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STATE OF WASHINGTON

Respondent,

v.

CECIL DAVIS

Appellant.

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**AMICUS CURIAE BRIEF OF DISABILITY RIGHTS  
WASHINGTON IN SUPPORT OF APPELLANT'S APPEAL**

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## I. INTERESTS AND IDENTITY OF AMICUS

Proposed amicus Disability Rights Washington is an organization with experience and knowledge of people with disabilities. *Amicus* supports Respondent's Appeal, and respectfully requests that it be provided the opportunity to provide information to the Court on how the combined effect of multiple disabilities can limit the appropriateness of applying the death penalty.

*Amicus* Disability Rights Washington is the organization designated by federal law and the Governor of Washington to provide protection and advocacy services to people in Washington with mental, developmental, physical, and sensory disabilities. *See* Motion to Appear as *Amicus Curiae* and Declaration of Mark Stroh in support thereof. As the designated protection and advocacy organization for the state of Washington, Disability Rights Washington is part of a network of protection and advocacy systems located in each of the fifty States, the District of Columbia, the Commonwealths and the territories. Stroh Decl., ¶ 2. Disability Rights Washington has a Congressional mandate to advocate on behalf of people with disabilities through the provision of a full range of legal assistance including legal representation, regulatory and legislative advocacy, and education and training. *Id.*

Disability Rights Washington has extensive experience representing the interests of people with a variety of disabilities, including individuals with multiple co-occurring disabilities. Disability Rights Washington has been class counsel in several class action lawsuits pertaining to the needs of individuals with intellectual disabilities, mental illness, and other disabilities affecting individuals' cognitive abilities. *See e.g. Allen, et al. v. Western State Hospital, et al.*, USDC C99-5018 RBL (class action regarding treatment of individuals with dual diagnosis of developmental disabilities and mental illness); *Marr, et al. v. Eastern State Hospital, et al.*, USDC CV-02-0067 WFN (similar to *Allen* covering dually diagnosed patients at Eastern State Hospital); *Boyle, et al. v. Robin Arnold-Williams, et al.*, USDC C-01-5687 JKA (class action regarding assessment, delivery, and due process relating to community based services for people with developmental disabilities); *G.R. v. DSHS*, USDC C05-5420 RBL (class action regarding DSHS notices which did not account for individual clients' inability to understand or act upon notices due to developmental disabilities); *Rust., et al. v. Western State Hospital, et al.*, USDC C00-5749 RJB (class action regarding treatment of forensic mental health patients including patients with brain co-occurring traumatic brain injuries, borderline intellectual functioning, and other cognitive disabilities); *D.S., et al., v. Western State Hospital, et al.*, USDC

C03-5271 RBL (class action regarding discharge of involuntarily detained patients with dual diagnosis of developmental disabilities and mental illness); and *Pierce County, et al. v. Washington State et al.*, Thurston County Superior Court, 03-2-00918-8 (organizational plaintiff in case regarding the admissions and discharges of people at Western State Hospital).

## II. STATEMENT OF THE CASE

*Amicus* Disability Rights Washington, joins in Appellant's Statement of the Case. Of specific relevance to the arguments of *Amicus* regarding the consideration of disability in the application of the death penalty are pages 14-20 of Appellant's Opening Brief in which there is a description of Appellant's disabilities. The opening brief describes circumstances that reflect the impact of Appellant's disabilities: his history of inclusion in special education classes; the recognition by others from early childhood that he was not able to process information as well as others; his inability to complete high school; a car accident that lead to post-concussive disorder, major neurological problems, and a change in behavior; and his reliance on family for support as an adult. Appellant's Opening Brief at 14-20. In addition to the documented history which indicates Appellant has significant disabilities, the record also reflects clinical findings of low IQ scores throughout his life, starting in childhood

with scores of 81, 71, 73, and as an adult 82 in 1994 and 81 in 1997, and most recently 68 and 74 in recent evaluations in connection with this case. *Id.* at 16-19. Clinicians determined he reads and does math at a fourth grade level. *Id.* at p. 19. They also determined he processes information poorly. *Id.* Appellant was described by clinicians as having decreased cognitive functioning that, although not fitting the specific diagnostic criteria of “mental retardation,” is classified as having a “cognitive disorder not otherwise specified with multiple etiologies”; moderately severe brain slowing and disorganization; brain function abnormalities; major mental illness; co-occurring cognitive disorder and major depression with psychotic features; occasional auditory hallucinations and suicidal thoughts; and borderline intellectual skills. *Id.* at p. 16, 19-20.

### III. ARGUMENT

#### A. *The Eighth Amendment Forbids the State From executing People with Impaired Reasoning and Impulse Control*

The Eighth Amendment is violated when the State seeks to execute certain individuals with disabilities in contradiction of our evolving civilized standards. Society’s civilized standards prohibit the execution of individuals with intellectual disabilities who have impaired ability to reason or control impulses to such an extent that the deterrent and retributive effects from the heightened punishment of death is nonexistent.

*Atkins v. Virginia*, 536 U.S. 304, 122 S. Ct. 2242, 153 L.Ed.2d 335 (2002).<sup>1</sup> In Washington State we have a statute, RCW 10.94.030, which provides an exemption from the death penalty for individuals with intellectual disabilities. This statute is consistent with civilized standards described by *Atkins*, but it does not completely reflect the extent of the Eight Amendment's protections for people with disabilities.

Washington's statute, RCW 10.95.030, describes a test for excluding people with intellectual disabilities from the death penalty. In pertinent part the law provides that:

In no case, however, shall a person be sentenced to death if the person had an intellectual disability at the time the crime was committed, under the definition of intellectual disability set forth in (a) of this subsection. A diagnosis of intellectual disability shall be documented by a licensed psychiatrist or licensed psychologist designated by the court, who is an expert in the diagnosis and evaluation of intellectual disabilities. The defense must establish an intellectual disability by a preponderance of the evidence and the court must make a finding as to the existence of an intellectual disability.

(a) "Intellectual disability" means the individual has: (i) Significantly subaverage general intellectual functioning; (ii) existing concurrently with deficits in adaptive behavior; and (iii) both significantly subaverage general intellectual functioning and deficits in adaptive behavior were

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<sup>1</sup> In *Atkins* the U.S. Supreme Court used the term "mental retardation." However, just as that Court recognized public and legislative opinion about the appropriateness of executing people with a particular disability can change over time, it should be noted that in the years since *Atkins* was decided, the term "mental retardation" has been replaced with "intellectual disability" by people with disabilities, clinicians, advocates, and both state and federal legislatures. See e.g., RCW 44.04.280; Rosa's Law, Pub. Law 111-256 (S 2781) (Attached as Exhibits A and B respectively).

manifested during the developmental period.

(b) "General intellectual functioning" means the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.

(c) "Significantly subaverage general intellectual functioning" means intelligence quotient seventy or below.

(d) "Adaptive behavior" means the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for his or her age.

(e) "Developmental period" means the period of time between conception and the eighteenth birthday.

RCW 10.95.030.

Unfortunately, the statute fails to equally consider all other disabilities that similarly impair reason and impulse control. Therefore, rigid adherence to this statutory rule is inadequate to meet Constitutional requirements. The statute only approximates the basic Constitutional precepts and reduces them into a formulaic rule, but this proxy for the Constitutional protection cannot be mistaken for the actual Constitutional protection itself. The Constitutional precepts, as articulated by the U.S. Supreme Court in *Atkins*, do not hinge upon the application of a particular statutory formula. Instead, they reflect an evolving public conscience that reinforces the Eighth Amendment principle that death cannot be used to punish people with impaired reason and impulse control as it does not serve the punitive purposes of heightened deterrence or retribution beyond

imprisonment. *Atkins*, 536 U.S. at 318-19, 122 S. Ct. 2250-51, 153 L.Ed.2d 335.

Washington's statute applies these principles adequately for only some of the individuals whose disabilities impair reason and impulse control to the extent the heightened deterrent or retributive purposes of the death penalty are not applicable. When an individual does not meet the formulaic statutory rule for intellectual disability, but evidences the impaired reason and impulse control demonstrated by those who meet the formula, the court is still bound by the Constitutional precepts found in the Eighth Amendment. The Court should consider and make findings pertaining to two factors: (1) how the individual's disability relates to our current civilized standards, and (2) whether the impairments to reason and impulse control impact the applicability of the heightened deterrence and retribution inherent in the death penalty.

***B. The Death Penalty Cannot be Applied to Certain People***

In 1986, the State of Georgia put a convicted murderer with an intellectual disability to death. There was significant outcry from the public, and the first statute was passed forbidding the execution of individuals with intellectual disabilities. *Atkins v. Virginia*, 536 U.S. 304, 313 n. 8, 122 S. Ct. 2242, 2247-78, 153 L.Ed.2d 335 (2002). The statutory and case law limitations involving the execution of people with

disabilities evolved from this incident, which resulted in subsequent statutes and cases addressing solely people with intellectual disabilities.

*Id.* at 314-16.

Legal scholars from around the country have looked at the holding in *Atkins*, as well as the decisions in *Roper v. Simmons*, 543 U.S. 551, 125 S. Ct. 1183, 161 L.Ed.2d 1 (2005) (prohibiting the execution of individuals who were minors at the time of the crime), and *Ford v. Wainwright*, 477 U.S. 399, 106 S. Ct. 2595, 91 L.Ed.2d 335 (1986) and *Penetti v. Quarterman*, 551 U.S. 930, 127 S. Ct. 2842, 168 L.Ed.2d 662 (2007) (prohibiting the execution of an individual experiencing a significant mental illness at the time of execution), as supporting exemptions for people experiencing certain mental illnesses and traumatic brain injuries at the time of the crime.<sup>2</sup> Additional evidence that civilized standards prohibit the execution of certain people with mental illness and other disabilities affecting reason and impulse control at the time of the crime is found in the policy statements of numerous national organizations with specialized knowledge in the interaction between people with mental illness and the legal system. These organizations include the American

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<sup>2</sup> See e.g., Bruce J. Winick, *The Supreme Court's Evolving Death Penalty Jurisprudence: Severe Mental Illness and the Next Frontier*, 50 B.C. L.Rev. 785 (2009); Judith M. Barger, *Avoiding Atkins v. Virginia: How States are Circumventing Both the Letter and the Spirit of the Court's Mandate*, 13 Berkley J. Crim. L. 215 (2008); Ronald J. Tabak, *Mental Disability and Capital Punishment A More Rational Approach to a Disturbing Subject*, 34 SPG Hum. Rts. 5 (2007).

Bar Association, National Alliance on Mental Illness, American Psychiatric Association, American Psychological Association, and Mental Health America.<sup>3</sup> The U.S. Supreme Court relied on statements from similar groups pertaining to intellectual disabilities when it concluded civilized standards no longer allowed the execution of people with intellectual disabilities. *Atkins*, 536 U.S. at 316 n. 21, 122 S. Ct. 2249, 153 L.Ed.2d 335. The Court also relied upon international law to gauge death penalty standards when it prohibited the execution of people with intellectual disabilities and minors. *Id*; *Roper*, 543 U.S. at 576-77, 125 S. Ct. 1198, 161 L.Ed.2d 1. Here too, there is international support for considering certain mental illnesses and traumatic brain injuries that would constitute “mental disorders” as sufficient in and of themselves to preclude execution. *See, e.g.*, U.N. Commission on Human Rights Res. 2001/68, ¶ 4(e), U.N. Doc. /CN.4/RES/2001/68 (Apr. 25, 2001) (calling

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<sup>3</sup> American Bar Association Task Force on Mental Disability and the Death Penalty, *Recommendation and Report on the Death Penalty and Persons with Mental Disabilities*, 30 MENTAL & PHYSICAL DISABILITY L. REP. 668 (2006) (Attached as Exhibit C); NAT'L ALLIANCE ON MENTAL ILLNESS, PUBLIC POLICY PLATFORM OF THE NATIONAL ALLIANCE ON MENTAL ILLNESS § 10.9.1.2, at 56-57 (8th ed. 2008) (Attached as Exhibit D); Am. Psychiatric Ass'n, Position Statement: Diminished Responsibility in Capital Sentencing, Dec. 2004, <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200406.aspx>(Attached as Exhibit E); Am. Psychological Ass'n, Council Policy Manual: Public Interest, Feb. 2006, <http://www.apa.org/about/division/cpmpubint2.html> (Attached as Exhibit F); Mental Health Am., Position Statement 54: Death Penalty and People with Mental Illnesses, June 11, 2006, <http://www.nmha.org/go/position-statements/54>. (Attached as Exhibit G).

for ban on execution of people with mental disorders) (Attached as Exhibit H).

In the present case, the appellant's disabilities go beyond simply a single intellectual disability or mental illness. Instead, Appellant presents a complex clinical makeup arising from several co-occurring disabilities that reduce his ability to exercise reason and impulse control. The record reflects that Appellant has co-occurring disabilities including decreased intellectual functioning, mental illness, and traumatic brain injury, the combination of which does not fit neatly into the singular categorical box created by RCW 10.95.030. Researchers<sup>4</sup> and federal courts<sup>5</sup> alike have recognized that people with co-occurring disabilities present different symptoms and need different responses than people with a simple, single intellectual disability, mental illness, or traumatic brain injury. It is the *combination* of these multiple disabilities that results in Appellant's significant functional limitations. Therefore, it is necessary to go beyond

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<sup>4</sup> See, e.g., Colin Hudson, Jeffrey Chan, *Individuals with intellectual disability and mental illness: a literature review*, Australian Journal of Social Issues, Feb. 1. 2002 (Attached as Exhibit I).

<sup>5</sup> Three separate class actions all resulted in Settlement Orders requiring the creation of specialized hospital units for people with co-occurring intellectual disabilities and mental illness. *Allen, et al. v. Western State Hospital, et al.*, USDC C99-5018 RBL; (Hospital Settlement Order Attached as Exhibit J); *Marr, et al. v. Eastern State Hospital, et al.*, USDC CS-02-0067-WFN (Settlement Order Attached as Exhibit K); *Rust., et al. v. Western State Hospital, et al.*, USDC C00-5749 RJB (Amended Settlement Order Attached as Exhibit L). Additionally, *Allen* and *Marr* had class members in community settings and settlement orders which required intensive services specially designed to meet the unique needs of people with co-occurring disabilities (*Allen* Community Settlement Agreement Attached as Exhibit M).

the strict formulaic statutory definition of intellectual disability and examine how these combined conditions impair Appellant's reason and impulse control. This is required to ensure that the intent of the death penalty statute is realized and the Constitutional prohibitions on cruel and unusual punishment are not violated.

**C. "Civilized Standards" Reflect Evolving Public Beliefs**

Each disability is an objective individualized experience that can be subjectively categorized and defined using social, legal, or medical constructs. The definition of intellectual disabilities used in clinical settings has limited applicability in the legal system. California's Supreme Court recognized this when, in a capital appeal, it cautioned that "[i]n assessing the role the Full Scale IQ score (or any other single test score) plays in determining mental retardation, we must distinguish between rules of law and diagnostic criteria of psychology." *People v. Superior Court*, 40 Cal.4<sup>th</sup> 999, 155 P.3d 259, 56 Cal. Rptr.3d 851 (Cal. 2007). The primary clinical manual of mental health professionals, the Diagnostic and Statistical Manual of Mental Disorders IV Text Revision (DSM IV-TR), explicitly cautions against conflating the clinical measurements of disability with legal disability categorization. "The introduction to the DSM IV-TR notes that there is an imperfect fit between clinical diagnoses and the questions of ultimate concern of the law. In

determining satisfaction of a legal standard, additional information is usually required, including information about the individual's functional impairments and how these impairments affect the particular abilities in question." (internal quotations omitted) Bruce J. Winick, *The Supreme Court's Evolving Death Penalty Jurisprudence: Severe Mental Illness and the Next Frontier*, 50 B.C. L.Rev. 785 (2009).

Here, the question that must be answered is how well the statutory definition reflects the civilized standard for exemption from the death penalty. The question is not whether the statutory definition of disability prevents conviction, as that is a different test. *Atkins*, 536 U.S. at 305, 122 S. Ct. 2243, 153 L.Ed.2d 335. People with intellectual disabilities

frequently know the difference between right and wrong and are competent to stand trial, but, by definition, they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand others' reactions. Their deficiencies do not warrant an exemption from criminal sanctions, but diminish their personal culpability.

*Id.* Appellant was convicted, and his disabilities are not a bar to punishment, however, they should preclude the imposition of the death penalty. "While the State has the power to punish, the Eighth Amendment stands to assure that this power be exercised within the limits of civilized standards." *Trop v. Dulles*, 356 U.S. 86, 78 S. Ct. 590, 2 L.Ed.2d 630

(1958). These standards are not, however, set in stone, because “the words of the Amendment are not precise, and that their scope is not static. The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.” *Id.*

The flexible imprecision of the “civilized standards” used to measure the appropriateness of applying a particular punishment was recognized by the U.S. Supreme Court when it considered the execution of people with intellectual disabilities in *Atkins v. Virginia*. 536 U.S. 304, 311-312 122 S. Ct. 2242, 2246-47, 153 L.Ed.2d 335 (2002). In *Atkins*, the Court held executing someone with an intellectual disability was unconstitutional pursuant to the Eighth Amendment. *Id.* In doing so, the U.S. Supreme Court directly overruled its own holding in *Penry v. Lynaugh*, 492 U.S. 302, 109 S. Ct. 2934, 106 L.Ed.2d 256 (1989), decided 13 years earlier. *Id.* In both cases, the court considered whether the Eighth Amendment permitted the execution of convicted murders with intellectual disabilities. In the first case, the Court determined that it was not prohibited. Following that decision, Washington responded by amending the death penalty statutes to specifically exclude people with intellectual disabilities.

The U.S. Supreme Court recognized in *Atkins* that despite its earlier ruling in *Penry* allowing the execution of individuals with

intellectual disabilities, the policies of national disability organizations, international law, public opinion, and state statutes served as persuasive evidence that there was a shift in “civilized standards” away from executing people with intellectual disabilities. *Atkins*, 536 U.S. at 314-15, 122 S. Ct. 2248-49, 153 L.Ed.2d 335.

The U.S. Supreme Court made this change because “[t]he basic concept underlying the Eighth Amendment is nothing less than the dignity of man. The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.” *Id.* at 311-12, quoting *Trop v. Dulles*, 356 U.S. 86, 78 S. Ct. 590, 2 L.Ed.2d 630 (1958). Therefore, instead of holding rigidly to a particular statutory construct, the Court focused its analysis on whether the rule accurately reflects the current state of “civilized standards.”

***D. RCW 10.95.030 Does Not Reflect Evolving “Civilized Standards”***

This Court has not had an opportunity to consider an appeal dealing with the impact of disability in death penalty cases since the U.S. Supreme Court’s ruling in *Atkins*. Furthermore, the Court now has before it the application of the death penalty to a case where the appellant has not one, but *multiple* cognitive disabilities.

As mentioned above, RCW 10.95.030 was amended to exempt people with intellectual disabilities from execution *prior* to the U.S. Supreme Court's decision in *Atkins* announcing it was unconstitutional to execute people with intellectual disabilities. Washington's statute adequately describes a simple test for a single type of disability impacting decision-making and impulse control. However, because it is limited to a specific disability, it does not accurately reflect the full scope of current civilized standards regarding the use of the death penalty on people with other or multiple cognitive disabilities. Therefore, while the test may be sufficient in identifying a particular category of people who cannot be executed, the statutory test cannot be the exclusive test for adherence to the Eighth Amendment, as there are others with similar disabilities who must be examined on an individual as opposed to categorical basis.

***E. The Death Penalty Should be Applied Consistently to People with Functionally Similar Disabilities***

The Washington statute mandates an exemption for a narrow and specific class of individuals with disabilities, those who can demonstrate that they meet a rigid formula, including a bright line IQ test score. Individuals who have co-occurring disabilities, but who, like Appellant, at times score marginally over the maximum set for the exemption, are subject to the death penalty unless this Court acts to require a full

examination of their functional impairment. Failure to exempt people with impairments functionally similar to people who fit a particularized rigid definition from the death penalty is arbitrary and runs afoul of the Equal Protection Clauses of the Washington and U.S. Constitutions.

The rigid formulaic definition of intellectual disability in the Washington statute runs afoul of the Equal Protection Clauses of both the Washington and the U.S. Constitutions because it allows the State to put certain people with disabilities affecting reasoning and impulse control to death, while exempting others with similarly impaired reasoning ability by virtue of their specific score on an IQ test.<sup>6</sup> The rule is based solely on a particular category of disability and does not accurately identify all of the people who, because of cognitive disabilities, fall within the “civilized standards” prohibiting the execution of individuals who have disabilities that limit their reasoning and impulse control.

The State is allowed to set parameters regarding its use of the death penalty. *Atkins*, 536 U.S. at 317, 122 St. Ct. 2250, 153 L.Ed.2d 335; *Ford v. Wainwright*, 477 U.S. 399, 106 S. Ct. 2595, 91 L.Ed.2d 335 (1986).

However, due to the fundamental right at issue, the standard of review for

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<sup>6</sup> See John H. Blume, Sheri Lynn Johnson, Christopher Seeds, *Of Atkins and Men: Deviations From Clinical Definitions of Mental Retardation in Death Penalty Cases*, 18 Cornell J.L. & Pub. Pol'y 689 (2009); see also, supra Section B. discussion of limitations of applying IQ test as proxy for legal analysis of a disability's effect.

Equal Protection is strict scrutiny which requires the law be narrowly tailored to achieve a compelling state interest. *See Skinner v. Okla.*, 316 U.S. 535, 541, 62 S. Ct. 1110, 1113, 86 L.Ed. 1655 (1942); *Harper v. Va. State Bd. of Elections*, 383 U.S. 663, 670, 86 S. Ct. 1079, 1083, 16 L.Ed.2d 169 (1966); *Police Dep't of Chicago v. Mosley*, 408 U.S. 92, 94-96, 92 S. Ct. 2286, 2289-91, 33 L.Ed.2d 212 (1972); *Young v. Weston*, 192 F.3d 870, 876 (9th Cir. 1999), *rev'd on other grounds sub nom.*; *Seling v. Young*, 531 U.S. 250, 121 S. Ct. 727, 148 L.Ed.2d 734 (2001).

Here, the state singled out a particular type of disability to exempt from the death penalty, but did not account for similarly situated people with disabilities who, due to the clinical complexity resulting from co-occurring disorders, have similar functional limitations but cannot meet the rigid IQ score or age requirements established by the legislature. These people are largely indistinguishable from people with lower IQ scores you meet on the street, but they can be put to death by the State.<sup>7</sup> Currently, Washington's statute distinguishes between people who have slightly different test scores or ages for onset of disability, even if they have similar functional limitations to their cognition. This distinction is

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<sup>7</sup> Strict adherence to IQ is not even adequate when looking at a single intellectual disability. *See* John H. Blume, Sheri Lynn Johnson, Christopher Seeds, *Of Atkins and Men: Deviations From Clinical Definitions of Mental Retardation in Death Penalty Cases*, 18 Cornell J.L. & Pub. Pol'y 689 (2009).

not narrowly tailored to achieve the state's compelling interest of not executing people whose disabilities cause the deterrence and retribution of the death penalty to be ineffective. *Atkins*, 536 U.S. at 321, 122 S. Ct. 2252, 153 L.Ed.2d 335 (Holding that execution of criminals with intellectual disabilities does not "measurably advance the deterrent or the retributive purpose of the death penalty.")

The only prong of Washington's current statutorily proscribed three part test that has anything to do with the civilized standards described by the U.S. Supreme Court is the examination of functional limitations. However, meeting this prong alone is not sufficient to be exempted from the death penalty under Washington's statute. The statute also requires that the disability exist prior to the individual's 18<sup>th</sup> birthday and result in a particular score on a test designed to measure a particular type of disability. This limits the scope of the law, excluding many people who have disabilities that impair their reason or impulse control.

While the statutory requirement that the disability onset occur before age 18 may be helpful in classification for clinical purposes, this requirement does not serve the "civilized standards" and underlying principles of applying the death penalty. Civilized standards, and the punitive purposes of the death penalty, do not apply differently where an individual acquired a cognitive disability in a car accident the day before

his 18<sup>th</sup> birthday verses a person who acquired the same disability in a car accident the day after his 18<sup>th</sup> birthday. Here, the record shows the appellant's disabilities became more significant in adulthood. Appellant's Opening Brief at 16-19. He had a car accident that caused additional neurological problems and cognitive disabilities beyond those which clearly already existed in his childhood; physical tests on his brain later in life indicate brain slowing, and his score IQ scores have gone down over time. Appellant's Opening Brief, at 14-20.

Similarly, making rigid distinctions between people with similar functional disabilities based upon diagnostic constructs does not further the "civilized standards" or punitive purpose. The statute requires that a person first qualify as having an intellectual disability (referred to as "mental retardation" elsewhere) by scoring under a specific number on an IQ test. Here, clinicians recognized that although Appellant did not have "mental retardation" he did have a "cognitive disorder not otherwise specified with multiple etiologies" resulting from the compounding effects of multiple disabilities including borderline intellectual functioning, traumatic brain injury, and major mental illness with psychotic features. Appellant's Opening Brief at 16-17, 19-20.

The test applied in Washington's statute is necessarily inadequate, because it is built around a clinical definition of intellectual disability

which is controlled by a specific score on an IQ test and a specific age for the onset of disability. Due to this construction, it cannot be used to identify and exempt people with other cognitive disabilities that, whether individually or in concert with other co-occurring disabilities, impact reason and impulse control in the same way as the qualifying intellectual disabilities.

#### **IV. CONCLUSION**

For the foregoing reasons *Amicus* Disability Rights Washington respectfully requests that the Court grant Appellant's appeal after it considers and make findings regarding: (1) how Appellant's disabilities relate to our current civilized standards, and (2) whether Appellant's impairments to reason and impulse control impact the applicability of the heightened deterrence and retribution inherent in the death penalty.

Respectfully submitted this 10<sup>th</sup> day of January, 2011.

**DISABILITY RIGHTS WASHINGTON**

A handwritten signature in black ink, appearing to read "David Carlson", written over a horizontal line.

David Carlson, WSBA #35767

**Certificate of Service**

I certify, under penalty of perjury pursuant to the laws of the State of Washington, that on January 10, 2011 a true and correct copy of the foregoing document was served upon counsel listed below by legal messenger:

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DATED January 10, 2011 at Seattle, Washington.

Mona Rennie  
Mona Rennie

RCW 44.04.280

State laws — Respectful language.

(1) The legislature recognizes that language used in reference to individuals with disabilities shapes and reflects society's attitudes towards people with disabilities. Many of the terms currently used diminish the humanity and natural condition of having a disability. Certain terms are demeaning and create an invisible barrier to inclusion as equal community members. The legislature finds it necessary to clarify preferred language for new and revised laws by requiring the use of terminology that puts the person before the disability.

(2)(a) The code reviser is directed to avoid all references to: Disabled, developmentally disabled, mentally disabled, mentally ill, mentally retarded, handicapped, cripple, and crippled, in any new statute, memorial, or resolution, and to change such references in any existing statute, memorial, or resolution as sections including these references are otherwise amended by law.

(b) The code reviser is directed to replace terms referenced in (a) of this subsection as appropriate with the following revised terminology: "Individuals with disabilities," "individuals with developmental disabilities," "individuals with mental illness," and "individuals with intellectual disabilities."

(3) No statute, memorial, or resolution is invalid because it does not comply with this section.

(4) The replacement of outmoded terminology with more appropriate references may not be construed as changing the application of any provision of this code to any person.

[2010 c 94 § 2; 2009 c 377 § 1; 2004 c 175 § 1.]

Notes:

**Purpose -- 2010 c 94:** "The purpose of this act is to move toward fulfillment of the goals stated in RCW 44.04.280, to remove demeaning language from the Revised Code of Washington and to use respectful language when referring to individuals with disabilities. It is not the intent of the legislature to expand or contract the scope or application of any provision of this code. Nothing in this act may be construed to change the application of any provision of this code to any person." [2010 c 94 § 1.]

Public Law 111-256  
111th Congress

An Act

To change references in Federal law to mental retardation to references to an intellectual disability, and change references to a mentally retarded individual to references to an individual with an intellectual disability.

Oct. 5, 2010

[S. 2781]

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

Rosa's Law.

**SECTION 1. SHORT TITLE.**

This Act may be cited as "Rosa's Law".

20 USC 1400  
note.

**SEC. 2. INDIVIDUALS WITH INTELLECTUAL DISABILITIES.**

(a) HIGHER EDUCATION ACT OF 1965.—Section 760(2)(A) of the Higher Education Act of 1965 (20 U.S.C. 1140(2)(A)) is amended by striking "mental retardation or".

(b) INDIVIDUALS WITH DISABILITIES EDUCATION ACT.—

(1) Section 601(c)(12)(C) of the Individuals with Disabilities Education Act (20 U.S.C. 1400(c)(12)(C)) is amended by striking "having mental retardation" and inserting "having intellectual disabilities".

(2) Section 602 of such Act (20 U.S.C. 1401) is amended—

(A) in paragraph (3)(A)(i), by striking "with mental retardation" and inserting "with intellectual disabilities"; and

(B) in paragraph (3)(C), by striking "of mental retardation" and inserting "of intellectual disabilities".

(c) ELEMENTARY AND SECONDARY EDUCATION ACT OF 1965.—Section 7202(16)(E) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7512(16)(E)) is amended by striking "mild mental retardation," and inserting "mild intellectual disabilities,".

(d) REHABILITATION ACT OF 1973.—

(1) Section 7(21)(A)(iii) of the Rehabilitation Act of 1973 (29 U.S.C. 705(21)(A)(iii)) is amended by striking "mental retardation," and inserting "intellectual disability,".

(2) Section 204(b)(2)(C)(vi) of such Act (29 U.S.C. 764(b)(2)(C)(vi)) is amended by striking "mental retardation and other developmental disabilities" and inserting "intellectual disabilities and other developmental disabilities".

(3) Section 501(a) of such Act (29 U.S.C. 791(a)) is amended, in the third sentence, by striking "President's Committees on Employment of People With Disabilities and on Mental Retardation" and inserting "President's Disability Employment Partnership Board and the President's Committee for People with Intellectual Disabilities".

(e) HEALTH RESEARCH AND HEALTH SERVICES AMENDMENTS OF 1976.—Section 1001 of the Health Research and Health Services

Amendments of 1976 (42 U.S.C. 217a-1) is amended by striking “the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.”

(f) PUBLIC HEALTH SERVICE ACT.—

(1) Section 317C(a)(4)(B)(i) of the Public Health Service Act (42 U.S.C. 247b-4(a)(4)(B)(i)) is amended by striking “mental retardation;” and inserting “intellectual disabilities;”.

(2) Section 448 of such Act (42 U.S.C. 285g) is amended by striking “mental retardation,” and inserting “intellectual disabilities;”.

(3) Section 450 of such Act (42 U.S.C. 285g-2) is amended to read as follows:

“SEC. 450. RESEARCH ON INTELLECTUAL DISABILITIES.

“The Director of the Institute shall conduct and support research and related activities into the causes, prevention, and treatment of intellectual disabilities.”

(4) Section 641(a) of such Act (42 U.S.C. 291k(a)) is amended by striking “matters relating to the mentally retarded” and inserting “matters relating to individuals with intellectual disabilities”.

(5) Section 753(b)(2)(E) of such Act (42 U.S.C. 294c(b)(2)(E)) is amended by striking “elderly mentally retarded individuals” and inserting “elderly individuals with intellectual disabilities”.

(6) Section 1252(f)(3)(E) of such Act (42 U.S.C. 300d-52(f)(3)(E)) is amended by striking “mental retardation/developmental disorders,” and inserting “intellectual disabilities or developmental disorders;”.

(g) HEALTH PROFESSIONS EDUCATION PARTNERSHIPS ACT OF 1998.—Section 419(b)(1) of the Health Professions Education Partnerships Act of 1998 (42 U.S.C. 280f note) is amended by striking “mental retardation” and inserting “intellectual disabilities”.

(h) PUBLIC LAW 110-154.—Section 1(a)(2)(B) of Public Law 110-154 (42 U.S.C. 285g note) is amended by striking “mental retardation” and inserting “intellectual disabilities”.

(i) NATIONAL SICKLE CELL ANEMIA, COOLEY'S ANEMIA, TAY-SACHS, AND GENETIC DISEASES ACT.—Section 402 of the National Sickle Cell Anemia, Cooley's Anemia, Tay-Sachs, and Genetic Diseases Act (42 U.S.C. 300b-1 note) is amended by striking “leading to mental retardation” and inserting “leading to intellectual disabilities”.

(j) GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008.—Section 2(2) of the Genetic Information Nondiscrimination Act of 2008 (42 U.S.C. 2000ff note) is amended by striking “mental retardation,” and inserting “intellectual disabilities;”.

(k) REFERENCES.—For purposes of each provision amended by this section—

(1) a reference to “an intellectual disability” shall mean a condition previously referred to as “mental retardation”, or a variation of this term, and shall have the same meaning with respect to programs, or qualifications for programs, for individuals with such a condition; and

(2) a reference to individuals with intellectual disabilities shall mean individuals who were previously referred to as individuals who are “individuals with mental retardation” or “the mentally retarded”, or variations of those terms.

**SEC. 3. REGULATIONS.**20 USC 1400  
note.

For purposes of regulations issued to carry out a provision amended by this Act—

(1) before the regulations are amended to carry out this Act—

(A) a reference in the regulations to mental retardation shall be considered to be a reference to an intellectual disability; and

(B) a reference in the regulations to the mentally retarded, or individuals who are mentally retarded, shall be considered to be a reference to individuals with intellectual disabilities; and

(2) in amending the regulations to carry out this Act, a Federal agency shall ensure that the regulations clearly state—

(A) that an intellectual disability was formerly termed mental retardation; and

(B) that individuals with intellectual disabilities were formerly termed individuals who are mentally retarded.

**SEC. 4. RULE OF CONSTRUCTION.**20 USC 1400  
note.

This Act shall be construed to make amendments to provisions of Federal law to substitute the term “an intellectual disability” for “mental retardation”, and “individuals with intellectual disabilities” for “the mentally retarded” or “individuals who are mentally retarded”, without any intent to—

(1) change the coverage, eligibility, rights, responsibilities, or definitions referred to in the amended provisions; or

(2) compel States to change terminology in State laws for individuals covered by a provision amended by this Act.

Approved October 5, 2010.

**LEGISLATIVE HISTORY—S. 2781:**

SENATE REPORTS: No. 111-244 (Comm. on Health, Education, Labor, and Pensions).

CONGRESSIONAL RECORD, Vol. 156 (2010):

Aug. 5, considered and passed Senate.

Sept. 22, considered and passed House.



Mental and Physical Disability Law Reporter  
September/October, 2006

## Special Feature

**\*668 RECOMMENDATION AND REPORT ON THE DEATH PENALTY AND PERSONS WITH MENTAL DISABILITIES**

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*[This Recommendation, which was adopted by the American Bar Association (ABA), had been previously adopted by the American Psychiatric Association, the American Psychological Association, and the National Alliance of the Mentally Ill. The Task Force on Mental Disability and the Death Penalty prepared the recommendation and report. The Task Force was established by the ABA's Section of Individual Rights and Responsibilities. Ronald J. Tabak is Chair of the Task Force.]*

**AMERICAN BAR ASSOCIATION RECOMMENDATION****ADOPTED BY THE HOUSE OF DELEGATES August 7-8, 2006**

RESOLVED, That the American Bar Association, without taking a position supporting or opposing the death penalty, urges each jurisdiction that imposes capital punishment to implement the following policies and procedures:

1. Defendants should not be executed or sentenced to death if, at the time of the offense, they had significant limitations in both their intellectual functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from mental retardation, dementia, or a traumatic brain injury.

2. Defendants should not be executed or sentenced to death if, at the time of the offense, they had a severe mental disorder or disability that significantly impaired their capacity (a) to appreciate the nature, consequences or wrongfulness of their conduct, (b) to exercise rational judgment in relation to conduct, or (c) to conform their conduct to the requirements of the law. A disorder manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs does not, standing alone, constitute a mental disorder or disability for purposes of this provision.

3. Mental Disorder or Disability after Sentencing

(a) *Grounds for Precluding Execution.* A sentence of death should not be carried out if the prisoner has a mental disorder or disability that significantly impairs his or her capacity (i) to make a rational decision to forgo or terminate post-conviction proceedings available to challenge the validity of the conviction or sentence; (ii) to understand or communicate pertinent information, or otherwise assist counsel, in relation to specific claims bearing on the validity of the conviction or sentence that cannot be fairly resolved without the prisoner's participation; or (iii) to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case. Procedures to be followed in each of these categories of cases are specified in (b) through (d) below.

(b) *Procedure in Cases Involving Prisoners Seeking to Forgo or Terminate Post-Conviction Proceedings.* If a

court finds that a prisoner under sentence of death who wishes to forgo or terminate post-conviction proceedings has a mental disorder or disability that significantly impairs his or her capacity to make a rational decision, the court should permit a next friend acting on the prisoner's behalf to initiate or pursue available remedies to set aside the conviction or death sentence.

(c) *Procedure in Cases Involving Prisoners Unable to Assist Counsel in Post-Conviction Proceedings.* If a court finds at any time that a prisoner under sentence of death has a mental disorder or disability that significantly impairs his or her capacity to understand or communicate pertinent information, or otherwise to assist counsel, in connection with post-conviction proceedings, and that the prisoner's participation is necessary for a fair resolution of specific claims bearing on the validity of the conviction or death sentence, the court should suspend the proceedings. If the court finds that there is no significant likelihood of restoring the prisoner's capacity to participate in post-conviction proceedings in the foreseeable future, it should reduce the prisoner's sentence to the sentence imposed in capital cases when execution is not an option.

(d) *Procedure in Cases Involving Prisoners Unable to Understand the Punishment or its Purpose.* If, after challenges to the validity of the conviction and death sentence have been exhausted and execution has been scheduled, a court finds that a prisoner has a mental disorder or disability that significantly impairs his or her capacity to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case, the sentence of death should be reduced to the sentence imposed in capital cases when execution is not an option.

## REPORT

### **PREAMBLE**

In *Atkins v. Virginia*, 536 U.S. 304 (2002), the United States Supreme Court held that execution of people with mental retardation violates the Eighth Amendment's ban on cruel and unusual punishment. The Individual Rights and Responsibilities Section of the American Bar Association recognized that *Atkins* \*669 offered a timely opportunity to consider the extent, if any, to which other types of impaired mental conditions ought to lead to exemption from the death penalty. To achieve that objective, the Section established a Task Force on Mental Disability and the Death Penalty. The Task Force, which carried out its deliberations from April, 2003 to March, 2005, was composed of 24 lawyers and mental health professionals (both practitioners and academics), and included members of the American Psychiatric Association and the American Psychological Association. [FN1] The American Psychiatric Association [FN2] and the American Psychological Association [FN3] have officially endorsed the Task Force's proposal. [FN4] The following commentary discusses the three paragraphs of the proposal.

### **PARAGRAPH 1:**

Paragraph 1 of the Recommendation is meant to exempt from the death penalty persons charged with capital offenses who have significant limitations in both intellectual functioning and adaptive skills. Its primary purpose is to implement the United States Supreme Court's holding in *Atkins v. Virginia*, [FN5] which declared that execution of offenders with mental retardation violates the cruel and unusual punishment prohibition in the Eighth Amendment. The Court based this decision both on a determination that a "national consensus" had been reached that people with mental retardation should not be executed, [FN6] and on its own conclusion that people with retardation who kill are not as culpable or deterrable as the "average murderer," much less the type of murderer for whom the death penalty may be viewed as justifiable. [FN7]

While the *Atkins* Court clearly prohibited execution of people with mental retardation, it did not define that term. The Recommendation embraces the language most recently endorsed by the American Association of Mental Retardation, which defines mental retardation as a disability originating before the age of eighteen that is "characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social,

and practical adaptive skills.” [FN8] The language of the Recommendation is also consistent with the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, which defines a person as mentally retarded if, before the age of 18, he or she exhibits “significantly subaverage intellectual functioning” (defined as “an IQ of approximately 70 or below”) and “concurrent deficits or impairments in present adaptive functioning ... in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.” [FN9] Both of these definitions were referenced (albeit not explicitly endorsed) by the Supreme Court in *Atkins*, and both have been models for states that have defined retardation for purposes of the death penalty exemption. [FN10] Both capture the universe of people who, if involved in crime, *Atkins* describes as less culpable and less deterrable than the “average murderer.” As the APA's Diagnostic and Statistical Manual indicates, even a person with only “mild” mental retardation, as that term is defined in the Manual, has a mental age below that of a teenager. [FN11]

The language in this part of the Recommendation is also meant to encompass dementia and traumatic brain injury, disabilities very similar to mental retardation in their impact on intellectual and adaptive functioning except that they always (in the case of dementia) or often (in the case of head injury) are manifested after age eighteen. Dementia resulting from the aging process is generally progressive and irreversible, and is associated with a number of deficits in intellectual and adaptive functioning, such as agnosia (failure to recognize or identify objects) and \*670 disturbances in executive functioning connected with planning, organizing, sequencing, and abstracting. [FN12] The same symptoms can be experienced by people with serious brain injury. Of course, people with dementia or a traumatic head injury severe enough to result in “significant limitations in both intellectual functioning or adaptive behavior” rarely commit capital offenses. If they do, however, the reasoning in *Atkins* should apply and an exemption from the death penalty is warranted, because the only significant characteristic that differentiates these severe disabilities from mental retardation is the age of onset. [FN13]

## PARAGRAPH 2:

Paragraph 2 of the Recommendation is meant to prohibit execution of persons with severe mental disabilities whose demonstrated impairments of mental and emotional functioning at the time of the offense would render a death sentence disproportionate to their culpability. The Recommendation uses the phrase “disorder or disability” because, even though those words are often used interchangeably, some prefer one over the other. The Recommendation indicates that only those individuals with “severe” disorders or disabilities are to be exempted from the death penalty, and it specifically excludes from the exemption those diagnosed with conditions that are primarily manifested by criminal behavior and those whose abuse of psychoactive substances, standing alone, renders them impaired at the time of the offense.

*Rationale:* This part of the Recommendation is based on long-established principles of Anglo-American law that the Supreme Court recognized and embraced in *Atkins* and recently affirmed in *Roper v. Simmons*, [FN14] in which it held that the execution of juveniles who commit crimes while under the age of eighteen is prohibited by the Eighth Amendment. In reaching its holding in *Atkins*, the Court emphasized that execution of people with mental retardation is inconsistent with both the retributive and deterrent functions of the death penalty. More specifically, as noted above, it held that people with mental retardation who kill are both less culpable and less deterrable than the average murderer, because of their “diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others.” [FN15] As the Court noted, “[i]f the culpability of the average murderer is insufficient to justify the most extreme sanction available to the State, the lesser culpability of the mentally retarded offender surely does not merit that form of retribution.” [FN16] Similarly, with respect to deterrence, the Court stated, “[e]xempting the mentally retarded from [the death penalty] will not affect the ‘cold calculus that precedes the decision’ of other potential murderers.” [FN17]

The Court made analogous observations in *Simmons*. With respect to culpability, the Court stated:

Whether viewed as an attempt to express the community's moral outrage or as an attempt to right the balance for the wrong to the victim, the case for retribution is not as strong with a minor as with an adult. Retribution is not proportional if the law's most severe penalty is imposed on one whose culpability or blameworthiness is diminished, to a substantial degree, by reason of youth and immaturity. [FN18]

On the deterrence issue it said, “[t]he likelihood that the teenage offender has made the kind of cost-benefit analysis that attaches any weight to the possibility of execution is so remote as to be virtually nonexistent.” [FN19]

The same reasoning applies to people who, in the words of the Recommendation, have a “severe mental disorder or disability” that, at the time of the offense: “significantly impaired their capacity” (1) “to appreciate the nature, consequences, or wrongfulness of their conduct”; (2) “to exercise rational judgment in relation to the conduct”; or (3) “to conform their conduct to the requirements of law.” Offenders who meet these requirements, even if found sane at trial, are not as culpable or deterrable as the average offender. A close examination of this part of the Recommendation makes clear why this is so.

