSE TYPE	CATEGORY	SUB-CATEGORY
Misdemeanor	Other	Alcohol
Misdemeanor	Other	DUI/DWI
Misdemeanor	Other	Sentence Violations
Misdemeanor	Other	Sex Offender Fail to Register
Misdemeanor	Other	Miscellaneous Criminal
Misdemeanor	Other	Fish and Game
Misdemeanor	Other	Criminal Conduct
Misdemeanor	Other	Escape
Misdemeanor	Other	Bail Jump
Misdemeanor	Other	Cruelty to Animals
Misdemeanor	Drug	Drugs
Misdemeanor	Drug	Possession
Misdemeanor	Drug	Deliver
Misdemeanor	Property	Other
Misdemeanor	Property	Trespass
Misdemeanor	Property	Destruction
Misdemeanor	Property	Theft/Fraud/Larceny
Misdemeanor	Property	Domestic Violence Related
Misdemeanor	Property	Fire Setting
Misdemeanor	Against Person	Weapon
Misdemeanor	Against Person	Firearm
Misdemeanor	Sex	Prostitution
Misdemeanor	Sex	Other
Misdemeanor	Sex	Child Sex
Misdemeanor	Against Person	Other
Misdemeanor	Against Person	School
Misdemeanor	Against Person	Harassment/Domestic Violence (minus Assault)
Misdemeanor	Against Person	Assault
Misdemeanor	Against Person	Assault Domestic Violence Related
Felony	Other	Other
Felony	Other	Escape
Felony	Other	Animal Cruelty
Felony	Drug	Other
Felony	Drug	Possession
Felony	Drug	Deliver
Felony	Property	Other
Felony	Property	Trespass
Felony	Property	Destruction
Felony	Property	Domestic Violence Related
Felony	Property	Theft/Fraud/Larceny
Felony	Property	Burglary Except First Degree
Felony	Property	Arson Except First Degree
Felony	Against Person	Burglary First Degree
Felony	Against Person	Arson First Degree
Felony	Against Person	Weapon
Felony	Against Person	Firearm
Felony	Against Person	Other
Felony	Against Person	Domestic Violence (minus Assault)
Felony	Against Person	Assault
Felony	Against Person	Assault Domestic Violence Related
Felony	Against Person	Kidnapping
Felony	Against Person	Robbery
Felony	Sex	Other Sex
Felony	Sex	Child Sex
Felony	Sex	Rape
Felony	Against Person	Manslaughter
Felony	Against Person	Murder

APPENDIX D: MAJOR MENTAL ILLNESS AND SUBSTANCE DISORDER CATEGORIES

Major Mental Illness Category	DSM IV* Code
Schizophrenia	295's, except 295.40 and 295.70
Other Psychotic Disorder (Schizophreniform, schizoaffective, brief psychotic disorder, psychosis NOS)	295.40, 295.70, 297.1, 297.3, 298.80, 298.90
Bipolar Disorders	296.00 – 296.06, 296.40 – 296.89
Major Depression	296.20 – 296.36
Other Mood Disorder	296.90
Organic Brain Syndrome, Dementia	290's, 293 – 293.9, 294's

*Diagnostic and Statistical Manual of the American Psychiatric Association (4th Edition).

Substance Disorder Category	DSM IV* Code
Substance Induced Persisting and Substance Disorders	291's, 292's, 303's, 304's, 305's
Polysubstance abuse	No specific code

*Diagnostic and Statistical Manual of the American Psychiatric Association (4th Edition).

APPENDIX E: LOGISTIC REGRESSION MODEL PREDICTING RECEIPT OF COMPETENCY RESTORATION TREATMENT: 1999 MISDEMEANANT DEFENDANTS EVALUATED AS INCOMPETENT TO STAND TRIAL