*The Severe Mental Disorder or Disability Requirement.* First, the predicate for exclusion from capital punishment under this part of the Recommendation is that offenders have a “severe” disorder or disability, which is meant to signify a disorder that is roughly equivalent to disorders that mental health professionals would consider the most serious “Axis I diagnoses.” [FN20] These disorders include schizophrenia and other psychotic disorders, mania, major depressive disorder, and dissociative disorders—with schizophrenia being by far the most common disorder seen in capital defendants. In their acute state, all of these disorders are typically associated with delusions (fixed, clearly false beliefs), hallucinations (clearly erroneous perceptions of reality), extremely disorganized thinking, or very significant disruption of consciousness, memory and perception of the environment. [FN21] \*671 Some conditions that are not considered an Axis I condition might also, on rare occasions, become “severe” as that word is used in this Recommendation. For instance, some persons whose predominant diagnosis is a personality disorder, which is an Axis II disorder, may at times experience more significant dysfunction. Thus, people with borderline personality disorder can experience “psychotic-like symptoms ... during times of stress.” [FN22] However, only if these more serious symptoms occur at the time of the capital offense would the predicate for this Recommendation's exemption be present.

*The Significant Impairment Requirement.* To ensure that the exemption only applies to offenders less culpable and less deterrable than the average murderer, this part of the Recommendation further requires that the disorder significantly impair cognitive or volitional functioning at the time of the offense. *Atkins* held the death penalty excessive for every person with mental retardation, and the Supreme Court therefore dispensed with a case-by-case assessment of responsibility. However, for the disorders covered by this second part of the Recommendation, preclusion of a death sentence based on diagnosis alone would not be sensible, because the symptoms of these disorders are much more variable than those associated with retardation or the other disabilities covered by the Recommendation's first paragraph.

The first specific type of impairment that this part of the Recommendation recognizes as a basis for exemption from the death penalty (if there was a severe disorder at the time of the offense) is a significant incapacity “to appreciate the nature, consequences, or wrongfulness” of the conduct associated with the offense (section (a)). This provision is meant to encompass those individuals with severe disorder who have serious difficulty appreciating the wrongfulness of their criminal conduct. For instance, people who, because of psychosis, erroneously perceived their victims to be threatening them with serious harm would be covered by this language, [FN23] as would delusional offenders who believed that God had ordered them to commit the offense. [FN24]

Section (a) also refers to offenders who fail to appreciate the “nature and consequences” of the crime. This language would clearly apply to offenders who, because of severe disorder or disability, did not intend to engage in the conduct constituting the crime or were unaware they were committing it. [FN25] It would also apply to delusional

offenders who intended to commit the crime and knew that the conduct was wrongful, but experienced confusion and self-referential thinking that prevented them from recognizing its full ramifications. For example, a person who experiences delusional beliefs that electric power lines are implanting demonic curses, and thus comes to believe that he or she must blow up a city's power station, might understand that destruction of property and taking the law into one's own hands is wrong but might nonetheless fail to appreciate that the act would harm and perhaps kill those who relied on the electricity.

The second type of impairment recognized as a basis for exemption from the death penalty under this part of the Recommendation (in section (b)) is a significant incapacity "to exercise rational judgment in relation to the conduct" at the time of the crime. Numerous commentators have argued that irrationality is the core determinant of diminished responsibility. [FN26] As used by these commentators, and as made clear by the Recommendation's threshold requirement of severe mental disability, "irrational" judgment in this context does not mean "inaccurate," "unusual" or "bad" judgment. Rather, it refers to the type of disoriented, incoherent and delusional thinking that only people with serious mental disability experience. Furthermore, as noted above, the Recommendation requires that the irrationality occur in connection with the offense, rather than simply have existed prior to the criminal conduct.

Under these conditions, offenders who come within section (b) would often also fail to appreciate the "nature, consequences, or wrongfulness" of their conduct. But there is a subset of severely impaired individuals who may not meet the latter test and yet who should still be exempted from the death penalty because they are clearly not as culpable or deterrable as the average murderer. For instance, a jury rejected Andrea Yates' insanity defense despite strong evidence of psychosis at the time she drowned her five children. Apparently, the jury believed that, even though her delusions existed at the time of the offense, she could still appreciate the wrongfulness (and maybe even the fatal consequences) of her acts. Yet that same jury spared Yates the death penalty, probably because it believed her serious mental disorder significantly impaired her ability to exercise rational judgment in relation to the conduct. [FN27]

The third and final type of offense-related impairment recognized as a basis for exemption from the death penalty by this part of the Recommendation is a significant incapacity "to conform [one's] conduct to the requirements of law" (section (c)). Most people who meet this definition will probably also \*672 experience significant cognitive impairment at the time of the crime. However, some may not. For example, people who have a mood disorder with psychotic features might understand the wrongfulness of their acts and their consequences, but nonetheless feel impervious to punishment because of delusion-inspired grandiosity. [FN28] Because a large number of offenders can make plausible claims that they felt compelled to commit their crime, however, enforcement of the Recommendation's requirement that impairment arise from a "severe" disorder is especially important here.

*Exclusions.* In addition to the severe disability threshold and the requirement of significant cognitive or volitional impairment at the time of the offense, a third way this part of the Recommendation assures that those it exempts from the death penalty are less culpable and deterrable than the average murderer is to exclude explicitly from its coverage those offenders whose disorder is "manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs." The Recommendation's reference to mental disorders "manifested primarily by repeated criminal conduct" is meant to deny the death penalty exemption to those offenders whose only diagnosis is Antisocial Personality Disorder. [FN29] This language is virtually identical to language in the Model Penal Code's insanity formulation, which was designed to achieve the same purpose. [FN30] However, the Recommendation uses the word "primarily" where the MPC uses the word "solely" because Antisocial Personality Disorder consists of a number of symptom traits in addition to antisocial behavior, and therefore the MPC language does not achieve its intended effect. Compared to the MPC's provision, then, the Recommendation's language broadens the category of offenders whose responsibility is not considered sufficiently diminished to warrant exemption from capital punishment.

Similarly, the Recommendation denies the death penalty exemption to those offenders who lack appreciation or control of their actions at the time of the offense due "solely to the acute effects of voluntary use of alcohol or other drugs." Substance abuse often plays a role in crime. When voluntary ingestion of psychoactive substances compro-

mises an offender's cognitive or volitional capacities, the law sometimes is willing to reduce the grade of offense at trial, especially in murder cases, [FN31] and evidence of intoxication should certainly be taken into account if it is offered in mitigation in a capital sentencing proceeding. [FN32] However, in light of the wide variability in the effects of alcohol and other drugs on mental and emotional functioning, voluntary intoxication alone does not warrant an automatic exclusion from the death penalty. [FN33] At the same time, this Recommendation is not meant to prevent exemption from the death penalty for those offenders whose substance abuse has caused organic brain disorders or who have other serious disorders that, in combination with the acute effects of substance abuse, significantly impaired appreciation or control at the time of the offense. [FN34]

*How This Recommendation Relates to the Insanity Defense.* The language proposed in this part of the Recommendation is similar to modern formulations of the insanity defense. [FN35] Nonetheless, in light of the narrow reach of the defense in most states (and its abolition in a few), [FN36] many offenders who meet these criteria will still be convicted rather than acquitted by reason of insanity. Even in those states with insanity formulations that are very similar to the Recommendation's language, these individuals might be convicted, for a whole host of reasons; [FN37] in such cases, the Recommendation would require juries and judges to consider whether cognitive and volitional impairment removes the defendant from being among the most morally culpable offenders. This approach rests on the traditional understanding that significant cognitive or volitional impairment attributable to a severe disorder or disability often renders the death penalty disproportionate to the defendant's culpability, even though the \*673 offender may still be held accountable for the crime. [FN38] It also underlies the various formulations of diminished responsibility that predated the contemporary generation of capital sentencing statutes. [FN39]

*How This Recommendation Relates to Mitigating Factors.* This part of the Recommendation sets up, in effect, a conclusive "defense" against the death penalty for capital defendants who can demonstrate the requisite level of impairment due to severe disorder at the time of the offense. However, the criteria in the Recommendation do not exhaust the relevance of mental disorder or disability in capital sentencing. Those offenders whose mental disorder or disability at the time of the offense was not severe or did not cause one of the enumerated impairments would still be entitled to argue that their mental dysfunction is a mitigating factor, to be considered with aggravating factors and other mitigating factors in determining whether capital punishment should be imposed. [FN40]

### PARAGRAPH 3:

This paragraph of the Recommendation is meant to address three different circumstances under which concerns about a prisoner's mental competence and suitability for execution arise after the prisoner has been sentenced to death. Subpart (a) states that execution should be precluded when a prisoner lacks the capacity (i) to make a rational decision regarding whether to pursue post-conviction proceedings, (ii) to assist counsel in post-conviction adjudication, or (iii) to appreciate the meaning or purpose of an impending execution. The succeeding subparts spell out the conditions under which execution should be barred in these three situations.

*Prisoners Seeking to Forgo or Terminate Post-Conviction Proceedings.* The United States Supreme Court has ruled that a competent prisoner is entitled to forgo available appeals. [FN41] If the prisoner is not competent, the standard procedure is to allow a so-called "next friend" (including the attorney) to pursue direct appeal and collateral proceedings aiming to set aside the conviction or sentence. Subpart 3(b) of the Recommendation addresses the definition of competence in such cases, providing that a next friend petition should be allowed when the prisoner has a mental disorder or disability "that significantly impairs his or her capacity to make a rational decision."

Reportedly, 13% of the prisoners executed in the post-*Gregg* era have been so-called "volunteers." [FN42] Any meaningful competence inquiry in this context must focus not only on the prisoner's understanding of the consequences of the decision, but also on his or her *reasons* for wanting to surrender, and on the rationality of the prisoner's thinking and reasoning. In *Rees v. Peyton*, [FN43] the U.S. Supreme Court instructed the lower court to determine whether the prisoner had the "capacity to appreciate his position and make a rational choice with respect to continuing or abandoning further litigation or on the other hand whether the prisoner is suffering from a mental disease, disorder

or defect which may substantially affect his capacity in the premises.” [FN44] Unfortunately, the two alternative findings mentioned by the Court are not mutually exclusive — a person with a mental disorder that “affects” his or her decision-making may nonetheless be able to appreciate his or her position and make a “rational” choice. For this reason, the lower courts have integrated the *Rees* formula into a three-step test: (1) does the prisoner have a mental disorder? (2) if so, does this condition prevent the prisoner from understanding his or her legal position and the options available to the prisoner? (3) even if understanding is unimpaired, does the condition nonetheless prevent the prisoner from making a rational choice among the options? [FN45]

Because the courts have adopted a fairly broad conception of mental disorder (the first step) and the prisoner's understanding of his or her “legal position” (the second step) is hardly ever in doubt in these cases, virtually all the work under the *Rees* test is done by the third step. [FN46] Conceptually, the question is relatively straightforward—is the prisoner's decision attributable to the mental disorder or to “rational choice”?

Unequivocal cases of irrationality rarely arise. For example, if an offender suffering from schizophrenia tells his or her attorney to forgo appeals because the future of civilization depends upon the offender's death, [FN47] the “reason” for the prisoner's choice can comfortably be attributed to the psychotic symptom. However, decisions rooted in delusions are atypical in these cases. The usual case involves articulated reasons that may seem “rational” under the circumstances, such as (a) a desire to take responsibility for one's actions and a belief that one deserves the death penalty or (b) a preference for the death penalty over life imprisonment. The \*674 cases that give the courts the most trouble are those in which such apparently “rational” reasons are intertwined with emotional distress (especially depression), feelings of guilt and remorse, and hopelessness. In many cases, choices that may otherwise seem “rational” may be rooted in suicidal motivations. Assuming, for example, that the prisoner is depressed and suicidal but has a genuine desire to take responsibility, how is one to say which motivation “predominates”?

John Blume has studied the prevalence of significant mental disorder among the 106 prisoners who have volunteered for execution. According to Blume, 14 of the “volunteers” had recorded diagnoses of schizophrenia, 23 had recorded diagnoses of depression or bipolar disorder, 10 had records of PTSD, 4 had diagnoses of borderline personality disorder and 2 had been diagnosed with multiple personality disorder. Another 12 had unspecified histories of “mental illness.” [FN48] Given this high prevalence of mental illness, the courts should be more willing than they now are to acknowledge suicidal motivations when they are evident and should be more inclined than they are now to attribute suicidal motivations to mental illness when the clinical evidence of such a link is convincing. The third step of the *Rees* test would then amount to the following: Is the prisoner who seeks execution able to give plausible reasons for doing so that are clearly *not* grounded in symptoms of mental disorder? [FN49] Given the stakes of the decision, a relatively high degree of rationality ought to be required in order to find people competent to make decisions to abandon proceedings concerning the validity of a death sentence. [FN50]

*Prisoners Unable to Assist Counsel in Post-Conviction Proceedings.* Subpart 3(c) of the Recommendation addresses the circumstances under which impaired competence to participate in adjudication should affect the initiation or continuation of post-conviction proceedings. The law in this area is both undeveloped and uncertain in many respects. However, some principles have begun to emerge.

Under the laws of many states and the federal Anti-Terrorism and Effective Death Penalty Act (AEDPA), collateral proceedings are barred if they are not initiated within a specified period of time. However, it is undisputed that a prisoner's failure to file within the specified time must be excused if such failure was attributable to a mental disability that impaired the prisoner's ability to recognize the basis for, or to take advantage of, possible collateral remedies. Similarly, the prisoner should be able to lodge new claims, or re-litigate previously raised claims, if the newly available evidence upon which the claim would have been based, or that would have been presented during the earlier proceeding relating to the claim, was unavailable to counsel due to the prisoner's mental disorder or disability. [FN51]

Assuming, however, that collateral proceedings have been initiated in a timely fashion, the more difficult question is whether, and under what circumstances, a prisoner's mental disability should require suspension of the proceedings.

Subpart 3(c) provides that courts should suspend post-conviction proceedings upon proof that a prisoner is incompetent to assist counsel in such proceedings and that the prisoner's participation is necessary for fair resolution of a specific claim.

Thorough post-conviction review of the legality of death sentences has become an integral component of modern death penalty law, analogous in some respects to direct review. Any impediment to thorough collateral review undermines the integrity of the review process and therefore of the death sentence itself. Many issues raised in collateral proceedings can be adjudicated without the prisoner's participation, and these matters should be litigated according to customary practice. However, collateral proceedings should be suspended if the prisoner's counsel makes a substantial and particularized showing that the prisoner's impairment would prevent a fair and accurate resolution of specific claims, [FN52] and subpart 3(c) so provides.

Where the prisoner's incapacity to assist counsel warrants suspension of the collateral proceedings, it should bar execution as well, just as ABA Standards recommend. ABA Standard 7-5.6 provides that prisoners should not be executed if they cannot understand the nature of the pending proceedings or if they “[lack] sufficient capacity to recognize or understand any fact which might exist which would make the punishment unjust or unlawful, or [lack] the ability to convey such information to counsel or to the court.” [FN53] As the commentary to Standard 7-5.6 indicates, this rule “rests less on sympathy for the sentenced convict than on concern \*675 for the integrity of the criminal justice system.” [FN54] Scores of people on death row have been exonerated based on claims of factual innocence, and many more offenders have been removed from death row and given sentences less than death because of subsequent discovery of mitigating evidence. The possibility, however slim, that incompetent individuals may not be able to assist counsel in reconstructing a viable factual or legal claim requires that executions be barred under these circumstances.

Once the post-conviction proceedings have been suspended on grounds of the prisoner's incompetence to assist counsel, should the death sentence remain under an indefinite stay? The situation is analogous to the suspension of criminal proceedings before trial; in that context, the proceedings are typically terminated (and charges are dismissed) after a specified period if a court has found that competence for adjudication is not likely to be restored in the foreseeable future. In the present context, it would be unfair to hold the death sentence in perpetual suspension. A judicial finding that the prisoner's competence to assist counsel is not likely to be restored in the foreseeable future should trigger an automatic reduction of the sentence to the disposition the relevant law imposes on capital offenders when execution is not an option.

*Prisoners Unable to Understand the Punishment or its Purpose.* In *Ford v. Wainwright* (1986), [FN55] the U.S. Supreme Court held that execution of an incompetent prisoner constitutes cruel and unusual punishment proscribed by the Eighth Amendment. Unfortunately, the Court failed to specify a constitutional definition of incompetence or to prescribe the constitutionally required procedures for adjudicating the issue. [FN56] The Court also failed to set forth a definitive rationale for its holding that might have helped resolve these open questions. Rather it listed, without indicating their relative importance, a number of possible reasons for the competence requirement. These rationales included the need to ensure that the offenders could provide counsel with information that might lead to vacation of sentence; the view that, in the words of Lord Coke, execution of “mad” people is a “miserable spectacle ... of extreme inhumanity and cruelty [that] can be no example to others”; and the notion that retribution cannot be exacted from people who do not understand why they are being executed. [FN57] Apparently based on the latter rationale, Justice Powell, in his concurring opinion in *Ford*, stated: “I would hold that the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it.” [FN58] Justice Powell pointed out that states are free to preclude execution on other grounds (particularly inability to assist counsel), but most courts and commentators have assumed that the Eighth Amendment requirement is limited to the test stated by Justice Powell. Most commentators have also agreed with Justice Powell's view that the *Ford* competence requirement is grounded in the retributive purpose of punishment. [FN59]

There has been some confusion about the meaning of the idea that the prisoner must be able to understand (or be aware of) the nature and purpose for (reasons for) the execution. In *Barnard v. Collins*, [FN60] decided by the Fifth

Circuit in 1994, the state habeas court had found that Barnard's "perception of the reason for his conviction and impending execution is at times distorted by a delusional system in which he attributes anything negative that happens to him to a conspiracy of Asians, Jews, Blacks, homosexuals and the Mafia." [FN61] Despite the fact that Barnard's understanding of the reason for his execution was impaired by delusions, the Fifth Circuit concluded that his awareness that "his pending execution was because he had been found guilty of the crime" was sufficient to support the state habeas court's legal conclusion that he was competent to be executed. [FN62]

In order to emphasize the need for a deeper understanding of the state's justifying purpose for the execution, subpart 3(d) of the Recommendation would require that an offender not only must be "aware" of the nature and purpose of punishment but also must "appreciate" its personal application in the offender's own case — that is, why it is being imposed *on the offender*. This formulation is analogous to the distinction often drawn between a "factual understanding" and a "rational understanding" of the reason for the execution. [FN63] If, as is generally assumed, the primary purpose of the competence-to-be-executed requirement is to vindicate the retributive aim of punishment, then offenders should have more than a shallow understanding of why they are being executed. \*676 Similarly, the offender should also have a meaningful understanding of what it means to be dead—in the sense that life is terminated and that the prisoner will not be "waking up" or otherwise continuing his existence. Deficient understanding of what it means to be dead can be associated with mental retardation and with delusional beliefs symptomatic of severe mental illness. These profound deficiencies in understanding associated with mental disability should not be trivialized or ignored by analogizing them to widely shared uncertainty among normal persons about the existence of some form of spiritual "life" after death or about the possibility of resurrection.

The underlying point here is that the retributive purpose of capital punishment is not served by executing an offender who lacks a meaningful understanding that the state is taking his life in order to hold him accountable for taking the life of one or more people. Holding a person accountable is intended to be an affirmation of personal responsibility. Executing someone who lacks a meaningful understanding of the nature of this awesome punishment and its retributive purpose offends the concept of personal responsibility rather than affirming it.

Whether a person found incompetent to be executed should be treated to restore competence implicates not only the prisoner's constitutional right to refuse treatment but also the ethical integrity of the mental health professions. [FN64] Some courts have decided that the government may forcibly medicate incompetent individuals if necessary to render them competent to be executed, on the ground that once an individual is fairly convicted and sentenced to death, the state's interest in carrying out the sentence outweighs any individual interest in avoiding medication. [FN65] However, treating a condemned prisoner, especially over his or her objection, for the purpose of enabling the state to execute the prisoner strikes many observers as barbaric and also violates fundamental ethical norms of the mental health professions.

Mental health professionals are nearly unanimous in the view that treatment with the purpose or likely effect of enabling the state to carry out an execution of a person who has been found incompetent for execution is unethical, whether or not the prisoner objects, except in two highly restricted circumstances (an advance directive by the prisoner while competent requesting such treatment or a compelling need to alleviate extreme suffering). [FN66] Because treatment is unethical, it is not "medically appropriate" and is therefore constitutionally impermissible when a prisoner objects under the criteria enunciated by the Supreme Court in *Sell v. United States* [FN67] and *Washington v. Harper*. [FN68] As the Louisiana Supreme Court observed in *Perry v. Louisiana*, [FN69] medical treatment to restore execution competence "is antithetical to the basic principles of the healing arts," fails to "measurably contribute to the social goals of capital punishment," and "is apt to be administered erroneously, arbitrarily or capriciously." [FN70]

There is only one sensible policy here: a death sentence should be automatically commuted to a lesser punishment (the precise nature of which will be governed by the jurisdiction's death penalty jurisprudence) after a prisoner has been found incompetent for execution. [FN71] Maryland has so prescribed, [FN72] and subpart 3(d) of the Recommendation embraces this view. Once an offender is found incompetent to be executed, execution should no longer be a permissible punishment.

The current judicial practice is to entertain *Ford* claims only when execution is genuinely imminent. Should courts be willing to adjudicate these claims at an earlier time? Assuming that a judicial finding of incompetence—whenever rendered—would permanently bar execution (as proposed above), subpart 3(d) provides that *Ford* adjudications should be available only when legal challenges to the validity of the conviction and sentence have been exhausted, and execution has been scheduled. [FN73]

*Procedures:* While this paragraph contemplates that hearings will have to be held to determine competency to proceed and competency to be executed, it does not make any recommendations with respect to procedures. Federal constitutional principles and state law will govern whether the necessary decisions must be made by a judge or a jury, what burdens and standards of proof apply, and the scope of other rights to be accorded offenders. \*677 Additionally, in any proceedings necessary to make these determinations, the victim's next-of-kin should be accorded rights recognized by law, which may include the right to be present during the proceedings, the right to be heard, and the right to confer with the government's attorney. Victim's next-of-kin should be treated with fairness and respect throughout the process.

Respectfully Submitted,

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[FN2]. See Am. Psychiatric Ass'n, *Diminished Responsibility in Capital Sentencing; Death Sentences for Persons with*

Dementia or Traumatic Brain Injury; Mentally III Prisoners on Death Row: *available at [http://www.psych.org/edu/other\\_res/lib\\_archives/archives/200406.pdf,200508.pdf,200505.pdf](http://www.psych.org/edu/other_res/lib_archives/archives/200406.pdf,200508.pdf,200505.pdf)*.

[FN3]. *See* American Psychological Association, Excerpt from the Council of Representatives 2005 Meeting Minutes (Feb. 18-20, 2005); Excerpt from the Council of Representatives 2006 Meeting Minutes (Feb. 17-19, 2006).

[FN4]. The recommendation being presented to the House of Delegates is identical to the wording approved by these other groups, except that minor changes have been made to paragraph 3(c) and 3(d) to remove any potential doubt that, where either provision applies, the sentence would be the one that would be applicable in a capital case in situations in which the death penalty is not a sentencing option.

[FN5]. 536 U.S. 304 (2002).

[FN6]. *Id.* at 313-17.

[FN7]. *Id.* at 318-20.

[FN8]. MANUAL OF THE AMERICAN ASSOCIATION OF MENTAL RETARDATION 13 (10th ed., 2002).

[FN9]. *See* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL 49 (text rev. 4th ed. 2000) (hereafter DSM-IV-TR).

[FN10]. 536 U.S. at 308 n.3. DEATH PENALTY INFO. CTR., STATE STATUTES PROHIBITING THE DEATH PENALTY FOR PEOPLE WITH MENTAL RETARDATION, at <http://www.deathpenaltyinfo.org/article.php?scid> (describing state laws).

[FN11]. DSM-IV-TR, *supra* note 9, at 43 (stating that people with “mild” mental retardation develop academic skills up to the sixth-grade level, amounting to the maturity of a twelve year old). For more on the definition of retardation, *see* James W. Ellis, *Mental Retardation and the Death Penalty: A Guide to State Legislative Issues*, 27 MEN. & PHYS. DIS. L. REP. 11-24 (2003); Richard J. Bonnie, *The APA's Resource Document on Mental Retardation and Capital Sentencing: Implementing Atkins v. Virginia*, 32 J. AM. ACAD. PSYCHIATRY & L. 304, 308 (2004).

[FN12]. DSM-IV-TR, *supra* note 9, at 135 (describing symptoms of dementia).

[FN13]. *Compare id.* at 135 (describing symptoms of dementia) *with id.* at 46 (symptoms of mental retardation).

[FN14]. 125 S. Ct. 1183 (2005).

[FN15]. 536 U.S. at 318.

[FN16]. *Id.* at 319.

[FN17]. *Id.*

[FN18]. 125 S. Ct. at 1196.

[FN19]. *Id.* (quoting *Thompson v. Oklahoma*, 487 U.S. 815, 837 (1988)).

[FN20]. See DSM-IV-TR, *supra* note 9, at 25-26 (distinguishing Axis I diagnoses from Axis II diagnoses).

[FN21]. See *id.* at 275-76 (schizophrenia); 301 (delusional disorders); 332-33 (mood disorder with psychotic features); 125 (delirium); 477 (dissociative disorders).

[FN22]. See *id.* at 652. Other Axis II diagnoses that might produce psychotic-like symptoms include Autistic Disorder, *id.* at 75, and Asperger's Disorder, *id.* at 84.

[FN23]. This is a fairly common perception of people with schizophrenia who commit violent acts. See Dale E. McNiel, *The Relationship Between Aggressive Attributional Style and Violence by Psychiatric Patients*, 71 J. CONSULTING & CLINICAL PSYCHOLOGY 404, 405 (2003).

[FN24]. Cf. *People v. Schmidt*, 216 N.Y. 324, 110 N.E. 945 (1915) (stating that if a person has “an insane delusion that God has appeared to [him] and ordained the commission of a crime, we think it cannot be said of the offender that he knows the act to be wrong”).

[FN25]. These offenders would not have the *mens rea* for murder, and perhaps not even meet the voluntary act requirement for crime. See WAYNE LAFAVE, CRIMINAL LAW 405 (3d ed. 2000) (describing the voluntary act requirement under the common law).

[FN26]. See, e.g., HERBERT FINGARETTE & ANN FINGARETTE HASSE, MENTAL DISABILITIES AND CRIMINAL RESPONSIBILITY 218 (1979); MICHAEL MOORE, LAW AND PSYCHIATRY: RETHINKING THE RELATIONSHIP 244-45 (1985); Stephen J. Morse, *Immaturity and Irresponsibility*, 88 J. CRIM. L. & CRIMINOLOGY 15, 24 (1997); ROBERT F. SCHOPP, AUTOMATISM, INSANITY AND THE PSYCHOLOGY OF CRIMINAL RESPONSIBILITY: A PHILOSOPHICAL INQUIRY 215 (1991).

[FN27]. For a description of the *Yates* case, see Deborah W. Denno, *Who is Andrea Yates? A Short Story About Insanity*, 10 DUKE J. GENDER L. & POL'Y 37 (2003).

[FN28]. DSM-IV-TR, *supra* note 9, at 332-33.

[FN29]. *Id.* at 650 *et seq.* (defining as a symptom of antisocial personality disorder “failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest”).

[FN30]. See AMERICAN LAW INSTITUTE, MODEL PENAL CODE §4.01(2) and commentary (draft, 1962) (stating that “‘mental disease or defect’ as used in the insanity formulation does not include abnormality manifested only by repeated or otherwise anti-social conduct”).

[FN31]. See generally LAFAVE, *supra* note 25, at 415-16.

[FN32]. See Jeffrey L. Kirchmeier, *A Tear in the Eye of the Law: Mitigating Factors and the Progression Toward a Disease Model of Criminal Justice*, 83 OREGON L. REV. 631, 679 n.237 (2004) (listing statutes and judicial decisions from over a dozen states that have recognized intoxication as a mitigating circumstance).

[FN33]. In *Montana v. Egelhoff*, 518 U.S. 37 (1996), a plurality of the Supreme Court held that the voluntary intoxication defense is not constitutionally required. *Id.* at 38. At least 13 states now reject the voluntary intoxication defense. See Molly McDonough, *Sobering Up*, 88 A.B.A. J. 28 (2002).

[FN34]. See, e.g., DSM-IV-TR, *supra* note 9, at 170 (describing dementia due to prolonged substance abuse).

[FN35]. The language in 2(a) and 2(c), for instance, is almost identical to the language in the MODEL PENAL CODE's insanity formulation. *See* MODEL PENAL CODE, *supra* note 30, at §4.01(1).

[FN36]. Today, 5 states do not have an insanity defense, another 25 do not recognize volitional impairment as a basis for the defense, and many states define the cognitive prong in terms of an inability to “know” (as opposed to “appreciate”) the wrongfulness of the act or, as is true in federal court, leave out the word “substantial” in the phrase “lack of substantial capacity to appreciate” in the MODEL PENAL CODE formulation. *See* RALPH REISNER ET AL., *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* 534-36 (4th ed. 2004).

[FN37]. *See generally* Michael L. Perlin, “*The Borderline Which Separated You from Me*”: *The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment*, 82 IOWA L. REV. 1375 (1997) (exploring reasons for hostility to the insanity defense).

[FN38]. *See* Ellen Fels Berkman, *Mental Illness as an Aggravating Circumstance in Capital Sentencing*, 89 COLUM. L. REV. 291, 297 (1989) (noting that “nearly two dozen jurisdictions list as a statutory mitigating circumstance the fact that the defendant's capacity to appreciate the criminality of her conduct was substantially impaired, often as a result of mental defect or disease” and that “an equally high number of states includes extreme mental or emotional disturbance as a mitigating factor”).

[FN39]. *See generally* SHELDON GLUECK, *MENTAL DISORDER AND THE CRIMINAL LAW* (1925).

[FN40]. *See, e.g.*, MODEL PENAL CODE, *supra* note 30, at §210.6.

[FN41]. *See, e.g.*, *Gilmore v. Utah*, 429 U.S.1012 (1977).

[FN42]. John Blume, *Killing the Willing: Volunteers, Suicide and Competency*, 103 MICH. L. REV. 939, 959 (2005).

[FN43]. 384 U.S. 312 (1966) (case remanded for competency determination after condemned prisoner directed attorney to withdraw petition for certiorari).

[FN44]. *Id.* at 314.

[FN45]. *See, e.g.*, *Hauser v. Moore*, 223 F.3d 1316, 1322 (11th Cir. 2000); *Rumbaugh v. Procunier*, 753 F.2d 395 (5th Cir. 1985).

[FN46]. Richard J. Bonnie, *Mentally III Prisoners on Death Row: Unsolved Puzzles for Courts and Legislatures*, 54 CATH. UNIV. L. REV. 1169 (2005).

[FN47]. *Cf. Illinois v. Haynes*, 737 N.E.2d 169, 178 (Ill. 2000); *In re Heidnick*, 720 A.2d 1016 (Pa. 1998).

[FN48]. Blume, *supra* note 41, Appendix B, at 989-96. The text refers only to significant mental disorders that could have distorted the prisoner's reasoning process and impaired capacity for “rational choice.” In addition to these cases, Blume reports that 20 of these prisoners had histories of substance abuse unaccompanied by any other mental disorder diagnosis, another 6 had personality disorders (with or without substance abuse) and 4 had sexual impulse disorders.

[FN49]. *See* Bonnie, *supra* note 46, at 1187-88. A more demanding approach would ask whether the prisoner is able to give plausible reasons that reflect authentic values and enduring preferences.

[FN50]. See Richard J. Bonnie, *The Dignity of the Condemned*, 74 VA.L. REV. 1363, 1388-89 (1988); Cf. Richard J. Bonnie, *The Competence of Criminal Defendants: Beyond Dusky and Drope*, 47 UNIV. MIAMI L. REV. 539, 579-80 (1993).

[FN51]. See, e.g., *Council v. Catoe*, 359 S.C. 120, 597 S.E.2d 782, 787 (S.C. 2004); *Commonwealth v. Haag*, 809 A.2d 271, 285 (Pa. 2001).

[FN52]. *Catoe*, 359 S.C. 120, 597 S.E.2d 782, 787 (“[T]he default rule is that PCR [post-conviction review] hearings must proceed even though a petitioner is incompetent. For issues requiring the petitioner's competence to assist his PCR counsel, such as a fact-based challenge to his defense counsel's conduct at trial, the PCR judge may grant a continuance, staying review of these issues until petitioner regains his competence.”); *Carter v. State*, 706 So. 2d 873, 875-77 (Fla. 1997); *State v. Debra*, 523 N.W.2d 727 (Wis. 1994) (non-capital case); *People v. Kelly*, 822 P.2d 385, 413 (Cal. 1992).

[FN53]. *ABA Criminal Justice Mental Health Standards* 290 (1989).

[FN54]. *Id.* at 291.

[FN55]. 477 U.S. 399.

[FN56]. State courts have disagreed about the procedures required to make *Ford* competence determinations. This Recommendation does not deal with such procedural issues. For a treatment of this topic, see *ABA Standard 7.5-7* and *Coe v. Bell*, 209 F.3d 815 (6th Cir. 2000), which should be read in conjunction with the *ABA Guidelines for Appointment and Performance of Defense Counsel in Death Penalty Cases* at <http://www.abanet.org/deathpenalty/publications/2005/2003Guidelines.pdf>.

[FN57]. *Id.* at 406-08.

[FN58]. *Id.* at 422 (Powell, J., concurring).

[FN59]. See Barbara Ward, *Competency for Execution: Problems in Law and Psychiatry*, 14 FLA. ST. UNIV. L. REV. 35, 49-56 (1986); Christopher Slobogin, *Mental Illness and the Death Penalty*, 24 MEN. & PHYS. DIS. L. REP. 667, 675-77 (2000).

[FN60]. 13 F.3d 871 (5th Cir. 1994).

[FN61]. *Id.* at 876.

[FN62]. *Id.*

[FN63]. See *Martin v. Florida*, 515 So. 2d 189, 190 (Fla. 1987).

[FN64]. Kirk S. Heilbrun, Michael L. Radelet & Joel A. Dvoskin, *The Debate on Treating Individuals Incompetent for Execution*, 149 AM. J. PSYCHIATRY 596 (1992); Richard J. Bonnie, *Dilemmas in Administering the Death Penalty: Conscientious Abstention, Professional Ethics and the Needs of the Legal System*, 14 LAW & HUMAN BEHAVIOR 67 (1990).

[FN65]. *Singleton v. Norris*, 319 F.3d 1018 (8th Cir.) (*en banc*), *cert denied*, 124 S. Ct. 74 (2003).

[FN66]. See Council on Ethical and Judicial Affairs, American Medical Association, *Physician Participation in Capital Punishment*, 270 JAMA 365 (1993); AMERICAN PSYCHIATRIC ASSOCIATION & AMERICAN MEDICAL ASSOCIATION, AMICUS BRIEF IN SUPPORT OF PETITIONER IN PERRY V. LOUISIANA, 498 U.S. 38 (1990); Richard J. Bonnie, *Medical Ethics and the Death Penalty*, 20 HASTINGS CENTER REPORT, May/June 1990, at 12, 15-17.

[FN67]. 539 U.S. 166 (2003).

[FN68]. 494 U.S. 210 (1990).

[FN69]. 610 So. 2d 746 (La. 1992).

[FN70]. *Id.* at 751.

[FN71]. A state could try to restore a prisoner's competence without medical treatment, but the prospects of an enduring change in the prisoner's condition are slight.

[FN72]. MD. CODE CORR. SERVS. §3-904(a)(2), (d)(1).

[FN73]. This does not mean that no litigation challenging the validity of the sentence can be simultaneously occurring. For all practical purposes, "exhaustion" means that one full sequence of state post-conviction review and federal habeas review have occurred where, as in most jurisdictions, no execution date set during the initial round of collateral review is a "real" date. Given the many procedural barriers to successive petitions for collateral review, an execution date set after the completion of the initial round may be a "real" date, even if a successive petition has been filed or is being planned. In such a case, the state may contest the prisoner's request for a stay of execution. A *Ford* claim should be considered on its merits in such a case, and it should be considered earlier on in a jurisdiction where a "real" execution date is set during the initial round of collateral review.

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## **10. Criminal Justice and Forensic Issues**

### **10.1 Ultimate Responsibility of Mental Health Systems**

Mental health systems have ultimate responsibility for treating all people with severe mental illness. A substantial number of people with severe mental illness require twenty-four hour, seven day a week structured care, either for long or short periods of time. It is never appropriate to allow the care of such persons to be shifted to the criminal justice system.

### **10.2 Therapeutic Jurisprudence**

NAMI endorses the principal of therapeutic jurisprudence, which emphasizes that the law should be used, whenever possible, to promote the mental and physical well being of the people it affects. For example, in a system characterized by therapeutic jurisprudence, people with serious mental illnesses charged with non-violent crimes are diverted into programs designed to address their treatment and service needs, rather than incarcerated. Individuals with serious mental illnesses convicted of serious crimes are provided with humane and appropriate treatment while incarcerated. And, these individuals are provided with appropriate linkages to needed services and supports upon discharge to enable them to successfully reenter their communities.

### **10.3 Education at all levels of Judicial and Legal Systems**

NAMI believes that education about serious mental illnesses at all levels of judicial and legal systems is crucial to the appropriate disposition of cases involving offenders with serious mental illnesses. Judges, lawyers, police officers, correctional officers, parole and probation officers, law enforcement personnel, court officers, and emergency medical transport and service personnel should be required to complete at least 20 hours of training about these disorders. Consumers and family members should be a part of this educational process.

### **10.4 Collaboration**

NAMI believes that state and local mental health authorities must work closely in conjunction with state and local correctional and law enforcement agencies to develop strategies and programs for compassionate intervention by law enforcement, jail diversion, treatment of individuals with serious mental illnesses who are incarcerated, and discharge planning and community reintegration services for individuals with serious mental illnesses released from correctional facilities.

### **10.5 Boot Camps**

Youth with serious mental illnesses should never be placed in boot camps, "scared straight" or similar programs that use punishment as the primary source of behavior change. There is sufficient evidence that these programs are non-therapeutic and cause harm. In some cases, placement in boot camps has led to the unnecessary and tragic deaths of these youths.

### **10.6 Right to Treatment (Regardless of Criminal Status)**

(10.6.1) Humane and effective treatment for serious mental illnesses while in correctional settings is the constitutional right of inmates with severe mental illnesses. NAMI strongly urges the enactment of state statutes expanding treatment programs within prison and jail settings, including first line access to new generation medications whenever clinically indicated.

(10.6.2) NAMI endorses state laws and policies establishing systems of community treatment for offenders with serious mental illnesses who are released on parole and/or are in the community on probation or parole status.

### **10.7 Jail Diversion**

(10.7.1) NAMI believes that persons who have committed offenses due to states of mind or behavior caused by a serious mental illness do not belong in penal or correctional institutions. Such persons require treatment, not punishment. A prison or jail is never an optimal therapeutic setting.

(10.7.2) NAMI supports a variety of approaches to diverting individuals from unnecessary incarceration into appropriate treatment, including pre-booking (police-based) diversion, post-booking (court-based) diversion, alternative sentencing programs, and post-adjudication diversion (conditional release).

### **10.8 Violence**

(10.8.1) NAMI believes that, in the overwhelming majority of cases, dangerous or violent acts committed by persons with serious mental illnesses are the result of neglect or inappropriate or inadequate treatment of their illness. State and local mental health authorities must develop policies and programs to provide care and appropriate treatment for persons who suffer from serious mental illnesses that produce behaviors assessed and labeled by society as "criminal" or "violent." Where a mental illness and substance abuse co-occur they should be treated with integrated treatment.

### **10.9 Death Penalty**

NAMI opposes the death penalty for persons with serious mental illnesses.

(10.9.1) NAMI urges jurisdictions that impose capital punishment not to execute persons with mental disabilities under the following circumstances:

(10.9.1.1) Defendants shall not be sentenced to death or executed if they have a persistent mental disability, with onset before the offense, characterized by significant limitations in both intellectual functioning and adaptive behavior as expressed in their conceptual, social, and practical adaptive skills.

(10.9.1.2) Defendants shall not be sentenced to death or executed if, at the time of their offense, they had a severe mental disorder or disability that significantly impaired their capacity

(a) to appreciate the nature, consequences or wrongfulness of their conduct, (b) to exercise rational judgment in relation to conduct, or (c) to conform their conduct to the requirements of the law. A disorder manifested primarily by repeated criminal conduct or attributable solely to the acute effects of alcohol or other drugs does not, standing alone, constitute a mental disorder or disability, for

purposes of this provision.

(10.9.1.3) Sentences of death shall be reduced to lesser punishment if prisoners under such sentences are found at any time subsequent to sentencing to have a mental disorder or disability that significantly impairs their ability

(a) to understand and appreciate the nature of the punishment or its purpose, (b) to understand and communicate information relating to the death sentence and any proceedings brought to set it aside, or (c) to make rational choices about such proceedings.

#### 10.10 Insanity Defense

NAMI supports the retention of the "insanity defense" and favors the two-prong ("ALI") [2] test that includes the volitional as well as the cognitive standard.

##### (10.10.1) "Guilty but Mentally Ill"

NAMI opposes "guilty but mentally ill" statutes as presently applied because they are used to punish rather than to treat persons with serious mental illnesses who have committed crimes as a consequence of their serious mental illnesses.

##### (10.10.2) "Guilty except for insanity" and other alternative terminology for the insanity defense

NAMI supports systems that provide comprehensive, long-term care and supervision to individuals who are found "not guilty by reason of insanity", "guilty except for insanity", and any other similar terminology used in state statutes [3].

##### (10.10.3) "Informing Juries about the Consequences of Insanity Verdicts"

NAMI believes that juries in cases where the insanity defense is at issue should be informed about the likely consequences of an insanity verdict to enable them to make a fair decision.

[2] *The "ALI test" refers to the rule for insanity adopted in Section 4.01(1) of the American Law Institute's Model Penal Code. The Code states that "a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (or alternatively, wrongfulness) of his conduct (cognitive standard) or to conform his conduct to the requirements of law (volitional standard)."*

[3] *States currently apply three different terms to verdicts incorporating a formal finding or acknowledgement of mental illness.*

*"Not guilty by reason of insanity" is the traditional term used when a person is determined as not criminally responsible due to mental illness. Individuals found "not guilty by reason of insanity" are typically sentenced to secure psychiatric treatment facilities instead of prison.*

*"Guilty but mentally ill" (GBMI) statutes have been adopted in the criminal codes of a number of states. These statutes currently function very similarly to "guilty" verdicts. An individual found GBMI could be sentenced to life in prison or even to death. Additionally, a verdict of GBMI does not guarantee psychiatric treatment.*

*"Guilty except for insanity" statutes have been adopted in several states such as Oregon and Arizona as substitutes for "not guilty by reason of insanity." These states have developed effective systems for providing long-term treatment and supervision to individuals who are found "guilty except for insanity."*

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## Diminished Responsibility in Capital Sentencing POSITION STATEMENT

Approved by the Board of Trustees, November 2004  
Approved by the Assembly, December 2004

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... position statements that define APA official policy on specific subjects..." -- APA  
*Operations Manual.*

**Defendants shall not be sentenced to death or executed if, at the time of the offense, they had a severe mental disorder or disability that significantly impaired their capacity (a) to appreciate the nature, consequences or wrongfulness of their conduct, (b) to exercise rational judgment in relation to their conduct, or (c) to conform their conduct to the requirements of the law. A disorder manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs does not, standing alone, constitute a mental disorder or disability for purposes of this provision.**

### Commentary

Anglo-American law has long recognized that serious mental disorder diminishes a person's responsibility for criminal conduct and that execution is often a cruel and excessive punishment for offenders who were severely disturbed at the time of the offense. The insanity defense itself originally served primarily to prevent execution of mentally ill offenders, especially when the death penalty was mandatory for murder and other felonies. During the 20th century, even after the death penalty was no longer a mandatory punishment for murder, many states allowed evidence of mental disorder to be used to reduce a first-degree murder charge to second-degree murder, thereby precluding a death sentence.

Under the current generation of capital sentencing statutes upheld by the Supreme Court in 1976, a defendant convicted of a capital crime is entitled to introduce evidence of mental disorder in mitigation at the sentencing phase of the trial, where it is weighed by the jury, together with the prosecution's evidence in aggravation, in deciding whether the death penalty is justified. However, many observers of capital sentencing proceedings, including participating psychiatrists, believe that juries tend to give too little weight to mitigating evidence of severe mental disorder, leading to inappropriate execution of offenders whose responsibility was significantly diminished by mental retardation or mental illness.

The important decision in *Atkins v. Virginia*, 536 U.S. 304 (2002), shows that this concern is shared by the Supreme Court. The Court recognized in *Atkins* that the ordinary practice of capital adjudication does not prevent persons with severely diminished responsibility due to mental retardation from being sentenced to death and thereby being punished in a manner grossly disproportionate to their culpability. The remedy adopted by the Supreme Court in *Atkins* was to preclude death sentences for defendants diagnosed with mental retardation. This categorical remedy was based on the judgment that virtually all defendants with mental retardation lack the morally requisite capacities for capital punishment.

A systematic risk of disproportionate punishment also arises in cases involving defendants with severe mental illness. Even though defendants with mental illness are entitled to introduce mental health evidence in mitigation of sentence, commentators on capital sentencing have often observed that juries tend to devalue undisputed and strong evidence of diminished responsibility in the face of strong evidence in aggravation. See, e.g., Phyllis Crocker, *Concepts of Culpability and Deathworthiness: Differentiating Between Guilt and Punishment in Death Penalty Cases*, 22 *Fordham L. Rev.* 21 ((1997)). Indeed, such evidence is often a double-edged sword, tending to show both impaired capacity as well as future dangerousness. See, e.g., Richard J. Bonnie and C. Robert Showalter, *Psychiatrists and Capital Sentencing: Risks and Responsibilities in a Unique Legal Setting*, 12 *Bulletin of the American Academy of Psychiatry and Law* 159-67 (1984)

As the Supreme Court observed in *Zant v. Stephens*, treating evidence of mental illness as an aggravating factor would violate the due process clause:

[In this case, Georgia did not attach] the "aggravating" label to ... conduct that actually should militate in favor of a lesser penalty, such as perhaps the defendant's mental illness. Cf. *Miller v. Florida*, 373 So.2d 882, 885-886 (Fla.1979). If the aggravating circumstance at issue in this case had been invalid for reasons such as these, due process of law would require that the jury's decision to impose death be set aside. (462 U.S. at 885)

Similarly, one of the problems with the Texas capital sentencing statute that has been before the Court repeatedly is that juries were instructed for three decades to consider the aggravating force of the evidence (in proving future dangerousness) without being told to consider its potentially mitigating weight. (See, e.g., *Penry v. Johnson*, 121 S.Ct 1910 (2001) and *Penry v. Lynaugh*, 492 U.S. 302 (1989)).

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Exhibit E

Strong evidence of diminished responsibility due to mental illness should preclude a death sentence and should not be weighed against evidence in aggravation. The core rationale for precluding death sentences for defendants with mental retardation is equally applicable to defendants with severe mental illness. However, the purely diagnostic exclusion utilized by the Supreme Court in *Atkins* is not a plausible approach for dealing with mental illness. Even among persons with major mental disorders, such as schizophrenia, symptoms vary widely in severity, as does the impact of the disorder on the person's behavior. Thus, a mere diagnosis of a major mental disorder does not identify a narrow class of cases in which a death sentence would virtually always be disproportionate to the offenders' culpability. Instead, the category must be further narrowed to include only those defendants whose severe mental disorders are characterized by significant impairments of responsibility-related capacities.

The task of defining criteria of diminished responsibility must start with the criteria for the insanity defense – the goal is to specify a degree of impairment that significantly reduces responsibility even though it does not foreclose conviction and punishment. The most widely accepted formula for defining diminished responsibility is found in the capital sentencing provisions in the Model Penal Code. Section 210.6 (4) includes among mitigating circumstances the following:

"(g) At the time of the murder, the capacity of the defendant to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law was impaired as a result of mental disease or defect or intoxication."

This provision, which appears in the capital sentencing laws of a great majority of death penalty states, was designed to identify conditions of strong mitigation that should be balanced against aggravating circumstances. Because the task at hand is to identify an exclusionary criterion, the best approach is to tighten and narrow the Model Penal Code's language to require a significant impairment of the relevant responsibility-related capacities (ability to appreciate and conform) resulting from severe mental disorder. Impairments associated with other disorders or with intoxication should not be given preclusive force, although they should continue to be taken into account in determining the suitability of a death sentence.

The Position Statement language supplements the Model Penal Code criteria of impaired capacity with an additional phrase (impaired capacity "to exercise rational judgment in relation to conduct") in order to encompass what many people intuitively regard as the most basic prerequisite for moral agency – a capacity for rationality. This language is also designed to correct for unduly narrow interpretations of what it means to lack "appreciation." Some expert witnesses and courts have said that "appreciation" refers only to cognitive functioning, thereby failing to include affective disturbance that can distort a person's understanding and judgment.

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# Report of the Task Force on Mental Disability and the Death Penalty

## REPORT

### PREAMBLE

In *Atkins v. Virginia*, 536 U.S. 304 (2002), the United States Supreme Court held that execution of people with mental retardation violates the Eighth Amendment's ban on cruel and unusual punishment. The Individual Rights and Responsibilities Section of the American Bar Association recognized that *Atkins* offered a timely opportunity to consider the extent, if any, to which other types of impaired mental conditions ought to lead to exemption from the death penalty. To achieve that objective, the Section established a Task Force on Mental Disability and the Death Penalty. The Task Force, which carried out its deliberations from April, 2003 to March, 2005, was composed of 24 lawyers and mental health professionals (both practitioners and academics), and included members of the American Bar Association, the American Psychological Association, the American Psychiatric Association, the National Association for the Mentally Ill and the National Mental Health Association.<sup>1</sup> The following commentary discusses the three paragraphs of the proposal.

### PARAGRAPH 1:

Paragraph 1 of the Recommendation is meant to exempt from the death penalty persons charged with capital offenses who have significant limitations in both intellectual functioning and adaptive skills. Its primary purpose is to implement the United States Supreme Court's holding in *Atkins v. Virginia*,<sup>2</sup> which declared that execution of offenders with mental retardation violates the cruel and unusual punishment prohibition in the Eighth Amendment. The Court based this decision both on a determination that a "national consensus" had been reached that people with mental retardation should not be executed,<sup>3</sup> and on its own conclusion that people with retardation who kill are not as culpable or deterrable as the "average murderer," much less the type of murderer for whom the death penalty may be viewed as justifiable.<sup>4</sup>

While the *Atkins* Court clearly prohibited execution of people with mental retardation, it did not define that term. The Recommendation embraces the language most recently endorsed by the American Association of Mental Retardation, which defines mental retardation as a disability originating before the age of eighteen that is "characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills."<sup>5</sup> The language of the Recommendation is also consistent with the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, which defines a person as mentally retarded if, before the age of 18, he or she

<sup>1</sup> The Task Force's members are Dr. Michael Abramsky; Dr. Xavier F. Amador; Michael Allen, Esq.; Donna Beavers; Professor John H. Blume; Professor Richard J. Bonnie; Colleen Quinn Brady, Esq.; Richard Burr, Esq.; Dr. Joel A. Dvoskin; Dr. James R. Eisenberg; Professor I. Michael Greenberger; Dr. Kirk S. Heilbrun; Ronald Honberg, Esq.; Ralph Ibson; Dr. Matthew B. Johnson; Professor Dorean M. Koenig; Dr. Diane T. Marsh; Hazel Moran; John Parry, Esq.; Professor Jennifer Radden; Professor Laura Lee Rovner; Robyn S. Shapiro, Esq.; Professor Christopher Slobogin; and Ronald J. Tabak, Esq. Drs. Paul S. Appelbaum, Howard V. Zonana and Jeffrey Metzner also contributed significantly to the Task Force's deliberations and recommendations.

<sup>2</sup> 536 U.S. 304 (2002).

<sup>3</sup> *Id.* at 313-17.

<sup>4</sup> *Id.* at 318-20.

<sup>5</sup> MANUAL OF THE AMERICAN ASSOCIATION OF MENTAL RETARDATION 13 (10th ed., 2002).

exhibits "significantly subaverage intellectual functioning" (defined as "an IQ of approximately 70 or below") and "concurrent deficits or impairments in present adaptive functioning . . . in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety."<sup>6</sup> Both of these definitions were referenced (albeit not explicitly endorsed) by the Supreme Court in *Atkins*, and both have been models for states that have defined retardation for purposes of the death penalty exemption.<sup>7</sup> Both capture the universe of people who, if involved in crime, *Atkins* describes as less culpable and less deterrable than the "average murderer." As the APA's Diagnostic and Statistical Manual indicates, even a person with only "mild" mental retardation, as that term is defined in the Manual, has a mental age below that of a teenager.<sup>8</sup>

The language in this part of the Recommendation is also meant to encompass dementia and traumatic brain injury, disabilities very similar to mental retardation in their impact on intellectual and adaptive functioning except that they always (in the case of dementia) or often (in the case of head injury) are manifested after age eighteen. Dementia resulting from the aging process is generally progressive and irreversible, and is associated with a number of deficits in intellectual and adaptive functioning, such as agnosia (failure to recognize or identify objects) and disturbances in executive functioning connected with planning, organizing, sequencing, and abstracting.<sup>9</sup> The same symptoms can be experienced by people with serious brain injury. Of course, people with dementia or a traumatic head injury severe enough to result in "significant limitations in both intellectual functioning or adaptive behavior" rarely commit capital offenses. If they do, however, the reasoning in *Atkins* should apply and an exemption from the death penalty is warranted, because the only significant characteristic that differentiates these severe disabilities from mental retardation is the age of onset.<sup>10</sup>

## PARAGRAPH 2:

Paragraph 2 of the Recommendation is meant to prohibit execution of persons with severe mental disabilities whose demonstrated impairments of mental and emotional functioning at the time of the offense would render a death sentence disproportionate to their culpability. The Recommendation uses the phrase "disorder or disability" because, even though those words are often used interchangeably, some prefer one over the other. The Recommendation indicates that only those individuals with "severe" disorders or disabilities are to be exempted from the death penalty, and it specifically excludes from the exemption those diagnosed with conditions that are primarily manifested by criminal behavior and those whose abuse of psychoactive substances, standing alone, renders them impaired at the time of the offense.

<sup>6</sup> See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL 49 (text rev. 4<sup>th</sup> ed. 2000) (hereafter DSM-IV-TR).

<sup>7</sup> 536 U.S. at 308 n.3. DEATH PENALTY INFO. CTR., STATE STATUTES PROHIBITING THE DEATH PENALTY FOR PEOPLE WITH MENTAL RETARDATION, [www.deathpenaltyinfo.org/article.php?scid](http://www.deathpenaltyinfo.org/article.php?scid) (describing state laws).

<sup>8</sup> DSM-IV-TR, *supra* note 9, at 43 (stating that people with "mild" mental retardation develop academic skills up to the sixth-grade level, amounting to the maturity of a twelve year-old). For more on the definition of retardation, see James W. Ellis, *Mental Retardation and the Death Penalty: A Guide to State Legislative Issues*, 27 MEN. & PHYS. DIS. L. REP. 11-24 (2003); Richard J. Bonnie, *The APA's Resource Document on Mental Retardation and Capital Sentencing: Implementing Atkins v. Virginia*, 32 J. AM. ACAD. PSYCHIAT. & L. 304, 308 (2004).

<sup>9</sup> DSM-IV-TR, *supra* note 9, at 135 (describing symptoms of dementia).

<sup>10</sup> Compare *id.*, at 135 (describing symptoms of dementia) with *id.* at 46 (symptoms of mental retardation).

*Rationale:* This part of the Recommendation is based on long-established principles of Anglo-American law that the Supreme Court recognized and embraced in *Atkins* and recently affirmed in *Roper v. Simmons*,<sup>11</sup> in which it held that the execution of juveniles who commit crimes while under the age of eighteen is prohibited by the Eighth Amendment. In reaching its holding in *Atkins*, the Court emphasized that execution of people with mental retardation is inconsistent with both the retributive and deterrent functions of the death penalty. More specifically, as noted above, it held that people with mental retardation who kill are both less culpable and less deterrable than the average murderer, because of their "diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others."<sup>12</sup> As the Court noted, "[i]f the culpability of the average murderer is insufficient to justify the most extreme sanction available to the State, the lesser culpability of the mentally retarded offender surely does not merit that form of retribution."<sup>13</sup> Similarly, with respect to deterrence, the Court stated, "[e]xempting the mentally retarded from [the death penalty] will not affect the 'cold calculus that precedes the decision' of other potential murderers."<sup>14</sup>

The Court made analogous observations in *Simmons*. With respect to culpability, the Court stated:

Whether viewed as an attempt to express the community's moral outrage or as an attempt to right the balance for the wrong to the victim, the case for retribution is not as strong with a minor as with an adult. Retribution is not proportional if the law's most severe penalty is imposed on one whose culpability or blameworthiness is diminished, to a substantial degree, by reason of youth and immaturity.<sup>15</sup>

On the deterrence issue it said, "[t]he likelihood that the teenage offender has made the kind of cost-benefit analysis that attaches any weight to the possibility of execution is so remote as to be virtually nonexistent."<sup>16</sup>

The same reasoning applies to people who, in the words of the Recommendation, have a "severe mental disorder or disability" that, at the time of the offense: "significantly impaired their capacity" (1) "to appreciate the nature, consequences, or wrongfulness of their conduct"; (2) "to exercise rational judgment in relation to the conduct"; or (3) "to conform their conduct to the requirements of law." Offenders who meet these requirements, even if found sane at trial, are not as culpable or deterrable as the average offender. A close examination of this part of the Recommendation makes clear why this is so.

*The Severe Mental Disorder or Disability Requirement.* First, the predicate for exclusion from capital punishment under this part of the Recommendation is that offenders have a "severe" disorder or disability, which is meant to signify a disorder that is roughly equivalent to disorders that mental health professionals would consider the most serious "Axis I diagnoses."<sup>17</sup> These disorders include schizophrenia and other psychotic disorders, mania, major depressive disorder,

<sup>11</sup> 125 S.Ct. 1183 (2005).

<sup>12</sup> 536 U.S. at 318.

<sup>13</sup> *Id.* at 319.

<sup>14</sup> *Id.*

<sup>15</sup> 125 S.Ct. at 1196.

<sup>16</sup> *Id.* (quoting *Thompson v. Oklahoma*, 487 U.S. 815, 837 (1988)).

<sup>17</sup> See DSM-IV-TR, *supra* note 9, at 25-26 (distinguishing Axis I diagnoses from Axis II diagnoses).

and dissociative disorders – with schizophrenia being by far the most common disorder seen in capital defendants. In their acute state, all of these disorders are typically associated with delusions (fixed, clearly false beliefs), hallucinations (clearly erroneous perceptions of reality), extremely disorganized thinking, or very significant disruption of consciousness, memory and perception of the environment.<sup>18</sup> Some conditions that are not considered an Axis I condition might also, on rare occasions, become "severe" as that word is used in this Recommendation. For instance, some persons whose predominant diagnosis is a personality disorder, which is an Axis II disorder, may at times experience more significant dysfunction. Thus, people with borderline personality disorder can experience "psychotic-like symptoms ... during times of stress."<sup>19</sup> However, only if these more serious symptoms occur at the time of the capital offense would the predicate for this Recommendation's exemption be present.

*The Significant Impairment Requirement.* To ensure that the exemption only applies to offenders less culpable and less deterrable than the average murderer, this part of the Recommendation further requires that the disorder significantly impair cognitive or volitional functioning at the time of the offense. *Atkins* held the death penalty excessive for every person with mental retardation, and the Supreme Court therefore dispensed with a case-by-case assessment of responsibility. However, for the disorders covered by this second part of the Recommendation, preclusion of a death sentence based on diagnosis alone would not be sensible, because the symptoms of these disorders are much more variable than those associated with retardation or the other disabilities covered by the Recommendation's first paragraph.

The first specific type of impairment that this part of the Recommendation recognizes as a basis for exemption from the death penalty (if there was a severe disorder at the time of the offense) is a significant incapacity "to appreciate the nature, consequences, or wrongfulness" of the conduct associated with the offense (section (a)). This provision is meant to encompass those individuals with severe disorder who have serious difficulty appreciating the wrongfulness of their criminal conduct. For instance, people who, because of psychosis, erroneously perceived their victims to be threatening them with serious harm would be covered by this language,<sup>20</sup> as would delusional offenders who believed that God had ordered them to commit the offense.<sup>21</sup>

Section (a) also refers to offenders who fail to appreciate the "nature and consequences" of the crime. This language would clearly apply to offenders who, because of severe disorder or disability, did not intend to engage in the conduct constituting the crime or were unaware they were committing it.<sup>22</sup> It would also apply to delusional offenders who intended to commit the crime and knew that the conduct was wrongful, but experienced confusion and self-referential thinking that prevented them from recognizing its full ramifications. For example, a person who experiences delusional beliefs that electric power lines are implanting demonic curses, and thus comes to believe that he or she must blow up a city's power station, might understand that

<sup>18</sup> See *id.*, at 275-76 (schizophrenia); 301 (delusional disorders); 332-33 (mood disorder with psychotic features); 125 (delirium); 477 (dissociative disorders).

<sup>19</sup> See *id.*, at 652. Other Axis II diagnoses that might produce psychotic-like symptoms include Autistic Disorder, *id.* at 75, and Asperger's Disorder. *Id.* at 84.

<sup>20</sup> This is a fairly common perception of people with schizophrenia who commit violent acts. See Dale E. McNeil, *The Relationship Between Aggressive Attributional Style and Violence by Psychiatric Patients*, 71 J. CONSULTING & CLINICAL PSYCHOLOGY 404, 405 (2003).

<sup>21</sup> Cf. *People v. Schmidt*, 216 N.Y. 324, 110 N.E. 945 (1915) (stating that if a person has "an insane delusion that God has appeared to [him] and ordained the commission of a crime, we think it cannot be said of the offender that he knows the act to be wrong").

<sup>22</sup> These offenders would not have the *mens rea* for murder, and perhaps not even meet the voluntary act requirement for crime. See Wayne LaFare, *Criminal Law* 405 (3d ed. 2000) (describing the voluntary act requirement under the common law).

destruction of property and taking the law into one's own hands is wrong but might nonetheless fail to appreciate that the act would harm and perhaps kill those who relied on the electricity.

The second type of impairment recognized as a basis for exemption from the death penalty under this part of the Recommendation (in section (b)) is a significant incapacity "to exercise rational judgment in relation to the conduct" at the time of the crime. Numerous commentators have argued that irrationality is the core determinant of diminished responsibility.<sup>23</sup> As used by these commentators, and as made clear by the Recommendation's threshold requirement of severe mental disability, "irrational" judgment in this context does not mean "inaccurate," "unusual" or "bad" judgment. Rather, it refers to the type of disoriented, incoherent and delusional thinking that only people with serious mental disability experience. Furthermore, as noted above, the Recommendation requires that the irrationality occur in connection with the offense, rather than simply have existed prior to the criminal conduct.

Under these conditions, offenders who come within section (b) would often also fail to appreciate the "nature, consequences, or wrongfulness" of their conduct. But there is a subset of severely impaired individuals who may not meet the latter test and yet who should still be exempted from the death penalty because they are clearly not as culpable or deterrable as the average murderer. For instance, a jury rejected Andrea Yates' insanity defense despite strong evidence of psychosis at the time she drowned her five children. Apparently, the jury believed that, even though her delusions existed at the time of the offense, she could still appreciate the wrongfulness (and maybe even the fatal consequences) of her acts. Yet that same jury spared Yates the death penalty, probably because it believed her serious mental disorder significantly impaired her ability to exercise rational judgment in relation to the conduct.<sup>24</sup>

The third and final type of offense-related impairment recognized as a basis for exemption from the death penalty by this part of the Recommendation is a significant incapacity "to conform [one's] conduct to the requirements of law" (section (c)). Most people who meet this definition will probably also experience significant cognitive impairment at the time of the crime. However, some may not. For example, people who have a mood disorder with psychotic features might understand the wrongfulness of their acts and their consequences, but nonetheless feel impervious to punishment because of delusion-inspired grandiosity.<sup>25</sup> Because a large number of offenders can make plausible claims that they felt compelled to commit their crime, however, enforcement of the Recommendation's requirement that impairment arise from a "severe" disorder is especially important here.

*Exclusions.* In addition to the severe disability threshold and the requirement of significant cognitive or volitional impairment at the time of the offense, a third way this part of the Recommendation assures that those it exempts from the death penalty are less culpable and deterrable than the average murderer is to exclude explicitly from its coverage those offenders whose disorder is "manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs." The Recommendation's reference to mental disorders "manifested primarily by repeated criminal conduct" is meant to deny the death

<sup>23</sup> See, e.g., HERBERT FINGARETTE & ANN FINGARETTE HASSE, MENTAL DISABILITIES AND CRIMINAL RESPONSIBILITY 218 (1979); MICHAEL MOORE, LAW AND PSYCHIATRY: RETHINKING THE RELATIONSHIP 244-245 (1985); Stephen J. Morse, *Immaturity and Irresponsibility*, 88 J. Crim. L. & Criminology 15, 24 (1997); ROBERT F. SCHOPP, AUTOMATISM, INSANITY AND THE PSYCHOLOGY OF CRIMINAL RESPONSIBILITY: A PHILOSOPHICAL INQUIRY 215 (1991).

<sup>24</sup> For a description of the Yates case, see Deborah W. Denno, *Who is Andrea Yates? A Short Story About Insanity*, 10 Duke J. Gender L. & Pol'y 37 (2003).

<sup>25</sup> DSM-IV-TR, *supra* note 9, at 332-33.

penalty exemption to those offenders whose only diagnosis is Antisocial Personality Disorder.<sup>26</sup> This language is virtually identical to language in the Model Penal Code's insanity formulation, which was designed to achieve the same purpose.<sup>27</sup> However, the Recommendation uses the word "primarily" where the MPC uses the word "solely" because Antisocial Personality Disorder consists of a number of symptom traits in addition to antisocial behavior, and therefore the MPC language does not achieve its intended effect. Compared to the MPC's provision, then, the Recommendation's language broadens the category of offenders whose responsibility is not considered sufficiently diminished to warrant exemption from capital punishment.

Similarly, the Recommendation denies the death penalty exemption to those offenders who lack appreciation or control of their actions at the time of the offense due "solely to the acute effects of voluntary use of alcohol or other drugs." Substance abuse often plays a role in crime. When voluntary ingestion of psychoactive substances compromises an offender's cognitive or volitional capacities, the law sometimes is willing to reduce the grade of offense at trial, especially in murder cases,<sup>28</sup> and evidence of intoxication should certainly be taken into account if it is offered in mitigation in a capital sentencing proceeding.<sup>29</sup> However, in light of the wide variability in the effects of alcohol and other drugs on mental and emotional functioning, voluntary intoxication alone does not warrant an automatic exclusion from the death penalty.<sup>30</sup> At the same time, this Recommendation is not meant to prevent exemption from the death penalty for those offenders whose substance abuse has caused organic brain disorders or who have other serious disorders that, in combination with the acute effects of substance abuse, significantly impaired appreciation or control at the time of the offense.<sup>31</sup>

*How This Recommendation Relates to the Insanity Defense.* The language proposed in this part of the Recommendation is similar to modern formulations of the insanity defense.<sup>32</sup> Nonetheless, in light of the narrow reach of the defense in most states (and its abolition in a few),<sup>33</sup> many offenders who meet these criteria will still be convicted rather than acquitted by reason of insanity. Even in those states with insanity formulations that are very similar to the

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<sup>26</sup> *Id.* at 650 et. seq. (defining as a symptom of antisocial personality disorder "failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest").

<sup>27</sup> See AMERICAN LAW INSTITUTE, MODEL PENAL CODE § 4.01(2) and commentary (draft, 1962) (stating that "mental disease or defect as used in the insanity formulation does not include "abnormality manifested only by repeated or otherwise anti-social conduct").

<sup>28</sup> See generally LAFAYE, *supra* note 25, at 415-16.

<sup>29</sup> See Jeffrey L. Kirchmeier, *A Tear in the Eye of the Law: Mitigating Factors and the Progression Toward a Disease Model of Criminal Justice*, 83 OREGON L. REV. 631, 679 n.237 (2004) (listing statutes and judicial decisions from over a dozen states that have recognized intoxication as a mitigating circumstance).

<sup>30</sup> In *Montana v. Egelhoff*, 518 U.S. 37 (1996), a plurality of the Supreme Court held that the voluntary intoxication defense is not constitutionally required. *Id.* at 38. At least 13 states now reject the voluntary intoxication defense. See Molly McDonough, *Sobering Up*, 88 A.B.A. J. 28 (2002).

<sup>31</sup> See, e.g., DSM-IV-TR, *supra* note 9, at 170 (describing dementia due to prolonged substance abuse).

<sup>32</sup> The language in 2(a) and 2(c), for instance, is almost identical to the language in the Model Penal Code's insanity formulation. See MODEL PENAL CODE, *supra* note 30, at § 4.01(1).

<sup>33</sup> Today, five states do not have an insanity defense, another twenty-five do not recognize volitional impairment as a basis for the defense, and many states define the cognitive prong in terms of an inability to "know" (as opposed to "appreciate") the wrongfulness of the act or, as is true in federal court, leave out the word "substantial" in the phrase "lack of substantial capacity to appreciate" in the Model Penal Code formulation. See RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 534-36 (4<sup>th</sup> ed. 2004).

Recommendation's language, these individuals might be convicted, for a whole host of reasons;<sup>34</sup> in such cases, the Recommendation would require juries and judges to consider whether cognitive and volitional impairment removes the defendant from being among the most morally culpable offenders. This approach rests on the traditional understanding that significant cognitive or volitional impairment attributable to a severe disorder or disability often renders the death penalty disproportionate to the defendant's culpability, even though the offender may still be held accountable for the crime.<sup>35</sup> It also underlies the various formulations of diminished responsibility that predated the contemporary generation of capital sentencing statutes.<sup>36</sup>

*How This Recommendation Relates to Mitigating Factors.* This part of the Recommendation sets up, in effect, a conclusive "defense" against the death penalty for capital defendants who can demonstrate the requisite level of impairment due to severe disorder at the time of the offense. However, the criteria in the Recommendation do not exhaust the relevance of mental disorder or disability in capital sentencing. Those offenders whose mental disorder or disability at the time of the offense was not severe or did not cause one of the enumerated impairments would still be entitled to argue that their mental dysfunction is a mitigating factor, to be considered with aggravating factors and other mitigating factors in determining whether capital punishment should be imposed.<sup>37</sup>

### PARAGRAPH 3:

This paragraph of the Recommendation is meant to address three different circumstances under which concerns about a prisoner's mental competence and suitability for execution arise after the prisoner has been sentenced to death. Subpart (a) states that execution should be precluded when a prisoner lacks the capacity (i) to make a rational decision regarding whether to pursue post-conviction proceedings, (ii) to assist counsel in post-conviction adjudication, or (iii) to appreciate the meaning or purpose of an impending execution. The succeeding subparts spell out the conditions under which execution should be barred in these three situations.

*Prisoners Seeking to Forgo or Terminate Post-Conviction Proceedings.* The United States Supreme Court has ruled that a competent prisoner is entitled to forgo available appeals.<sup>38</sup> If the prisoner is not competent, the standard procedure is to allow a so-called "next friend" (including the attorney) to pursue direct appeal and collateral proceedings aiming to set aside the conviction or sentence. Subpart 3(b) of the Recommendation addresses the definition of competence in such cases, providing that a next friend petition should be allowed when the prisoner has a mental disorder or disability "that significantly impairs his or her capacity to make a rational decision."

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<sup>34</sup> See generally Michael L. Perlin, *"The Borderline Which Separated You from Me": The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment*, 82 IOWA L. REV. 1375 (1997) (exploring reasons for hostility to the insanity defense).

<sup>35</sup> See Ellen Fels Berkman, *Mental Illness as an Aggravating Circumstance in Capital Sentencing*, 89 COLUM. L. REV. 291, 297 (1989) (noting that "nearly two dozen jurisdictions list as a statutory mitigating circumstance the fact that the defendant's capacity to appreciate the criminality of her conduct was substantially impaired, often as a result of mental defect or disease" and that "an equally high number of states includes extreme mental or emotional disturbance as a mitigating factor").

<sup>36</sup> See generally SHELDON GLUECK, *MENTAL DISORDER AND THE CRIMINAL LAW* (1925).

<sup>37</sup> See, e.g., MODEL PENAL CODE, *supra* note 30, at § 210.6.

<sup>38</sup> See, e.g., *Gilmore v. Utah*, 429 U.S.1012 (1977).

Reportedly, 13% of the prisoners executed in the post-*Gregg* era have been so-called "volunteers."<sup>39</sup> Any meaningful competence inquiry in this context must focus not only on the prisoner's understanding of the consequences of the decision, but also on his or her *reasons* for wanting to surrender, and on the rationality of the prisoner's thinking and reasoning. In *Rees v. Peyton*,<sup>40</sup> the U.S. Supreme Court instructed the lower court to determine whether the prisoner had the "capacity to appreciate his position and make a rational choice with respect to continuing or abandoning further litigation or on the other hand whether the prisoner is suffering from a mental disease, disorder or defect which may substantially affect his capacity in the premises."<sup>41</sup> Unfortunately, the two alternative findings mentioned by the Court are not mutually exclusive – a person with a mental disorder that "affects" his or her decision-making may nonetheless be able to appreciate his or her position and make a "rational" choice. For this reason, the lower courts have integrated the *Rees* formula into a three-step test: (1) does the prisoner have a mental disorder? (2) if so, does this condition prevent the prisoner from understanding his or her legal position and the options available to the prisoner? (3) even if understanding is unimpaired, does the condition nonetheless prevent the prisoner from making a rational choice among the options?<sup>42</sup>

Because the courts have adopted a fairly broad conception of mental disorder (the first step) and the prisoner's understanding of his or her "legal position" (the second step) is hardly ever in doubt in these cases, virtually all the work under the *Rees* test is done by the third step.<sup>43</sup> Conceptually, the question is relatively straightforward – is the prisoner's decision attributable to the mental disorder or to "rational choice"?

Unequivocal cases of irrationality rarely arise. For example, if an offender suffering from schizophrenia tells his or her attorney to forgo appeals because the future of civilization depends upon the offender's death,<sup>44</sup> the "reason" for the prisoner's choice can comfortably be attributed to the psychotic symptom. However, decisions rooted in delusions are atypical in these cases. The usual case involves articulated reasons that may seem "rational" under the circumstances, such as (a) a desire to take responsibility for one's actions and a belief that one deserves the death penalty or (b) a preference for the death penalty over life imprisonment. The cases that give the courts the most trouble are those in which such apparently "rational" reasons are intertwined with emotional distress (especially depression), feelings of guilt and remorse, and hopelessness. In many cases, choices that may otherwise seem "rational" may be rooted in suicidal motivations. Assuming, for example, that the prisoner is depressed and suicidal but has a genuine desire to take responsibility, how is one to say which motivation "predominates"?

John Blume has studied the prevalence of significant mental disorder among the 106 prisoners who have volunteered for execution. According to Blume, 14 of the "volunteers" had recorded diagnoses of schizophrenia, 23 had recorded diagnoses of depression or bipolar disorder, 10 had records of PTSD, 4 had diagnoses of borderline personality disorder and 2 had been diagnosed with multiple personality disorder. Another 12 had unspecified histories of

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<sup>39</sup> John Blume, *Killing the Willing: "Volunteers, Suicide and Competency*, 103 MICH. L. REV. 939, 959 (2005).

<sup>40</sup> 384 U.S. 312 (1966) (case remanded for competency determination after condemned prisoner directed attorney to withdraw petition for certiorari).

<sup>41</sup> *Id.* at 314.

<sup>42</sup> *See, e.g., Hauser v. Moore*, 223 F.3d 1316, 1322 (11<sup>th</sup> Cir. 2000); *Rumbaugh v. Proconier*, 753 F.2d 395 (5<sup>th</sup> Cir 1985).

<sup>43</sup> Richard J. Bonnie, *Mentally Ill Prisoners on Death Row: Unsolved Puzzles for Courts and Legislatures*, 54 CATH. UNIV. L. REV. 1169 (2005).

<sup>44</sup> *Cf. Illinois v. Haynes*, 737 N.E.2d 169, 178 (Ill. 2000); *In re Heidnick*, 720 A. 2d 1016 (Pa 1998).

"mental illness."<sup>45</sup> Given this high prevalence of mental illness, the courts should be more willing than they now are to acknowledge suicidal motivations when they are evident and should be more inclined than they are now to attribute suicidal motivations to mental illness when the clinical evidence of such a link is convincing. The third step of the *Rees* test would then amount to the following: Is the prisoner who seeks execution able to give plausible reasons for doing so that are clearly *not* grounded in symptoms of mental disorder?<sup>46</sup> Given the stakes of the decision, a relatively high degree of rationality ought to be required in order to find people competent to make decisions to abandon proceedings concerning the validity of a death sentence.<sup>47</sup>

*Prisoners Unable to Assist Counsel in Post-Conviction Proceedings.* Subpart 3(c) of the Recommendation addresses the circumstances under which impaired competence to participate in adjudication should affect the initiation or continuation of post-conviction proceedings. The law in this area is both undeveloped and uncertain in many respects. However, some principles have begun to emerge.

Under the laws of many states and the federal Anti-Terrorism and Effective Death Penalty Act (AEDPA), collateral proceedings are barred if they are not initiated within a specified period of time. However, it is undisputed that a prisoner's failure to file within the specified time must be excused if such failure was attributable to a mental disability that impaired the prisoner's ability to recognize the basis for, or to take advantage of, possible collateral remedies. Similarly, the prisoner should be able to lodge new claims, or re-litigate previously raised claims, if the newly available evidence upon which the claim would have been based, or that would have been presented during the earlier proceeding relating to the claim, was unavailable to counsel due to the prisoner's mental disorder or disability.<sup>48</sup>

Assuming, however, that collateral proceedings have been initiated in a timely fashion, the more difficult question is whether, and under what circumstances, a prisoner's mental disability should require suspension of the proceedings. Subpart 3(c) provides that courts should suspend post-conviction proceedings upon proof that a prisoner is incompetent to assist counsel in such proceedings and that the prisoner's participation is necessary for fair resolution of a specific claim.

Thorough post-conviction review of the legality of death sentences has become an integral component of modern death penalty law, analogous in some respects to direct review. Any impediment to thorough collateral review undermines the integrity of the review process and therefore of the death sentence itself. Many issues raised in collateral proceedings can be adjudicated without the prisoner's participation, and these matters should be litigated according to customary practice. However, collateral proceedings should be suspended if the prisoner's

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<sup>45</sup> Blume, *supra* note 41, Appendix B, at 989-96. The text refers only to significant mental disorders that could have distorted the prisoner's reasoning process and impaired capacity for "rational choice." In addition to these cases, Blume reports that 20 of these prisoners had histories of substance abuse unaccompanied by any other mental disorder diagnosis, another 6 had personality disorders (with or without substance abuse) and 4 had sexual impulse disorders.

<sup>46</sup> See Bonnie, *supra* note 46, at 1187-88. A more demanding approach would ask whether the prisoner is able to give plausible reasons that reflect authentic values and enduring preferences.

<sup>47</sup> See Richard J. Bonnie, *The Dignity of the Condemned*, 74 VA.L. REV. 1363, 1388-89 (1988); Cf. Richard J. Bonnie, *The Competence of Criminal Defendants: Beyond Dusky and Drope*, 47 UNIV. MIAMI L. REV. 539, 579-80 (1993).

<sup>48</sup> See, e.g., *Council v. Catoe*, 359 S.C. 120, 597 S.E.2d 782, 787 (2004); *Commonwealth v. Haag*, 809 A.2d 271, 285 (PA, 2001).

counsel makes a substantial and particularized showing that the prisoner's impairment would prevent a fair and accurate resolution of specific claims,<sup>49</sup> and subpart 3(c) so provides.

Where the prisoner's incapacity to assist counsel warrants suspension of the collateral proceedings, it should bar execution as well, just as ABA Standards recommend. ABA Standard 7-5.6 provides that prisoners should not be executed if they cannot understand the nature of the pending proceedings or if they "[lack] sufficient capacity to recognize or understand any fact which might exist which would make the punishment unjust or unlawful, or [lack] the ability to convey such information to counsel or to the court."<sup>50</sup> As the commentary to Standard 7-5.6 indicates, this rule "rests less on sympathy for the sentenced convict than on concern for the integrity of the criminal justice system."<sup>51</sup> Scores of people on death row have been exonerated based on claims of factual innocence, and many more offenders have been removed from death row and given sentences less than death because of subsequent discovery of mitigating evidence. The possibility, however slim, that incompetent individuals may not be able to assist counsel in reconstructing a viable factual or legal claim requires that executions be barred under these circumstances.

Once the post-conviction proceedings have been suspended on grounds of the prisoner's incompetence to assist counsel, should the death sentence remain under an indefinite stay? The situation is analogous to the suspension of criminal proceedings before trial; in that context, the proceedings are typically terminated (and charges are dismissed) after a specified period if a court has found that competence for adjudication is not likely to be restored in the foreseeable future. In the present context, it would be unfair to hold the death sentence in perpetual suspension. A judicial finding that the prisoner's competence to assist counsel is not likely to be restored in the foreseeable future should trigger an automatic reduction of the sentence to the disposition the relevant law imposes on capital offenders when execution is not an option.

*Prisoners Unable to Understand the Punishment or its Purpose.* In *Ford v. Wainwright* (1986),<sup>52</sup> the U.S. Supreme Court held that execution of an incompetent prisoner constitutes cruel and unusual punishment proscribed by the Eighth Amendment. Unfortunately, the Court failed to specify a constitutional definition of incompetence or to prescribe the constitutionally required procedures for adjudicating the issue.<sup>53</sup> The Court also failed to set forth a definitive rationale for its holding that might have helped resolve these open questions. Rather it listed, without indicating their relative importance, a number of possible reasons for the competence requirement. These rationales included the need to ensure that the offenders could provide counsel with information that might lead to vacation of sentence; the view that, in the words of Lord Coke, execution of "mad" people is a "miserable spectacle . . . of extream inhumanity and cruelty [that] can be no example to others"; and the notion that retribution cannot be exacted

<sup>49</sup> *Council v. Catoe*, 359 S.C. 120, 597 S.E.2d 782, 787 ("[T]he default rule is that PCR [post-conviction review] hearings must proceed even though a petitioner is incompetent. For issues requiring the petitioner's competence to assist his PCR counsel, such as a fact-based challenge to his defense counsel's conduct at trial, the PCR judge may grant a continuance, staying review of these issues until petitioner regains his competence."); *Carter v. State*, 706 So.2d 873, 875-77 (Fla. 1997); *State v. Debra*, 523 N.W.2d 727 (Wisc. 1994) (non-capital case); *People v. Kelly*, 822 P.2d 385, 413 (Cal. 1992).

<sup>50</sup> *ABA Criminal Justice Mental Health Standards* 290 (1989).

<sup>51</sup> *Id.* at 291.

<sup>52</sup> 477 U.S. 399.

<sup>53</sup> State courts have disagreed about the procedures required to make *Ford* competence determinations. This Recommendation does not deal with such procedural issues. For a treatment of this topic, see *ABA Standard 7.5-7* and *Coe v. Bell*, 209 F.3d 815 (6<sup>th</sup> Cir. 2000), which should be read in conjunction with the *ABA Guidelines for Appointment and Performance of Defense Counsel in Death Penalty Cases at* <http://www.abanet.org/deathpenalty/publications/2005/2003Guidelines.pdf>.

from people who do not understand why they are being executed.<sup>54</sup> Apparently based on the latter rationale, Justice Powell, in his concurring opinion in *Ford*, stated: "I would hold that the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it."<sup>55</sup> Justice Powell pointed out that states are free to preclude execution on other grounds (particularly inability to assist counsel), but most courts and commentators have assumed that the Eighth Amendment requirement is limited to the test stated by Justice Powell. Most commentators have also agreed with Justice Powell's view that the *Ford* competence requirement is grounded in the retributive purpose of punishment.<sup>56</sup>

There has been some confusion about the meaning of the idea that the prisoner must be able to understand (or be aware of) the nature and purpose for (reasons for) the execution. In *Barnard v. Collins*,<sup>57</sup> decided by the Fifth Circuit in 1994, the state habeas court had found that Barnard's "perception of the reason for his conviction and impending execution is at times distorted by a delusional system in which he attributes anything negative that happens to him to a conspiracy of Asians, Jews, Blacks, homosexuals and the Mafia."<sup>58</sup> Despite the fact that Barnard's understanding of the reason for his execution was impaired by delusions, the Fifth Circuit concluded that his awareness that "his pending execution was because he had been found guilty of the crime" was sufficient to support the state habeas court's legal conclusion that he was competent to be executed.<sup>59</sup>

In order to emphasize the need for a deeper understanding of the state's justifying purpose for the execution, subpart 3(d) of the Recommendation would require that an offender not only must be "aware" of the nature and purpose of punishment but also must "appreciate" its personal application in the offender's own case – that is, why it is being imposed *on the offender*. This formulation is analogous to the distinction often drawn between a "factual understanding" and a "rational understanding" of the reason for the execution.<sup>60</sup> If, as is generally assumed, the primary purpose of the competence-to-be-executed requirement is to vindicate the retributive aim of punishment, then offenders should have more than a shallow understanding of why they are being executed. Similarly, the offender should also have a meaningful understanding of what it means to be dead -- in the sense that life is terminated and that the prisoner will not be "waking up" or otherwise continuing his existence. Deficient understanding of what it means to be dead can be associated with mental retardation and with delusional beliefs symptomatic of severe mental illness. These profound deficiencies in understanding associated with mental disability should not be trivialized or ignored by analogizing them to widely shared uncertainty among normal persons about the existence of some form of spiritual "life" after death or about the possibility of resurrection.

The underlying point here is that the retributive purpose of capital punishment is not served by executing an offender who lacks a meaningful understanding that the state is taking his life in order to hold him accountable for taking the life of one or more people. Holding a person accountable is intended to be an affirmation of personal responsibility. Executing someone who

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<sup>54</sup> *Id.* at 406-08.

<sup>55</sup> *Id.* at 422 (Powell, J., concurring).

<sup>56</sup> See Barbara Ward, *Competency for Execution: Problems in Law and Psychiatry*, 14 FLA. ST. UNIV. L. REV. 35, 49-56 (1986); Christopher Slobogin, *Mental Illness and the Death Penalty*, 24 MEN. & PHYS. L. REP. 667, 675-77 (2000).

<sup>57</sup> 13 F.3d 871 (5<sup>th</sup> Cir, 1994).

<sup>58</sup> *Id.* at 876.

<sup>59</sup> *Id.*

<sup>60</sup> See *Martin v. Florida*, 515 So. 2d 189, 190 (Fla. 1987).

lacks a meaningful understanding of the nature of this awesome punishment and its retributive purpose offends the concept of personal responsibility rather than affirming it.

Whether a person found incompetent to be executed should be treated to restore competence implicates not only the prisoner's constitutional right to refuse treatment but also the ethical integrity of the mental health professions.<sup>61</sup> Some courts have decided that the government may forcibly medicate incompetent individuals if necessary to render them competent to be executed, on the ground that once an individual is fairly convicted and sentenced to death, the state's interest in carrying out the sentence outweighs any individual interest in avoiding medication.<sup>62</sup> However, treating a condemned prisoner, especially over his or her objection, for the purpose of enabling the state to execute the prisoner strikes many observers as barbaric and also violates fundamental ethical norms of the mental health professions.

Mental health professionals are nearly unanimous in the view that treatment with the purpose or likely effect of enabling the state to carry out an execution of a person who has been found incompetent for execution is unethical, whether or not the prisoner objects, except in two highly restricted circumstances (an advance directive by the prisoner while competent requesting such treatment or a compelling need to alleviate extreme suffering).<sup>63</sup> Because treatment is unethical, it is not "medically appropriate" and is therefore constitutionally impermissible when a prisoner objects under the criteria enunciated by the Supreme Court in *Sell v. United States*<sup>64</sup> and *Washington v. Harper*.<sup>65</sup> As the Louisiana Supreme Court observed in *Perry v. Louisiana*,<sup>66</sup> medical treatment to restore execution competence "is antithetical to the basic principles of the healing arts," fails to "measurably contribute to the social goals of capital punishment," and "is apt to be administered erroneously, arbitrarily or capriciously."<sup>67</sup>

There is only one sensible policy here: a death sentence should be automatically commuted to a lesser punishment (the precise nature of which will be governed by the jurisdiction's death penalty jurisprudence) after a prisoner has been found incompetent for execution.<sup>68</sup> Maryland has so prescribed,<sup>69</sup> and subpart 3(d) of the Recommendation embraces this view. Once an offender is found incompetent to be executed, execution should no longer be a permissible punishment.