Variable	Coefficient	Std. Error	Z-Statistic	Prob > Z
Constant	-3.126828	1.060425	-2.948654	0.0032
Female	0.440241	0.389343	1.130729	0.2582
Age	-0.002900	0.012667	-0.228968	0.8189
Black	0.580008	0.375575	1.544319	0.1225
Asian	0.839312	0.592116	1.417479	0.1563
Hispanic	0.422695	1.276528	0.331129	0.7405
Native American	-1.238954	1.627015	-0.761489	0.4464
Schizophrenia	1.755070	0.601923	2.915772	0.0035
Bipolar disorder	2.663118	0.746482	3.567560	0.0004
Organic disorder	-0.800624	1.088080	-0.735814	0.4618
Other psychotic disorder	1.604826	0.612836	2.618689	0.0088
Number of filings for person misdemeanor	0.235336	0.073146	3.217347	0.0013
Number of filings for property misdemeanor	-0.180502	0.062684	-2.879563	0.0040
Any conviction for felony against person	1.619421	0.579337	2.795302	0.0052
Any conviction for felony drug crime	-2.163191	1.193568	-1.812373	0.0699
Clark County	1.184741	1.897191	0.624471	0.5323
Yakima County	0.862034	1.761749	0.489306	0.6246
Lewis County	-0.565363	1.752124	-0.322673	0.7469
Kitsap County	-0.899480	1.415420	-0.635486	0.5251
Snohomish County	-0.320698	0.873102	-0.367309	0.7134
Mason County	-0.190366	1.634607	-0.116460	0.9073
Grays Harbor County	-0.123566	1.185753	-0.104209	0.9170
Benton County	0.154929	1.371534	0.112960	0.9101
Chelan County	-1.181830	1.299186	-0.909670	0.3630
Clallam County	-1.018293	1.415541	-0.719367	0.4719
Thurston County	-0.021505	0.975229	-0.022051	0.9824
Spokane County	2.713161	1.098672	2.469491	0.0135
King County	-0.521909	0.747154	-0.698529	0.4848
Pierce County	-0.095988	0.887514	-0.108154	0.9139
Any community mental health hours one year prior to evaluation	0.536503	0.315903	1.698318	0.0894
Any community inpatient days one year prior to evaluation	-0.152992	0.350351	-0.436682	0.6623
Any state hospital non-forensic days one year prior to evaluation	0.234058	0.456819	0.512365	0.6084
Any state hospital forensic days one year prior to evaluation	-0.156871	0.489548	-0.320441	0.7486
Current violent offense in evaluation/court report	0.628197	0.310287	2.024565	0.0429
Past violent offense in evaluation/court report	0.687680	0.305013	2.254590	0.0242

Mean dependent var	0.407767	S.D. dependent var	0.492217
S.E. of regression	0.435334	Akaike info criterion	1.233574
Sum squared resid	51.92724	Schwarz criterion	1.656445
Log likelihood	-155.5872	Hannan-Quinn criter	1.402639
Restr. log likelihood	-208.8950	Avg log likelihood	-0.503518
LR statistic (34 df)	106.6155	McFadden R-squared	0.255189
Probability(LR stat)	2.03E-09		

Obs with Dep=0, did not receive treatment	183	Total observations	309
Obs with Dep=1, received treatment	126		

Italics indicate statistical significance.

APPENDIX F: LOGISTIC REGRESSION MODEL PREDICTING RECEIPT OF COMPETENCY RESTORATION TREATMENT FOR PROPENSITY SCORES: 1999 MISDEMEANANT DEFENDANTS EVALUATED AS INCOMPETENT TO STAND TRIAL

Variable	Coefficient	Std. Error	Z-Statistic	Prob >Z
Constant	-3.886110	1.398332	-2.779104	0.0055
Female	0.442869	0.418341	1.058632	0.2898
Age	-0.000698	0.013930	-0.050074	0.9601
Black	0.510098	0.405803	1.257008	0.2088
Asian	0.485889	0.621985	0.781190	0.4347
Hispanic	0.231092	1.416554	0.163137	0.8704
Native American	-0.779143	1.666307	-0.467587	0.6401
Schizophrenia	2.305860	0.694794	3.318770	0.0009
Bipolar disorder	2.761914	0.835930	3.304003	0.0010
Organic disorder	-1.165975	1.282834	-0.908906	0.3634
Other psychotic disorder	2.091916	0.695297	3.008664	0.0026
Personality disorder	0.314056	0.559928	0.560887	0.5749
Substance disorder	-0.084508	0.372838	-0.226661	0.8207
Current violent offense	0.799796	0.356899	2.240961	0.0250
Past violent offense	0.836647	0.343473	2.435847	0.0149
Past incompetency finding for violent offense	-0.515279	0.540433	-0.953456	0.3404
Past insanity judgment for violent offense	2.264343	1.549681	1.461167	0.1440
No. filings for person misdemeanor	0.282775	0.106012	2.667387	0.0076
No. filings for property misdemeanor	-0.126496	0.058022	-2.180152	0.0292
No. filings for sex misdemeanor	0.170622	0.469730	0.363234	0.7164
No. filings for drug misdemeanor	-0.537696	0.314547	-1.709431	0.0874
No. filings for other misdemeanor	0.289076	0.213741	1.352460	0.1762
No. convictions for person felony	0.815447	0.401604	2.030476	0.0423
No. convictions for property felony	0.741121	0.322580	2.297480	0.0216
No. convictions for drug felony	-1.010111	0.661670	-1.526608	0.1269
No. convictions for other felony	-1.958608	1.604851	-1.220430	0.2223
Yakima County	1.007920	1.903676	0.529460	0.5965
Clark County	2.528165	3.305027	0.764945	0.4443
Lewis County	0.547692	3.225684	0.169791	0.8652
Mason County	3.097249	3.229631	0.959010	0.3376
Benton County	0.906441	1.539293	0.588869	0.5559
Grays Harbor County	2.253080	2.946170	0.764749	0.4444
Chelan County	-1.085882	1.545802	-0.702472	0.4824
Clallam County	2.024467	3.065309	0.660445	0.5090
Kitsap County	1.468421	3.010827	0.487714	0.6258
Thurston County	2.243622	2.853137	0.786370	0.4317
Spokane County	3.943127	1.457068	2.706207	0.0068
Snohomish County	1.752205	2.775223	0.631375	0.5278
King County	1.566390	2.749135	0.569776	0.5688
Pierce County	2.002141	2.816738	0.710801	0.4772
Community mental health hours one yr prior to evaluation	-0.004819	0.002351	-2.049843	0.0404
Forensic state hospital days one yr prior to evaluation	-0.009649	0.014883	-0.648301	0.5168
Non-forensic state hospital days one yr prior to evaluation	-0.005720	0.003271	-1.748845	0.0803
Community hospital days one yr prior to evaluation	0.023786	0.016411	1.449353	0.1472
Western State Hospital	-1.850771	2.952156	-0.626922	0.5307

Mean dependent var	0.409556	S.D. dependent var	0.492593
S.E. of regression	0.433145	Akaike info criterion	1.265011
Sum squared resid	46.52832	Schwarz criterion	1.830225
Log likelihood	-140.3241	Hannan-Quinn criter.	1.491387
Restr. log likelihood	-198.2721	Avg. log likelihood	-0.478922
LR statistic (44 df)	115.8961	McFadden R-squared	.292265
Probability(LR stat)	2.18E-08		

Obs with Dep=0, did not receive treatment	173	Total obs	293
Obs with Dep=1, received treatment	120	Area under ROC	.8474

APPENDIX G: LOGISTIC REGRESSION MODEL PREDICTING FELONY CONVICTION RECIDIVISM: TREATMENT AND COMPARISON GROUP MISDEMEANANT DEFENDANTS

1. Base Model

Variable	Coefficient	Std. Error	Z-Statistic	Prob > Z
Constant	-1.324058	1.085704	-1.219538	0.2226
Received treatment under new law	-1.084221	0.502445	-2.157890	0.0309
Female	-0.546435	0.583015	-0.937257	0.3486
Age	-0.030891	0.024195	-1.124035	0.2610
Black	1.126137	0.495783	2.271430	0.0231
Asian	0.027730	1.149098	-0.024132	0.9807
Hispanic	1.018941	1.182870	0.861414	0.3890
Number of misdemeanor convictions	0.045350	0.050495	0.8981124	0.3691
Any felony conviction	1.182038	0.475636	2.485172	0.0129
Any community inpatient days 1 year prior to evaluation	0.852471	0.538418	1.583290	0.1134
Average monthly hours community mental health treatment 1 yr prior to evaluation	0.037639	0.035383	1.063774	0.2874

Mean dependent var	0.130841	S.D. dependent var	0.338017
S.E. of regression	0.314957	Akaike info criterion	0.743202
Sum squared resid	20.13712	Schwarz criterion	0.916219
Log likelihood	-68.52258	Hannan-Quinn criter.	0.813116
Restr. log likelihood	-83.02826	Avg. log likelihood	-0.32-199
LR statistic (11 df)	29.01137	McFadden R-squared	0.174708
Probability(LR stat)	0.001241	Total obs=214	
Obs wth Dep=0, did not reoffend	186	Obs with Dep=1, reoffense	28