The current judicial practice is to entertain *Ford* claims only when execution is genuinely imminent. Should courts be willing to adjudicate these claims at an earlier time? Assuming that a judicial finding of incompetence – whenever rendered – would permanently bar execution (as proposed above), subpart 3(d) provides that *Ford* adjudications should be available only when

<sup>61</sup> Kirk S. Heilbrun, Michael L. Radelet, Joel A. Dvoskin, *The Debate on Treating Individuals Incompetent for Execution*, 149 AMERICAN JOURNAL OF PSYCHIATRY 596 (1992); Richard J. Bonnie, *Dilemmas in Administering the Death Penalty: Conscientious Abstention, Professional Ethics and the Needs of the Legal System*, 14 LAW & HUMAN BEHAVIOR 67 (1990).

<sup>62</sup> *Singleton v. Norris*, 319 F.3d 1018 (8th Cir.) (*en banc*), *cert denied*, 124 S. Ct. 74 (2003).

<sup>63</sup> See Council on Ethical and Judicial Affairs, American Medical Association, *Physician Participation in Capital Punishment*, 270 JAMA 365 (1993); American Psychiatric Association and American Medical Association, *Amicus Brief in Support of Petitioner in Perry v. Louisiana*, 498 U.S. 38 (1990); Richard J. Bonnie, *Medical Ethics and the Death Penalty*, 20 HASTINGS CENTER REPORT, MAY/JUNE, 1990, 12, 15-17.

<sup>64</sup> 539 U.S. 166 (2003).

<sup>65</sup> 494 U.S. 210 (1990).

<sup>66</sup> 610 So.2d 746 (La. 1992).

<sup>67</sup> *Id.* at 751.

<sup>68</sup> A state could try to restore a prisoner's competence without medical treatment, but the prospects of an enduring change in the prisoner's condition are slight.

<sup>69</sup> Md. Code of Correctional Services, 3-904(a)(2), (d)(1).

legal challenges to the validity of the conviction and sentence have been exhausted, and execution has been scheduled.<sup>70</sup>

*Procedures:* While this paragraph contemplates that hearings will have to be held to determine competency to proceed and competency to be executed, it does not make any recommendations with respect to procedures. Federal constitutional principles and state law will govern whether the necessary decisions must be made by a judge or a jury, what burdens and standards of proof apply, and the scope of other rights to be accorded offenders. Additionally, in any proceedings necessary to make these determinations, the victim's next-of-kin should be accorded rights recognized by law, which may include the right to be present during the proceedings, the right to be heard, and the right to confer with the government's attorney. Victim's next-of-kin should be treated with fairness and respect throughout the process.

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<sup>70</sup> This does not mean that no litigation challenging the validity of the sentence can be simultaneously occurring. For all practical purposes, "exhaustion" means that one full sequence of state post-conviction review and federal habeas review have occurred where, as in most jurisdictions, no execution date set during the initial round of collateral review is a "real" date. Given the many procedural barriers to successive petitions for collateral review, an execution date set after the completion of the initial round may be a "real" date, even if a successive petition has been filed or is being planned. In such a case, the state may contest the prisoner's request for a stay of execution. A *Ford* claim should be considered on its merits in such a case, and it should be considered earlier on in a jurisdiction where a "real" execution date is set during the initial round of collateral review.



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## Position Statement 54: Death Penalty and People with Mental Illnesses

### Policy Position

- Our current system of criminal justice inadequately addresses the complexity of cases involving criminal defendants with mental illnesses. Therefore, Mental Health America calls upon states to suspend using the death penalty until more just, accurate and systematic ways of determining and considering a defendant's mental status are developed. [1]
- Defendants should not be executed or sentenced to death if, at the time of the offense, they had a severe mental disorder or disability that significantly impaired their capacity (a) to appreciate the nature, consequences or wrongfulness of their conduct, (b) to exercise rational judgment in relation to conduct, or (c) to conform their conduct to the requirements of the law. A disorder manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs does not, standing alone, constitute a mental disorder or disability for purposes of this provision.[2]
- Defendants should not be executed or sentenced to death if, at the time of the offense, they had significant limitations in both their intellectual functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from mental retardation, dementia, or a traumatic brain injury.[3]
- Mental Health America believes that mental illnesses should always be taken into account during all phases of a death penalty case. Moreover, the assessment of competency to stand trial as well as competency to be executed should be conducted by a multi-disciplinary team of qualified professionals, including professionals with expertise in the defendant's particular mental illness.
- Mental Health America is opposed to the practice of having a psychiatrist or other mental health professional treat a person in order to restore competency solely to permit the state to execute that person, and Mental Health America opposes the practice of medicating defendants involuntarily in order to make them competent to be executed.
- Research studies have demonstrated that a persistent pattern of racial disparities exists in the implementation of the death penalty. African Americans defendants are four times more likely to receive the death sentence than white defendants[4]. African Americans persons are also less likely to receive mental health treatment. Mental Health America believes that these discrepancies are linked, at least in part, to the pervasive effects of racism in American society and thus serve as an independent reason to oppose the death penalty.

### Background

Over the past thirty years, the number of people with mental illnesses and other mental disabilities on death row has steadily increased.[5] Although precise statistics are not available, it is estimated that 5-10 percent of people on death row have a serious mental illness.[6]

Mental Health America believes that mental illnesses can influence an individual's mental state at the time he or she commits a crime, can affect how "voluntary" and reliable an individual's statements might be, can compromise a person's competence to stand trial and to waive his or her rights, and may have an effect upon a person's knowledge of the criminal justice system.

The process of determining guilt and imposing sentence is necessarily more complex for individuals with mental illnesses. A high standard of care is essential with regard to legal representation as well as psychological and psychiatric evaluation for individuals with mental illnesses involved in death penalty cases. Mental Health America believes mental illnesses should always be taken into account during all phases of a potential death penalty case. Moreover, the assessment of competency to stand trial as well as competency to be executed should be conducted by a multi-disciplinary team of qualified professionals, including professionals with expertise in the defendant's particular mental illnesses.

Some states require a prediction of future dangerousness in order to impose a death sentence. However, research has shown predictions of future dangerousness to be unscientific and frequently inaccurate. Therefore, such predictions are highly suspect as a basis on which to impose the death penalty. Moreover, there is a danger that the wholly unwarranted perception that mental illnesses are associated with violence could bias such predictions. In fact, research shows that people with mental illnesses pose no greater risk of violence than the average person.[7] Unfortunately, however, the misperceived link between mental illnesses and violence drives both legal policy and criminal justice system practice with respect to people with mental illness.

In 1986, the Supreme Court ruled in *Ford v. Wainwright*, 477 U.S. 399 (1986) that "the reasons at

common law for not condoning the execution of the insane -- that such an execution has questionable retributive value, presents no example to others, and thus has no deterrence value, and simply offends humanity -- have no less logical, moral, and practical force at present. Whether the aim is to protect the condemned from fear and pain without comfort of understanding, or to protect the dignity of society itself from the barbarity of exacting mindless vengeance, the restriction finds enforcement in the Eighth Amendment." 477 U.S. at 400. However, people with mental illnesses can be executed if they understand the punishment that awaits them and why they are being put to death. This ruling has prompted some states to provide psychiatric treatment to offenders with mental illnesses on death row in order to "restore their competency." Consistent with the code of ethics of the American Medical Association,[8] Mental Health America is opposed to the practice of having a psychiatrist or other mental health professional treat a person in order to restore competency solely to permit the state to execute that person. Similarly, Mental Health America is opposed to the practice of medicating defendants involuntarily in order to make them competent to be executed. Great care must be taken to assure informed consent for treatment / no treatment options.

Mental Health America believes that our current system of fact-finding in capital cases fails to identify who among those convicted and sentenced to death actually has a mental illness. Thus, there is reason to believe that individuals with mental illnesses are being executed without the criminal justice system knowing of the existence of that illness and, therefore, without the requisite consideration of whether that mental illness may be a mitigating factor in these cases. Therefore, Mental Health America calls upon states to suspend use of the death penalty until more just, accurate and systematic ways of determining a defendant's mental status are developed. This position supports the American Bar Association's (ABA) call for a moratorium on the imposition of the death penalty because, in its judgment, "fundamental due process is systematically lacking" in capital cases.[9]

### **Juveniles and the Death Penalty**

Mental Health America applauds the U.S. Supreme Court's March 1, 2005 ruling in *Roper v. Simmons* that declared the juvenile death penalty unconstitutional. Young people under age 18 should not be held to the same standard of culpability and accountability for their actions as adults. Impulsiveness, poor judgment, and a lack of self-control are frequently characteristics of childhood and are the reasons we limit many of the rights of minors. The age, maturity, mental status, and any history of abuse or trauma of a youthful offender should always be considered in deciding his or her punishment. Mental Health America considers the execution of people for crimes they committed as children to be unjust and inhumane, serving no principled purpose, and demeaning to our system of justice, and thus endorses the Court's holding that the juvenile death penalty constitutes "cruel and unusual punishment."

### **Effective Period**

**The Mental Health America Board of Directors approved this policy on June 11, 2006. It will remain in effect for five (5) years and is reviewed as required by the Mental Health America Public Policy Committee.**

**Expiration: June 11, 2011**

[1] Mental Health America previously advocated against the application of the death penalty to juveniles and adopts the logic of the United States Supreme Court in *Roper v. Simmons*, 543 U.S. 551 (2005) which declared that practice unconstitutional.

[2] Amnesty International. USA: The execution of mentally ill offenders. Recommendations of the American Bar Association Section of Individual Rights and Responsibilities, Task Force on Mental Disability and the Death Penalty. 2006

[3] Ibid.

[4] Dieter, Richard. The Death Penalty in Black and White: Who Lives, Who Dies, Who Decides. *Death Penalty Resource Center*. 1998

[5] The National Coalition to Abolish the Death Penalty. Fact Sheet: Mental Competency and the Death Penalty. Available: <http://www.ncadp.org/facts.html>

[6] Personal communication with the California Appellate Project.

[7] Steadman, H., Mulvey, E., Monahan, J., Robbins, P., Appelbaum, P., Grisso, T., Roth, L., Silver, E. (May 1998). Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods. *Archives of General Psychiatry*, (55).

[8] American Medical Association. D-140.979 Moratorium on the Imposition of the Death Penalty: "Our American Medical Association will actively disseminate its opinion regarding physician non-participation in legally authorized executions". (Res. 5, A-03).

[9] American Bar Association. Death Penalty Moratorium. 1997, [www.abanet.org/moratorium/resolution.html](http://www.abanet.org/moratorium/resolution.html)

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UNITED NATIONS HIGH COMMISSIONER  
FOR HUMAN RIGHTS



### The question of the death penalty

Commission on Human Rights resolution 2001/68

*The Commission on Human Rights,*

*Recalling* article 3 of the Universal Declaration of Human Rights, which affirms the right of everyone to life, article 6 of the International Covenant on Civil and Political Rights and articles 6 and 37 (a) of the Convention on the Rights of the Child,

*Recalling also* General Assembly resolutions 2857 (XXVI) of 20 December 1971 and 32/61 of 8 December 1977 on capital punishment, as well as resolution 44/128 of 15 December 1989, in which the Assembly adopted and opened for signature, ratification and accession the Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty,

*Recalling further* Economic and Social Council resolutions 1574 (L) of 20 May 1971, 1745 (LIV) of 16 May 1973, 1930 (LVIII) of 6 May 1975, 1984/50 of 25 May 1984, 1985/33 of 29 May 1985, 1989/64 of 24 May 1989, 1990/29 of 24 May 1990, 1990/51 of 24 July 1990 and 1996/15 of 23 July 1996,

*Recalling* its resolutions 1998/8 of 3 April 1998, 1999/61 of 28 April 1999 and 2000/65 of 26 April 2000, in which it expressed its conviction that abolition of the death penalty contributes to the enhancement of human dignity and to the progressive development of human rights,

*Welcoming* the exclusion of capital punishment from the penalties that the International Criminal Tribunal for the Former Yugoslavia, the International Tribunal for Rwanda and the International Criminal Court are authorized to impose,

*Also welcoming* the abolition of the death penalty which has taken place in some States since the Commission's last session, and in particular in those States that have abolished the death penalty for all crimes,

*Commending* the States that have recently acceded to the Second Optional Protocol to the International Covenant on Civil and Political Rights,

*Welcoming* the recent signatures of the Second Optional Protocol by some States,

*Welcoming* the fact that many countries, while still keeping the death penalty in their penal legislation, are applying a moratorium on executions,

*Referring* to the report of the Special Rapporteur on extrajudicial, summary or arbitrary executions (E/CN.4/2001/9 and Corr.1), with respect to the Safeguards guaranteeing protection of the rights of those facing the death penalty, set out in the annex to Economic and Social Council resolution 1984/50,

*Deeply concerned* that several countries impose the death penalty in disregard of the limitations provided for in the Covenant and the Convention on the Rights of the Child,

*Concerned* that several countries, in imposing the death penalty, do not take into account the Safeguards guaranteeing protection of the rights of those facing the death penalty,

1. *Welcomes* the sixth quinquennial report of the Secretary-General on capital punishment and implementation of the Safeguards guaranteeing protection of the rights of those facing the death penalty, submitted in accordance with Economic and Social Council resolution 1995/57 of 28 July 1995 (E/2000/3) and looks forward to receiving the yearly supplement on changes in law and practice concerning the death penalty worldwide as requested in Commission resolution 2000/65;

2. *Also welcomes* resolution 2000/17 of 17 August 2000 of the Sub-Commission on the Promotion and Protection of Human Rights;

3. *Calls upon* all States parties to the International Covenant on Civil and Political Rights that have not yet done so to consider acceding to or ratifying the Second Optional Protocol to the Covenant, aiming at the abolition of the death penalty;

4. *Urges* all States that still maintain the death penalty:

(a) To comply fully with their obligations under the Covenant and the Convention on the Rights of the Child, notably not to impose the death penalty for any but the most serious crimes and only pursuant to a final judgement rendered by an independent and impartial competent court, not to impose it for crimes committed by persons below eighteen years of age, to exclude pregnant women from capital punishment and to ensure the right to a fair trial and the right to seek pardon or commutation of sentence;

(b) To ensure that the notion of "most serious crimes" does not go beyond intentional crimes with lethal or extremely grave consequences and that the death penalty is not imposed for non-violent financial crimes or for non-violent religious practice or expression of conscience;

**Exhibit H**

(c) Not to enter any new reservations under article 6 of the Covenant which may be contrary to the object and the purpose of the Covenant and to withdraw any such existing reservations, given that article 6 of the Covenant enshrines the minimum rules for the protection of the right to life and the generally accepted standards in this area;

(d) To observe the Safeguards guaranteeing protection of the rights of those facing the death penalty and to comply fully with their international obligations, in particular with those under the Vienna Convention on Consular Relations;

(e) Not to impose the death penalty on a person suffering from any form of mental disorder or to execute any such person;

(f) Not to execute any person as long as any related legal procedure, at the international or at the national level, is pending;

5. *Calls upon* all States that still maintain the death penalty:

(a) Progressively to restrict the number of offences for which the death penalty may be imposed;

(b) To establish a moratorium on executions, with a view to completely abolishing the death penalty;

(c) To make available to the public information with regard to the imposition of the death penalty;

6. *Requests* States that have received a request for extradition on a capital charge to reserve explicitly the right to refuse extradition in the absence of effective assurances from relevant authorities of the requesting State that capital punishment will not be carried out;

7. *Requests* the Secretary-General to continue to submit to the Commission, at its fifty-eighth session, in consultation with Governments, specialized agencies and intergovernmental and non-governmental organizations, a yearly supplement on changes in law and practice concerning the death penalty worldwide to his quinquennial report on capital punishment and implementation of the Safeguards guaranteeing protection of the rights of those facing the death penalty, paying special attention to the imposition of the death penalty against persons younger than eighteen years of age at the time of the offence;

8. *Decides* to continue consideration of the matter at its fifty-eighth session under the same agenda item.

25 April 2001

[Adopted by a roll-call vote of 27 votes to 18,  
with 7 abstentions.]

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Office of the United Nations High Commissioner for Human Rights  
Geneva, Switzerland



## Individuals with intellectual disability and mental illness: a literature review.(Statistical Data Included)

Article from: *Australian Journal of Social Issues* Article date: February 1, 2002  
 Author: Hudson, Colin; Chan, Jeffrey

People with intellectual disability may be limited not only in their cognitive and adaptive behaviour skills, but also by emotional and behavioural disorders that further limit their ability to learn new skills, adapt to changing environments and develop appropriate social interaction skills. When these disorders are of a sufficient severity and intensity, they may constitute a diagnosable psychiatric disorder (Einfeld & Tonge, 1996). Hence when intellectual disability is complicated by mental illness, the common clinical term "dual diagnosis" is used to describe these individuals (Bongiorno, 1996; Matson & Sevin, 1994; Lovell & Reiss, 1993). The term "dual diagnosis" indicating a co-existence of intellectual disability and mental illness is relatively new and has only recently been acknowledged in the field (Borthwick-Duffy, 1994; Fuller & Sabatino, 1998; Parmenter, 2001).

Individuals with intellectual disability and mental illness present several challenges to both community and health services in terms of the difficult behaviours they present, the complexities of diagnoses and treatment, and the complex service needs they require (Dudley, Ahgrim-Dezell & Calhoun, 1999; King, DeAntonio, McCracken, Forness, & Ackerland, 1994; Moss, Emerson, Bouras & Holland, 1997). In order to appreciate the challenge people with intellectual disability and mental illness present, it is pertinent to understand the prevalence of the dual diagnosis in this population. The prevalence of mental illness is higher among people with intellectual disability than in the general population than previously reported (Borthwick-Duffy, 1994; Fuller & Sabatino, 1998; Linaker & Nitter, 1990).

However, the prevalence rates reported in the research literature vary from 10% (Borthwick-Duffy & Eymann, 1990) to 91% (Linaker & Nitter, 1990). It is also important to distinguish prevalence rates in individuals with intellectual disability in institutional care (Linaker & Nitter, 1990) and those living in the community (Bouras & Drummond, 1992; Torrey, 1993). There are several factors that might account for the wide range of reported prevalence rates (Borthwick-Duffy, 1994).

Briefly, Borthwick-Duffy (1994) identified issues relating to definition and identification of intellectual disability and mental illness, and the problems due to sampling of subjects. Clinical presentations of mental illness in people with intellectual disability may also be masked by poor language skills and life circumstances, where often reports of mental illness may be conveyed via a support worker rather than the individual himself or herself (Szymanski & King, 1999). Therefore Szymanski and King (1999) argue that diagnostic assessment might hinge heavily on observable behavioural symptoms. Fuller and Sabatino (1998) also reported that mental health practitioners might find it difficult to shift diagnostic practices to a dual focus rather than differential diagnoses. Whatever the discrepancy, there is growing evidence that mental illness is prevalent across all age groups in individuals with intellectual disability.

### Prevalence in Children and Adolescents with Intellectual Disability

Children and adolescents with intellectual disability and mental illness may experience a range of psychiatric disorders (Hurley, 1996; Masi, 1998; Walters, Barrett, Knapp & Borden, 1995). Examples of psychiatric disorders include mood disorders, psychotic disorders, personality disorders, anxiety disorders, depression and suicide ideation (Hurley, 1996; Masi, 1998; Walters, Barrett, Knapp & Borden, 1995). Both Hurley (1996) and Masi (1998) argue that often the symptoms presented by these children and adolescents are often mistaken for aberrant behaviours associated with intellectual or developmental disability. As a result, many of these individuals do not receive the appropriate psychiatric care that they require.

In a landmark study, Rutter, Graham and Yule (1970) found that the prevalence of psychiatric disorders in children with intellectual disability ranged between 30% to 42% as compared to typically developing children with a prevalence rate of 7% to 10%. Similar studies have confirmed the results found by Rutter et al. (1970) and the high prevalence rates are common in both children and adolescents with intellectual disability (Borthwick-Duffy, 1994; Dykens, 2000; Einfeld & Tonge, 1996; Jacobson & Janicki, 1985). For example, Borthwick-Duffy (1994) estimates prevalence rates from as low as 10% whereas Einfeld and Tonge (1996) found that 40.7% of those with intellectual disability aged between 4-18 years in New South Wales could be classified as having severe emotional and behaviour disorder or as being psychiatrically disordered. Gostason (1985) estimated a prevalence rate of 70% in a Swedish population.

According to Einfeld and Tonge (1996), those with profound intellectual disability had lower levels of psychiatric disturbance compared with those with mild, moderate and severe intellectual disability. They found that individuals with mild intellectual disability tended to show disruptive antisocial behaviours, and "self-absorbed" and autistic behaviours were prominent in those with severe intellectual disability. They also found that age and gender did not affect prevalence, a finding that is in contrast to that found in child psychopathology. Of significant importance in the study is that fewer than 10% of children and adolescence with intellectual disability had received any assistance they required (Einfeld & Tongue, 1996).

In a similar study of 582 young persons with intellectual disability aged 4-19 years in two Australian states (New South Wales and Victoria) from both urban and rural areas, Tonge and Einfeld (2000) surveyed the parents or primary caregivers in 1991-1992 and again in 1995-1996 using a 96-item questionnaire. The results of the study confirmed their previous finding that 40% of young people with intellectual disability had psychiatric disorders, which persisted over 4 years. The range of psychiatric symptoms included disruptive behaviours, antisocial behaviours, anxiety problems, social relating problems, self-absorbed behaviours and communication disturbance. They also found that although there is considerable persistence in psychiatric disorders, there is still a degree of clinically significant change in both directions with approximately 14% either deteriorating or showing improvement. Tonge and Einfeld (2000) show that psychiatric disorders is 3-4 times more prevalent in young people with intellectual disability than in the general population.

Walters et al. (1995) conducted an archival review of 90 consecutive admissions to a dual diagnosis specialty unit in a psychiatric hospital for children. Walters et al. (1995) found 19 subjects were identified as suicidal according to the DSM III R. The subjects were 10 male and 9 female with a mean age range of 15.8 years.

Walters et al. (1995) found that suicidal behaviour appear to be common among those with mild intellectual disability (53%), 32% in those with mild-moderate range of intellectual disability, 10.5% in those with borderline functioning and 5% in those with low average range of intellectual functioning. Walter et al. (1995) reported that 6 out of the 19 subjects were suicidal prior to admission and had expressed suicidal ideation, and 13 expressed suicidal ideation both prior to or during hospitalisation. They also reported that many of the subjects had attempted suicide, for example, of the 10 subjects who had demonstrated suicide behaviour, 6 of them were potentially fatal suicide acts.

Two studies using a population-based study indicated the prevalence rate of psychiatric disorders in children with intellectual disability to be about 59% (Steffenburg, Gillberg & Steffenburg, 1996) and 37% (Stremme & Diseth, 2000). However closer examination of the studies reveals that both studies had defined autism spectrum disorder or similar syndromes (e.g., "pervasive developmental disorder" in Stremme & Diseth, 2000 or "Asperger syndrome" in Steffenburg et al., 1996). The inclusion of these syndromes as a psychiatric disorder is problematic. The features associated with such syndromes are particular to these syndromes (e.g., stereotypy) and to include the features, as psychiatric symptoms would be considered misleading in the disability literature.

However Steffenburg et al. (1996) did find that 1% of their sample of 90 children aged 8-16 years had anxiety disorder and 1% had conduct disorder. Similarly Stremme and Diseth (2000) found 3% of their 178 children sample aged 8-13 years did have conduct disorder and 3% anxiety, obsessive-compulsive or phobic disorders. In both studies, the presence of challenging or self-injurious behaviours was prominent.

The studies also indicate that often these individuals miss out on appropriate psychiatric care that they require. The review indicates several limitations. A significant limitation is the definition of psychiatric disorder or mental illness that include autism spectrum disorder or similar syndromes. To include these syndromes as a psychiatric disorder is problematic in terms of service provision and treatment plans. There also appears to be a lack of common understanding between the definition challenging behaviour as symptomatic of a person's behaviour or syndrome and challenging behaviour as a distinguishing feature of a psychiatric disorder.

The studies reviewed so far indicate that the prevalence rates of mental illness in children and adolescents with intellectual disability is higher than the general population (Tonge & Einfeld, 2000). These individuals also experience a wide range of psychiatric disorders. There is an urgent need to respond to the needs of children and adolescents with intellectual disability and mental illness as these problems impact on their educational and vocational opportunities and well-being (Hurley, 1996). Hurley (1996) argues that failure to provide appropriate psychiatric care can lead to serious psychiatric disorders in adulthood.

#### Prevalence in Adults and Older People with Intellectual Disability

The trend towards deinstitutionalization where people with intellectual disability are integrated into community settings can have positive consequences for them. Conversely, when these individuals are integrated in to the community, they can also experience stressful situations that may impact on their mental health (Nezu & Nezu, 1994). Therefore, some researchers argue that the prevalence of psychiatric disorders in

people with intellectual disability is increased (Nezu & Nezu, 1994; Santosh & Baird, 1999). For example, Bouras and Drummond (1992) found a high prevalence rate of 41% of psychiatric diagnosis in 318 adults with intellectual disability living in the community. Whereas Linaker and Nitter (1990) found 91% prevalence rate of 91% in institutionalised adults with intellectual disability.

People with Intellectual disability are a diverse group with widely varying skills and impairments, and a large number of accompanying medical and neurological impairments (Matson & Sevin, 1994). People with intellectual

disability may experience and exhibit depression and anxiety (Davis, Judd & Herman, 1997; Marston, Perry & Roy, 1997), post-traumatic stress disorder (Ryan, 1993a), dementia (Cooper, 1999; Moss & Patel, 1997), bipolar disorder (Vanstraelen & Tyrer, 1999), psychosis, anti-social behaviours, personality disorder, or schizophrenia (Bodfish & Madson, 1993; Bouras & Drummond, 1992; Bouras, Kon, & Drummond, 1993; Davidson, Houser, Cain, Sloane-Reeves, Quijano, Matson, Glesow, & Ladrigan, 1999; King et al., 1994; Patel, Goldberg & Moss, 1993; Raitasuo, Taiminen, & Salokangas, 1999).

There have also been reports of a multiple personality disorder in a man with intellectual disability (Fairley, Jones, McGuire & Stevenson, 1995), antisocial personality disorder (Hurley & Sovner, 1995) and borderline personality disorder in persons with developmental disability (Mavromatis, 2000). The studies illustrate that people with intellectual disability do experience a wide range of mental illness or psychiatric disorders found in the general population.

Bouras and Drummond (1992) found that in their sample of 318 people with intellectual disability living in the community, 41% have a psychiatric disorder. Of these, 12.3% of these have schizophrenia/paranoid disorder with an equal number of them having other psychiatric disorders such as personality disorder (6.9%), adjustment disorder (6.9%), depression (6.6%), and anxiety disorder (6.6%). Bouras and Drummond (1992) also found that 52.5% of the sample demonstrated various types of challenging behaviours such as aggression towards others (33.3%), destruction of property (27.4%), excessive noise (27.4%), nocturnal disturbance (27.4%), wandering (16.4%) and self-injurious behaviours (13.2%). They also found that those with severe intellectual disability tended to have frequent behavioural problems than those with mild intellectual disability. In their sample, self-injurious behaviours were common in women and antisocial and socially inappropriate behaviours were common in men.

In a descriptive study, King et al. (1994) also found a high number of challenging behaviours reported to psychiatric services in 251 individuals with severe and profound intellectual disability. They reported that self-injurious behaviours (36%) and aggression (35%) were common for psychiatric referrals. Other symptoms reported in their sample included depression and suicidal behaviours.

Patel et al. (1993) examined the prevalence of psychiatric morbidity in people with intellectual disability aged over 50 years using a semi-structured clinical interview using a standardised instrument. The sample consisted of 105 male and female individuals who live in the community and those in institutional care. The prevalence of psychiatric disorder excluding dementia was 11.4%, most of which were depression and anxiety. If dementia is included then the prevalence rate is 21%.

Another psychiatric disorder not often recognised in people with intellectual disability is post-traumatic stress disorder (Ryan, 1993a). Ryan argues that post-traumatic stress disorder in people with developmental disabilities is more common than generally reported as these people are more likely to experience abuse. Davis et al. (1996) investigated 47 adults with intellectual disability over a 6-month period referred for psychiatric assessment. They found that depression (n=10) was common in their sample followed by schizophrenia (n=6). All 10 individuals with depression live in the community, 7 live in a group residence and 3 live with their parents.

Mental illness also appears common in elderly people with intellectual disability (Cooper, 1999; Davidson et al., 1999; Moss & Patel, 1997). Cooper (1999) conducted psychiatric and physical assessments on 134 people with varying levels of intellectual disability whom were aged 65 years and over. Cooper found that 29 of the sample had dementia (approximately 22%) and 63 had additional psychiatric disorder other than dementia (47%). The elderly people also had significant physical disorders (e.g. high rates of urinary incontinence, immobility).

People with dual diagnosis also present with challenging behaviours (Dudley et al., 1999). Often mental health practitioners attribute the presenting challenging behaviours as a result of the intellectual disability rather than symptomatic of mental illness (Dudley et al., 1999). Dudley et al. (1999) examined distinguishable patterns of mental illness in 940 people with varying intellectual disability aged between 17-91 years who lived in state psychiatric hospitals. The diagnosis of the sample were 31.4% had schizophrenia (295), 18.2% had non-specific psychiatric disorders (171), 10.7% had affective disorders (101), 8.2% had impulse disorders (77) and 5.6% had conduct disorders (53).

Dudley et al. (1999) found six distinct behaviour patterns of the group of people with dual diagnosis. These were aggression, withdrawal or asocial behaviour, inappropriate

behaviours, sociopathic characteristics, suicidal or runaway behaviours and pica. Of interest to mental health practitioners is the finding that mental illness is a significant characteristic of the following behaviour patterns, namely aggression/disturbing behaviours, withdrawal or asocial behaviours, and inappropriate behaviours. This finding is important for clinical practice issues because there is a tendency for mental health practitioners to turn away a person with intellectual disability on the basis of challenging behaviours rather than considering that the behaviours might relate to mental illness.

A similar finding is found in the study of 185 older people with intellectual disability living in the community who was referred for crisis intervention (Davidson et al., 1999) in a 7-year study. They were divided into 4 age cohort groups--20-29, 30-39, 40-49 and more than 50 years of age. Davidson et al. (1999) reported that many of these adults demonstrated significant challenging behaviours, for example, 84 of them showed aggression toward people, 108 showed aggression and 28 of them had self-injurious behaviours. It was reported that 50% of each cohort group had a psychiatric diagnosis prior to their referral for crisis intervention and about 50% were being treated with psychoactive medication. It was also found that only between 34-59% of them had any involvement with a psychiatrist. The findings reiterate the study by Dudley et al. (1999) of the relationship between challenging behaviours and mental illness.

A few difficulties with the studies described above are the small sample size and a lack of a control group (except for Dudley et al., 1999). Many of the studies were also descriptive in nature or case studies. Despite the limitations of the studies, they highlight the range and variability of psychiatric disorders in people with intellectual disability, affecting both children and adults. It is important to reiterate that a person with intellectual disability must be treated as a unique individual and careful diagnosis must be made in the context in which the observable symptoms present are in the individual rather than treating the individual as a homogenous group (Borthwick-Duffy, 1994; Szymanski & King, 1999).

#### Models of Service Delivery and Treatment Options

There is a wide range of treatment options and service models available for people with intellectual disability and mental illness. Treatment options include psychopharmacotherapy to behavioural training approaches (Campbell & Cueva, 1995; Petronko, Harris, & Kormann, 1994; Santosh & Baird, 1999; Spreat & Behar, 1994). Santosh and Baird (1999) provide a clear outline of psychopharmacotherapy in children and adults with intellectual disability. They strongly argue for an evidence-based practice in the prescribing and monitoring of drugs in this population group. It is not the scope of this review to examine the use of psychopharmacotherapy in this population group.

Varied service models have been trialled in the treatment of this population group. They include in-patient treatment models (Spreat & Behar, 1994; Raitasuo et al., 1999; Xenitidis, Henry, Russell, Ward, & Murphy, 1999), acute in-patient treatment model (Trower, Treadwell, & Bhaumik, 1998), family involvement in residential treatment (Baker, Blacher, & Pfeiffer, 1993), community-based models (Davidson, Cain, Sloane-Reeves, Glesow, Quijano, Van Heyningen & Sholam, 1995; Nezu & Nezu, 1994; Petronko et al., 1994; Woodward, 1993) or an inter-agency collaborative approach (Doyle, 2000; Patterson, Higgins, & Dyck, 1995). The service models described above report varying levels of success. It is not the scope of this review to examine each model of service delivery described above.

Instead this review will discuss several underlying factors that appear common in all the service models. They include the use of reliable diagnostic assessment tools and procedures, the participation and collaboration of a multidisciplinary team, the training of caregivers in the treatment plan, continued care from in-patient to outpatient stage, monitoring of the individual following treatment and the use of a multi-system treatment approach. A collaborative approach ensured greater coordination of services between community health services and the hospital that lead to improved services (Davidson et al., 1995; Patterson et al., 1995).

In a review of recent advances in psychiatric rehabilitation for patients with severe mental illness, Muesser, Drake and Bond (1997) highlight some significant rehabilitation strategies that have been the focus of extensive research, such as case management, social skills training, supported employment, family intervention and integrated treatment for comorbid substance use disorders. Muesser et al. (1997) identified several characteristics of successful psychiatric rehabilitation programs. They found that effective interventions tend to be direct and behavioural that is usually focussed on specific skills and situations rather than general life enhancements or personal growth. For example, assertive case management directs skills training and environmental supports to avoid relapse or supported employment rehabilitation is aimed at gaining the skills and supports required for a specific job.

Muesser et al. (1997) report that effective psychiatric rehabilitation are specific to their related outcomes with only minimal generalizability to other domains. They also noted that long-term intervention plans are more effective than short-term interventions (less than 6 months). Effective interventions are best delivered within the natural contexts of the individual. Hence there is increasing trend towards moving out of clinics to ecologically valid situations of the individual (Muesser et al., 1997). Lastly they found that effective interventions combine skills training and environmental supports.

Ryan (1993b) reiterates the importance of a collaborative team approach in the assessment and treatment of people with intellectual disability and mental illness. She argues that the collaborative team is multidisciplinary and may consist of the community psychiatrist, mental health practitioners, behaviour specialists and case managers. Ryan (1993b) also argues that it is important to highlight that no single professional group has monopoly or knowledge in this complex area. Failure to engage all professionals in this area will lead to fragmentation of services to the detriment of people with intellectual disability and mental illness (Doyle, 2000).

There is increasing evidence of the prevalence of mental illness in persons with intellectual disability (Borthwick-Duffy, 1994; Lovell & Reiss, 1993). There are also varied treatment options available as discussed above. Given the emerging research in the area, people with intellectual disability and mental illness continue to be a forgotten group of people that is often considered as too difficult (McNally, 1996). Historical factors may explain this anomaly.

#### Historical Perspectives of Intellectual Disability and Mental Illness

Historically, persons with intellectual disability were viewed as less than human or "feeble-minded" and hence incapable of emotions (Parmenter, 2001). It was viewed that people with intellectual disability were incapable of developing emotional disorders that could be characterized as mental illness (Borthwick-Duffy, 1994). Secondly, there was a view that many of the challenging behaviours demonstrated by people with intellectual disability can be attributed to impaired development that characterized intellectual disability (Lovell & Reiss, 1993; Nezu & Nezu, 1994).

Thirdly, there was a perspective that while people with intellectual disability might be vulnerable to mental illness but that their emotional difficulties were of a different quality and were usually biological in origin (Borthwick-Duffy, 1994; Nezu, 1994). Fourthly, there were fewer formal role expectations of people with intellectual disability in society (e.g., in employment) and hence the assumption that they did not have demanding roles that might contribute to a mental illness (Moss, 2001). These beliefs have contributed to the lack of understanding of people with intellectual disability who may have mental illness and the failure to treat these people appropriately in the past (Fuller & Sabatino, 1998; Santosh & Baird, 1999).

The lack of specialized training in the mental health needs of people with intellectual disability in universities and research centres contributed to the gap between the fields of intellectual disability and mental illness (Moss et al., 1997; Nezu, 1994). For example, Nezu (1994) reported that in a survey of all research articles in the *Journal of Consulting and Clinical Psychology* over a 20-year period indicated that only 11 out of 3,341 articles published addressed intellectual disability. Phelps and Hammer (1989 cited in Nezu, 1994) reported that 75% of clinical psychology and 67% of counseling psychology did not focus on intellectual disability in their curricula. However, since the 1960s the rigour in diagnosing and treating mental illness in the general population has influenced the care of people with intellectual disability (Ratey & Gualtieri, 1991).

Within the context of Australia, Doyle (2000) discusses the concerns and issues associated with the philosophy, policy and provision of health care to people with intellectual disability. Intellectual disability was perceived and treated with the same regimens of care and control afforded to insanity (Doyle, 2000). However in the 1980s, most Australian states entered the prevailing ethos that intellectual and developmental disability was not an illness, and therefore not necessarily a concern for health care providers. According to Doyle (2000), this paradigm shift contributed to a reduced and sporadic involvement of mental health professionals in the care of people with intellectual disability that resulted in a loss of professional engagement of mental health nurses in the area of intellectual disability and mental health. This loss of professional engagement has resulted in a lack of co-ordination and accessibility of services for people with intellectual disability and mental illness (Doyle, 2000).

#### Gaps in Access to Mental Health Services

While there is an increased in the treatment options available for people with intellectual disability and mental illness, there are still many of them who fall between the gaps (Cooper, 1999; Einfeld & Tonge, 1996; Gustafsson, 1997; Nezu & Nezu, 1994). Access to mental services still remains a predominant issue for people with intellectual disability. For example, Einfeld and Tonge (1996) found that of the 40.7% of clients aged 4-18 years with mental illness, only fewer than 10% of them had received assistance. Similar findings have also been reported by Gustafsson (1997). Gustafsson found a low frequency of psychiatric care utilization among people with intellectual disability and psychiatric disorders in comparison to the proportion of care utilization among people with psychiatric disorders in the general population.

Several factors may explain the lack of access of these people and some of them have been described previously in the historical perspectives on intellectual disability and mental illness. There is still a lack of understanding of dual diagnosis in this population group by caregivers and general practitioners (Cooper, 1999; Moss et al., 1997; Santosh & Baird, 1999). While there have been gains made in assisting practitioners in screening and assessing for mental illness in people with intellectual disability (Demb, Brier, Huron &

Tomor, 1994; Linaker & Helle, 1994; Moss, Prosser & Goldberg, 1996), there are still many practitioners in the community who have minimal understanding of the needs of people with intellectual disability. The lack of specialised training has already been discussed earlier but it is important to reiterate that mental health practitioners lack understanding of dual diagnosis in people with intellectual disability (Moss et al., 1997).

Moss et al. (1997) argue that the complexity of the definitions and symptoms of mental illness make diagnosis of dual diagnosis difficult. Furthermore diagnosis is also dependent on clear communication between the practitioner and patient. In most cases, individuals with intellectual disability may have difficulty describing their symptoms and problems to the mental health practitioner. They may also not have the means to communicate or inform the practitioner of his or her experience; or such information is conveyed to the practitioner by a support person who might not have all the relevant information (Moss et al., 1997). Furthermore a person with intellectual disability and mental illness is dependent on a third person to seek psychiatric help for them (Moss, 2001).

Access to community mental health services by these individuals are often impeded by government departmental territoriality, for example, mental health professionals in the Department of Health may insist that the care of these people with intellectual disability and mental illness is the responsibility of disability services. Furthermore, there are different intake and access criteria for mental health services within the same government area health service. Such separatist attitudes lead to these individuals falling between the gaps in service access (Nezu & Nezu, 1994). Many of these services do not provide to the specific needs of people with intellectual disability. However in South Australia a Dual Disability Unit was recently established to address the gap in service for this population (Kelly, 2001).

#### Conclusion

There is a growing need for these services in the community. The trend in intellectual disability is towards deinstitutionalisation and caring for the person within the family home (Doyle, 2000). This shift means there are more people with intellectual disability living in the community. Studies have demonstrated that people with intellectual disability living in the community are more likely to be in need for psychiatric services (Driessen, DuMoulin, Haveman, Van Os, 1997; Nezu & Nezu, 1994).

Driessen et al. (1997) examined 49 individuals with intellectual disability referred for psychiatric services. They reported that there are several predictors of people with intellectual disability who might be in need for psychiatric services, such as being older (95%), having milder intellectual disability (95%) and living alone. Further studies have also confirmed the results found by Driessen et al. (1997) with regards to age, that is, older people with intellectual disability are more likely to have a mental illness (Cooper, 1999; Davidson et al., 1999; Patel et al., 1993). On the other hand, Jacobson (1990) reported that age did not predict psychiatric morbidity at all in his study.

Dual diagnosis in people with intellectual disability is an emerging research interest and presents as a challenge for both community and health services. While there have been improvements in diagnosis and treatment options, there are still difficulties in terms of the day to day practice and service delivery to this population group.

Prevalence studies indicate that there is a higher incidence of mental illness in this group than in the general population. Furthermore, people with intellectual disability also experience a wide range of psychiatric disorders often seen in the general population. Factors underlying effective interventions and service models for this group have been described in this review. This review highlights the urgency for a seamless and co-ordinated approach to service delivery for people with intellectual disability and mental illness.

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99-CV-05018-ORD

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WESTERN DISTRICT OF WASHINGTON AT TACOMA  
BY \_\_\_\_\_ DEPUTY

The Honorable Robert B. Leighton

**UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON  
AT TACOMA**

SHARON ALLEN, *et al.*  
  
Plaintiffs,  
  
v.  
  
WESTERN STATE HOSPITAL, *et al.*  
  
Defendants.

No. C99-5018-RBL  
  
~~(PROPOSED)~~ ORDER AND  
PARTIAL SETTLEMENT  
AGREEMENT

This matter is before the Court on the parties Joint Motion and Entry of Order Scheduling Fairness Hearing in the above-captioned action. The Court has reviewed the Motion, including attachments thereto, and the pleadings and other documents on file herein. Being fully advised, the Court hereby orders as follows:

**I. PURPOSE OF ORDER:**

A. The purpose of this settlement agreement is to address, without defining constitutional standards or statutory requirements, the protection of the Constitutional rights to minimally adequate care and protection from harm, and statutory rights to reasonable modifications to treatment of *Allen* class members at Western State Hospital ("WSH") based upon their cognitive deficits.

(PROPOSED) ORDER AND PARTIAL  
SETTLEMENT AGREEMENT  
NO. C99-5018-RBL

ATTORNEY GENERAL OF WASHINGTON  
670 Woodland Square Loop SE  
PO Box 40124  
Olympia, WA 98504-0124  
(360) 459-6558

1           B.       Specifically, the settlement addresses: overall conditions of care; protection  
2 from harm; treatment and habilitation; behavior management and freedom from unnecessary  
3 restraint; census of the Habilitative Mental Health Unit ("HMH") Unit; vocational training and  
4 employment opportunities; personal choice; dignity and freedom of association; discharge  
5 planning; patient regression; and access to community-based services.

6           C.       The parties agree that this Partial Settlement and Order does not affect the stay  
7 as previously ordered in the Agreed Order on Joint Motion to Stay Proceedings approved and  
8 entered by the Court on December 2, 1999, as it relates to all claims regarding the services  
9 provided in the community to the plaintiffs and the plaintiff class.

10       **II.    ENFORCEABILITY, DISPUTE RESOLUTION, AND NON-WAIVER OF**  
11       **CLAIMS AND DEFENSES**

12       **A.    The attached Settlement Agreement regarding WSH is enforceable as follows:**

13               Sections III A through E and IV below are enforceable subject to the dispute resolution  
14 provisions and requirements set forth below in paragraphs B 1-5 of this Section.

15       **B.    Western State Hospital Dispute Resolution:**

16           1.       If at any time during the monitoring period, plaintiffs' counsel believes that  
17 defendants are not substantially in compliance with this Order, plaintiffs' counsel shall contact  
18 defendant's counsel to request a consultation with the medical director or program manager of  
19 the rehabilitative mental health unit at WSH. The parties shall make a good faith attempt to  
20 informally and timely resolve the dispute. Consultation with the Independent Monitor may be  
21 requested by either party.