2. Base Model with Outpatient Mental Health Treatment Days

Variable	Coefficient	Std. Error	Z-Statistic	Prob > Z
Constant	-1.026282	1.138847	-0.901159	0.3675
Treatment received under new law	-0.875386	0.545787	-1.603897	0.1087
Female	-0.900217	0.613584	-1.467146	0.1423
Age	-0.024690	0.024617	-1.002963	0.3159
Black	1.291622	0.529279	2.440341	0.0147
Asian	0.032945	1.189937	0.027686	0.9779
Hispanic	1.256355	1.203221	1.044160	0.2964
Number of misdemeanor convictions	0.107305	0.064466	1.664516	0.0960
Any felony conviction	1.182927	0.505281	2.341129	0.0192
Any community inpatient days 1 yr prior to evaluation	1.335185	0.581767	2.295050	0.0217
Average monthly hours community mental health treatment 1 yr prior to evaluation	0.076000	0.038314	1.983579	0.0473
Average monthly hours community mental health treatment 1 yr post treatment/eval	-0.275322	0.111273	-2.474294	0.0133

Mean dependent var	0.130841	S.D. dependent var	0.338017
S.E. of regression	0.298702	Akaike info criterion	0.694582
Sum squared resid	18.02305	Schwarz criterion	0.883329
Log likelihood	-62.32030	Hannan-Quinn criter.	0.770853
Restr. log likelihood	-83.02826	Avg. log likelihood	-0.291216
LR statistic (12 df)	41.41591	McFadden R-squared	0.249409
Probability(LR stat)	2.04E-05	Total obs	214
Obs with Dep=0, did not reoffend	186	Obs with Dep=1, reoffense	28

Italics indicate statistical significance.

3. Base Model With Restoration Treatment/Outpatient Mental Health Post Treatment Interaction

Variable	Coefficient	Std. Error	Z-Statistic	Prob >Z
Constant	-1.593462	1.204069	-1.323398	0.1857
Received treatment under new law	-0.184064	0.638950	-0.288072	0.7733
Female	-0.787375	0.637652	-1.234804	0.2169
Age	-0.022987	0.024726	-0.929696	0.3525
Black	1.280925	0.540497	2.369901	0.0178
Asian	0.275039	1.239044	0.221977	0.8243
Hispanic	1.487468	1.226617	1.212659	0.2253
Number of misdemeanor convictions	0.153204	0.081099	1.889097	0.0589
Any felony conviction	1.190259	0.525236	2.266143	0.0234
Any community inpatient days 1 yr prior to evaluation	1.641085	0.620658	2.644104	0.0082
Average monthly hours community mental health treatment 1 yr prior to evaluation	0.073994	0.036906	2.004949	0.0450
Average monthly hours community mental health treatment 1 yr post treatment/eval	-0.117150	0.087358	-1.341040	0.1799
Interaction of treatment under new law and post community mental health average monthly hours	-0.397457	0.211003	-1.883652	0.0596

Mean dependent var	0.130841	S.D. dependent var	0.338017
S.E. of regression	0.300358	Akaike info criterion	0.685907
Sum squared resid	18.13321	Schwarz criterion	0.890382
Log likelihood	-60.39201	Hannan-Quinn criter.	0.768533
Restr. log likelihood	-83.02826	Avg. log likelihood	-0.282206
LR statistic (13 df)	45.27249	McFadden R-squared	0.272633
Probability(LR stat)	9.25E-06		

Obs with Dep=0	186	Total obs	214
Obs with Dep=1	28		

Italics indicate statistical significance.

4. Wald Test of Joint Significance of Treatment Under New Law and Post Mental Health Community Treatment Average Monthly Hours

Test Statistic	Value	df	Probability
F-statistic	5.387203	(2, 202)	0.0053
Chi-square	10.77441	2	0.0046

5. Wald Test of Joint Significance of Community Inpatient Treatment and Community Outpatient Treatment Average Hours One Year Prior to Evaluation

Test Statistic	Value	df	Probability
F-statistic	5.238062	(2, 201)	0.0061
Chi-square	10.47612	2	0.0053

6. Wald Test of Joint Significance of Counties

Test Statistic	Value	df	Probability
F-statistic	1.035276	(9, 192)	0.4134
Chi-square	9.317484	9	0.4085

APPENDIX H: LOGISTIC REGRESSION MODEL PREDICTING MISDEMEANOR AGAINST A PERSON CHARGES FILED: TREATMENT AND COMPARISON GROUP MISDEMEANANT DEFENDANTS

1. Base Model

Variable	Coefficient	Std. Error	Z-Statistic	Prob.
Constant	0.510817	0.806971	0.633006	0.5267
Received treatment under new law	-0.768964	0.357647	-2.150063	0.0316
Female	-0.025872	0.457774	-0.056518	0.9549
Age	-0.047690	0.016375	-2.912414	0.0036
Black	-0.288785	0.436928	-0.660944	0.5086
Asian	0.193491	0.706084	0.274034	0.7841
Hispanic	-0.779270	1.162889	-0.670116	0.5028
Any community mental health treatment 1 yr prior to evaluation	-0.163913	0.367689	-0.445794	0.6557
Any community inpatient days 1 yr prior to evaluation	0.143554	0.430610	0.333374	0.7389
Any felony conviction	0.286979	0.362782	0.791051	0.4289
Number of misdemeanor against person filings	0.172647	0.065091	2.652408	0.0080
Average monthly hours community mental health treatment 1 yr post treatment/evaluation	0.558781	0.394617	1.416007	0.1568

Mean dependent var	0.299065	S.D. dependent var	0.458922
S.E. of regression	0.434086	Akaike info criterion	1.182674
Sum squared resid	38.06300	Schwarz criterion	1.371420
Log likelihood	-114.5461	Hannan-Quinn criter.	1.258944
Restr. log likelihood	-130.5551	Avg. log likelihood	-0.535262
LR statistic (14 df)	32.01796	McFadden R-squared	0.122622
Probability(LR stat)	0.000758	Total obs	214

Obs with Dep=0, did not reoffend 150 Obs with Dep=1, reoffense 64

Italics indicate statistical significance.

2. Wald Test of Joint Significance of Counties

Test Statistic	Value	df	Probability
F-statistic	0.480016	(8, 194)	0.8694
Chi-square	3.840127	8	0.8713

APPENDIX I: LOGISTIC REGRESSION MODEL PREDICTING MISDEMEANOR CHARGES FILED: TREATMENT AND COMPARISON GROUP MISDEMEANANT DEFENDANTS

1. Base Model

Variable	Coefficient	Std. Error	Z-Statistic	Prob.
Constant	0.452888	0.744096	0.608643	0.5428
Received treatment under new law	-0.583218	0.325591	-1.791258	0.0733
Female	0.216524	0.424231	0.510393	0.6098
Age	-0.023840	0.014038	-1.698283	0.0895
Black	-0.208175	0.398590	-0.522279	0.6015
Asian	-0.371544	0.723876	-0.513271	0.6078
Hispanic	-0.686433	0.968879	-0.708482	0.4786
Any prior felony	0.574403	0.354383	1.620855	0.1050
Number of prior misdemeanor filings	0.117747	0.036635	3.214037	0.0013
Any community outpatient treatment 1 year prior to evaluation	-0.743519	0.347490	-2.139687	0.0324
Any community inpatient treatment one year prior to evaluation	0.427806	0.403877	1.059247	0.2895
Any community outpatient treatment 1 year after evaluation/treatment	0.459475	0.356175	1.290026	0.1970

Mean dependent var	0.523364	S.D. dependent var	0.500625
S.E. of regression	0.466109	Akaike info criterion	1.305788
Sum squared resid	43.88607	Schwarz criterion	1.494535
Log likelihood	-127.7194	Hannan-Quinn criter.	1.382059
Restr. log likelihood	-148.0998	Avg. log likelihood	-0.596819
LR statistic (13 df)	40.76081	McFadden R-squared	0.137613
Probability(LR stat)	2.65E-05		
Obs with Dep=0, did not reoffend	102	Total obs	214
Obs with Dep=1, reoffense	112		

Italics indicate statistical significance.

2. Wald Test of Joint Significance of Counties

Test Statistic	Value	df	Probability
F-statistic	0.710619	(9, 193)	0.6988
Chi-square	6.395575	9	0.6998

APPENDIX J: KEY INFORMANTS

Between July 1999 and March 2000, interviews were conducted with key informants regarding information sharing. The informants included representatives from the following:

State Hospitals
ESH and WSH Forensic Evaluation Management and Staff
ESH and WSH Civil Evaluation Management and Staff

Community Hospitals
Puget Sound Hospital, Tacoma
Sacred Heart Hospital, Spokane

Criminal Courts
Seattle, Spokane Municipal and District Mental Health Court Judges
Seattle, Spokane Municipal Court Prosecutors
Spokane Municipal Court Defense Attorney

Civil Courts
Spokane/ESH Defense, Prosecution, Commissioners

Community Designated Mental Health Professionals
Pierce and Spokane Counties

Jails
Pierce County Jail Program, Pierce County Regional Support Network
Spokane County Jail Program, Spokane Mental Health