22           2.       If a timely and informal resolution cannot be reached by the parties, the parties  
23 shall participate in formal mediation to resolve the issue. Mediation of the disputed matter  
24 shall occur within 30 business days of a party's formal written request for mediation, unless  
25 otherwise agreed in writing by the parties or the mediator is unavailable. A formal request for  
26 mediation in the form of a letter shall be submitted by the party requesting mediation. This

1 request shall be served on all counsel for the parties, the Independent Monitor, and the  
2 mediator.

3 3. The Honorable J. Kelly Arnold shall be appointed as the mediator for any  
4 dispute arising out of this Order. If Judge Arnold is unavailable, the parties shall mutually  
5 agree upon alternative mediators. Each party shall bear its own costs associated with  
6 mediation.

7 4. If, after participating in good faith at the mediation, no resolution is reached,  
8 Plaintiffs may file a motion with the U.S. District Court in this matter requesting the Court to  
9 hold a "show cause" hearing ordering the defendants to show cause why they are not  
10 substantially in compliance with this Order. Plaintiffs shall provide the appropriate notice to  
11 defendants' counsel of such action.

12 5. In the event that plaintiffs have reasonable cause to believe that there is a risk of  
13 imminent harm to a class member as a result of the defendants' failure to comply with this  
14 Order, plaintiffs will make a good faith effort to consult with defendants' counsel and the  
15 medical director of WSH to discuss the issue or issues before filing a motion requesting a show  
16 cause hearing. Consultation with the Independent Monitor may be requested by either party, at  
17 the requesting party's expense. If the matter is not resolved, Plaintiffs may proceed directly to  
18 the Court and request a show cause hearing without first going through mediation or may take  
19 any other necessary legal action. Plaintiffs will provide at least one business day written notice  
20 to defendants' counsel via facsimile or e-mail and first class mail prior to initiating court  
21 action.

22 6. In the event that the Court grants plaintiffs' motion requesting a show cause  
23 hearing, the parties will brief the issues and with the Court's approval, present oral arguments  
24 and/or present evidence at a show cause hearing on the issue of defendants' substantial  
25 compliance with this agreement.  
26

1 C. Nothing in this Order shall be deemed to limit:  
2 1. The Court's powers of contempt or any other power possessed by this Court;  
3 2. The ability of any class member to seek relief of any kind to which they would  
4 otherwise be entitled under state or federal law other than the claims for injunctive relief  
5 adjudicated in this action;  
6 3. The ability of the Washington Protection and Advocacy System ("WPAS") to  
7 fulfill its federal mandates pursuant to the "Protection and Advocacy for Individuals with  
8 Mental Illness (PAIMI) Act," 42 U.S.C. § 10801, *et seq.* and the regulations promulgated  
9 thereto, 42 C.F.R. § 51 and the "Developmental Disabilities Assistance and Bill of Rights (DD)  
10 Act," 42 U.S.C. § 15041, *et seq.* and the regulations promulgated thereto, 45 C.F.R. § 1386.  
11 D. By agreeing to continue to stay proceedings and to entry this Order and Partial  
12 Settlement Agreement, defendants have waived no defenses to allegations that they have or  
13 are violating plaintiffs' constitutional or other legal rights, and have admitted no liability  
14 regarding plaintiffs' claims.  
15 E. By agreeing to continue to stay proceedings and to entry of this Order and Partial  
16 Settlement Agreement, plaintiffs have waived no claims as to allegations that defendants have  
17 or are violating plaintiffs constitutional or other legal rights.  
18 F. The parties acknowledge, and the Court recognizes, that the Partial Settlement  
19 Agreement set forth herein is a negotiated settlement of disputed claims. This settlement does  
20 not constitute an agreement of the parties as to the constitutional or legal standards applicable  
21 to plaintiffs' claims, and shall not limit any party's right to litigate such standards in future  
22 proceedings.  
23 G. During the monitoring period WPAS may, at its own expense, consult with the  
24 Independent Monitor.  
25  
26

1 III. AGREEMENT REGARDING SERVICES AT WESTERN STATE HOSPITAL

2 A. Controlling the Census of the Habilitative Mental Health Unit at Western State  
3 Hospital (WSH); Adequate Staffing to Provide Care to *Allen Class* Members at  
4 WSH.

5 1. Eligibility:

6 Within 180 days of the entry of this Order, defendants shall:

7 a. Identify and prioritize and conduct eligibility re-determination for  
8 individuals whose Division of Developmental Disabilities ("DDD") eligibility needs to be  
9 clarified in order to proceed with appropriate treatment and/or discharge planning. In the event  
10 that a class member is found ineligible for DDD services, WSH will notify the designated  
11 Regional Support Network liaison for this individual as to this determination and the status of  
12 the individual's readiness for discharge.

13 b. Revise DDD Policy 11.03, *Eligibility Expirations and Reviews*, to  
14 facilitate timely reviews of all class members residing at WSH. In cases in which psychiatric  
15 stability is not relevant to the eligibility re-determination, the re-determination may occur as  
16 soon as possible. When psychiatric stability is relevant to the eligibility re-determination, the  
17 re-determination may occur when the treating psychiatrist determines the individual to be  
18 sufficiently stable for assessment.

19 2. Notification:

20 Within 90 days of the entry this Order:

21 a. The Mental Health Division ("MHD") will notify community hospitals  
22 that have certified evaluation and treatment beds, and free-standing Evaluation and Treatment  
23 Centers of the requirements of this order for a pre-screening assessment prior to admission to  
24 WSH for individuals enrolled with DDD. The notice will provide for the facilities to notify  
25 WSH at the time a fourteen day involuntary detention order is entered or upon filing of a  
26 petition for revocation.

b. The pre-screening assessment referred to item 2.a above shall be

1 performed by WSH staff to determine the most appropriate placement at the hospital and to  
2 evaluate and recommend alternatives to WSH admission.

3 c. DDD will issue a management bulletin directing DDD case managers to  
4 notify the DDD mental health case resource manager of any community hospital admission.

5 **3. Census of Current HMH Unit:**

6 a. Within 180 days of the entry of this Order, defendants will reduce the  
7 census of the HMH unit at its current location to the target cap of 26.

8 b. Within 180 days of the entry of this order, the defendants will discharge  
9 a minimum of four individuals identified by defendants as ready for discharge and for whom  
10 an appropriate discharge plan has been developed.

11 c. Defendants will make best efforts to maintain the target cap of 26. The  
12 target cap can be exceeded only as follows:

13 1) The WSII medical director, or designee, in consultation with the  
14 HMH program manager, deems it necessary to exceed this maximum. WPAS shall be notified  
15 in writing by e-mail or facsimile within one business day whenever the census exceeds the  
16 target cap, and shall be notified of the clinical basis for the decision.

17 2) In the event that the cap is exceeded, WSH will jointly develop  
18 and implement a plan with DDD to return to the target census of 26. In situations in which  
19 coordination with DDD is not required to achieve the reduction in census, WSII will develop  
20 and implement the plan. The plan will be developed and a copy will be provided to WPAS  
21 within three business days unless the parties mutually agree in writing to an extension of time.  
22 The plan will be reviewed on at least a monthly basis by the medical director, in consultation  
23 with the HMH unit manager. Defendants shall also review the progress of the implementation  
24 of the plan with WPAS on at least a monthly basis until the census no longer exceeds 26.  
25 Whenever the census exceeds 26, the MHD program administrator and the DDD MH program  
26 manager will notify their respective division directors and assistant secretaries of the current

1 census and the plan to return the census to 26. The MHD program administrator and the  
2 DDD MH program manager shall be regularly apprised by the WSH medical director or his or  
3 her designee, of the status of the census on the HMII unit until such time as the census is  
4 decreased to the target cap of 26.

5 3) The census of the HMII unit in its current location will not  
6 exceed 30.

7 **4. Future Placement of Class Members within WSH**

8 Within 60 days of the entry of this Order, defendants will develop a policy regarding  
9 the future placement of class members who have historically been placed on the HMH Unit  
10 onto other treatment units at WSH. This policy shall provide that all class members reside on  
11 the HMH unit, with the following exceptions:

12 a. Class members whom the HMH treatment team identifies as being more  
13 appropriately served on another unit may be placed on another unit at the approval of the  
14 medical director. In the event that a class member is moved to a unit other than that of the  
15 HMII unit, the class member will be afforded the opportunity to receive all treatment,  
16 vocational, and recreational supports and services set forth in this Order, consistent with the  
17 treatment provided to class members residing on the HMII unit, as clinically indicated. The  
18 clinical appropriateness of the placement of a civilly committed class member on a unit other  
19 than the HMII unit will be regularly reviewed by the medical director at least every thirty days  
20 or more often as clinically indicated, and promptly shared with WPAS.

21 b. A class member may be placed on a ward other than that of the HMII  
22 unit if in the opinion of the medical director the person presents an unacceptable level of risk to  
23 the safety of the class members residing on the HMII unit, in accordance with paragraph 3(a),  
24 above.

25 c. Class members committed to WSH for competency evaluation and/or  
26 restoration will be placed at CFS unless the medical director determines that placement on

1 another unit is more appropriate. In the event that a civil detention in accordance with RCW  
2 Chapter 71.05 is subsequently ordered, the IIMH program manager or designee will assess the  
3 person for clinical appropriateness for admission to the HMH unit. If the medical director, in  
4 consultation with the HMH unit manager determines that the class member is not clinically  
5 appropriate for the HMH unit, the class member may be placed on another unit, in accordance  
6 with paragraph 3.a. above.

7 **5. Staffing of HMH Unit:**

8 If staff on the IIMH unit is reduced based on the reduction in census, staffing will be  
9 restored commensurate with an increase in census.

10 **B. Reducing the risk of patient-to-patient assaults on the HMH Unit at WSH:**

11 1. Within 90 days of the entry of this Order, Defendants shall adopt a policy  
12 regarding program environment and safety that will promote the improvement of safety for all  
13 *Allen* class members at WSH. This policy shall be developed in consultation with the  
14 mutually agreed upon consultant as set forth in Section IV.A of this Order. Implementation of  
15 this policy will be monitored by the Independent Monitor as set forth in Section IV.B of this  
16 Order.

17 2. Within 90 days of the entry of this Order, Defendants shall adopt a policy  
18 regarding the reduction of patient-to-patient assaults. This policy will include a description of  
19 a standardized "debriefing" tool to be used with each *Allen* class member involved in each  
20 patient-to-patient assault. This policy shall be developed in consultation with the mutually  
21 agreed upon consultant as set forth in Section IV.A of this Order. Implementation of this  
22 policy will be monitored by the Independent Monitor as set forth in Section IV.B of this Order.

23 3. a. Within 30 days of the entry of this Order, defendants shall create a  
24 multidisciplinary team, including a psychiatrist, a psychologist, and the IIMH program  
25 manager or his or her designee, with expertise in habilitative mental health treatment and in  
26 treatment modalities for individuals with assaultive or self-injurious behaviors. The HMH

1 Program Manager will identify class members residing on the IIMH Unit who are  
2 demonstrating a recent pattern of highly assaultive or self-injurious behavior that has not been  
3 reduced by current treatment approaches.

4           **b.**       Within three business days of the identification of a class member who  
5 has been demonstrating a recent pattern of highly assaultive or self-injurious behavior that has  
6 not been reduced by current treatment approaches, the multidisciplinary team described in the  
7 preceding paragraph will be notified of the need for a review. The team will meet as soon as  
8 practicable and will make treatment recommendations. The team will meet at least quarterly,  
9 or more often as clinically indicated, when individuals with highly assaultive or self-injurious  
10 behavior who are not responding to current treatment approaches are identified. A written copy  
11 of the team's recommendations and current progress will be shared with WPAS.

12  
13 **C.   Data collection, assessment, treatment planning and active treatment, behavioral**  
14 **supports, medication administration and monitoring, consultation and second**  
15 **opinions, and staffing levels and training.**

16           **I.   Data Collection**

17           **a.**       Within 90 days of the entry of this Order, defendants shall adopt a policy  
18 regarding the administration of PRN medications to *Allen* class members. This policy shall  
19 include provisions requiring that defendants track data regarding PRN usage in regard to the  
20 *Allen* class members at WSH. This policy shall be developed in consultation with the mutually  
21 agreed upon consultant as set forth in Section IV.A of this Order.

22           **b.**       Within 90 days of the entry of this Order, defendants shall adopt a policy  
23 regarding the development and implementation of a behavioral tracking system. This policy  
24 shall include provisions requiring that defendants track data regarding class member behavior  
25 and integrate this data into the class member's WSH treatment plan and the treatment planning  
26 process. This policy shall be developed in consultation with the mutually agreed upon  
consultant as set forth in Section IV.A of this Order.

1           c.       Within 90 days of the entry of this Order, defendants shall adopt a policy  
2 regarding the development of a process to measure consumer satisfaction.

3           **2.       Assessments**

4           Within 90 days of the entry of this Order, defendants shall adopt a policy  
5 regarding the development and implementation a multi-disciplinary diagnostic assessment  
6 procedure for all *Allen* class members at WSH. This policy shall be developed in consultation  
7 with the mutually agreed upon consultant as set forth in Section IV.A of this Order.

8           **3.       Treatment Planning and Active Treatment**

9           a.       Within 90 days of the entry of this Order, defendants shall adopt a policy  
10 regarding the development and implementation of a procedure for individual treatment  
11 planning, including treatment plan review and modification, and behavioral support planning  
12 and implementation for all *Allen* class members at WSH. This policy shall be developed in  
13 consultation with the mutually agreed upon consultant as set forth in Section IV.A of this  
14 Order.

15           b.       Within 90 days of the entry of this Order, defendants shall adopt a policy  
16 regarding community integration for all *Allen* class members at WSH. This policy shall be  
17 developed in consultation with the mutually agreed upon consultant as set forth in Section  
18 IV.A of this Order.

19           c.       Within 90 days of the entry of this Order, Defendants shall adopt a  
20 policy regarding the provision of vocational treatment for *Allen* class members at WSH. This  
21 policy will provide that vocational treatment is integrated with other treatment approaches of  
22 the individual treatment plan. This policy shall be developed in consultation with the mutually  
23 agreed upon consultant as set forth in Section IV.A of this Order.

24           d.       Within 90 days of the entry of this Order, Defendants shall adopt a  
25 policy regarding recreational treatment for *Allen* class members at WSH. This policy shall be  
26 developed in consultation with the mutually agreed upon consultant as set forth in Section

1 IV.A of this Order.

2 e. Within 90 days of the entry of this Order, Defendants shall adopt a  
3 policy regarding the provision of active treatment for all *Allen* class members at WSH. This  
4 policy shall provide that each class member at WSH receive individualized, active, habilitative  
5 mental health treatment and shall:

6 1) Provide that each class member shall receive, within 14 days of  
7 admission to WSH, and at such later intervals as are clinically indicated, a comprehensive  
8 assessment of the medical, psychiatric, and psychological conditions presumed to have  
9 produced the behavioral and/or psychiatric symptoms that resulted in the class member being  
10 placed at WSH, as well as his or her other clinical needs. The treatment team also will be  
11 responsible for contacting the case manager, community provider, or other concerned  
12 individual, as applicable, to inquire about antecedent conditions, including environmental  
13 conditions, that may have precipitated the current admission.

14 2) Provide that within seven days of admission, the IHMH or other  
15 relevant treatment team at WSH shall develop a diagnostically-based treatment plan that  
16 addresses the class member's identified clinical needs. The policy shall further provide that  
17 treatment plans shall be updated no later than 30 days after admission and at least quarterly  
18 thereafter, with more frequent updates occurring as clinically indicated. The treatment plans  
19 shall be updated to reflect the results of any assessments conducted, but no later than 30 days  
20 following admission.

21 3) Include a description of the methodology regarding  
22 individualized case formulation that will be applied to each class member admitted to WSH.

23 4) Require that WSH staff, upon the admission of a class member  
24 for whom it is clinically appropriate, begin the process of developing and incorporating into  
25 each class member's treatment plan the elements of a current positive behavior support plan  
26 (PBSP). The policy shall also provide that, while the elements of a PBSP are being developed,

1 WSH shall use appropriate preliminary behavioral supports, as clinically indicated and as  
2 incorporated into the treatment plan, to address the major behavioral problems that precipitated  
3 the current hospitalization.

4                   5)     Adopt an objective data collection system to facilitate  
5 habilitative mental health treatment team monitoring of patient progress.

6                   6)     Require that at least six hours per day, excluding weekends and  
7 holidays, of active, individualized, habilitative mental health treatment be available to each  
8 class member. Exceptions to this policy will require staff documentation that the patient is not  
9 psychiatrically or medically stable and is therefore unable to participate in the full six hours of  
10 treatment. The policy will further provide that class members will receive weekend and  
11 evening habilitative activities, appropriate to the class member's individual needs.

12           This policy shall be developed in consultation with the mutually agreed upon consultant  
13 as set forth in Section II of this Order.

14           **4. Behavioral Support and Restrictive Procedures**

15           Within 90 days of the entry of this Order, defendants shall adopt a policy  
16 regarding the use of restrictive procedures in regard to *Allen* class members at WSH. This  
17 policy's goal will be to minimize the use of restrictive procedures for this population and  
18 emphasize the use of less intrusive procedures. This policy will include a description of a  
19 standardized "debriefing" tool to be used with each *Allen* class member following the use of a  
20 restrictive procedure. This policy shall be developed in consultation with the mutually agreed  
21 upon consultant as set forth in Section IV.A of this Order.

22           **5. Medication Administration and Monitoring**

23           Within 90 days of the entry of this Order, defendants shall adopt a policy  
24 regarding the development and implementation of a procedure for the ongoing assessment of  
25 efficacy of medication regimens in regard to treatment goals for all *Allen* class members at  
26 WSH. This policy shall be developed in consultation with the mutually agreed upon consultant

1 as set forth in Section IV.A of this Order.

2 **6. Consultation and Second Opinions**

3 a. Within 90 days of the entry of this Order, defendants shall adopt a policy  
4 setting forth a procedure for WSH treating professionals to procure outside consultation for  
5 *Allen* class members who present refractory treatment issues. This policy shall be developed in  
6 consultation with the mutually agreed upon consultant as set forth below in Section IV.A of  
7 this Order.

8 b. Within 90 days of the entry of this Order, defendants shall adopt a policy  
9 setting forth a procedure for WSH treating professionals to obtain a second opinion for the  
10 treatment of *Allen* class members. This policy shall be developed in consultation with the  
11 mutually agreed upon consultant as set forth in Section IV.A of this Order.

12 **7. Staffing Levels and Staff Training**

13 a. Within 90 days of the entry of this Order, defendants shall adopt a policy  
14 regarding staff training in core competencies. This policy shall include the requirement that  
15 Defendants develop core competency curricula and that there is data tracking of staff training  
16 in core competencies, including identification of staff members who have received training.  
17 All staff at WSH providing supports and services to *Allen* class members will be trained in  
18 these identified core competencies. This policy shall be developed in consultation with the  
19 mutually agreed upon consultant as set forth in Section IV.A of this Order.

20 b. Defendants shall continue to track data of staffing level, including RN,  
21 LPN, and IC staff for the care and treatment of *Allen* class members at WSH.

22 c. Within 90 days of the entry of this Order, Defendants shall adopt a  
23 policy ensuring that adequate nursing services are available for *Allen* class members at WSH.  
24 This policy shall be developed in consultation with the mutually agreed upon consultant as set  
25 forth in Section IV.A of this Order.

26

1 **D. Discharge from WSH for Class Members**

2 Within 90 days of the entry of this Order, Defendants shall adopt a policy regarding  
3 discharge and discharge planning for *Allen* class members at WSH. This policy shall be  
4 developed in consultation with the mutually agreed upon consultant as set forth in Section  
5 IV.A of this Order.

6 **E. Appropriate and Timely Reports of Incidents of Alleged Patient Abuse and  
7 Neglect**

8 1. The implementation of the policy regarding program environment and safety, as  
9 set forth in paragraph III. B.1, shall ensure that incidents are appropriately and timely reported.

10 2. The implementation of the policy regarding restrictive procedures, as set forth  
11 in paragraph III. B.11, shall ensure that use of restrictive procedures is appropriately and  
12 timely reported.

13 3. Within 90 days of the entry of the Order, defendants shall adopt a policy  
14 regarding the reporting of incidents involving *Allen* class members providing as follows:

15 a. All administrative reports of incidents (AROI) will be reviewed by the  
16 HMH Program Manager;

17 b. Those reports which, in the opinion of the HMH Program Manager,  
18 present credible allegations of suspected patient abuse or the neglect of an *Allen* class member  
19 at WSH as defined by WSH Policy No. 3.4.4, will be assigned to a supervisor for investigation  
20 pursuant to the procedures set forth in the WSH Personnel Policy No. 545;

21 c. A copy of the AROI, described in paragraph (b) above, and the referral  
22 to the supervisor will be forwarded to the chief executive officer of WSH, Mental Health  
23 Division (MHD), and the appropriate DSHS audit team.

24 d. An appropriate DSHS audit team will review and maintain a database of  
25 the AROIs and follow up with MHD to ensure that an appropriate investigation has occurred;

26 e. The HMH program manager will review the results of the supervisor's

1 investigation and take appropriate action;

2 f. The WSH CEO will be provided with a copy of the results of the  
3 supervisor's investigation;

4 g. Copies of the AROIs will be sent to WPAS for the pendency of the  
5 monitoring period described in Section IV of the Order;

6 h. All of the AROIs that contain allegations of patient abuse and neglect, as  
7 defined by WSH Policy 3.4.4, and all security reports involving *Allen* class members at WSII  
8 which a) relate to a patient injury of unknown origin; b) allege abuse or neglect; or c) relate to  
9 probable serious injuries as a result of assault or self-injurious behavior, will be reviewed on the  
10 next business day by the quality assurance investigative team (Team) at WSH. This Team shall  
11 be independent of ward staff and include at least one RN, one physician, and an additional  
12 member of the quality assurance department and a member of the security department.

13 i. Based upon its review, the Team will independently evaluate incidents  
14 of patient to patient assault that could have resulted from abuse or neglect, as defined in WSII  
15 Policy No. 3.4.4. Such evaluation may include an interview and/or examination of the patient  
16 who is the alleged victim, interviews with ward staff, or such other investigative actions as  
17 deemed appropriate by the team. In the event that the Team concludes that the incident may  
18 have constituted abuse or neglect, as defined by WSII Policy No. 3.4.4, the Team shall refer  
19 the matter to the Medical Director, who shall require a supervisory investigation according to  
20 WSH Personnel Policy No. 545, if such investigation has not previously been ordered.

21 j. This policy shall be developed in consultation with the mutually agreed  
22 upon consultant as set forth in Section IV.A of this Order.

23 4. The Team shall continue to report all incidents of suspected abuse or neglect, as  
24 defined by WSH Policy No. 3.4.4, to the appropriate state agencies and law enforcement as  
25 required by law. The Team shall also report all instances of failure to report suspected patient  
26 abuse and neglect to the appropriate agencies.

1           5. Defendants will maintain a policy for the mandatory reporting of suspected  
2 patient abuse and neglect as defined by RCW 74.34 and RCW 71.124. This policy will be  
3 applicable to all *Allen* class members at WSH.

4           6. Within 90 days of the entry of this Order, all staff working with *Allen* class  
5 members will be informed or be reminded of their obligations to report suspected abuse and  
6 neglect and informed of the appropriate reporting procedure and will be informed or be  
7 reminded that the failure to report is grounds for disciplinary action and will be reported to the  
8 appropriate agencies. All new employees will receive this information at the time of  
9 orientation and sign an acknowledgment of receipt of this information. All current employees  
10 will be asked to review the reporting policy and signed an acknowledgment that they have  
11 reviewed and understand the policy annually at the time of their evaluations. Defendants shall  
12 take appropriate disciplinary action in accordance with personnel policies against any staff  
13 member found to have engaged in abuse and/or neglect of a patient as defined in WSH Policy  
14 3.4.4.

15           7. Within 90 days of the entry of this Order, each unit on the HMH unit will have  
16 an easily identifiable notebook containing all pertinent policies and forms related to incident  
17 reporting and containing an easily understandable summary of procedures that staff will follow  
18 when they obtain information related to allegations of patient abuse or neglect. The program  
19 director of the HMH unit will be responsible for ensuring implementation of this policy.

20           8. Within 90 days of the entry of this Order, defendants will develop and  
21 implement a process whereby the program director of the HMH unit, or his or her designee,  
22 shall conduct two or more unannounced spot checks of *Allen* class member records at WSU  
23 each month to ensure that incidents as defined by WSH Policy 3.4.4 have been reported on an  
24 AROI. The HMH program manager shall report the results of these spot checks to the  
25 Independent Monitor and the state's self-monitoring committee and WSH CEO and Medical  
26 Director.

1 IV. MONITORING AND CONSULTATION REGARDING SERVICES FOR  
2 ALLEN CLASS MEMBERS AT WSH

3 A. Appointment, Duties, and Compensation of Outside Consultant for WSH

4 Within 30 days of the entry of this Order, defendants will take all reasonable steps to  
5 retain a mutually agreed upon independent consultant with experience in the provision of long-  
6 term habilitative mental health treatment to provide consultation to WSH treatment teams  
7 providing care and treatment to *Allen* class members. If such consultant cannot be retained  
8 within the thirty day period, defendants will retain such consultant at the earliest possible date,  
9 and shall inform plaintiffs of its efforts to do so.

10 B. Appointment, Duties, and Compensation of Independent Monitor

11 1. Within 30 days of the entry of this Order, defendants will retain a mutually  
12 agreed upon independent monitor, whose role will be to monitor the implementation of the  
13 policies set forth in Section III, and who shall perform such role for a period of twelve months  
14 following appointment unless the period is extended an additional six months pursuant to  
15 paragraph 7 below. For the purposes of this Order and Settlement Agreement, the term  
16 "monitoring period" shall mean the 12 or 18 month term of the independent monitor set forth  
17 in this paragraph.

18 2. Upon the request of the defendants, the Independent Monitor will provide  
19 technical assistance and training to defendants regarding the implementation of this  
20 Agreement. The specific duties of the Independent Monitor are set forth below in this section  
21 in paragraphs 6.a through u. The Independent Monitor shall consult with the medical director  
22 of WSH and the program manager of the HMH unit, as he deems necessary to perform his  
23 duties.

24 3. The parties have mutually agreed that the Independent Monitor shall be William  
25 I. Gardner, Ph.D., an expert in the area of habilitative mental health treatment.

26 4. The Independent Monitor shall have access to the materials that he requires to

1 | conduct the requisite monitoring duties as set forth in paragraph 6.a. through u. Such  
2 | materials include, but are not limited to, all data related to HMII census, seclusion and  
3 | restraint, admissions, discharge, and other relevant data; relevant WSH and HMH policies and  
4 | protocols; patient records; and incident or security reports of class members, as requested by  
5 | the Independent Monitor that are not protected by the attorney-client or attorney work product  
6 | privilege as defined by relevant state and federal law.

7 |         5. The monitoring period will commence 180 days after the entry of this Order,  
8 | unless the parties jointly provide written notice to the court of an earlier date for such  
9 | commencement. The Independent Monitor, at his discretion, may make up to three two-day  
10 | monitoring visits to WSH as part of conducting his monitoring duties with respect to the  
11 | provisions set forth in paragraphs 6.a through u below.

12 |                 In addition, the independent monitor will conduct a one-day on-site visit for  
13 | *Rust* class members, which will occur prior to the commencement of the monitoring period for  
14 | *Allen* class members at WSH.

15 |         6. During this 12 month period, the Independent Monitor shall:

16 |                 a. Monitor the implementation of the policy regarding nursing services as  
17 | set forth in section III.C.7.c.

18 |                 b. Monitor the implementation of the policies regarding program  
19 | environment and safety as set forth in section III.B.1.

20 |                 c. Monitor the implementation of the policy regarding staff training in core  
21 | competencies as set forth in section III.C.7.

22 |                 d. Monitor the implementation of the policy regarding the use of restrictive  
23 | procedures in regard to *Allen* class members as set forth above in section III.C.4.

24 |                 e. Monitor the implementation of the policy regarding the reduction of  
25 | patient-to-patient assaults as set forth in section III.B.2.

26 |                 f. Monitor the implementation of the policy regarding admission of *Allen*

1 class members to WSH as set forth in section III.A.2.

2 g. Monitor the implementation of the policy regarding data tracking of  
3 staffing levels as set forth in section III.C.7.b.

4 h. Monitor the implementation of the policy regarding the administration  
5 of PRN medications as set forth in section III.C.1.a.

6 i. Monitor the implementation of the policy regarding the development  
7 and utilization of a behavioral tracking system as set forth in section III.C.1.b.

8 j. Monitor the implementation of the policy regarding the use of seclusion  
9 and restraint for all *Allen* class members at WSH as set forth in section III.C.4.

10 k. Monitor the implementation of the policy regarding the development  
11 and adoption of a multi-disciplinary diagnostic assessment procedure for all *Allen* class  
12 members at WSH as set forth in section III.C.2.

13 l. Monitor the implementation of the policy regarding the development  
14 and adoption of a procedure for the ongoing assessment of efficacy of medication regimens in  
15 regard to treatment goals for all *Allen* class members at WSH as set forth in section III.C.5.

16 m. Monitor the implementation of the policy regarding the development  
17 and adoption of a procedure for individual treatment planning, including treatment plan review  
18 and modification, and behavioral support planning and implementation for all *Allen* class  
19 members at WSH as set forth in section III.C.3.a.

20 n. Monitor the implementation of the policy regarding community  
21 integration for all *Allen* class members at WSH as set forth in section III.C.3.b.

22 o. Monitor the implementation of the policy regarding the provision of  
23 vocational treatment for all *Allen* class members at WSH as set forth in section III.C.3.c.

24 p. Monitor the implementation of the policy regarding the provision of  
25 recreational treatment for all *Allen* class members at WSH as set forth in section III.C.3.d.

26 q. Monitor the implementation of the policy regarding the provision of

1 active treatment for all *Allen* class members at WSH as set forth in section III.C.3.e.

2           r.       Monitor the implementation of the policy regarding the timely discharge  
3 planning and discharge of *Allen* class members at WSH as set forth in section III.D.

4           s.       Monitor the implementation of the policy regarding the development  
5 and adoption of a procedure for WSH treating professionals to procure outside consultation for  
6 *Allen* class members at WSH who present refractory treatment issues as set forth in section  
7 III.C.6.a.

8           t.       Monitor the implementation of the policy regarding the development  
9 and adoption of a procedure for WSH treating professionals to obtain a second opinion for the  
10 treatment of *Allen* class members at WSH as set forth in section III.C.6.b.

11           u.       Monitor the implementation of the policies and procedures regarding the  
12 reporting of incidents of alleged abuse and neglect of *Allen* class members at WSH, as defined  
13 by WSH Policy 3.4.4 and as set forth in section III.E.

14           7.       If, at the end of the twelve month monitoring period, the Independent Monitor  
15 finds that the defendants have substantially complied with this Order and Settlement  
16 Agreement, the Independent Monitor shall discontinue his monitoring and defendants shall  
17 continue their self-monitoring. Following termination of Independent Monitoring under this  
18 Agreement, WPAS may, at its own expense, retain the Independent Monitor for consultation  
19 purposes.

20           8.       If, at the end of the twelve month monitoring period, the Independent Monitor  
21 finds that the defendants have not substantially complied with the terms of this Order and  
22 Settlement Agreement, the Independent Monitor shall identify the specific areas of  
23 noncompliance and shall continue with his monitoring function with regard to those identified  
24 areas of noncompliance, for an additional period at his discretion not to exceed six months.  
25 During this period of additional monitoring, the Independent Monitor shall visit WSH only as  
26 is necessary to perform his responsibilities with regard to the specific areas of noncompliance.

1 At the same time, defendants shall continue their self-monitoring.

2 9. Defendants shall bear the reasonable costs of the Independent Monitor to carry  
3 out his monitoring duties.

4 **V. TERMINATION OF ORDER AND DISMISSAL OF LAWSUIT:**

5 This Order shall terminate and plaintiffs' claims relevant to services provided to class  
6 members while patients at WSII shall be dismissed without prejudice thirty days following  
7 receipt of the final monitoring report, or sixty days following the conclusion of the independent  
8 monitoring period, whichever is earlier.

9 DATED this 15<sup>th</sup> day of February, 2006.

10 

11 RONALD B. LEIGHTON  
12 United States District Judge

13 Presented By:

14  
15 /s/ Deborah A. Dorfman  
16 Deborah A. Dorfman, WSBA #23823  
17 Washington Protection & Advocacy System  
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EASTERN DISTRICT OF WASHINGTON

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7 UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF WASHINGTON

8 BILLIE SUE MARR, by and  
through her Legal Guardian and  
9 Father, Grant Marr; TODD  
PINARD; GREG ROGERS;  
10 JASON DUPPER, by and  
through his Legal Guardians,  
11 Margaret and Russell Dupper;  
BRYAN SAUNDERS, on behalf  
12 of themselves and all others  
similarly situated;

13 and

14 WASHINGTON PROTECTION  
AND ADVOCACY SYSTEM,  
15 INC., a Washington Corporation,  
16

17 Plaintiffs,

18 v.

19 EASTERN STATE HOSPITAL,  
et al.,

20 Defendants.

NO. CV-02-0067-WFN

ORDER AND SETTLEMENT  
AGREEMENT

CLASS ACTION

21 This matter is before the Court on the parties' Joint Motion for Approval  
22 of the Settlement Agreement in the above-captioned action. The Court having

1 reviewed the Motion including the attachments and Declarations in support  
2 thereof, and the pleadings and documents on file herein; and being fully  
3 advised, the Court hereby **ORDERS:**

4 **I. PURPOSE AND SCOPE OF ORDER**

5 A. The purpose of this Settlement Agreement is to address, without  
6 defining legal standards or statutory requirements, the statutory rights of *Marr*  
7 class members to receive minimally adequate treatment and care at Eastern  
8 State Hospital (ESH) and reasonable modifications to services, supports,  
9 policies and practices so that they may have an opportunity to participate in  
10 defendants' programs and services at ESH.

11 B. Specifically, this Settlement Agreement addresses the plaintiff  
12 class' claims in regard to care and treatment at ESH brought under the  
13 Fourteenth Amendment to the United States Constitution, by and through  
14 42 U.S.C. § 1983, and their right to reasonable modifications in defendants'  
15 services, supports, policies and practices and services in the most integrated  
16 setting under Section 504 of the Rehabilitation Act and Title II of the  
17 Americans with Disabilities Act, and their implementing regulations, as set  
18 forth in the First Amended Complaint.

19 C. In addition, the parties agree that the purpose of the Settlement  
20 Agreement and the Settlement Plan is to address issues raised in this lawsuit so  
21 that appropriate, timely, effective, and safe habilitative mental health services  
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1 and treatment are provided to class members in the least restrictive environment  
2 required by law.

3 D. The parties agree that *Marr* class members who are placed in the  
4 community shall have the same remedies available to *Allen* class members  
5 placed in the community for noncompliance with the provisions of the *Allen*  
6 Order and Settlement Agreement entered on April 4, 2007 in the United States  
7 District Court for the Western District of Washington, in civil action number  
8 C99-5018RJB, relating to defendants' programs and services in the community.  
9 The parties further agree that *Marr* class members shall be included in the  
10 group from which the sample is taken for the Regional Comprehensive Reviews  
11 completed pursuant to the terms of the *Allen* Order and Settlement Agreement  
12 entered on April 4, 2007.

13 E. This Settlement Agreement supersedes and replaces the original  
14 settlement agreement in this case that was approved and entered by the Court on  
15 December 24, 2002.

16 **II. THE SETTLEMENT PLAN**

17 Within 90 days of entry of this Settlement Order, the defendants shall  
18 implement the Settlement Plan which is attached hereto as Appendix 1 and  
19 incorporated herein by reference.  
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**III. SETTLEMENT IMPLEMENTATION PERIOD**

The settlement implementation period shall be for a period of up to two years from the date of the entry of this Order, plus any extensions in accordance with the provisions of Section IV below.

**IV. EXTERNAL OVERSIGHT**

A. Defendants agree to take necessary steps to retain an Independent Monitor within ten days of the entry of this Order. The Independent Monitor shall be mutually agreed upon by the parties.

B. Except as otherwise provided in this Order in regard to providing consultation to the parties, the role of the Independent Monitor shall be limited to evaluation, within the settlement implementation period defined in Section III above, of the defendants' implementation of the Settlement Plan attached as Appendix 1. The Self-Monitoring processes detailed in the Settlement Plan will be accomplished using the Self-Monitoring Tool attached as Appendix 2.

C. At any time within the two year settlement implementation period, the defendants may provide notice to the Independent Monitor and to Disability Rights Washington (DRW) that a final review by the Independent Monitor is to be completed. Upon notice, the final on-site review will be scheduled at a date and time agreed to by the parties and the Independent Monitor.

D. If not requested earlier, no later than 60 days prior to the end of the two year settlement implementation period, the Independent Monitor shall conduct an on-site review at ESH to assess the extent to which defendants have

1 successfully implemented the Settlement Plan, attached hereto as Appendix 1  
2 and incorporated by reference herein.

3 E. The Independent Monitor will provide the parties a written report  
4 within 30 days following the on-site visit. The report shall provide the  
5 assessment of the Independent Monitor concerning the degree of  
6 implementation by the defendants with each step identified in the settlement  
7 plan, and shall provide documentation of the finding of successful  
8 implementation.

9 F. If the Independent Monitor finds that the defendants have  
10 successfully implemented the steps in the Settlement Plan, the case will be  
11 dismissed without prejudice in accordance with the terms set forth in Section  
12 VIII, below. Successful implementation of the Settlement Plan for purposes of  
13 dismissal without prejudice of the case shall require that the Independent  
14 Monitor make findings that the terms of the Settlement Plan have been  
15 completed to the extent that defendants will reasonably sustain each program  
16 area of the Settlement Plan whereby class members obtain, receive, enjoy or  
17 otherwise have access to the specific provisions therein.

18 G. If the Independent Monitor finds that the defendants have not  
19 successfully implemented one or more of the steps identified in the Settlement  
20 Plan, the Independent Monitor shall identify those steps, and shall provide  
21 documentation of the finding that the step was not successfully implemented.  
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1 H. If the defendants request a review by the Independent Monitor  
2 prior to the end of the two year period, and the Independent Monitor does not  
3 find that the defendants have successfully implemented all steps in the  
4 Settlement Plan, the two year period of settlement implementation will continue  
5 to run. If the Independent Monitor finds that the defendants have not  
6 successfully implemented all steps in the Settlement Plan, he or she has the  
7 discretion to extend the settlement implementation period for up to an  
8 additional six months from the date of the report, or from the end of the two  
9 year settlement implementation period, whichever is later.

10 I. In the event that the settlement implementation period is extended,  
11 no later than 60 days prior to the end of the extended settlement implementation  
12 period, the Independent Monitor will, in the monitor's discretion, either make a  
13 final site visit or will conduct a final review based on documentation provided  
14 to the Independent Monitor, to assess whether the Defendants have successfully  
15 implemented the remaining steps identified in the last report. The scope of this  
16 final review will be limited to the defendants' successful implementation of the  
17 steps identified as not yet successfully implemented in the prior review.

18 J. Within 15 days following the final visit or review, the Independent  
19 Monitor shall provide the parties with a written report of the assessment. The  
20 final report shall provide documentation supporting the Independent Monitor's  
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1 assessment of whether the defendants have successfully implemented the  
2 remaining steps.

3 K. In the event that a final report completed pursuant to an extended  
4 settlement period finds that the defendants have not successfully implemented  
5 the remaining steps identified in the last report, the defendants will provide  
6 plaintiffs with a written response to the report that will include a detailed  
7 description as to how defendants propose to address the areas identified as still  
8 not being successfully implemented. This response will be provided to the  
9 plaintiffs within 15 business days of receipt of the final written report of the  
10 Independent Monitor. The parties will meet and confer to discuss this response  
11 within ten business days from the day plaintiffs receive defendants' response.

12 L. The Independent Monitor shall have access to all materials needed  
13 to conduct external monitoring that are not protected by the attorney-client or  
14 attorney work product privilege as described by state and federal law.

15 **V. DISABILITY RIGHTS WASHINGTON ACCESS AND**  
16 **PARTICIPATION**

17 A. Defendants will share all data and documents provided to the  
18 Independent Monitor with DRW.

19 B. Upon completion of each self-monitoring report, DRW will be  
20 provided with a copy of the self-monitoring report. DRW will also be provided  
21 with access, upon request, to documents supporting the outcome and findings of  
22

1 the self-monitoring reports by ESH staff, except those documents that are  
2 considered attorney-client communications or attorney-work product, until the  
3 termination of the this lawsuit

4 C. Nothing in this Order shall be deemed to limit the ability of DRW  
5 to fulfill its federal mandates pursuant to the "Protection and Advocacy for  
6 Individuals with Mental Illness (PAIMI) Act," 42 U.S.C. § 10801, *et seq.* and  
7 the regulations promulgated thereto, 42 C.F.R. § 51 and the "Developmental  
8 Disabilities Assistance and Bill of Rights (DD) Act," 42 U.S.C. § 15041, *et seq.*  
9 and the regulations promulgated thereto, 45 C.F.R. § 1386, *et seq.*

10 D. During the term of this Order, DRW will be provided access upon  
11 request to all *Marr* class members' medical, psychological, and psychiatric  
12 records, and all reports of incidents concerning *Marr* class members generated,  
13 collected, or possessed by the defendants. Since a class has been certified in  
14 this case, no release of information or probable cause letter will be required.  
15 The parties agree that the terms of access to class members' records and related  
16 information shall be the same as those specified in the December 28, 1999,  
17 letter from Assistant Attorney General, Edward Dee, to Deborah Dorfman.

18 E. During the settlement implementation period, plaintiffs and  
19 defendants, at their own expense, may consult with the Independent Monitor.  
20 The parameters of the consultation by counsel shall be detailed in a letter of  
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1 understanding between the parties. ESH may consult with the Independent  
2 Monitor during the settlement implementation period.

3 **VI. ATTORNEYS' FEES & COSTS**

4 A. Defendants will bear all costs of the notice of the settlement to the  
5 class and the fairness hearing required for the implementation of this Settlement  
6 Agreement.

7 B. Plaintiffs will bear their own attorneys' fees and costs. If,  
8 however, plaintiffs are successful on a motion for contempt in the event that the  
9 defendants have not substantially complied with this Settlement Agreement,  
10 plaintiffs may seek an award of attorneys' fees and costs and defendants may  
11 oppose any fee petition filed by plaintiffs.

12 **VII. ENFORCEABILITY, DISPUTE RESOLUTION AND NON-  
13 WAIVER OF CLAIMS AND DEFENSES**

14 **A. Enforceability of Settlement Agreement**

15 Sections I through V herein are enforceable subject to the dispute  
16 resolution provisions and requirements set forth below in paragraphs B.1.  
17 through B.4. of this Section.

18 **B. Dispute Resolution**

19 1. If at any time during the settlement implementation period,  
20 plaintiffs' counsel believes that defendants are not substantially in compliance  
21 with this Order, plaintiffs' counsel shall contact defendants' counsel to request  
22 a meeting with defendants and their counsel to attempt, in good faith, to

1 informally and timely resolve the dispute. Consultation with the Independent  
2 Monitor may be requested by either party.

3           2. If a timely and informal resolution cannot be reached by the  
4 parties, the parties shall participate in formal mediation to resolve the issue.  
5 Mediation of the disputed matters shall occur within thirty business days of a  
6 party's formal written request for mediation, unless otherwise agreed in writing  
7 by the parties or the mediator is unavailable. A formal request for mediation in  
8 the form of a letter shall be submitted by the party requesting mediation. This  
9 request shall be served on all counsel for the parties, the Independent Monitor  
10 and the mediator.

11           3. The Honorable J. Kelly Arnold shall be appointed as the  
12 mediator for any dispute arising out of this Order. If Judge Arnold is  
13 unavailable, the parties shall mutually agree upon alternative mediators. Each  
14 party shall bear its own costs associated with mediation.

15           4. If, after participating in good faith at the mediation, no  
16 resolution is reached, plaintiffs may file a motion with United States District  
17 Court in this matter requesting the Court to hold a "show cause" hearing  
18 ordering defendants to show cause why they are not in substantial compliance  
19 with this Order. Plaintiffs shall provide the appropriate notice to defendants'  
20 counsel of such action.

1           5. In the event that plaintiffs have reasonable cause to believe  
2 that there is a risk of imminent harm to a class member as a result of  
3 defendants' failure to comply with this Order, plaintiffs will make a good faith  
4 effort to consult with defendants' counsel and defendants to discuss the issue or  
5 issues before filing a motion requesting a show cause hearing. Consultation  
6 with the Independent Monitor may be requested by either party, at the  
7 requesting party's expense. If the matter is not resolved, plaintiffs may proceed  
8 directly to the Court and request a show cause hearing without first going  
9 through mediation or may take any other necessary legal action. Plaintiffs will  
10 provide at least one business day's written notice to defendants' counsel via  
11 facsimile or e-mail and first class mail prior to initiating court action.

12           6. In the event that the Court grants plaintiffs' motion  
13 requesting a show cause hearing, the parties will brief the issues with the  
14 Court's approval, present oral arguments and/or present evidence at a show  
15 cause hearing on the issues of defendants' substantial compliance with the  
16 agreement.

17           **C. Nonwaiver of Claims and Defenses**

18           1. Nothing in this Order shall be deemed to limit the Court's  
19 powers of contempt or any other power possessed by the Court.

20           2. Nothing in this Order shall be deemed to limit the ability of  
21 any class member to seek relief of any kind to which they would be otherwise  
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1 entitled under state or federal law other than the claims for systemic injunctive  
2 relief adjudicated in this action.

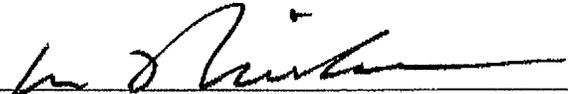
3 3. By agreeing to the entry of this Order, defendants have  
4 waived no defenses to the allegations in plaintiffs' complaint and have admitted  
5 no liability regarding plaintiffs' claims as set forth in their complaint.

6 4. By agreeing to the entry of this Order, plaintiffs have waived  
7 no claims raised in their Complaint.

8 **VIII. TERMINATION OF ORDER AND DISMISSAL OF LAWSUIT**

9 This Order shall terminate and plaintiffs' claims relevant to services  
10 provided to class members at ESH shall be dismissed without prejudice thirty  
11 days following receipt of a monitoring report completed pursuant to Section  
12 IV. C. of this order finding that the defendants have successfully implemented  
13 all steps in the Settlement Plan, or sixty days following the conclusion of the  
14 two year settlement implementation period, plus any extensions of the  
15 settlement implementation period by the independent monitor pursuant to  
16 Section IV.H. of this Order, whichever is earlier.

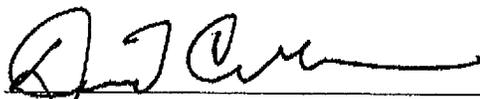
17 DATED this 12<sup>th</sup> day of FEB, 2008.

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20 Honorable William Fremming Neilson  
United States District Judge

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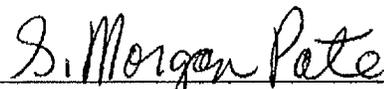


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Attorneys for Defendants

# **APPENDIX 1**

MARR SETTLEMENT PLAN

Program Area	Action Steps
<p>Timely and Appropriate Discharge</p>	<ul style="list-style-type: none"> <li>• ESH will implement all components of the <u>DSHS Protocol for Discharge of DDD Patients from State Psychiatric Hospitals</u> for which ESH has responsibility per the policy.</li> <li>• For Class members committed to ESH pursuant to RCW 10.77                         <ul style="list-style-type: none"> <li>○ ESH will develop an ESH HMH Program Guideline that addresses exceptions and revisions to the <u>DSHS Protocol for Discharge of DDD Patients from State Psychiatric Hospitals</u>, which apply to Marr Class members. A copy will be provided to DRW.</li> <li>○ When a staffing review is needed to discuss treatment team input for letters to the court, the HMH treatment team will be assigned this responsibility. The team will also include the Forensic Services Unit Clinical Director and Community Therapist as members of this meeting. Forensic Services Unit participants will ensure availability to participate in these reviews within one week of request for review from the HMH treatment team.</li> <li>○ The HMH psychiatric social worker will be responsible to develop letters to the court utilizing guidelines outlined in the ESH Forensic Services Unit policies covering court letters. A copy of these guidelines will be provided to DRW.</li> <li>○ The HMH psychiatrist and Forensic Services Unit Clinical Director will be responsible to review, approve, and sign all letters to the court. Each letter addressed to the court will clearly and accurately document the progress or deterioration of the patient since the last court update. A copy of the current treatment plan will accompany each court letter. If the HMH psychiatrist and the Forensic Services Unit Clinical Director are not able to reach agreement regarding the content of a court letter, dispute resolution will be implemented utilizing ESH Policy 2.4, Patient Care Decision-Making and Problem-Solving Process. A copy of this policy will be provided to DRW.</li> </ul> </li> </ul>
<p>Clinical Staffing</p>	<p>ESH will utilize the formulas for Nursing and Rehabilitation Services staffing developed in collaboration with the Marr Monitors. These formulas include adjustments for census, acuity, and high intensity patient support.</p> <ul style="list-style-type: none"> <li>▪ These parameters will be applied daily on all shifts.</li> <li>▪ Compliance with these parameters will be monitored by the Nurse Executive and the Director of Rehabilitation Services on a daily basis.</li> <li>▪ The Nurse Executive and Rehabilitation Services Director will be responsible to submit a summary report regarding compliance to the HMH Program Director and the CEO on a monthly basis.</li> <li>▪ The summary report will be a component of review and evaluation by the self-monitoring team on a quarterly basis.</li> </ul> <p>The HMH Treatment Team will utilize a collaborative, multimodal, interactive process to identify pertinent behavioral data to be collected and tracked for each individual patient.</p> <ul style="list-style-type: none"> <li>▪ The HMH psychologist will be assigned lead responsibility to evaluate appropriateness of behavioral data selected for the individual patient with input from the treatment team.</li> <li>▪ Nursing staff on all three shifts will be responsible to collect identified data.</li> <li>▪ The unit secretary will be responsible to enter this data electronically for all patients on a daily basis and backup staffing for this activity will be provided to ensure continuity.</li> <li>▪ Summary data for individual patients will be reviewed by the treatment team under the clinical direction of the psychologist on at least a weekly basis and whenever a treatment plan is completed for the patient.</li> <li>▪ The program psychologist will be responsible to analyze summary data for each patient on a weekly basis at a minimum.</li> </ul>
<p>Data Collection, Treatment Planning, And Behavioral Supports</p>	<ul style="list-style-type: none"> <li>▪ The program psychologist will be responsible to graph the data and provide graphed information to the treatment team and community participants at the time of all scheduled treatment plans. This information will inform decisions regarding individualized, rehabilitative treatment for the patient. An appropriate behavioral analysis data gathering package will be identified by the program psychologist and will be purchased by ESH and provided for use in generating graphs.</li> </ul>

Program Area	Action Steps
Habilitative Mental Health Treatment	<ul style="list-style-type: none"> <li>▪ Analysis of the data and resulting decisions will be documented in the weekly habilitative summaries and treatment plan review note.</li> <li>▪ Responsibility to complete the weekly habilitative summaries will be assigned to members of the treatment team.</li> <li>▪ The Social Worker will be responsible to document the treatment plan review note summarizing communication decisions, and actions planned.</li> <li>▪ The summary report will be a component of review and evaluation by the self-monitoring team on a quarterly basis.</li> <li>▪ The self-monitoring team will include participation by a consulting psychologist with habilitative mental health experience and education or other mutually agreeable clinical expert.</li> <li>▪ In addition to participating in the self-monitoring activities, the consulting psychologist or other mutually agreeable clinical expert will provide onsite case review and consultation to the HMMH team on at least a quarterly basis with a focus on evaluating quality of treatment and assisting HMMH staff to improve understanding and integration of habilitative mental health principles.</li> <li>▪ The consulting psychologist or other mutually agreeable clinical expert will be required to provide a written report within 30 days of each visit regarding findings and outcomes of consultations with staff and recommendations to support and improve habilitative treatment and services. This will be a specific summary report in addition to the report provided quarterly by the self-monitoring team.</li> <li>▪ The Region 1 DDD community psychologist will provide training to the HMMH treatment team and program staff regarding functional assessment tools, Spokane community hospital tool "Hospitalization/Urgent Care Service Plan" and DDD Policy 5.14 "Positive Behavior Support" to improve compliance with comprehensive assessment and habilitative treatment. This training will be videotaped for greater availability to ESH staff.</li> </ul>
Psychiatric Care Clinical Formulation	<ul style="list-style-type: none"> <li>▪ A checklist for use in developing the clinical formulation will be utilized to improve organization and structure.</li> <li>▪ The psychiatrist/treatment team will utilize these guidelines each time a clinical formulation is developed and documented in the patient record.</li> </ul>
Initial Diagnostic Hypothesis	<ul style="list-style-type: none"> <li>▪ A checklist for use in developing the clinical formulation will be utilized to improve organization and structure.</li> <li>▪ The psychiatrist/treatment team will utilize these guidelines each time a clinical formulation is developed and documented in the patient record.</li> <li>▪ After initial development of the BSP by the psychologist, an updated BSP will be provided to the treatment team by the psychologist at the time of all subsequent treatment plans. This information will be utilized in developing initial and ongoing diagnostic impressions.</li> <li>▪ The Region 1 DDD community psychologist will provide training to the HMMH treatment team and program staff regarding functional assessment tools, Spokane community hospital tool "Hospitalization/Urgent Care Service Plan" and DDD Policy 5.14 "Positive Behavior Support" to improve compliance with comprehensive assessment and habilitative treatment. This training will be videotaped for greater availability to ESH staff.</li> <li>▪ The program psychologist will provide training to the treatment team and program staff regarding use of the new <i>Diagnostic Manual for Intellectual Disability</i> when the publication is available. This training will be videotaped for greater availability to staff.</li> </ul>
Initial Assessments	<ul style="list-style-type: none"> <li>▪ A protocol regarding required information and communication from the community to ESH prior to patient admission will be developed. ESH will use a process for development similar to that used for the DSHS Protocol for Discharge of DDD Patients from State Psychiatric Hospitals.</li> <li>▪ The Region 1 DDD community psychologist will provide training to the HMMH treatment team and program staff regarding functional assessment tools, Spokane community hospital tool "Hospitalization/Urgent Care Service Plan" and DDD Policy 5.14</li> </ul>

Program Area	Action Steps
	<ul style="list-style-type: none"> <li>▪ "Positive Behavior Support" to improve compliance with comprehensive assessment and rehabilitative treatment. This training will be videotaped for greater availability to ESH staff.</li> <li>▪ The program psychologist will provide training to the treatment team and program staff regarding use of the new <i>Diagnostic Manual for Intellectual Disability</i> when the publication is available. This training will be videotaped for greater availability to staff.</li> <li>▪ Program-specific assessment guidelines for HMH will be developed and will include current behaviors, physical issues and medical care needs, pain issues, medication use and effectiveness, reinforcers, triggers, setting events, vocational and psychosocial needs; level of support needed for ADLs, safety, ambulation, communication, and individual strengths. The BSP will be developed utilizing all of the above information components.</li> </ul>
Patient History	<ul style="list-style-type: none"> <li>▪ A clinical formulation checklist will be utilized to ensure documentation of multimodal thought processes resulting from the comprehensive assessments.</li> <li>▪ Region 1 DDD community psychologist will provide training to the HMH treatment team and program staff regarding functional assessment tools, Spokane community hospital tool "Hospitalization/Urgent Care Service Plan" and DDD Policy 5.14 "Positive Behavior Support" to improve compliance with comprehensive assessment and rehabilitative treatment. This training will be videotaped for greater availability to ESH staff.</li> <li>▪ The program psychologist will provide training to the treatment team and program staff regarding use of the new <i>Diagnostic Manual for Intellectual Disability</i> when the publication is available. This training will be videotaped for greater availability to staff.</li> <li>▪ Program-specific assessment guidelines for HMH will be developed and will include current behaviors, physical issues and medical care needs, pain issues, medication use and effectiveness, reinforcers, triggers, setting events, vocational and psychosocial needs; level of support needed for ADLs, safety, ambulation, communication, and individual strengths. The BSP will be developed utilizing all of the above information components.</li> <li>▪ A protocol regarding required information and communication from the community to ESH prior to patient admission will be developed. ESH will use a process for development similar to that used for the <u>DSHS Protocol for Discharge of DDD Patients from State Psychiatric Hospitals</u>.</li> <li>▪ ESH assessments will include current behaviors, physical issues and medical care needs, pain issues, medication use and effectiveness, reinforcers, triggers, setting events, vocational and psychosocial needs as well as strengths.</li> <li>▪ The program psychologist will be responsible to develop the initial BSP within 24 hours of admission. In the event of an unplanned admission on a weekend or holiday, when no psychologist is available, a basic preliminary behavior support plan will be developed by clinical staff. The preliminary plan will be reviewed and modified as necessary by the program psychologist on the next business day.</li> <li>▪ The HMH Community Nurse Specialist will be responsible to ensure that information needed by the ESH treatment team to complete a comprehensive assessment is provided in a timely manner as directed by the protocol regarding admissions.</li> </ul>
Habilitative Treatment Plans	<ul style="list-style-type: none"> <li>▪ The self-monitoring team will include participation by a consulting psychologist with rehabilitative mental health experience and education or other mutually agreeable clinical expert.</li> <li>▪ In addition to participating in the self-monitoring activities, the consulting psychologist or other mutually agreeable clinical expert will provide onsite case review and consultation to the HMH team on at least a quarterly basis with a focus on evaluating quality of treatment and assisting HMH staff to improve understanding and integration of habilitative mental health principles.</li> <li>▪ The consulting psychologist or other mutually agreeable clinical expert will be required to provide a written report within 30 days of each visit regarding findings and outcomes of consultations with staff and recommendations to support and improve habilitative treatment and services. This will be a specific summary report in addition to the report provided quarterly by the self-monitoring team.</li> <li>▪ After initial development of the BSP by the HMH psychologist, an updated BSP will be provided to the treatment team by the psychologist at the time of all subsequent treatment plans. This information will be utilized in developing initial and ongoing treatment interventions and strategies.</li> </ul>

Program Area	Action Steps
<p>Identification of Patient Needs</p>	<ul style="list-style-type: none"> <li>▪ The data collection system and the process of incorporating the analyzed data into treatment team decisions will be refined and expanded. Treatment team members and program staff will utilize strengthened systems of communication with community providers at the point of patient admission, including                             <ul style="list-style-type: none"> <li>○ A protocol will be developed regarding required information and communication from the community to ESH prior to patient admission. ESH will use a process for development similar to that used for the <u>DSHS Protocol for Discharge of DDD Patients from State Psychiatric Hospitals</u>.</li> <li>○ Training by a community psychologist regarding functional analysis, positive behavioral support, and development of BSP will be provided and will be videotaped for greater availability for staff.</li> <li>○ The HMH program psychologist will provide training to the treatment team and program staff regarding use of the new <i>Diagnostic Manual for Intellectual Disability</i> when this publication is available. This training will be videotaped for greater availability to staff.</li> </ul> </li> <li>▪ Program-specific assessment guidelines for HMH will be developed and will include current behaviors, physical issues and medical care needs, pain issues, medication use and effectiveness, reinforcers, triggers, setting events, vocational and psychosocial needs, level of support needed for ADLs, safety, ambulation, communication, and individual strengths. The BSP will be developed utilizing all of the above information components.</li> <li>▪ The program psychologist will be responsible to develop the initial BSP within 24 hours of admission. In the event of an unplanned admission on a weekend or holiday, when no psychologist is available, a basic preliminary behavior support plan will be developed by clinical staff. The preliminary plan will be reviewed and modified as necessary by the program psychologist on the next business day. A clinical formulation checklist will be utilized to ensure documentation of multimodal thought processes resulting from the comprehensive assessment.</li> <li>▪ The HMH psychologist will be assigned responsibility to evaluate appropriateness of behavioral data selected for the individual patient.</li> <li>▪ Nursing staff on all three shifts will be responsible to collect identified data.</li> <li>▪ The unit secretary will be responsible to enter this data electronically for all patients on a daily basis and backup staffing for this activity will be provided to ensure consistency.</li> <li>▪ Summary data for individual patients will be reviewed by the treatment team under the clinical direction of the psychologist on at least a weekly basis and whenever a treatment plan is completed for the patient.</li> <li>▪ The psychologist will be responsible to analyze summary data for each patient on a weekly basis at a minimum.</li> <li>▪ The psychologist will be responsible to graph the data and provide graphed information to the treatment team and community participants at the time of all scheduled treatment plan meetings. An appropriate behavioral analysis data gathering package will be identified by the program psychologist and will be purchased by the hospital for use in generating graphs.</li> <li>▪ Analysis of the data and resulting decisions will be documented by assigned treatment team members in the weekly habitative summaries and treatment plan review note.</li> <li>▪ Checklists for content of assessments, clinical formulations, progress notes, habitative weekly summaries, treatment plans, and treatment plan review notes will be developed to ensure development of treatment plans that reflect the critical elements of habitative treatment.</li> </ul>
<p>Staff Interpretation of Patient Observations</p>	<ul style="list-style-type: none"> <li>▪ A flowchart will be developed for use as a treatment planning tool to guide staff in a problem-solving process that includes first consideration of antecedents, the environment and changes, and possible physical issues so that psychopharmacologic interventions are applied only when appropriate.</li> <li>▪ A component of review and consultation by the consulting psychologist or other mutually agreeable clinical expert will include review of treatment plans as well as interview of treatment team and program staff and analysis of identification and use of non-psychopharmacologic interventions.</li> </ul>
<p>Use of Non-</p>	<ul style="list-style-type: none"> <li>▪ A flowchart will be developed for use as a treatment planning tool to guide staff in a problem-solving process that includes first</li> </ul>

Program Area	Action Steps
<p>psychopharmacologic Strategies</p>	<p>consideration of antecedents, the environment and changes, and possible physical issues so that psychopharmacologic interventions are applied only when appropriate.</p> <ul style="list-style-type: none"> <li>▪ ESH will develop a checklist for weekly habitative summaries to ensure documentation reflects the non-psychopharmacologic strategies contributing to patient outcomes. These guidelines will be utilized by all treatment team members responsible to complete weekly habitative summaries.</li> <li>▪ A component of review and consultation by the consulting psychologist or other mutually agreeable clinical expert will include review of treatment plans as well as interview of team and program staff and analysis of identification and use of non-psychopharmacologic interventions.</li> <li>▪ The Region 1 DDD community psychologist will provide training to the HMH treatment team and program staff regarding functional assessment tools, Spokane community hospital tool "Hospitalization/Urgent Care Service Plan" and DDD Policy 5.14 "Positive Behavior Support" to improve compliance with comprehensive assessment and habitative treatment. This training will be videotaped for greater availability to ESH staff.</li> <li>▪ The HMH psychologist will provide training to the treatment team as well as all assigned program staff regarding required components of a functional analysis.</li> <li>▪ The program psychologist will ensure pertinent data is collected to monitor mood lability of individual patients.</li> <li>▪ The HMH Treatment Team will utilize a collaborative, multimodal, interactive process to identify pertinent behavioral data to be collected and tracked for each individual patient.</li> <li>▪ The HMH psychologist will be assigned responsibility to evaluate appropriateness of behavioral data selected for the ind. patient.</li> <li>▪ Nursing staff on all three shifts will be responsible to collect identified data.</li> <li>▪ The Unit secretary will be responsible to enter this data electronically for all patients on a daily basis. Backup staffing for this activity will be provided to ensure continuity.</li> <li>▪ Summary data for individual patients will be reviewed by the treatment team under the clinical direction of the psychologist on at least a weekly basis and whenever a treatment plan is completed for the patient.</li> <li>▪ The psychologist will be responsible to analyze summary data for each patient on a weekly basis at a minimum.</li> <li>▪ The psychologist will be responsible to graph the data and provide graphed information to the treatment team and community participants at the time of all scheduled treatment plans. This information will be considered in decisions regarding individualized, habitative treatment for the patient. Analysis of the data and resulting decisions will be documented in the weekly habitative summaries and treatment plan review note.</li> <li>▪ Responsibility to complete the weekly habitative summaries will be assigned to members of the treatment team.</li> <li>▪ The Social Worker will be responsible to document the treatment plan review note summarizing communication decisions, and actions planned.</li> <li>▪ The Program Director will provide written information received from Dr. Charlot <u>Questions Regarding Behavioral Functioning</u> to staff for integration into training regarding functional analysis.</li> <li>▪ The program psychologist will be assigned responsibility to ensure that adequate and appropriate functional analysis is integrated into each BSP and that BSPs are updated as needed based on analysis of the data and patient responses to habitative treatments.</li> </ul>
<p>Monitoring of Medication and Medication Side Effects</p>	<ul style="list-style-type: none"> <li>▪ A contract will be executed with a qualified physician to provide training to HMH staff on the monitoring of medications and recognition of medication side effects. This training will be provided both to treatment team members and line staff, and will include both lecture format and consultation on the HMH Unit.</li> <li>▪ Unit-specific policies and procedures will be developed to require administration of the MOSES whenever there is a decision to start a new psychopharmacologic or anticonvulsant medication.</li> <li>▪ The Nurse Executive will be responsible to ensure that all RN staff assigned to HMH receive training and demonstrate competence</li> </ul>
<p>Recognition of Side Effects</p>	

Program Area	Action Steps
	<p>to administer the Moses</p> <ul style="list-style-type: none"> <li>▪ A checklist to ensure comprehensive information is provided by all members of the team in daily rounds will be developed. Review of possible or potential side effects for each patient will be a component of this checklist.</li> <li>▪ Individual treatment team members will be responsible to track side effect related information provided in daily intershift communications and in rounds for assigned patients; ensure this information is communicated to the psychiatrist in a timely manner, and incorporate this information into the weekly habitative progress notes.</li> <li>▪ A schedule will be developed to ensure that the clinical pharmacist meets with the treatment team and attends ward rounds at least one time per week. The psychiatrist will be responsible to document assessments, conclusions, and recommendations emerging from this collaborative process in the patient record.</li> <li>▪ A review of NADD literature and training material as well as other reference resources pertinent to monitoring and treatment of side effects of medications for this population will be conducted and appropriate training materials purchased.</li> </ul>
Treatment of Side Effects	<ul style="list-style-type: none"> <li>▪ A contract will be executed with a qualified physician to provide training to HMH staff on the monitoring of medications and recognition of medication side effects. This training will be provided both to treatment team members and line staff, and will include both lecture format and consultation on the HMH Unit.</li> <li>▪ Unit-specific policies and procedures will be developed to require administration of the MOSES whenever there is a decision to start a new psychopharmacologic or anticonvulsant medication.</li> <li>▪ A checklist to ensure comprehensive information is provided by all members of the team in daily rounds will be developed. Review of possible or potential side effects for each patient will be a component of this checklist.</li> <li>▪ Individual treatment team members will be responsible to track side effect related information provided in daily intershift communications and in rounds for assigned patients; ensure this information is communicated to the psychiatrist in a timely manner, and incorporate this information into the weekly habitative progress notes.</li> <li>▪ A schedule will be developed to ensure that the clinical pharmacist meets with the treatment team and attends ward rounds at least one time per week. The psychiatrist will be responsible to document assessments, conclusions, and recommendations emerging from this collaborative process in the patient record.</li> <li>▪ A review of NADD literature and training material as well as other reference resources pertinent to monitoring and treatment of side effects of medications for this population will be conducted and appropriate training materials purchased.</li> </ul>
Use of Tools to Monitor Side Effects	<ul style="list-style-type: none"> <li>▪ A contract will be executed with a qualified physician to provide training to HMH staff on the monitoring of medications and recognition of medication side effects. This training will be provided both to treatment team members and line staff, and will include both lecture format and consultation on the HMH Unit.</li> <li>▪ Unit-specific policies and procedures will be developed to require administration of the MOSES whenever there is a decision to start a new psychopharmacologic or anticonvulsant medication.</li> <li>▪ A checklist to ensure comprehensive information is provided by all members of the team in daily rounds will be developed. Review of possible or potential side effects for each patient will be a component of this checklist.</li> <li>▪ Individual treatment team members will be responsible to track side effect related information provided in daily intershift communications and in rounds for assigned patients; ensure this information is communicated to the psychiatrist in a timely manner, and incorporate this information into the weekly habitative progress notes.</li> <li>▪ A schedule will be developed to ensure that the clinical pharmacist meets with the treatment team and attends ward rounds at least one time per week. The psychiatrist will be responsible to document assessments, conclusions, and recommendations emerging from this collaborative process in the patient record.</li> <li>▪ A review of NADD literature and training material as well as other appropriate reference resources pertinent to monitoring and</li> </ul>

Program Area	Action Steps
<p>Staff Training Regarding Recognition and Treatment of Side Effects</p>	<ul style="list-style-type: none"> <li>▪ treatment of side effects of medications for this population will be conducted and appropriate training materials purchased. ESH will identify a regional resource to provide consultations to the treatment team on an ongoing basis such as an individual from the University of Washington.</li> <li>▪ A contract will be executed with a qualified physician to provide training to HMH staff on the monitoring of medications and recognition of medication side effects. This training will be provided both to treatment team members and line staff, and will include both lecture format and consultation on the HMH Unit.</li> <li>▪ Unit-specific policies and procedures will be developed to require administration of the MOSES whenever there is a decision to start a new psychopharmacologic or anticonvulsant medication.</li> <li>▪ A checklist to ensure comprehensive information is provided by all members of the team in daily rounds will be developed. Review of possible or potential side effects for each patient will be a component of this checklist.</li> <li>▪ Individual treatment team members will be responsible to track side effect related information provided in daily intershift communications and in rounds for assigned patients; ensure this information is communicated to the psychiatrist in a timely manner, and incorporate this information into the weekly habitative progress notes.</li> <li>▪ A schedule will be developed to ensure that the clinical pharmacist meets with the treatment team and attends ward rounds at least one time per week. The psychiatrist will be responsible to document assessments, conclusions, and recommendations emerging from this collaborative process in the patient record.</li> <li>▪ A review of NADD literature and training material as well as other reference resources pertinent to monitoring and treatment of side effects of medications for this population will be conducted and appropriate training materials purchased.</li> <li>▪ ESH will identify a regional resource to provide consultations to the treatment team on an ongoing basis such as an individual from the University of Washington.</li> </ul>
<p>Education and Training Regarding Habitative Mental Health for Physicians/Medical Team</p>	<ul style="list-style-type: none"> <li>▪ A contract will be executed with a qualified physician to provide training to HMH staff on the monitoring of medications and recognition of medication side effects. This training will be provided both to treatment team members and line staff, and will include both lecture format and consultation on the HMH Unit.</li> <li>▪ DSHS will arrange training for the HMH psychiatrist and medical team physician that focuses on assessment and treatment of pain and physical care needs of individuals with co-occurring ID and MI. In addition, training will be provided to increase knowledge and understanding of depression, anxiety and genetic issues pertinent to this population.</li> <li>▪ The hospital will join NADD and inform the psychiatrist and medical team physician regarding available CME as well as training appropriate for additional treatment team members.</li> <li>▪ A review of NADD literature and training materials as well as other reference resources will be conducted by the program director and findings will be provided to treatment team members (including the psychiatrist and medical team physician) for identification of relevant training materials to be purchased by the hospital.</li> <li>▪ A monthly "journal club" format will be utilized to ensure attendance by treatment team and program staff at trainings provided that include the NADD materials selected. In addition, these materials will be provided in formats appropriate for presentation on all shifts on the unit.</li> <li>▪ The program psychologist will provide training to the treatment team and program staff regarding use of the new <i>Diagnostic Manual for Intellectual Disability (DMID)</i> when the publication is available. This training will be videotaped for greater availability to staff.</li> </ul>
<p>Documentation of Thought Process Regarding Diagnosis and Treatment</p>	<ul style="list-style-type: none"> <li>▪ The program psychologist will provide training to the treatment team and program staff regarding use of the new <i>Diagnostic Manual for Intellectual Disability</i> when the publication is available. This training will be videotaped for greater availability to staff.</li> <li>▪ The Program Director will be responsible to develop a series of documentation checklists that will be utilized as guides and prompts to treatment team members and other program staff in multiple areas of patient record documentation.</li> <li>▪ These checklists will also be used as tools for document review by the self-monitoring team.</li> <li>▪ Documentation checklists to be developed include:                         <ul style="list-style-type: none"> <li>o Assessment and clinical formulation</li> </ul> </li> </ul>

Program Area	Action Steps
Treatment of Aggression and Anxiety	<ul style="list-style-type: none"> <li>o Progress notes</li> <li>o Weekly rehabilitative summaries</li> <li>o Treatment plan review notes</li> </ul> <ul style="list-style-type: none"> <li>• Overall guiding principles will continue to be to ensure patient health and safety by utilizing the least restrictive interventions including medications that are consistent with the diagnosis and environmental factors.</li> <li>• Differential diagnosis will be developed with the aid of the new <u>Diagnostic Manual for Intellectual Disability</u>.</li> <li>• ESH will obtain additional resources such as Reiss and Aman's <u>Psychotropic Medications for Developmental Disabilities: International Consensus Handbook</u> and their medication guidelines will be integrated with applicable more recent research in formulating medication selection.</li> </ul>
Recognition and Treatment of Depression and Anxiety	<ul style="list-style-type: none"> <li>• Standardized assessment tools appropriate for this population will be reviewed by the program psychologist and utilized when indicated.</li> <li>• DSHS will arrange training for the HMH psychiatrist and medical team physician that focuses on assessment and treatment of pain and physical care needs of individuals with co-occurring ID and MI. In addition, training will be provided to increase knowledge and understanding of depression, anxiety and genetic issues pertinent to this population.</li> <li>• The hospital will join NADD and inform the psychiatrist and medical team physician regarding available CME as well as training appropriate for additional treatment team members.</li> <li>• A review of NADD literature and training materials as well as other appropriate reference resources will be conducted by the program director and findings will be provided to treatment team members (including the psychiatrist and medical team physician) for identification of relevant training materials to be purchased by the hospital.</li> <li>• A monthly "journal club" format will be utilized to ensure attendance by treatment team and program staff at trainings provided that include the NADD materials selected. In addition, these materials will be provided in formats appropriate for presentation on all shifts on the unit.</li> </ul>
Use of Multimodal Approaches Early in Treatment	<p>Overall guiding principles will continue to be to ensure patient health and safety by utilizing the least restrictive interventions including medications that are consistent with the diagnosis and with environmental factors.</p> <ul style="list-style-type: none"> <li>• Differential diagnosis will be developed with the aid of the new <u>Diagnostic Manual for Intellectual Disability</u>.</li> <li>• ESH will obtain additional resources such as Reiss and Aman's <u>Psychotropic Medications for Developmental Disabilities: International Consensus Handbook</u> and their medication guidelines will be integrated with applicable more recent research in formulating medication selection.</li> </ul>
Recognition of Pain and Impacts on Behavior	<ul style="list-style-type: none"> <li>• DSHS will arrange training for the HMH psychiatrist and medical team physician that focuses on assessment and treatment of pain and physical care needs of individuals with co-occurring ID and MI. In addition, training will be provided to increase knowledge and understanding of depression, anxiety and genetic issues pertinent to this population.</li> <li>• The hospital will join NADD and inform the psychiatrist and medical team physician regarding available CME as well as training appropriate for additional treatment team members.</li> <li>• A review of NADD literature and training materials as well as other reference resources will be conducted by the program director and findings will be provided to treatment team members (including the psychiatrist and medical team physician) for identification of relevant training materials to be purchased by the hospital.</li> <li>• The program psychologist will provide training to the treatment team and program staff regarding use of the new <u>Diagnostic Manual for Intellectual Disability</u> when the publication is available. This training will be videotaped for greater availability to staff.</li> <li>• A monthly "journal club" format will be utilized to ensure attendance by treatment team and program staff at trainings provided that include the NADD materials selected. In addition, these materials will be provided in formats appropriate for presentation on all</li> </ul>

Program Area	Action Steps
	<ul style="list-style-type: none"> <li>▪ shifts on the unit.</li> <li>▪ A protocol regarding required information and communication from the community to ESH prior to patient admission will be developed. ESH will use a process for development similar to that used for the <u>DSHS Protocol for Discharge of DDD Patients from State Psychiatric Hospitals</u>.</li> <li>▪ ESH assessments will include current behaviors, physical issues and medical care needs, pain issues, medication use and effectiveness, reinforcers, triggers, setting events, vocational and psychosocial needs as well as strengths. The ESP will be developed utilizing all of the above information components.</li> <li>▪ The medical team physician will implement a program specific pain evaluation and treatment guideline which will include the following elements:               <ul style="list-style-type: none"> <li>○ Comprehensive review of history to ascertain potential sources of pain and known behavioral manifestations of pain</li> <li>○ Physical examination to assess for pathology</li> <li>○ Laboratory work and ancillary testing as indicated</li> <li>○ Monitor bowel movements to detect early signs of constipation</li> <li>○ When appropriate, prophylactically treat for conditions not readily detectable by physical exam or lab work</li> <li>○ Review all behavioral changes as a team to consider possible medical/pain etiologies for the change</li> <li>○ Provide direction to staff regarding careful observation for behavioral indicators of pain and potential sources including:                   <ul style="list-style-type: none"> <li>▪ Dental pain</li> <li>▪ Sinusitis, allergies</li> <li>▪ Constipation or urinary tract infections</li> <li>▪ Extremity pathology</li> </ul> </li> </ul> </li> </ul>
Recognition and Treatment of Seizure Disorder	<ul style="list-style-type: none"> <li>▪ The medical team physician will implement a program-specific evaluation and treatment guidelines regarding assessment and treatment of individuals with seizure disorders which will include the following elements:               <ul style="list-style-type: none"> <li>○ Comprehensive review of history to ascertain any prior history documenting seizures or behaviors suggesting seizures.</li> <li>○ Update cranial imaging especially in cases of known abuse/traumatic injuries to assess for traumatic residuals which could serve as a seizure focus</li> <li>○ When the possibility of a seizure disorder is suspected, institute detailed behavioral tracking including recording of antecedent events, documenting the sequence of behaviors and any evidence of post-ictal behavior.</li> <li>○ For patients with known seizure disorders, the medical team physician will maintain communication with their established neurologist</li> <li>○ When a seizure disorder is suspected but not confirmed, the medical team physician will refer the patient to a seizure specialist in the community for further evaluation</li> <li>○ When appropriate, the medical team physician will coordinate with the Epilepsy Center for inpatient video monitoring EEG to assess for presence of seizure activity during behaviors suspected to be seizure-like.</li> </ul> </li> </ul>
Use of Data to Monitor Treatment Response	<p>The HMH Treatment Team will utilize a collaborative, multimodal, interactive process to identify pertinent behavioral data to be collected and tracked for each individual patient.</p> <ul style="list-style-type: none"> <li>▪ The HMH psychologist will be assigned responsibility to evaluate appropriateness of behavioral data selected for the individual patient.</li> <li>▪ Nursing staff on all three shifts will be responsible to collect identified data.</li> <li>▪ The unit secretary will be responsible to enter this data electronically for all patients on a daily basis and backup staffing for this activity will be provided to ensure continuity.</li> <li>▪ Summary data for individual patients will be reviewed by the treatment team under the clinical direction of the psychologist on at least a weekly basis and whenever a treatment plan is completed for the patient.</li> </ul>

Program Area	Action Steps
	<ul style="list-style-type: none"> <li>▪ The psychologist will be responsible to analyze summary data for each patient on a weekly basis at a minimum.</li> <li>▪ Program-specific assessment guidelines for HMFH will be developed and will include current behaviors, physical issues and medical care needs, pain issues, medication use and effectiveness, reinforcers, triggers, setting events, vocational and psychosocial needs, level of support needed for ADLs, safety, ambulation, communication, and individual strengths. The BSP will be developed utilizing all of the above information components.</li> <li>▪ The psychologist will be responsible to graph the data and provide graphed information to the treatment team and community participants at the time of all scheduled treatment plans. This information will inform decisions regarding individualized, rehabilitative treatment for the patient.</li> <li>▪ Analysis of the data and resulting decisions will be documented in the weekly rehabilitative summaries and treatment plan review note. Responsibility to complete the weekly rehabilitative summaries will be assigned to members of the treatment team.</li> <li>▪ The Social Worker will be responsible to document the treatment plan review note summarizing communication decisions, and actions planned.</li> <li>▪ The summary report will be a component of review and evaluation by the self-monitoring team on a quarterly basis.</li> </ul>
Recognition, Assessment, and Treatment of Patients with Genetic Disorders	<ul style="list-style-type: none"> <li>▪ The medical team physician will implement program-specific guidelines regarding assessment and treatment of patients with genetic disorders including: <ul style="list-style-type: none"> <li>○ Comprehensive review of history and discussion with care providers/family members for any family history of genetic disorders or documentation of priority genetic testing</li> <li>○ Complete chromosomal studies on all patients and more detailed DNA probe studies if indicated (for example if physical exam is suggestive of Fragile X).</li> <li>○ Obtain consultation with Director of Molecular Diagnostic Laboratory at Sacred Heart Medical Center and the Cytogeneticist for assistance in obtaining appropriate testing in specific clinical situations – use of additional computer resources recommended by these experts for further assistance.</li> </ul> </li> <li>▪ The medical team physician will identify appropriate materials to expand program reference library genetic disorders utilizing NADD and other resources</li> </ul>
Use of Neuropsychological Resources Recognition of Need for Physical Therapy, Speech Therapy, and Occupational Therapy and Accommodations for Sensory Impairment	<ul style="list-style-type: none"> <li>▪ The program psychologist will identify a group of community based neuropsychologists at St Luke's Rehabilitation Center in Spokane. These individuals will have appropriate credentials to provide consultation and testing upon referral from the HMFH program and have agreed to provide these services on referral. This resource will be utilized for HMFH patients as indicated.</li> <li>▪ The medical team physician will assess need for the following services for each patient and will be responsible for the following: <ul style="list-style-type: none"> <li>○ Order physical therapy consultation and treatment for any patient with ambulation disorders, musculoskeletal pathology or risk for falls</li> <li>○ Refer to community footwear experts to provide proper fitting shoes/orthotics in cases of gait disturbance or pedal pathology</li> <li>○ Ensure occupational therapy consultations are obtained for all patients to assess their needs, skills, unique capabilities or limitations for participation in therapy in the Work Center</li> <li>○ Order occupational therapy consults to evaluate and recommend assistive devices for patients with special needs in the area of self-care and independence</li> <li>○ Order speech therapy consultations for any patient who is suspected of a swallowing or communication impairment</li> <li>○ Order speech consultations to assess the capability of patients with limited verbal communication and alternative communication techniques and to train staff members in the use of appropriate alternative communication techniques</li> <li>○ Order hearing assessments and consultations for patients with suspected or confirmed hearing deficits.</li> <li>○ Ensure that PT and/or OT services necessary to assist patients to maintain ADL, IADL, and other skills necessary to promote independence and functioning in the community are provided while hospitalized at ESH.</li> </ul> </li> <li>▪ The speech pathologist will be scheduled to attend program rounds on a weekly basis and identify patients appropriate for further</li> </ul>

Program Area	Action Steps
<p>Self-Monitoring Process</p>	<ul style="list-style-type: none"> <li>• evaluation/consultation. The Work Center occupational therapist will be scheduled to attend program rounds on a weekly basis to discuss patient progress or needs in the Work Center and help to assist the team to problem solve to enhance the patient's successful integration into a work setting after discharge.</li> <li>• ESH will conduct self-monitoring activities on a quarterly basis utilizing the monitoring tool previously approved by the Marr monitors. Changes to this tool may be made with agreement by DRW. Recommendations for changes will be provided by the hospital to DRW in writing. DRW may respond to proposed changes in writing within 14 days and to specify any concerns or disagreements with proposed changes. ESH and DRW will work in good faith to resolve any disagreements that arise. If the parties are unable to resolve the disagreement, either party may invoke dispute resolution process set forth in the Marr Settlement Order. If DRW does not respond in writing within 14 days, ESH will move forward with implementation of changes.</li> <li>• All Marr class members treated on the HMMH unit as well as on other units of ESH will be included in the group of individuals whose care may be reviewed quarterly by the Self-Monitoring team. The Self-Monitoring team will select a minimum of two individuals whose care and medical record will be reviewed each quarter. If class members are being treated on other units, the self monitors will select a minimum of one case for review from the individuals treated off the HMMH unit. Review timeframe for each of the cases selected will be six months retrospective from the date of the self-monitoring review. Reviewers may consider earlier medical record information if necessary to conduct the case review.</li> <li>• The Self-Monitoring team will be responsible to provide written reports of findings and recommendations for improvement to ESH and DRW within 10 business days of each quarterly review. The HMMH Program Director will be responsible to respond to these reports with a plan for improvement, whenever indicated, within 30 days of receipt of the Self-Monitoring team report. This plan will be provided to DRW, to the MHD and DDD Program Administrators, and to the members of the Self-Monitoring Team within 10 days of completion of the written plan for improvement.</li> <li>• Upon completion of each self-monitoring report, upon request, DRW will be provided with access to all data relied upon by ESH in conducting their self-monitoring of the implementation of the attached Settlement Plan. DRW will also be provided upon request with access to all documents supporting the outcome and findings of the self-monitoring reports by ESH staff, except those documents that are considered attorney-client communications or attorney-work product, until the termination of the this lawsuit.</li> </ul>

## **APPENDIX 2**

EASTERN STATE  
HOSPITAL

HABILITATIVE  
MENTAL HEALTH UNIT

SELF-MONITORING

HMH UNIT SELF-MONITORING  
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- VI. STAFF TRAINING
- VII. DISCHARGE PLANNING

Patient:

- I. INITIAL ASSESSMENT AND TREATMENT PLANNING
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## PREFACE

Eastern State Hospital utilizes an ongoing monitoring system in accordance with the Marr Settlement through the following process:

### **Monitoring Schedule**

Once every three months. Review covers a six month time frame for each self-monitoring activity.

### **Monitoring Recommendations/Reports**

A preliminary report will be available at the conclusion of each review with specific recommendations for improvement. Plans for improvement based on the findings and recommendations will be developed and implemented by ESH within 30 days of review completion. A copy of findings, recommendations, and plans for improvement will be submitted to Washington Protection and Advocacy Services and to the MHD and DDD Program Administrators for presentation to the Cross Systems Committee.

### **Monitoring Team**

- Rob Henry, DO – Medical Staff
- Paul Murphy, MS
- Connie Wilmot, COO

### **Resource People to the Monitoring Team**

- Marsha Blasingame, PhD – HMH
- Lynn Flaherty, CNS – HMH Program Manager
- Sheryl Gosser, RN – Quality Management/Utilization Review

**PATIENT: (initials)**

**Review Period** \_\_\_\_\_

**I. INITIAL ASSESSMENT AND TREATMENT PLANNING**

At the time of admission, the Psychiatric, Medical, Nursing, Social Work and Rehabilitation Services disciplines shall initiate completion of their portions of the clinical profile in the Comprehensive Assessment prior to the 7 day treatment plan. By the 7 day treatment plan, the treatment team and community caregivers will meet with the patient. A comprehensive interview and assessment will be compiled using a multimodal approach. The comprehensive assessment is completed with the community and treatment team following the patient interview. Components of the Comprehensive Assessment are incorporated into the Individualized Treatment Plan and the Behavior Support Plan. Within 14 days of admission, the initial comprehensive assessment will be updated with new information from any source gained since admission.

Measurable Outcome	Met	Not Met	Comments
1. Did the attending psychiatrist evaluate the patient within the first 24 hours after admission?			
2. Admission meeting with collaborative team occurred within first 7 days of admission? (DD/MH/Residential Providers present)			
3. Evidence that HMH team obtained data/documentation from community agencies. If important documents not found, note shows that a call was made clinician-clinician. <ul style="list-style-type: none"> <li>• Discharge Summaries from recent hospitalizations</li> <li>• Medication history/response</li> <li>• Recent physical/exams</li> <li>• Behavior Support Plan</li> <li>• Cross System Crisis Plan</li> <li>• Developmental History</li> <li>• Family History</li> <li>• Incident Reports</li> </ul>			
4. Initial Risk Assessment incorporates pertinent information from multiple informants/comprehensive assessment.			
5. Initial Comprehensive Assessment includes thorough history/description of; <ul style="list-style-type: none"> <li>• developmental facts</li> <li>• bio-psycho-social information</li> <li>• setting events &amp; triggers for current admission</li> <li>• current presentation of symptoms and interaction of such.</li> </ul>			
6. Clinical Formulation incorporates the team's thought process related to the diagnosis and related symptoms, history, problems being treated, contributing factors, the treatment plan, and DSM Diagnoses I-V found in treatment			

Measurable Outcome	Met	Not Met	Comments
plan.			
7. The treatment plan is habilitative: <ul style="list-style-type: none"> <li>• Individualized</li> <li>• Based on comprehensive assessment</li> <li>• teaching skills (not reacting to behavior)</li> <li>• uses psychosocial therapies/teaching methods appropriate for persons with limited cognitive function</li> <li>• uses individualized, habilitative treatment goals</li> <li>• the plan teaches skills to be carried over to residential living</li> <li>• the plan includes meaningful social and work activities per individual's strengths and interests</li> </ul>			
8. There is diagnostic agreement throughout the chart.			
9. There are multimodal interventions identified to address each clinical need <ul style="list-style-type: none"> <li>• psychiatric</li> <li>• behavioral/functional analysis</li> <li>• physical/medical</li> <li>• environmental</li> <li>• pro-social</li> </ul>			
10. Evidence that approaches (other than prns) are being used to support behavior including: <ul style="list-style-type: none"> <li>• prevention</li> <li>• antecedent controls</li> <li>• teaching coping strategies</li> <li>• environmental management</li> </ul>			

SURVEY FINDINGS
AREAS OF STRENGTH:
RECOMMENDATIONS:

II. PSYCHIATRIC AND MEDICAL TREATMENT AND EVALUATION

Measurable Outcome	Met	Not Met	Comments
1. Rationale for choice of medication doses and changes are clearly stated in documentation from psychiatrist.			
2. Documentation from psychiatrist includes thought process related to: <ul style="list-style-type: none"> <li>• Off label use of medication</li> <li>• Medications administered: "start low and go slow" (tapering present)</li> <li>• Poly-pharmacy</li> <li>• Drug interactions</li> <li>• Possible adverse effects</li> <li>• Use of anti-libidinal medications</li> <li>• Dosage selection</li> <li>• Adequate trials on medications</li> </ul>			
3. Evidence that lab tests are ordered per standard of each medication prescribed			
4. Evidence of side effect monitoring through the use of the MOSES			
5. Evidence that the MOSES provides quality information to guide treatment			
6. Evidence in documentation that data on PRN use was reviewed and addressed regularly (monthly PRN review with Pharmacist)			
7. Off label medications will be documented describing monitoring procedure and results expected			
8. When ECT is used, there is evidence of informed consent and due process laws have been followed			
9. The initial medical evaluation will include PEX (if possible) and laboratory screening to look for evidence of medical conditions which may be contributing to the patient's decompensation. These will including the following: <ul style="list-style-type: none"> <li>• assessing for glucose abnormalities</li> <li>• infection</li> <li>• electrolyte abnormalities</li> <li>• thyroid disorders</li> <li>• hepatic dysfunction</li> <li>• renal dysfunction</li> <li>• vitamin deficiencies as appropriate.</li> </ul>			

SEE APPENDIX FOR ADDITIONAL DETAILS OF ASSESSMENT OF APPROPRIATE MEDICAL CONCERNS

SURVEY FINDINGS	
AREAS OF STRENGTH:	
RECOMMENDATIONS:	

### III. DEVELOPING AND INTEGRATING BEHAVIOR SUPPORT PLANS

Behavior Support Plans are developed as an outcome of the Comprehensive Assessment Process. Part of this process includes a Functional Assessment, which seeks to understand some of the more complex transactions and patterns between a person's history of learning, internal state factors and contextual variables which produce behavioral outcomes. The timeliness of BSP production and communication of important elements to staff who must implement them, is also vital.

Measurable Outcome	Met	Not Met	Comments
1. BSP completed within 7 days			
2. BSP is habilitative – identifies key behaviors to increase, identifies key behaviors to decrease, then setting events, triggers, cues, and interventions for behaviors to decrease, including what to do if the patient or others are at risk of harm. Are there proactive strategies to address identified triggers and setting events.			
3. Staff interventions are clear so that staff know what to do, when to do it, how to best approach this individual, key concerns, what behaviors will be positively reinforced, what the reinforcers are, who delivers them etc. Are there proactive strategies to address identified triggers and setting events. Refer to BSP			
4. Current BSP is in the record			
5. Functional Analysis is part of the BSP			
6. Tracking system in place and relevant to treatment outcomes.			
7. Behavior to be increased or decreased is reflected in the treatment plan, data sheets and in progress notes.			
8. Decisions regarding treatment revisions are supported by data collected as reflected in TPRN and progress notes.			
9. Functional analysis is revised based on data and observations.			
10. BSP interventions changed and dated to reflect new understanding such as setting events, triggers, and contextual issues.			
11. BSP includes positive-goals. (For example, are there any goals related to building self-esteem, use of adaptive strategies to gain interactions and support from others?)			
12. BSP was modified as needed for any problem identified that placed patient at risk of harm. If the BSP was not modified, the reason is documented.			
13. BSP is integrated into the treatment plan.			
14. HMH staff know what to do based on the BSP as evidenced by staff interview.			

SURVEY FINDINGS
AREAS OF STRENGTH:
RECOMMENDATIONS:

IV. PROGRAMS/GROUPS/WORK

Active Treatment: Purpose is to develop new rehabilitative skills which allow the patient to be engaged throughout their day in personally meaningful programs. HMH will provide programs, groups, and work experiences that emphasize developing skills and strategies for return to patient's community and prevention of re-hospitalization. Active Treatment will be provided for a minimum of six hours a day including but not limited to the following areas: Anger Management, Social Interaction Training, Counseling Sessions, Coping Skills Training, ADLS, Prevocational/Vocational Training, Recreational/Leisure Skills, and Social Activities. Active treatment goals will be individualized for each patient based upon their comprehensive assessment, treatment plan, BSP, risk assessment, and discharge plan.

Measurable Outcome	Met	Not Met	Comments
1. Patient is receiving six hours of active treatment as evidenced by the following A. Structured activities are implemented as defined in the comprehensive assessment/treatment plan B. Hours of active treatment form C. Behavioral Interval Data Form			
2. If patient is not participating in six hours of active treatment, the bio-psycho-social problems causing this have been regularly assessed. This is evidenced by the following: A. Goals have been changed and other plans have been implemented at least monthly if active treatment is not occurring. B. Multimodal approaches are used which might include altering the tasks to reflect less demand on the patient, evaluate reinforcers which might lead to better attendance, ask the patient what he or she would like to learn, medical problems are being addressed. C. Barriers might include fatigue, side effects of medications, anxiety, etc. This information should be documented in the TPRN Note/treatment plan.			
3. If the patient is unable to leave the ward for medical or risk factors, active treatment is being provided on the ward for six hours a day. Refer to the active treatment Data Collection form.			
4. When appropriate to attend the Work Center, work goals are reflected in the treatment plan and are individualized.			
5. The patient's goals are individualized to meet their unique needs? This will be reflected in the specific interventions as a result of the comprehensive assessment, /treatment plan, and work center section of the treatment plan and daily schedule.			

SURVEY FINDINGS
AREAS OF STRENGTH:
RECOMMENDATIONS:

### V. PATIENT SAFETY AND TROUBLE SHOOTING

Assuring patient safety is a complex process involving such areas as risk assessment, ward milieu, staffing patterns, staff education and training, census, and procedural safeguards.

Measurable Outcome	Met	Not Met	Comments
1. An initial admission risk assessment was completed as evidenced by A. Admission Risk Assessment in the chart B. Informant information has been incorporated into the admission risk assessment			
2. The risk assessment information was incorporated into the 7 day treatment plan as evidenced by: A. Informant information included in the comprehensive assessment regarding risk factors B. BSP contains antecedents, triggers, for evaluating risk factors?			
3. ABC contains a thorough identification of events prior to the occurrence, a clear description of event, and what happened following the event. Clinical team member makes note of recent ABCs and comments on what is suggested by an analysis of these.			
4. There is evidence of change in patient treatment plans reflecting outcomes based on risk assessment, ABC forms and UORs. For example use of 1 to 1s, patient assignment to rooms or training areas, and additional staff training as documented in progress notes.			
5. UORs that give rise to reasonable cause to believe that patient abuse or neglect of class members has occurred have been investigated. This is reflected in the UOR data from QM.			
6. When a patient is very aggressive or self-injurious, the entire treatment team collaborates to rapidly put a plan into place to increase safety for all concerned. This is reflected in the TPRN note or review of the progress notes.			

Sample HMH Staffing Pattern

EASTERN STATE HOSPITAL DEPARTMENT OF NURSING HMH STAFFING

SHIFT: 0645-1500 ( 1:1s on day shift during this time period)

Date	ON DUTY	SCHD	ON DUTY								
JOB CLASS	ON DUTY	SCHD	ON DUTY								
RN											
LPN											
MHT											
TOTAL											
Full Training											
No HMH Exp.											
Assigned Staff											
Float Staff											

SHIFT: 1445-2300 ( 1:1s on evening shift during this time period)

Date	ON DUTY	SCHD	ON DUTY								
JOB CLASS	ON DUTY	SCHD	ON DUTY								
RN											
LPN											
MHT											
TOTAL											
Full Training											
No HMH Exp.											
Assigned Staff											
Float Staff											

SHIFT: 2245-0700 ( 1:1s on night shift during this time period)

Date	ON DUTY	SCHD	ON DUTY								
JOB CLASS	ON DUTY	SCHD	ON DUTY								
RN											
LPN											
MHT											
TOTAL											
Full Training											
No HMH Exp.											
Assigned Staff											
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SURVEY FINDINGS
AREAS OF STRENGTH:
RECOMMENDATIONS:

## VI. STAFF TRAINING AND CORE COMPETENCIES

Specialized training is required for staff to work effectively with patients on the HMH Unit, consisting of both a core curriculum for all staff, and a specialized curriculum for various clinical disciplines. For course titles refer to list below. The following trainings are included depending on one's position/specialty.

### Core Curriculum/All Staff:

1. Orientation Training including HMH topics.
2. The Core Curriculum classes 1-8.

### MHTs:

1. Include the above Core Curriculum

### Work Center Staff:

1. Include the above core curriculum.

### Licensed Practical Nurses:

1. Include the above core curriculum plus training #9.

### Registered Nurses:

1. Include the above core curriculum 1-8
2. Also take 9, 10, 12, and 13.

### Physicians:

1. Include the above core curriculum 1-13

## CORE CURRICULUM CLASSES:

NUMBER	TITLE	PRESENTER
	Special Needs of People with ID Developmental Effects and Mental Illness Communication and Processing Issues	All Hospital Orientation
1	Positive Behavior Support (video 2.18.05)	Mike Myers
2	Physical Hold Training	Stella Raulston Howard Peake
3	Presentation of Mental Illness in the Context of Intellectual Disability (video 4.29.05)	Marsha Blasingame
4	Creating a Habilitative Environment (video 3.1.05)	Marsha Blasingame
5	Understanding Challenging Behaviors (video 7.21.05)	Marsha Blasingame
6	Patient Abuse Training Information/Post Test/ Instructions on T drive - must be updated annually	Educational Services
7	HMH Monitoring of Side Effects Scale (video 4.05)	William Sherman Joan Reuthinger
8	Autism (video 4.21.05)	Lauren Charlot Scott Stiefel
9	Advanced Training in the Effects of Medical Conditions on Mental Health (video 8.15.05)	William Sherman
10	Sleep Disorders in ID Individuals	Abhijit Despande
11	Neuropsychological Testing	Russell Strandquist
12	Advanced Training in Psychiatric Presentations in the HMH Population/Common Presentations (video Part I 9.19.05; Part II 10.3.05)	William Sherman Marsha Blasingame
13	Pain Management (video 8.29.05)	Deborah Tonhofer Eva Dacanay Carmen Kuhn Joan Reuthinger Clarke St. Dennis

Measurable Outcome	Met	Not Met	Comments
1. HMH staff attended the HMH Core Competency Trainings for their position/clinical specialty and HRDIS form is completed within 3 months of assignment to HMH.			
2. HMH on-call staff and float staff have attended orientation and appropriate Core Competency training as evidenced by HRDIS completion.			
3. The treatment team has engaged in ongoing educational activities about treatment methods and issues for the HMH population, including but not limited to: subscriptions to the NAAD publication, participation in teleconferences with relevant habilitation mental health topics, conference attendance, presentations of special topics in habilitation mental health to HMH and other hospital staff by HMH staff or other presenters.			
4. The staff who were involved in events where there was property destruction, assault, or patient injury are trained in HMH Core Curriculum. This information is reflected in the QM data system regarding staff trainings.			
5. Nursing Management submitted a 2-week staffing pattern for this quarter using the approved form (see example, next page) The unit core staffing numbers were maintained on each shift and the staffing pattern was adequate to support patient needs. See CNO Records.			
6. Training in the process and responsibility staff regarding abuse issues is included in orientation as evidenced by review of orientation HRDIS information from QM including annual evaluation documentation for HMH staff.			
7. Staff have adequate skills to intervene with aggressive patients as evidenced by completion of physical hold training within 3 months of assignment to HMH.			

SURVEY FINDINGS	
AREAS OF STRENGTH:	
RECOMMENDATIONS:	

VII. DISCHARGE PLANNING

Measurable Outcome	Met	Not Met	Comments/Recommendations
1. Information is shared between HMH and the community as evidenced by progress notes.			
2. Community, family and patient were involved from the initial team meeting in identifying short-term and long-term goals toward community reintegration, documented by sign in sheets, progress notes and TPRN.			
3. During the initial meeting, there was discussion and documentation on effective and ineffective interventions as evidenced by TPRN.			
4. When there was no existing cross systems crisis plan, was the patient discharged with a meaningful, relevant CSPC?			
5. All appropriate parties from ESH and the community were involved in the cross systems crisis plan development as evidenced by the signature page with date, name and title. (See CSPC Notebook at nurses station above computer).			
6. The discharge criteria is objectively defined in operational terms that are clear to all parties and relate to the reason for admission. If barriers to discharge identified, these are clearly documented and a specific plan articulated as to how these will be overcome. (See treatment plan and TPRN).			
7. HMH staff confirm that a post-discharge follow-up appointment with a mental health provider has been arranged within two weeks of discharge and the RSN was notified of the appointment as evidenced in the social work discharge summary.			
8. If an HMH patient is being transferred within the hospital, there is documentation from a psychiatrist supporting that this transfer is appropriate and in the best interest of the patient. (See psychiatric Transfer Summary and recent Progress Notes).			

Measurable Outcome	Met	Not Met	Comments/Recommendations
9. A transfer plan will be developed prior to any transfer and involve a collaborative effort. (See progress notes).			
10. The attending psychiatrist evaluated the patient within 24 hours of planned discharge from hospital and document results in progress notes.			

SURVEY FINDINGS
<p>AREAS OF STRENGTH:</p>   
<p>RECOMMENDATIONS:</p>   

**APPENDIX: INITIAL EVALUATION/GUIDELINES**  
**PLEASE USE AS A GUIDELINE WHEN EVALUATING THIS PATIENT**

Measurable Outcome	Comments
1. Nursing will conduct a comprehensive skin, foot (and fall risk assessment if indicated) at the time of admission which will be repeated as appropriate for the individual patient. Abnormalities will be addressed. See assessment section of chart.	
2. If focal neurological findings are present, documentation of head imaging subsequent to the onset of findings will be completed.	
3. Documentation of screening for genetic abnormalities will be completed or documented if done previously.	
4. Hearing, vision and dental evaluations will be updated if needed and abnormalities treated as appropriate.	
5. Speech therapy evaluations will be conducted if language (speech or receptive) deficits are suspected.	
6. If a seizure disorder is documented, records from prior evaluations will be requested. If there has been no prior workup but a seizure disorder is suspected, appropriate neurology consultations will be obtained.	
7. Patients with suspected sleep disorders will be evaluated with data collection and referral to sleep specialists for evaluation where appropriate.	
8. Scheduled metabolic monitoring will be initiated. (lipids, chemsticks, blood pressure, weight). Additional appropriate laboratory monitoring for abnormalities due to psychotropic medications will be completed. This includes the following:	
9. Evaluation for the etiology of pain if present will be completed. Appropriate therapy will be provided. Possible sources of pain will be considered, including but not limited to discomfort due to bowel irregularity, infection, menstrual cramps, undiagnosed reflux or dyspepsia and trauma	
10. A PEX was completed at the time of admission or, if not, the reason was documented.	
11. If PEX was not completed at the time of admission, a plan was outlined to obtain this information.	

Measurable Outcome	Comments
12. There is evidence of a comprehensive laboratory evaluation at the time of admission (at ESH, or at another facility just prior to admission).	
13. The reasons for laboratory abnormalities are documented in the chart. Refer to progress note section of the chart.	
14. If the possibility of a genetic syndrome was considered possible, there is evidence of a genetic evaluation.	
15. If a genetic syndrome was identified, any known behavioral, psychiatric, or phenotypic data were incorporated into the treatment plan.	
16. There is documentation of hearing, vision and dental evaluations. Hearing Vision Dental	
17. If clinically significant abnormalities were found in the hearing, vision and dental evaluations these findings were incorporated into the treatment plan.	
18. Skin and foot assessments (and fall, if appropriate) are present in the chart.	
19. Clinically significant abnormalities identified in the skin and foot. Assessments were addressed.	
20. If the patient was found to be at an increased risk for falls appropriate precautions were instituted. See progress notes and Fall Protocol.	
21. Metabolic monitoring been conducted at least quarterly.	
22. Appropriate laboratory tests have been followed in accordance with recommended schedules according to a patient's psychotropic medication regimen. These tests would include the following: CBC      BMP      NH3      PT/INR      TSH	
23. If there are neurological abnormalities on PEX, a neurological evaluation has been documented.	
24. If the patient has a suspected seizure disorder or a history of spells or paradoxical behavior's the patient has been referred to a specialist to assess for a seizure disorder.	

Measurable Outcome	Comments
25. If the patient has a known seizure disorder, the behavioral characterization of the seizure are documented and incorporated into the treatment plan. This may include the following: Blank stares Aggression Tonic-Clonic	
26. If the patient has a known seizure disorder, appropriate safety precautions have been instituted. Please refer to the seizure protocol.	
27. If pain is present, there is a hypothesis as to the etiology as evidenced by the physician's progress notes and the treatment plan.	
28. When pain is present any known behavioral changes in the patient due to pain have been documented and incorporated into the treatment plan.	
29. Preliminary evaluation for a sleep disorder was initiated. If appropriate, consultations were initiated. Refer to consultation referrals/outside data.	
30. If there is evidence of a sleep disorder interventions have been instituted. Review treatment plan.	
31. If diabetes mellitus is present, there is evidence of glycohemoglobin measurements quarterly as well as annual thyroid screening, urine microalbumin, podiatry and vision evaluation.	
32. If language (receptive or speech) deficits are suspected, a speech evaluation was obtained.	

## RECOMMENDATION SUMMARY:

**PATIENT: (initials)**

**Review Period**

**I. INITIAL ASSESSMENT AND TREATMENT PLANNING**

At the time of admission, the Psychiatric, Medical, Nursing, Social Work and Rehabilitation Services disciplines shall initiate completion of their portions of the clinical profile in the Comprehensive Assessment prior to the 7 day treatment plan. By the 7 day treatment plan, the treatment team and community caregivers will meet with the patient. A comprehensive interview and assessment will be compiled using a multimodal approach. The comprehensive assessment is completed with the community and treatment team following the patient interview. Components of the Comprehensive Assessment are incorporated into the Individualized Treatment Plan and the Behavior Support Plan. Within 14 days of admission, the initial comprehensive assessment will be updated with new information from any source gained since admission.

Measurable Outcome	Met	Not Met	Comments
11. Did the attending psychiatrist evaluate the patient within the first 24 hours after admission?			
12. Admission meeting with collaborative team occurred within first 7 days of admission? (DD/MH/Residential Providers present)			
13. Evidence that HMH team obtained data/documentation from community agencies. If important documents not found, note shows that a call was made clinician-clinician. <ul style="list-style-type: none"> <li>• Discharge Summaries from recent hospitalizations</li> <li>• Medication history/response</li> <li>• Recent physical/exams</li> <li>• Behavior Support Plan</li> <li>• Cross System Crisis Plan</li> <li>• Developmental History</li> <li>• Family History</li> <li>• Incident Reports</li> </ul>			
14. Initial Risk Assessment incorporates pertinent information from multiple informants/comprehensive assessment.			
15. Initial Comprehensive Assessment includes thorough history/description of; <ul style="list-style-type: none"> <li>• developmental facts</li> <li>• bio-psycho-social information</li> <li>• setting events &amp; triggers for current admission</li> <li>• current presentation of symptoms and interaction of such.</li> </ul>			
16. Clinical Formulation incorporates the team's thought process related to the diagnosis and related symptoms, history, problems being treated, contributing factors, the treatment plan, and DSM Diagnoses I-V found in treatment			

Measurable Outcome	Met	Not Met	Comments
plan.			
17. The treatment plan is habilitative: <ul style="list-style-type: none"> <li>• Individualized</li> <li>• Based on comprehensive assessment</li> <li>• teaching skills (not reacting to behavior)</li> <li>• uses psychosocial therapies/teaching methods appropriate for persons with limited cognitive function</li> <li>• uses individualized, habilitative treatment goals</li> <li>• the plan teaches skills to be carried over to residential living</li> <li>• the plan includes meaningful social and work activities per individual's strengths and interests</li> </ul>			
18. There is diagnostic agreement throughout the chart.			
19. There are multimodal interventions identified to address each clinical need <ul style="list-style-type: none"> <li>• psychiatric</li> <li>• behavioral/functional analysis</li> <li>• physical/medical</li> <li>• environmental</li> <li>• pro-social</li> </ul>			
20. Evidence that approaches (other than prns) are being used to support behavior including: <ul style="list-style-type: none"> <li>• prevention</li> <li>• antecedent controls</li> <li>• teaching coping strategies</li> <li>• environmental management</li> </ul>			

SURVEY FINDINGS
AREAS OF STRENGTH:
RECOMMENDATIONS:

II. PSYCHIATRIC AND MEDICAL TREATMENT AND EVALUATION

Measurable Outcome	Met	Not Met	Comments
10. Rationale for choice of medication doses and changes are clearly stated in documentation from psychiatrist.			
11. Documentation from psychiatrist includes thought process related to: <ul style="list-style-type: none"> <li>• Off label use of medication</li> <li>• Medications administered: "start low and go slow" (tapering present)</li> <li>• Poly-pharmacy</li> <li>• Drug interactions</li> <li>• Possible adverse effects</li> <li>• Use of anti-libidinal medications</li> <li>• Dosage selection</li> <li>• Adequate trials on medications</li> </ul>			
12. Evidence that lab tests are ordered per standard of each medication prescribed			
13. Evidence of side effect monitoring through the use of the MOSES			
14. Evidence that the MOSES provides quality information to guide treatment			
15. Evidence in documentation that data on PRN use was reviewed and addressed regularly (monthly-PRN review with Pharmacist)			
16. Off label medications will be documented describing monitoring procedure and results expected			
17. When ECT is used, there is evidence of informed consent and due process laws have been followed			
18. The initial medical evaluation will include PEX (if possible) and laboratory screening to look for evidence of medical conditions which may be contributing to the patient's decompensation. These will including the following: <ul style="list-style-type: none"> <li>• assessing for glucose abnormalities</li> <li>• infection</li> <li>• electrolyte abnormalities</li> <li>• thyroid disorders</li> <li>• hepatic dysfunction</li> <li>• renal dysfunction</li> <li>• vitamin deficiencies as appropriate.</li> </ul>			

SEE APPENDIX FOR ADDITIONAL DETAILS OF ASSESSMENT OF APPROPRIATE MEDICAL CONCERNS

SURVEY FINDINGS	
AREAS OF STRENGTH:	
RECOMMENDATIONS:	

### III. DEVELOPING AND INTEGRATING BEHAVIOR SUPPORT PLANS

Behavior Support Plans are developed as an outcome of the Comprehensive Assessment Process. Part of this process includes a Functional Assessment, which seeks to understand some of the more complex transactions and patterns between a person's history of learning, internal state factors and contextual variables which produce behavioral outcomes. The timeliness of BSP production and communication of important elements to staff who must implement them, is also vital.

Measurable Outcome	Met	Not Met	Comments
15. BSP completed within 7 days			
16. BSP is habitative -- identifies key behaviors to increase, identifies key behaviors to decrease, then setting events, triggers, cues, and interventions for behaviors to decrease, including what to do if the patient or others are at risk of harm. Are there proactive strategies to address identified triggers and setting events.			
17. Staff interventions are clear so that staff know what to do, when to do it, how to best approach this individual, key concerns, what behaviors will be positively reinforced, what the reinforcers are, who delivers them etc. Are there proactive strategies to address identified triggers and setting events. Refer to BSP			
18. Current BSP is in the record			
19. Functional Analysis is part of the BSP			
20. Tracking system in place and relevant to treatment outcomes.			
21. Behavior to be increased or decreased is reflected in the treatment plan, data sheets and in progress notes.			
22. Decisions regarding treatment revisions are supported by data collected as reflected in TPRN and progress notes.			
23. Functional analysis is revised based on data and observations.			
24. BSP interventions changed and dated to reflect new understanding such as setting events, triggers, and contextual issues.			
25. BSP includes positive goals. (For example, are there any goals related to building self-esteem, use of adaptive strategies to gain interactions and support from others?)			
26. BSP was modified as needed for any problem identified that placed patient at risk of harm. If the BSP was not modified, the reason is documented.			
27. BSP is integrated into the treatment plan.			
28. HMH staff know what to do based on the BSP as evidenced by staff interview.			

SURVEY FINDINGS
AREAS OF STRENGTH:
RECOMMENDATIONS:

IV. PROGRAMS/GROUPS/WORK

Active Treatment: Purpose is to develop new rehabilitative skills which allow the patient to be engaged throughout their day in personally meaningful programs. HMH will provide programs, groups, and work experiences that emphasize developing skills and strategies for return to patient's community and prevention of re-hospitalization. Active Treatment will be provided for a minimum of six hours a day including but not limited to the following areas: Anger Management, Social Interaction Training, Counseling Sessions, Coping Skills Training, ADLS, Prevocational/Vocational Training, Recreational/Leisure Skills, and Social Activities. Active treatment goals will be individualized for each patient based upon their comprehensive assessment, treatment plan, BSP, risk assessment, and discharge plan.

Measurable Outcome	Met	Not Met	Comments
6. Patient is receiving six hours of active treatment as evidenced by the following A. Structured activities are implemented as defined in the comprehensive assessment/treatment plan B. Hours of active treatment form C. Behavioral Interval Data Form			
7. If patient is not participating in six hours of active treatment, the bio-psycho-social problems causing this have been regularly assessed. This is evidenced by the following: A. Goals have been changed and other plans have been implemented at least monthly if active treatment is not occurring. B. Multimodal approaches are used which might include altering the tasks to reflect less demand on the patient, evaluate reinforcers which might lead to better attendance, ask the patient what he or she would like to learn, medical problems are being addressed. C. Barriers might include fatigue, side effects of medications, anxiety, etc. This information should be documented in the TPRN Note/treatment plan.			
8. If the patient is unable to leave the ward for medical or risk factors, active treatment is being provided on the ward for six hours a day. Refer to the active treatment Data Collection form.			
9. When appropriate to attend the Work Center, work goals are reflected in the treatment plan and are individualized.			
10. The patient's goals are individualized to meet their unique needs? This will be reflected in the specific interventions as a result of the comprehensive assessment, /treatment plan, and work center section of the treatment plan and daily schedule.			

SURVEY FINDINGS
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V. PATIENT SAFETY AND TROUBLE SHOOTING

Assuring patient safety is a complex process involving such areas as risk assessment, ward milieu, staffing patterns, staff education and training, census, and procedural safeguards.

Measurable Outcome	Met	Not Met	Comments
7. An initial admission risk assessment was completed as evidenced by A. Admission Risk Assessment in the chart B. Informant information has been incorporated into the admission risk assessment			
8. The risk assessment information was incorporated into the 7 day treatment plan as evidenced by: A. Informant information included in the comprehensive assessment regarding risk factors B. BSP contains antecedents, triggers, for evaluating risk factors?			
9. ABC contains a thorough identification of events prior to the occurrence, a clear description of event, and what happened following the event. Clinical team member makes note of recent ABCs and comments on what is suggested by an analysis of these.			
10. There is evidence of change in patient treatment plans reflecting outcomes based on risk assessment, ABC forms and UORs. For example use of 1 to 1s, patient assignment to rooms or training areas, and additional staff training as documented in progress notes.			
11. UORs that give rise to reasonable cause to believe that patient abuse or neglect of class members has occurred have been investigated. This is reflected in the UOR data from QM.			
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Sample HMMH Staffing Pattern

EASTERN STATE HOSPITAL DEPARTMENT OF NURSING HMMH STAFFING

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	LPN									
	MHT									
	TOTAL									
	Full Training									
	No HMMH Exp.									
	Assigned Staff									
	Float Staff									

SHIFT: 1445-2300 ( 1:1s on evening shift during this time period)

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	RN									
	LPN									
	MHT									
	TOTAL									
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	No HMMH Exp.									
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SHIFT: 2245-0700 ( 1:1s on night shift during this time period)

Date	JOB CLASS	SCHD	ON DUTY							
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	LPN									
	MHT									
	TOTAL									
	Full Training									
	No HMMH Exp.									
	Assigned Staff									
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SURVEY FINDINGS
AREAS OF STRENGTH:
RECOMMENDATIONS:

## VI. STAFF TRAINING AND CORE COMPETENCIES

Specialized training is required for staff to work effectively with patients on the HMH Unit, consisting of both a core curriculum for all staff, and a specialized curriculum for various clinical disciplines. For course titles refer to list below. The following trainings are included depending on one's position/specialty.

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1. Orientation Training including HMH topics.
2. The Core Curriculum classes 1-8.

### MHTs:

1. Include the above Core Curriculum

### Work Center Staff:

1. Include the above core curriculum.

### Licensed Practical Nurses:

1. Include the above core curriculum plus training #9.

### Registered Nurses:

1. Include the above core curriculum 1-8
2. Also take 9, 10, 12, and 13.

### Physicians:

1. Include the above core curriculum 1-13

## CORE CURRICULUM CLASSES:

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5	Understanding Challenging Behaviors (video 7.21.05)	Marsha Blasingame
6	Patient Abuse Training Information/Post Test/ Instructions on T drive – must be updated annually	Educational Services
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Measurable Outcome	Met	Not Met	Comments
<ul style="list-style-type: none"> <li>1. HMH staff attended the HMH Core Competency Trainings for their position/clinical specialty and HRDIS form is completed within 3 months of assignment to HMH.</li> </ul>			
<ul style="list-style-type: none"> <li>2. HMH on-call staff and float staff have attended orientation and appropriate Core Competency training as evidenced by HRDIS completion.</li> </ul>			
<ul style="list-style-type: none"> <li>3. The treatment team has engaged in ongoing educational activities about treatment methods and issues for the HMH population, including but not limited to: subscriptions to the NAAD publication, participation in teleconferences with relevant habilitation mental health topics, conference attendance, presentations of special topics in habilitation mental health to HMH and other hospital staff by HMH staff or other presenters.</li> </ul>			
<ul style="list-style-type: none"> <li>4. The staff who were involved in events where there was property destruction, assault, or patient injury are trained in HMH Core Curriculum. This information is reflected in the QM data system regarding staff trainings.</li> </ul>			
<ul style="list-style-type: none"> <li>5. Nursing Management submitted a 2-week staffing pattern for this quarter using the approved form (see example, next page) The unit core staffing numbers were maintained on each shift and the staffing pattern was adequate to support patient needs. See CNO Records.</li> </ul>			
<ul style="list-style-type: none"> <li>6. Training in the process and responsibility staff regarding abuse issues is included in orientation as evidenced by review of orientation HRDIS information from QM including annual evaluation documentation for HMH staff.</li> </ul>			
<ul style="list-style-type: none"> <li>7. Staff have adequate skills to intervene with aggressive patients as evidenced by completion of physical hold training within 3 months of assignment to HMH.</li> </ul>			

SURVEY FINDINGS
AREAS OF STRENGTH:
RECOMMENDATIONS:

VII. DISCHARGE PLANNING

Measurable Outcome	Met	Not Met	Comments/Recommendations
<ul style="list-style-type: none"> <li>1. Information is shared between HMH and the community as evidenced by progress notes.</li> </ul>			
<ul style="list-style-type: none"> <li>2. Community, family and patient were involved from the initial team meeting in identifying short-term and long-term goals toward community reintegration, documented by sign in sheets, progress notes and TPRN.</li> </ul>			
<ul style="list-style-type: none"> <li>3. During the initial meeting, there was discussion and documentation on effective and ineffective interventions as evidenced by TPRN.</li> </ul>			
<ul style="list-style-type: none"> <li>4. When there was no existing cross systems crisis plan, was the patient discharged with a meaningful, relevant CSPC?</li> </ul>			
<ul style="list-style-type: none"> <li>5. All appropriate parties from ESH and the community were involved in the cross systems crisis plan development as evidenced by the signature page with date, name and title. (See CSPC Notebook at nurses station above computer).</li> </ul>			
<ul style="list-style-type: none"> <li>6. The discharge criteria is objectively defined in operational terms that are clear to all parties and relate to the reason for admission. If barriers to discharge identified, these are clearly documented and a specific plan articulated as to how these will be overcome. (See treatment plan and TPRN).</li> </ul>			
<ul style="list-style-type: none"> <li>7. HMH staff confirm that a post-discharge follow-up appointment with a mental health provider has been arranged within two weeks of discharge and the RSN was notified of the appointment as evidenced in the social work discharge summary.</li> </ul>			
<ul style="list-style-type: none"> <li>8. If an HMH patient is being transferred within the hospital, there is documentation from a psychiatrist supporting that this transfer is appropriate and in the best interest of the patient.</li> </ul>			

Measurable Outcome	Met	Not Met	Comments/Recommendations
(See psychiatric Transfer Summary and recent Progress Notes).			
<ul style="list-style-type: none"> <li>• 9. A transfer plan will be developed prior to any transfer and involve a collaborative effort. (See progress notes).</li> </ul>			
<ul style="list-style-type: none"> <li>• 10. The attending psychiatrist evaluated the patient within 24 hours of planned discharge from hospital and document results in progress notes.</li> </ul>			

SURVEY FINDINGS
<p>AREAS OF STRENGTH:</p>   
<p>RECOMMENDATIONS:</p>   

**APPENDIX: INITIAL EVALUATION/GUIDELINES**  
**PLEASE USE AS A GUIDELINE WHEN EVALUATING THIS PATIENT**

Measurable Outcome	Comments
1. Nursing will conduct a comprehensive skin, foot (and fall risk assessment if indicated) at the time of admission which will be repeated as appropriate for the individual patient. Abnormalities will be addressed. See assessment section of chart.	
• 2. If focal neurological findings are present, documentation of head imaging subsequent to the onset of findings will be completed.	
• 3. Documentation of screening for genetic abnormalities will be completed or documented if done previously.	
• 4. Hearing, vision and dental evaluations will be updated if needed and abnormalities treated as appropriate.	
• 5. Speech therapy evaluations will be conducted if language (speech or receptive) deficits are suspected.	
• 6. If a seizure disorder is documented, records from prior evaluations will be requested. If there has been no prior workup but a seizure disorder is suspected, appropriate neurology consultations will be obtained.	
• 7. Patients with suspected sleep disorders will be evaluated with data collection and referral to sleep specialists for evaluation where appropriate.	
8. Scheduled metabolic monitoring will be initiated. (lipids, chemsticks, blood pressure, weight). Additional appropriate laboratory monitoring for abnormalities due to psychotropic medications will be completed. This includes the following:	
• 9. Evaluation for the etiology of pain if present will be completed. Appropriate therapy will be provided. Possible sources of pain will be considered, including but not limited to discomfort due to bowel irregularity, infection, menstrual cramps, undiagnosed reflux or dyspepsia and trauma	
• 10. A PEX was completed at the time of admission or, if not, the reason was documented.	
• 11. If PEX was not completed at the time of admission, a plan was outlined to obtain this information.	

Measurable Outcome	Comments
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• 12. There is evidence of a comprehensive laboratory evaluation at the time of admission (at ESH, or at another facility just prior to admission).	
• 13. The reasons for laboratory abnormalities are documented in the chart. Refer to progress note section of the chart.	
• 14. If the possibility of a genetic syndrome was considered possible, there is evidence of a genetic evaluation.	
• 15. If a genetic syndrome was identified, any known behavioral, psychiatric, or phenotypic data were incorporated into the treatment plan.	
17. There is documentation of hearing, vision and dental evaluations. Hearing Vision • Dental	
• 17. If clinically significant abnormalities were found in the hearing, vision and dental evaluations these findings were incorporated into the treatment plan.	
• 18. Skin and foot assessments (and fall, if appropriate) are present in the chart.	
• 19. Clinically significant abnormalities identified in the skin and foot. Assessments were addressed.	
• 20. If the patient was found to be at an increased risk for falls appropriate precautions were instituted. See progress notes and Fall Protocol.	
• 21. Metabolic monitoring been conducted at least quarterly. •	
• 22. Appropriate laboratory tests have been followed in accordance with recommended schedules according to a patient's psychotropic medication regimen. These tests would include the following: CBC    BMP    NH3    PT/INR    TSH	
• 23. If there are neurological abnormalities on PEX, a neurological evaluation has been documented. •	
• 24. If the patient has a suspected seizure disorder or a history of spells or paradoxical	

Measurable Outcome	Comments
<p>behaviors the patient has been referred to a specialist to assess for a seizure disorder.</p> <ul style="list-style-type: none"> <li>•</li> </ul>	
<ul style="list-style-type: none"> <li>• 25. If the patient has a known seizure disorder, the behavioral characterization of the seizure are documented and incorporated into the treatment plan. This may include the following: <ul style="list-style-type: none"> <li>Blank stares</li> <li>Aggression</li> <li>Tonic-Clonic</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>• 26. If the patient has a known seizure disorder, appropriate safety precautions have been instituted. Please refer to the seizure protocol.</li> </ul>	
<ul style="list-style-type: none"> <li>• 27. If pain is present, there is a hypothesis as to the etiology as evidenced by the physician's progress notes and the treatment plan.</li> </ul>	
<ul style="list-style-type: none"> <li>• 28. When pain is present any known behavioral changes in the patient due to pain have been documented and incorporated into the treatment plan.</li> </ul>	
<ul style="list-style-type: none"> <li>• 29. Preliminary evaluation for a sleep disorder was initiated. If appropriate, consultations were initiated. Refer to consultation referrals/outside data.</li> </ul>	
<ul style="list-style-type: none"> <li>• 30. If there is evidence of a sleep disorder interventions have been instituted. Review treatment plan.</li> </ul>	
<ul style="list-style-type: none"> <li>• 31. If diabetes mellitus is present, there is evidence of glycohemoglobin measurements quarterly as well as annual thyroid screening, urine microalbumin, podiatry and vision evaluation.</li> </ul>	
<ul style="list-style-type: none"> <li>• 32. If language (receptive or speech) deficits are suspected, a speech evaluation was obtained.</li> </ul>	

## RECOMMENDATION SUMMARY:

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The Honorable ROBERT J. BRYAN

**UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON  
AT TACOMA**

CHRISTI RUST, et al.,

Plaintiffs,

v.

WESTERN STATE HOSPITAL, et al.,

Defendants.

NO. C00-5749RJB

AMENDED ORDER

After having reviewed the record and files in this matter and conducting a fairness hearing as required by Fed. R. Civ. P. 23 (e) , the Court found on September 28, 2001, that the requested relief was appropriate and necessary in order to ameliorate the allegedly inadequate conditions of care at the Center for Forensic Services (CFS) at Western State Hospital (WSH). The Order entered by this Court provided for a Monitoring Committee to monitor implementation of the terms of the Order. The Monitoring Committee also was empowered to recommend modifications of specific provisions of the Order as described more fully in Paragraph 1(h) of the Order.

The Monitoring Committee has issued a report finding the Defendants to be in substantial compliance with the Order, thus triggering the administration of the self-monitoring period described in Paragraph 1(g) of the September 28, 2001, Order. In addition, the monitors

1 have proposed one modification of the Order, relating to the establishment of an all female  
2 ward at Western State Hospital.

3 Having considered the Monitors' recommendation and heard from counsel for the  
4 parties, including counsel for the represented class, the Court finds that the modification  
5 proposed is in the best interests of the class and that the fairness hearing originally conducted  
6 in this matter, at which time all provisions related to the Monitors' authority were considered,  
7 satisfies the requirements of Rule 23, Fed. R. Civ. P. The Order of September 25, 2001, is  
8 hereby modified to read as follows:

9 The purpose of this Amended Order is to ensure that Defendants provide the named  
10 Plaintiffs and members of the Plaintiff class with:

- 11 1. Constitutionally minimally adequate protection from harm as required by the fourteenth  
12 amendment of the United States Constitution.
- 13 2. Constitutionally minimally adequate and timely dental and medical care as required by  
14 the fourteenth amendment of the United States Constitution.
- 15 3. Freedom from unnecessary restraint as required by the fourteenth amendment of the  
16 United States Constitution.
- 17 4. Constitutionally minimally adequate discharge planning as required by the fourteenth  
18 amendment of the United States Constitution.
- 19 5. Privacy as required by the first amendment of the United States Constitution.
- 20 6. Services, care, and treatment in the most integrated setting as required by Title II of the  
21 Americans with Disabilities Act.

22 Accordingly, it is hereby **ORDERED** that:

23 Defendants shall continue to implement the provisions set forth in this Amended Order  
24 and in Appendix A attached hereto and incorporated herein.  
25  
26

1 a) Defendants shall provide written self-monitoring reports to Plaintiffs' counsel with  
2 regard to compliance with Appendix A of this Amended Order for a period of three and  
3 a half years, or until February 28, 2008. The self-monitoring of this Amended Order  
4 will be in accordance with a set of objective criteria that was developed by the parties  
5 in consultation with the Monitoring Committee. During this self-monitoring period,  
6 WPAS may, at its own expense, retain the Monitoring Committee for additional  
7 consultations.

8 If, at any time during this period of monitoring, Plaintiffs' counsel believes that  
9 Defendants are failing to remain in substantial compliance with Appendix A of this  
10 Amended Order, Plaintiffs may invoke the Dispute Resolution and Enforcement section  
11 of this Amended Order.

12 b) The Monitoring Committee previously constituted in this action may recommend  
13 modifications of certain specific provisions of this Amended Order and the provisions  
14 set forth in Appendix A if the Monitoring Committee is satisfied that a different  
15 procedure or policy would adequately or more appropriately protect the rights of the  
16 Plaintiff class. Upon such recommendation the parties shall meet and confer to discuss  
17 whether the recommendation or recommendations should be adopted. If the parties  
18 agree to adopt these recommendations, the parties shall advise the Court.

19 **1. Dispute Resolution and Enforcement of this Amended Order**

20 a) If at any time during the self-monitoring period by the Defendants, Plaintiffs' counsel  
21 believes that Defendants are not substantially in compliance with this Amended Order,  
22 Plaintiffs' counsel shall consult with the Medical Director or Clinical Director and the  
23 parties shall make a good faith attempt to informally and timely resolve the dispute in  
24 consultation with the Monitoring Committee.

25 b) If a timely and informal resolution cannot be reached by the parties, the parties shall  
26 attend formal mediation to resolve the issue. Mediation of the disputed matter shall

1 occur within 30 business days of a party's formal written request for mediation, unless  
2 otherwise agreed in writing by the parties or the mediator is unavailable. A formal  
3 request for mediation in the form of a letter shall be submitted by the party requesting  
4 mediation. This request shall be served on all counsel for the parties and each member  
5 of the Monitoring Committee and to the mediator.

6 The Honorable J. Kelly Arnold shall be appointed as the mediator for any dispute  
7 arising out of this Amended Order. If Judge Arnold is unavailable, the parties shall  
8 mutually agree upon alternative mediators. Each party shall bear its own costs  
9 associated with mediation.

10 c) If, after participating in good faith at the mediation, no resolution is reached, Plaintiffs  
11 may file a motion with the U.S. District Court in this matter requesting the Court to  
12 hold a "show cause" hearing ordering the Defendants to show cause why they are not  
13 substantially in compliance with this Amended Order. Plaintiffs shall provide the  
14 appropriate notice to Defendants' counsel of such action.

15 d) In the event that Plaintiffs have reasonable cause to believe that there is a risk of  
16 imminent harm to a class member as a result of the Defendants' failure to comply with  
17 this Amended Order, Plaintiffs may proceed directly to the Court and request a show  
18 cause hearing without first going through mediation or may take any other necessary  
19 legal action. If such action is taken while the Monitoring Committee is in effect,  
20 Plaintiffs will make a good faith effort to consult with both members of the Monitoring  
21 Committee and the Medical Director to discuss the issue or issues before filing a  
22 motion requesting a show cause hearing. If the Monitoring Committee is no longer in  
23 effect, Plaintiffs will consult with the Medical Director regarding the situation before  
24 Plaintiffs take action. In either case Plaintiffs will provide at least one business day  
25 written notice to Defendants' counsel via facsimile and first class mail.  
26

1 e) In the event that the Court grants Plaintiffs' motion requesting a show cause hearing,  
2 the parties will brief the issues and with the Court's approval, present oral arguments  
3 and/or present evidence at a show cause hearing on the issue of the Defendants'  
4 substantial compliance with this agreement.

5 f) Nothing in this Amended Order shall be deemed to limit:

6 1) the Court's powers of contempt or any other power possessed by this Court;

7 2) the ability of any class member to seek relief of any kind to which they would  
8 otherwise be entitled under state or federal law other than claims for injunctive  
9 relief adjudicated in this action;

10 3) The ability of the Washington Protection and Advocacy System (WPAS) to fulfill  
11 its mandate pursuant to the "Protection and Advocacy for Individuals with Mental  
12 Illness (PAIMI) Act," 42 U.S.C. § 10801, et seq., and the regulations promulgated  
13 thereto, 42 C.F.R. § 51, including, but not limited to, access to all class member  
14 records during the pendency of the monitoring period as described in Section 1(e)-  
15 (g) of this Amended Order.

## 16 **2. Remedies/Penalties for Noncompliance with Amended Order**

17 In the event that the Court finds that Defendants have failed to substantially comply  
18 with the terms of this Amended Order, the Court may order any penalty or relief the Court  
19 deems legally appropriate.

## 20 **3. Notice to Class Members**

21 Pursuant to requirements of Fed. R. Civ. P. 23 (d), class members will be notified of  
22 this Amended Order by posting notices where all CFS patients can see them. In addition, all of  
23 the criminal courts, prosecutor, and public defender offices in the WSH cachement area shall  
24 be notified of this Amended Order. The parties will evenly share the costs of such notice and  
25 the Plaintiffs' counsel will ensure that this notice is provided.  
26

1 **4. Fairness Hearing**

2 As required by Fed. R. Civ. P. 23 (e), a fairness hearing was held to give the  
3 opportunity to any class member to contest the original Order. Appropriate notice of this  
4 hearing was afforded to class members along with the notice of the original Order. The  
5 original Order contemplated modifications that were recommended by the monitors and agreed  
6 by the parties to be in the best interest of members of the class. No further fairness hearing is  
7 required for such modifications.

8 **5. Attorneys' Fees and Costs**

9 Defendants paid an agreed amount of attorneys' fees upon entry of the original Order.  
10 No attorneys' fees will be assessed for modification of the Order after the monitors'  
11 recommendation.

12 Plaintiffs will not seek an award of attorneys' fees for time spent by their counsel in  
13 mediation or for preparation for mediation related to the enforcement of this Amended Order.  
14 However, if the Plaintiffs are the prevailing party as a result of any show cause hearing or other  
15 future litigation in this case due to Defendants' failure to comply with this Amended Order,  
16 Defendants shall reimburse Plaintiffs for reasonable attorneys' fees and costs incurred resulting  
17 from such litigation.

18 **6.** Plaintiffs' claims were resolved in their entirety upon entry of the September 28, 2001,  
19 Order. Plaintiffs' sole remedy for any claims related to this action shall be through the  
20 enforcement provisions set forth in Section 3 of this Amended Order.

21 **7.** This Amended Order and Appendix A shall be binding on all Defendants and any of  
22 their successors in interests, assigns, agents, and officers.

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1                    DATED this 19<sup>th</sup> day of November, 2004.

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3                    /S/ Robert J. Bryan  
4                    **ROBERT J. BRYAN**  
5                    **United States District Judge**

6                    **Presented by:**

7  
8                    telephonically approved  
9                    Deborah A. Dorfman, WSBA #23823  
10                    Stacie Siebrecht, WSBA # 29992  
11                    Washington Protection and Advocacy System  
12                    315 5<sup>th</sup> Avenue South, Ste. 850  
13                    Seattle, Washington 98104  
14                    Attorneys for Plaintiffs

15                    and

16                    **CHRISTINE O. GREGOIRE**  
17                    Attorney General

18                    /s/  
19                    Pamela H. Anderson, WSBA # 21835  
20                    Sarah J. Coats, WSBA #20333  
21                    670 Woodland Square Loop, SE  
22                    P.O. Box 40124  
23                    Olympia, Washington 98504-0124  
24                    Attorneys for Defendants

1 APPENDIX A TO AMENDED ORDER

2  
3 A. Defendants agree to take the following steps for the purpose of reducing the risk of  
4 assaults:

5 1. Defendants shall develop and implement a process for assessing institutional risk in  
6 accordance with the provisions set forth in 1(a) – (c) below:

- 7 a) By July 31, 2001, Defendants will develop and implement a process for Assessing  
8 Institutional Risk (AIR). The Defendants will consult with William Gardner, Ph.D.,  
9 a monitor on the monitoring committee in Allen, et al. v. Western State Hospital, et  
10 al. to develop and implement an AIR for patients with developmental disabilities.  
11 The AIR will include an assessment of observable, known historical, or other  
12 apparent factors that would create a risk of victimization or perpetration of violence  
13 to CFS staff or patients. To the extent practical, the AIR should include, but not be  
14 limited to, a history of violence or non-consensual sexual behavior in institutional  
15 and other settings; evidence of threats, impulsivity, hostility, and/or paranoia; a  
16 history of sexual or physical victimization in an institutional setting or elsewhere, or  
17 any other behaviors or characteristics that are deemed likely to present a danger to  
18 the patient, CFS staff or other patients.
- 19 b) Prior to or during the admission process, Defendants will perform an AIR on each  
20 patient. The AIR will be performed prior to the patient's assignment to a living  
21 unit. The results of the AIR will be documented as part of the admission note. The  
22 AIR will be updated at any time that new, relevant information becomes available.
- 23 c) An AIR will be performed on male patients who are being considered for  
24 placement on the co-ed competency unit

25 2. Defendants shall take the following additional steps to improve the safety of all patients  
26 at CFS:

- 1 a. All evaluation patients will be screened using the AIR while the patient is in  
2 jail. Defendants will make best efforts to complete the evaluation of all  
3 patients in jail. Defendants will not admit competency patients to CFS prior  
4 to evaluation if the person is deemed by CFS; a) to present an unacceptable  
5 risk to other patients or b) to be clinically inappropriate for admission.
- 6 b. CFS will adopt and implement a policy setting forth objective criteria for  
7 identifying patients with certain characteristics that may deem them  
8 vulnerable. For example, patients with developmental disabilities or  
9 borderline intellectual functioning, patients of advanced aged, patients who  
10 are medically fragile, and patients with physical disabilities may be  
11 considered vulnerable. This policy and practice will be established and  
12 implemented by April 12, 2001.

- 1 c. The Defendants will consult with William Gardner, Ph.D., to develop  
2 protocols to provide patients with developmental disabilities appropriate  
3 behavioral supports.
- 4 d. The Defendants will develop policies and protocols with the consultation of  
5 the Monitoring Committee to promote the safety of patients identified as  
6 vulnerable through the AIR. These policies and protocols will be  
7 implemented no later than September 30, 2001 and in accordance with the  
8 provisions relating to the Monitoring Committee as set forth in Section 1 of  
9 the Order above.
- 10 3. The Clinical Director of CFS will have the responsibility for ensuring compliance with  
11 Sections 1-2 above. These provisions will be incorporated into CFS policies by  
12 September 30, 2001.
- 13 4. Defendants shall take the following additional steps to improve the safety for all  
14 patients at CFS:
- 15 a. Draft and implement a policy giving the Clinical Director the authority to  
16 move patients within a unit. The policy will provide a procedure for a  
17 request to be submitted by or on behalf of the patient and for the Clinical  
18 Director to exercise his or her clinical judgment as to whether a request  
19 should be granted within a reasonable period of time. This will be a WSH  
20 policy. This policy will be established and implemented by April 12, 2001.
- 21 b. Draft a policy to clarify that the Medical Director has the authority to make  
22 inter unit transfers regardless of legal status of the patient. This policy will  
23 be established and implemented by April 12, 2001.
- 24 5. The Medical Director of WSH will have the responsibility for ensuring compliance with  
25 Sections 1-4 above.
- 26 B. Defendants agree to take the following steps for the purpose of reducing patient abuse  
and neglect:
1. By May 11, 2001, Defendants will develop and implement a written policy providing  
as follows:
- a) All administrative reports of incidents (AROI) will be reviewed by the CFS  
Clinical Director.
- b) Those reports which, in the opinion of the Clinical Director, present credible  
allegations of suspected patient abuse or the neglect of a CFS patient, as defined  
by WSH Policy No. 3.4.4, will be assigned to a supervisor for investigation  
pursuant to the procedures set forth in WSH Personnel Policy No. 545.
- c) A copy of the AROI, described in paragraph (b) above, and the referral to the  
supervisor will be forwarded to the Chief Executive Officer of WSH, Mental  
Health Division (MHD), and an audit team of the Administrative Services  
Division, of the Management Services Administration (MSA) of the  
Department of Social and Health Services (DSHS).

- d) MSA will review and maintain a database of the AROIs and follow up with MHD to ensure that an appropriate investigation has occurred.
- e) The Clinical Director will review the results of the supervisor's investigation and take appropriate action.
- f) The WSH CEO will be provided with a copy of the results of the supervisor's investigation.
- g) Copies of all AROIs will be sent to WPAS during the pendency of the monitoring period described in Section 1(f) of the Order.

This policy will be implemented in accordance with the provisions relating to the Monitoring Committee as set forth in Section 1 of the Order.

2. All AROIs that contain allegations of patient abuse and neglect, as defined by WSH Policy 3.4.4, and all security reports involving CFS patients which a) relate to a patient injury of unknown origin, b) allege abuse or neglect, or c) relate to probable serious injuries as a result of assault or self-injurious behavior will be reviewed on the next business day by the Quality Assurance Investigative Team (Team). This Team shall be independent of ward staff and include at least one RN, one physician, and an additional member of the quality assurance department and a member of the security department.

Based upon its review, the Team will independently investigate incidents that could have resulted from neglect or abuse, as defined in WSH Policy No. 3.4.4. Such investigation may include an interview and/or an examination of the patient who is the alleged victim, interviews with ward staff, or such other investigative actions as deemed appropriate by the Team. In the event that the Team concludes that the incident may have constituted abuse or neglect, as defined by WSH Policy No. 3.4.4, the Team shall refer the matter to the Clinical Director, who shall require a supervisory investigation according to WSH Personnel Policy No. 545, if such investigation has not previously been ordered.

The above procedures will be established and implemented by May 12, 2001. This policy will be implemented in accordance with the provisions relating to the Monitoring Committee as set forth in Section 1 of the above Order.

3. The Team shall continue to report all incidences of suspected abuse or neglect, as defined by WSH Policy No. 3.4.4, to the appropriate state agencies and law enforcement as required by law. The Team shall also report all instances of failure to report suspected patient abuse and neglect to the appropriate agencies.
4. By July 12, 2001, Defendants will develop and implement a policy that establishes a procedure for the mandatory reporting of suspected patient abuse and neglect as defined by RCW 74.34 and RCW 71.124. This policy will be applicable to all patients on CFS.
5. By May 12, 2001, all CFS employees and WSH security personnel will be informed or be reminded of their obligations to report suspected abuse and neglect and informed of the appropriate reporting procedure and will be informed or be reminded that the failure to report is grounds for disciplinary action and will be reported to the appropriate agencies. All new employees will receive this information at the time of orientation and sign an acknowledgment of receipt of this information. All current employees will be asked to review the reporting policy and sign an acknowledgement that they have reviewed and understand the policy annually at the time of their evaluations.

1 Defendants shall take appropriate disciplinary action in accordance with personnel  
2 policies against any staff member found to have engaged in abuse and/or neglect of a  
patient as defined in WSH policy 3.4.4.

3 6. By May 12, 2001, each ward station on CFS will have an easily identifiable notebook  
4 containing all pertinent policies and forms related to incident reporting and contains an  
5 easily understandable summary of procedures that staff are to follow when they obtain  
information related to allegations of patient abuse or neglect. The Clinical Director will  
be responsible for ensuring the implementation of this policy.

6 7. By May 12, 2001, Defendants will develop and implement a process  
7 whereby the Clinical Director of CFS, or another licensed clinician at WSH as  
8 designated by the CEO of WSH, shall conduct two or more unannounced spot checks  
9 of CFS patient records each month to ensure that incidents as defined by WSH Policy  
10 3.4.4 have been reported on an AROI. The Clinical Director shall report the results of  
11 these spot checks to the Monitoring Committee.

12 8. Defendants will develop and implement a WSH policy that defines morbidity and  
13 mortality events and sets forth procedures for staff to report such events to the  
14 appropriate committee. Defendants will notify professional staff of the procedure for  
15 reporting morbidity and mortality events.

16 9. The Morbidity and Mortality Committee of WSH will continue to review 100% of  
17 patient deaths and 100% of cases in which a patient receives medical care at another  
18 hospital facility. By May 12, 2001, Defendants will commission independent  
19 evaluations by a non-state employee for each unexpected patient death. Such  
20 evaluations will be conducted by a non-psychiatric physician or a psychiatrist as  
21 appropriate. The evaluation shall include an analysis of cause of death and any  
recommendations for changes as appropriate.

22 10. During the pendency of the monitoring period, as defined by Section 1(g) of the Order,  
23 WPAS will receive notification of the death of any patient on CFS. Defendants shall  
24 notify WPAS of any patient deaths on CFS within 7 days of the death.

25 11. By May 12, 2001, Defendants will distribute a written definition of an "adverse drug  
26 reaction" including a specific definition of neuroleptic malignancy syndrome to all  
professional staff and promulgate written procedures for reporting such event to the  
Adverse Drug Reaction task group for the pharmacy and therapeutic sub-committee.  
Professional staff will be informed of correct procedures for reporting adverse drug  
reactions.

C. Defendants agree to take the following steps in order to provide additional physical  
space for patients:

1. CFS shall remain at the current South Hall location until the new CFS facility opens.

2. Defendants will relocate civilly committed patients to the Adult Psychiatric Unit (APU)  
as security and clinical concerns permit. Each relevant patient will be assessed by May  
31, 2001 to determine the propriety of such placement.

- 1 3. Defendants will not accept any patients for competency evaluation at CFS until  
2 24 hours after Defendants have received the court order, discovery materials and other  
3 relevant information in the possession of the Court, prosecuting attorney, or defense  
4 attorney. Sanity and diminished capacity evaluation patients will remain in jail or be  
5 returned to jail until all documentation deemed by the evaluator to be necessary to the  
6 performance of the evaluation has been received from the prosecuting attorney or  
7 defense counsel who requested the evaluation.
- 8 4. By May 31, 2001, Defendants will develop and implement a CFS policy setting forth  
9 actions that the Clinical Director must undertake in the event that a ward becomes over  
10 census for more than twelve hours at a time.
- 11 5. Conditional Release patients will not be placed at South Hall prior to the opening of the  
12 new CFS facility. By April 30, 2001, WSH will prepare a list of placement options for  
13 Conditional Release Patients and confer and consult with WPAS in selecting an  
14 appropriate placement for these patients. If WPAS is not satisfied with the placement  
15 options presented by WSH, WPAS may amend its Complaint and take any other  
16 necessary legal action it deems necessary to address this issue.
- 17 6. Within 14 days of the signing of this Order, all CFS patients shall be afforded an  
18 opportunity for a minimum of one hour of fresh air per day at least five days a week  
19 unless a determination has been made and documented by a licensed clinician that such  
20 activity is clinically or medically contraindicated.
- 21 D. Defendants agree to take the following steps in order to ensure the safe and appropriate  
22 use of seclusion and restraints:
- 23 1. WSH and CFS will continue to follow the current Joint Commission on Accreditation  
24 of Hospital Organizations (JCAHO) standards on the use of seclusion and restraints.
- 25 2. WSH and CFS will continue to inform staff of the requirements of the current JCAHO  
26 standards on the use of seclusion and restraints. In addition, WSH and CFS will  
continue to provide staff with training regarding these standards.
3. The Quality Assurance Department of WSH will provide the Monitoring Committee  
with data regarding the use of seclusion and restraints at CFS. The type and frequency  
of this data will be determined in consultation with the Monitoring Committee.
- E. Defendants agree to take the following steps in order to provide minimally  
adequate & timely medical and dental care to CFS patients:
1. By April 12, 2001, CFS patients will begin to receive their medical exams in  
examination rooms at South Hall. After the new facility is opened, CFS patients will  
receive medical exams in examination rooms at the new facility.
2. Transport staff members have been reassigned and a new directive makes medical  
transport a top priority. Transport issues will be minimized in the new building  
because the new building is adjacent to medical facilities.
3. By June 30, 2001, CFS will inspect all medical equipment to ensure that it is in  
working order. Malfunctioning equipment will be repaired or replaced as necessary.

1 Professional staff will be trained on procedures for requesting repairs or replacement of  
2 equipment.

3 4. By April 30, 2001, CFS will formulate and implement clear policies on procedures for  
4 ordering outside medical treatment, including acute and emergency services and staff  
5 will be trained on these procedures.

6 5. Procedures for medication monitoring, including the use of the Abnormal Involuntary  
7 Movement Screening test on admission and at least annually are already in place and  
8 will continue.

9 6. The attending psychiatrists on CFS will review medications every 30 days or more  
10 often as clinically indicated and assess the effectiveness of the medications and any  
11 side effects. Implementation will be completed by April 12, 2001.

12 7. In consultation with the Monitoring Committee, Defendants will develop and  
13 implement an auditing system whereby the Pharmacy and Therapeutic sub-committee  
14 shall review the attending psychiatrist's notes of a statistically significant random  
15 sample of CFS patients. Such audit shall include review of clinical indication for the  
16 prescribed medication, effectiveness of prescribed medication, tolerance and side  
17 effects of the medication PRN indications, usage, and appropriateness, the reason for  
18 the discontinuation of any medication, and the frequency and consistency of  
19 examinations of patients by psychiatrists. The sub-committee shall report the results of  
20 its review to the Monitoring Committee and the Clinical Director of CFS. This review  
21 process is to be implemented within  
22 30 days of the adoption of the auditing system described above.

23 8. By June 12, 2001, CFS will implement a system for tracking doctor's appointments,  
24 dental appointments, transportation arrangements, whether an appointment is kept, and  
25 follow up measures that were taken in the event of cancellation. Defendants shall make  
26 good faith efforts to computerize the system in accordance with other information  
systems' priorities. CFS will provide a monthly report to Quality Assurance  
documenting outside doctor appointments and dental appointments. Such report will  
indicate whether appointments were kept and, if not kept, the reason for cancellation.  
The Medical Records Department will track the timeliness of annual physical exams  
and report the results to the Clinical Director.

9. By May 12, 2001, Defendants will train CFS staff on correct procedures for requesting  
services from the WSH laboratory and outside laboratories, retrieving information  
about completed laboratory work and ensuring that appropriate professional staff  
receive laboratory results in a timely manner. Psychiatrists and physicians will be  
directed to report unusual delays to the Clinical Director. The Clinical Director will  
take appropriate measures to ensure that results are provided in a timely manner.

G. Defendants agree to take the following steps in order to increase staffing levels :

1. Defendants shall add thirty-three new staff positions. Set forth below are the positions  
which the Defendants intend to fill based on the request authorized by the legislature:

- a) 3 Institutional Counselors 2s
- b) 5 Psychiatric Social Workers



1 7. Defendants shall provide documentation as requested by the Monitoring Committee to  
2 monitor the provisions of paragraphs 4-5 above. In addition, WPAS will be provided  
3 with copies of the documents sent to the Monitoring Committee. The Monitoring  
Committee shall have the discretion to conduct an on-site review of defendants  
compliance with paragraphs 4-5 above

4 K. Defendants agree to take the following steps in order to improve treatment plans:

5 1. An interdisciplinary treatment team shall meet with the patient to review his or her  
6 treatment plan at least every 90 days or more often as clinically necessary to review the  
7 patient's progress toward his or her treatment goals, determine whether the patient's  
8 treatment needs have changed and/or whether the treatment plan needs modification  
9 and if so, how it should be modified so as to meet the patient's treatment needs and  
help to facilitate the patient's ability to meet his or her treatment goals. The treatment  
team shall identify treatment that is necessary in order for the patient to progress  
towards discharge.

10 2. Defendants will institute a formal risk assessment for dangerousness as part of the  
11 treatment planning process. This treatment assessment for risk (TAR) will utilize  
12 current research and scholarship, and will include clinical, actuarial, situational, and  
other factors. This assessment will include the following components:

- 13 a. Actuarial assessment tools, such as the Psychopathy Checklist,  
14 HCR-20, V-RAG, or others that provide actuarial information about the  
likelihood of recidivism upon eventual release.
- 15 b. An assessment of prior violence and crime to determine the likely severity  
16 of recidivism if it were to occur.
- 17 c. An assessment of the individual's history and pattern of violence, crime, and  
18 victimization that will identify the clinical and situational risk factors that  
must be addressed in the treatment plan.
- 19 d. An assessment of skill deficits and barriers to skill utilization that make the  
20 patient vulnerable to the risk-laden situations identified above, and
- e. An assessment of existing protective factors that reduce the risk of harm,  
and which might be built upon by the treatment plan.

21 3. The treatment plan will be structured around the TAR. The goals of the treatment plan  
22 will include acquisition of the specific skills that will increase the patient's chances of  
23 eventual safe return to freedom. The treatment plan will allow for periodic objective  
assessment of the patient's progress in acquiring the necessary skills.

24 4. The TAR based treatment plan will be implemented for every newly admitted long-  
25 term treatment patient, on or before July 1, 2001.

26

- 1 5. The treatment plans for current patients will be revised to include the TAR at or before  
2 the time of the next scheduled treatment plan conference that occurs after July 31,  
3 2001.
- 4 6. Within 30 days of hiring or transferring two additional psychologists and two ward  
5 clerks, CFS will implement a computerized treatment plan format on two treatment  
6 wards which allows users to determine whether treatment plans are current and allows  
7 users to track the patient's progress towards his or her identified treatment goals and  
8 objectives. Once the treatment planning process  
9 has been developed and successfully implemented on these pilot wards, this process  
10 will be expanded to the other two CFS long-term treatment wards with appropriate  
11 additional staff.
- 12 7. By July 12, 2001, Defendants will develop an auditing system on two treatment wards  
13 that provides a computerized tool for assessing whether the treatment plan meets  
14 specified criteria for content and format, including whether the plan sets forth  
15 measurable criteria for response to treatment. Random samples will be selected from  
16 each participating ward at two week intervals and sent to trained auditors from another  
17 ward for analysis according to the auditing program. The results of such audit will be  
18 reported to the treatment team. Once the audit process has been developed and  
19 successfully implemented on these pilot wards, this process will be expanded to the  
20 other two CFS long-term treatment wards. This process will be implemented in  
21 accordance with the provisions relating to the Monitoring Committee of Section 1 of  
22 the above Order.
- 23 8. CFS will consult with Dr. Gardner on how to write and implement appropriate treatment  
24 plans for competency restoration patients with developmental disabilities or who have  
25 borderline intellectual functioning This will be implemented at the next Allen  
26 Monitoring Committee visit, currently scheduled for May 2001.
9. CFS will begin to implement a computerized tracking system that tracks class offerings, attendance and level of participation. The tracking system will be implemented on two pilot wards by October 12, 2001.
- L. The Defendants agree to take the following steps in order provide appropriate therapies and treatment interventions to meet the individual needs of each patient:
1. By June 12, 2001 CFS will provide admissions patient's opportunities to have access to outside areas in the fenced yards and on the porch at South Hall, where such access can be provided without an unreasonable increased safety risk.
2. By June 12, 2001, the adjacent structures to South Hall will be utilized to provide additional program and treatment activities.

1 3. Defendants will offer at least 20 hours per week of active treatment and programming  
2 to each patient. Active treatment is defined as that which is directly related to the  
3 patient's individual goals (as stated in the treatment plan) and documented in the  
4 patient's chart. Examples include psycho-educational and educational groups, skill-  
5 building groups, individual and group psychotherapy, occupational therapy, alcohol and  
6 chemical dependency treatment, and recreation therapy that is directly related to a  
7 patient's treatment goals. For evaluation patients and competency restoration patients,  
8 time spent in clinical evaluative  
9 interviews may be considered as a portion of active programming for the purposes of  
10 this section. Competency restoration groups also are considered to be active treatment.  
11 The Monitoring Committee, in consultation with Dr. Gardner, will monitor the  
12 development and implementation of the active treatment program at CFS to ensure that  
13 it complies with the following conditions to ensure that the active treatment program at  
14 CFS complies with the following conditions:

- 15 a. Active treatment will be consistent with the individual needs of all  
16 patients, including those patients with developmental disabilities and  
17 those patients with borderline intellectual functioning.
- 18 b. At the time of the initial treatment planning meeting, new patients will  
19 be assessed by the treatment team for borderline intellectual functioning.  
20 All current patients will be assessed by their treatment teams for  
21 cognitive deficits. Formal testing will be done within two weeks of the  
22 treatment team's determination that such testing is clinically indicated.  
23 Ongoing assessment of individual needs and cognitive functioning will  
24 be done as part of the treatment planning process described in Section K  
25 above. Defendants will fully implement these provisions within 30 days  
26 of the signing of this Order.
- c. Defendants will immediately begin to develop appropriate curricula to  
meet the individual needs of patients of differing cognitive levels and to  
assign patients to the appropriate treatment modalities.
- d. Incident reports will be reviewed on an ongoing basis to determine  
whether individual CFS patients have a need for a positive behavioral  
support plan. If such a plan is clinically indicated, the plan will become  
a part of the patient's treatment plan and staff will be trained in the  
implementation of the program. Defendants will fully implement these  
provisions within 30 days of the signing of this Order.
- e. Defendants shall provide individuals with developmental disabilities  
with at least six hours per day, seven days per week of individualized  
and active mental health treatment. This treatment shall include, but is  
not limited to, specialized competency restoration treatment that is  
designed to meet individual needs and appropriate habilitative mental

1 health treatment, including opportunities to participate in programs and  
2 social activities on the wards established for individuals with  
3 developmental disabilities under Allen or with other Allen class  
4 members, and opportunities to have recreational activities and  
5 supportive counseling with one-to-one staff on CFS. Defendants will  
6 fully implement these provisions within 30 days of the signing of this  
7 Order.

8 At least one staff person from the patient's ward will be assigned to  
9 accompany the CFS patients to the Allen ward for treatment and serve as  
10 a liaison between the Allen wards and CFS to ensure that the skills  
11 taught and learned on the Allen ward are reinforced on the home wards  
12 and in the evenings at CFS by all staff working directly working with  
13 the patient.

14 f. All developmentally disabled patients will have a positive behavioral  
15 support plan that shall be incorporated into his/her treatment plan. All  
16 staff working directly with the patient will be trained in the  
17 implementation of these plans and the habilitative mental health  
18 treatment model. Defendants will fully implement these provisions  
19 within 30 days of the signing of this Order.

20 4. Defendants will keep track of each patient's participation in active treatment, and will  
21 create monthly statistical reports on the average number of hours of active treatment  
22 actually provided to each patient. In the event that a patient's participation significantly  
23 falls below 20 hours per week of active treatment, the treatment team will meet with the  
24 patient to consider changes in the treatment plan or additional programming options  
25 that appear necessary.

26 5. Defendants will conduct ongoing assessment of the quality of the programming being  
offered and will make good faith efforts to make the programs interesting and desirable  
to patients.

6. All competency restoration patients with developmental disabilities who are later found  
to be not guilty by reason of insanity and committed for long-term treatment will be  
transferred to the ward for Allen class members. This provision is already being  
implemented and will continue.

M. The Defendants agree to take the following steps in order to provide improved  
discharge planning:

1. The civilly committed patients currently at CFS will be relocated to the APU if it is  
determined that such placement is not clinically contraindicated. The civilly committed  
patients will be permitted to earn grounds privileges as clinically indicated.

2. Defendants shall ensure that each patient's treatment plan contains individualized  
reasonable criteria for recommendation of conditional release to the Court pursuant  
RCW 10.77.150.

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3. Defendants shall review the patient's progress towards meeting the criteria for recommendation for conditional release at least every 90 days. This review can be conducted as part the quarterly treatment plan review. If it is determined that the patient is not making progress toward conditional release, the treatment team will review whether the conditional release criteria for the patient should be modified and make any necessary modifications.
4. Defendants will ensure that all CFS patients participate in their discharge planning and are aware of the discharge criteria they must meet.
5. Defendants will ensure compliance with the requirements set forth under RCW 10.77.140.
6. Defendants will ensure compliance with the requirements set forth under RCW 10.77.150.

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**CERTIFICATE OF SERVICE**

I hereby certify that on November 10, 2004, I electronically filed the foregoing with the Clerk of the court using the CM/ECF system which will send notification of such filing to the following:

DEBORAH A. DORFMAN                      debbied@wpas-rights.org

DAVID GIRARD.                              davidg@wpas-rights.org

DATED this 10<sup>th</sup> day of November, 2004, at Olympia, WA.

\_\_\_\_\_  
/S/  
Judith E. Parent  
Legal Assistant

Honorable Ronald B. Leighton

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IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF WASHINGTON  
AT TACOMA

SHARON ALLEN; THE WASHINGTON  
PROTECTION AND ADVOCACY SYSTEM,  
INC., a Washington corporation; and THE ARC  
OF CLARK COUNTY,

Plaintiffs,

v.

WESTERN STATE HOSPITAL and ANDREW  
PHILLIPS, in his capacity as the Chief Executive  
Officer of Western State Hospital; et al.,

Defendants.

No. C99-5018RJB

ORDER AND SETTLEMENT  
AGREEMENT

This matter is before the Court on the parties' Joint Motion for Approval of the Settlement Agreement and Entry of Order Scheduling a Fairness Hearing in the above-captioned action. The Court having reviewed the Motion including the attachments and declarations of Deborah A. Dorfman and Kevin Black in support thereof, and the pleadings and documents on file herein; and being fully advised, the Court hereby ORDERS:

ORDER AND SETTLEMENT AGREEMENT  
(Proposed) - 1  
C99-5018

Washington Protection & Advocacy System  
315 5<sup>TH</sup> Avenue South, Suite 850  
Seattle, Washington 98104  
(206) 324-1521 • Fax: (206) 957-0729

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4 **I. ENHANCED QUALITY ASSURANCE FOR CLASS MEMBERS**

5 A. Purpose

6  
7 The purpose of this Settlement Agreement is to address, without defining legal standards  
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9 or statutory requirements, the statutory rights of *Allen* class members to receive services and  
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11 supports in the most integrated settings and reasonable modifications to services, supports,  
12  
13 policies and practices so that they may have an opportunity to participate in defendants'  
14  
15 programs and services in the community.  
16

17 Specifically, this Settlement Agreement addresses the plaintiff class' claims in regard to  
18  
19 community services and supports made under Section 504 of the Rehabilitation Act and Title II  
20  
21 of the Americans with Disabilities Act, as set forth in the Complaint.  
22

23 B. Background

The Department of Social and Health Services (DSHS) maintains numerous levels of oversight and quality assurance for the services it provides. There is existing quality assurance structures mandated through federal and state law that apply to class members. These structures may include, but are not limited to, certification and licensing of services, facilities, and department subcontractors, annual assessment of clients to determine the appropriate level of care needed, creation of a plan of care that is consistent with identified need, assurance that all services are provided by qualified providers, and identification, resolution, and prevention measures regarding alleged incidents of abuse, neglect and/or exploitation.

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4 In addition to these existing quality assurance measures, defendants agree to provide and  
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6 maintain an enhanced quality assurance process for class members. This enhanced process will  
7  
8 include an additional four tiers of quality assurance activities that specifically target class  
9  
10 members. The four additional tiers are:

- 11 • Division of Developmental Disabilities/Mental Health Division (DDD/MHD) Cross  
12 Systems Committee;
- 13
- 14 • An Internal Oversight Review Team;
- 15
- 16 • Regional comprehensive reviews by DDD staff and Regional Support Network (RSN)  
17  
18 staff of a sample of randomly selected class members; and  
19
- 20 • DDD community follow-up reviews for class members for one year following discharge  
21  
22 from state psychiatric hospitals.  
23

A. DDD/MHD Cross Systems Committee

1. The CSC shall have accountability for the implementation of this Order.
2. The CSC shall be chaired by the directors of the DDD and MHD.

Membership shall include DDD and MHD headquarters program management staff, DDD field services management, and representatives from state hospitals, RSNs, and DDD and MHD quality assurance staff.

3. The CSC shall meet quarterly to review and analyze quality assurance data, including data from comprehensive reviews and corrective actions, in order to monitor

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4 program performance and make policy level recommendations for improvements, including  
5 trend analysis, identification of service gaps, and recommendations for development of  
6 additional resources where appropriate. The CSC will also review reports generated by the state  
7 hospitals and the DSHS Internal Oversight Review Team (IORT).  
8  
9

10  
11 B. Internal Oversight Review Team

12  
13 1. The IORT is a team of professionals who conduct targeted system  
14 reviews. The IORT will make recommendations to the CSC regarding possible systemic  
15 changes based on the result of its reviews.  
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18  
19 2. Membership in IORT shall include, at a minimum, one psychiatrist with  
20 experience in the care and treatment of individuals with developmental disabilities with co-  
21 occurring mental illness; one licensed clinical psychologist trained in the development and  
22 implementation of plans of care, positive behavior support plans, and cross system crisis plans;  
23 and two mental health professionals who are also developmental disability mental health  
specialists.

3. The IORT shall have the following responsibilities:

a) To conduct targeted system reviews at the request of the CSC and  
at its own discretion. The IORT will report the findings of such reviews to the CSC, and make  
recommendations for system improvements.

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4 b) To maintain the *Allen/Marr* Internal Oversight Review tool, and  
5  
6 propose revisions to the tool as appropriate, using the process described in Section I.C.2., below.

7  
8 c) To review records of the regional comprehensive review process  
9  
10 described in Section I.C., below, and to analyze significant findings, trends, or patterns for  
11  
12 presentation to the CSC.

13  
14 d) At least annually, the IORT will review all cases in which a  
15  
16 comprehensive review has resulted in a referral to the RSN Administrator or DDD Regional  
17  
18 Administrator for immediate action in response to an imminent threat to health and safety, as  
19  
20 described in Section I.C.4.c), below.

21 4. IORT shall meet quarterly.

22  
23 C. Regional Comprehensive Reviews of Randomly Selected Class Members

1. Defendants shall conduct regional comprehensive reviews of randomly selected class members in each region. These reviews shall be conducted quarterly and include an evaluation of the following components of care:

- a) Cross system crisis plans;
- b) Positive behavior support plan/functional analysis;
- c) Care Planning;
- d) Incident reporting;
- e) Residential services;

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- f) Vocational services;
- g) Outpatient mental health services, including state plan services and DDD funded services;
- h) In-patient mental health services;
- i) Crisis stabilization services; and
- j) DDD/MHD/RSN/Community Mental Health Agency (CMHA) cross-system collaboration.

2. These reviews shall be conducted using the *Allen/Marr* Internal Oversight Review tool. This tool is attached hereto as Appendix A and is incorporated by reference. This tool will be maintained by the IORT. The parties understand that it may be necessary for the defendants to make periodic modifications to this tool. Before such modifications are made, defendants shall notify WPAS with a description of the proposed change. WPAS shall then have 14 days to raise any concerns or disagreements over the proposed change. The parties will work in good faith to resolve any disagreements that arise.

3. On or before entry of this Order, defendants shall begin to transition the comprehensive review process to regional review teams. These regional review teams shall be composed of regional DDD and RSN staff. Once the regional review teams are fully trained, they shall develop a quarterly review schedule to assure that a 10% sample of randomly selected class members is reviewed annually in each region.

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4 Training for regional review teams shall be provided by the IORT team and will be based  
5 on a training curriculum developed by the IORT team in consultation with the appointed  
6 Independent Monitor (see Section II.A. below). This training will include side-by-side  
7 participation with the IORT team.  
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11 The training, except for the tandem reviews, shall be concluded by April 2, 2007. The  
12 tandem reviews will be completed in DDD regions 1-4 by May 31, 2007. Tandem reviews will  
13 be completed in DDD regions 5-6 by June 30, 2007. The regional review teams will then  
14 conduct regularly scheduled reviews starting in the final quarter of 2007 and each quarter  
15 thereafter.  
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21 4. Monitoring Compliance

22 a) All deficiencies noted in the comprehensive review process  
23 through the use of the *Allen/Marr* Internal Oversight tool will necessitate corrective action.  
When the review findings are reported, the regional review team will notify the party or parties  
under review what required follow-up actions are necessary to correct any and all identified  
deficiencies. This required follow-up notice will specify that all corrective actions are to be  
completed within 30 days of the receipt of said notice.

b) Compliance with required follow-up actions will be monitored by  
Quality Compliance and Control (QCC) staff or by a designee of the RSN Administrator, as  
appropriate. In the event that appropriate corrective action has not been taken in regard to an

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4 identified deficiency, the QCC staff or RSN will notify the DDD and MHD Program  
5 Administrators. DDD and MHD Program Administrators will then take appropriate action to  
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7 correct identified deficiencies.  
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10 c) If the regional review team has reasonable cause to believe that the  
11 health and safety of a client is at risk of imminent harm, the regional review team shall  
12 immediately inform the RSN Administrator, and/or the DDD Regional Administrator, as  
13  
14 appropriate. The Administrator(s) shall take appropriate steps to protect the health and safety of  
15  
16 the client. These findings will also be reported to the DDD and MHD Program Administrators,  
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18 who will follow up to evaluate whether the client's health and safety needs were met in an  
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20 effective and timely manner.  
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23 d) The results of the comprehensive review process will be forwarded  
to the appropriate DDD Regional Administrator, RSN Administrator, and DDD and MHD  
Program Administrators. Significant findings, trends, patterns, or noncompliance shall be  
reported to the CSC by DDD and MHD Program Administrators. DDD and MHD Directors  
and/or their designees will take appropriate action to correct any failures to comply with required  
follow up so that quality assurance is maintained.

e) All incidents of noncompliance with required follow-up actions  
will be shared with WPAS during quarterly meetings.

ORDER AND SETTLEMENT AGREEMENT  
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f) All staff conducting comprehensive reviews shall be trained prior to conducting reviews. This training curriculum shall be provided to the Independent Monitor at least 20 days before the training is conducted.

D. DDD Community Follow-Up Reviews

1. On or before entry of this order, DDD shall begin conducting community follow-up reviews for all class members discharged from state psychiatric hospitals who were in residence there for a minimum of 90 days. These reviews shall include evaluating the implementation of hospital discharge recommendation and the stated reasons for adopting alternative proposals.

2. These reviews shall occur at the following intervals at the discretion of the reviewer: within 0-30 days; within 90-180 days, and within 180-365 days following discharge from the hospital. They will include a review of the client's residential and vocational programs, and DDD core values of health, safety, competence, status, choice and relationships.

3. All completed community follow-up reviews will be reviewed by DDD quality assurance program staff and significant findings shall be reported to the CSC.

**II.EXTERNAL OVERSIGHT**

A. Defendants agree to retain an Independent Monitor within a reasonable time to monitor the enhanced quality assurance processes described in Section I of this Order. The Independent Monitor shall be mutually agreed upon by the parties.

ORDER AND SETTLEMENT AGREEMENT  
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4 B. The role of the Independent Monitor shall be limited to evaluation of the  
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6 defendants' implementation of the enhanced quality assurance programs for class members, as  
7  
8 described in Section I of this Order.

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10 C. The monitoring period shall be for a period of six months following appointment.  
11  
12 If substantial compliance is found by the Independent Monitor at the end of the six month  
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14 period, external monitoring shall end. If the Independent Monitor does not find substantial  
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16 compliance at that time, external monitoring may be extended for up to an additional six months,  
17  
18 at the discretion of the Independent Monitor.

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20 D. The Independent Monitor shall have access to all materials needed to conduct  
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22 external monitoring that are not protected by the attorney client or attorney work product  
23  
privilege as described by state and federal law.

### III. INCIDENT REPORT/REVIEW PROCESS

A. DDD requires each region to maintain written procedures for managing serious and emergent incidents involving clients. Within 60 days of the entry of this Order, defendants will review these procedures to determine if they adequately address serious and emergent incidents for class members and require that such incidents be promptly reported to central office. If necessary, DDD shall make changes to the written procedures in order to accomplish these objectives.

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B. Copies of all central office reportable incident reports shall be provided to WPAS on a bi-weekly basis. WPAS shall be provided on site access to all incident reports involving class members maintained at the regional level upon request, and will be allowed to make copies at its own expense. WPAS agrees to give seven days notice to the region before a visit for the purpose of monitoring this Agreement. In doing so, WPAS will make all requests through the Regional Administrator or Field Services Administrator of the relevant DDD regions and provide a copy of such requests to the Office of the Attorney General

C. DDD will maintain an incident report review team who will meet monthly to review trends and patterns, as well as incidents involving clients that raise systemic concerns. On a quarterly basis, this review will target class member incidents. The team will recommend changes as necessary, and members of the team will be assigned to follow-up with the regions. The team will review the results of follow-up actions at future meetings. Significant results will be reported to the CSC.

D. As mandatory reporters of suspected abuse, neglect, abandonment or financial exploitation against children or vulnerable adults under RCW 74.34, DDD, MHD, and their subcontractors will report any such incidents to the appropriate investigative authorities.

**IV.PROTECTION FOR CLASS MEMBERS IN JAILS**

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A. All DDD case managers are required to notify the DDD mental health resource manager within one business day from the time the case manager becomes aware that a class member has been incarcerated, per DDD Management Bulletin D06022, issued January 2006.

B. On or before the entry of this Order, DDD Policy 5.18 (Cross System Crisis Planning) shall be revised to require staff to invite probation/parole officers and other appropriate law enforcement staff who supervise or interact with class members to participate in cross system crisis planning meetings.

C. Within 60 days of the entry of this Order, and annually thereafter, DDD shall provide contact information to local jails to facilitate notification of DDD personnel when jail staff suspects an inmate may have a developmental disability.

D. DDD will continue to actively participate in training of law enforcement regarding effective and appropriate interactions with class members.

**V.ENHANCED CONTINUITY OF CARE**

A. On or before entry of this Order, defendants shall implement a standardized transfer letter for class members upon discharge from the hospital, offering consultation with treating physicians from the state hospital.

B. Within 60 days of entry of this Order, defendants shall review DDD Policies 5.02 and 11.03 and, if necessary, clarify that transition planning will occur for class members who are no longer determined to be DDD eligible.

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C. Any class member, upon receiving an intake assessment by an RSN mental health provider which results in a finding that the individual does not meet medical necessity standards, shall receive a notice of the right to request a second opinion. If a class member makes a request for services to the RSN following an intake assessment and the request is denied or reduced, the RSN shall provide a Notice of Action that informs the class member of his or her right to appeal this decision to the RSN. If, following this appeal, the class member is not satisfied with the outcome, the class member may file a demand for an administrative fair hearing.

**VI. CRISIS PLANNING AND POSITIVE BEHAVIORAL SUPPORT PLANNING**

Within 60 days of the entry of this Order, DDD Policy 5.18 shall be amended to require that when a class member has both a Cross Systems Crisis Plan (CSCP) and Positive Behavioral Support Plan (PBSP), the plans must be consistent.

**VII. DIVERSION BEDS AND CRISIS STABILIZATION SERVICES**

Defendants will use best efforts to maintain diversion beds and crisis stabilization for class members in the community protection program in both Eastern and Western Washington.

**VIII. GUIDELINES FOR INTENSIVE CASE MANAGEMENT SERVICES**

A. Intensive case management involves increased case management support for selected DDD clients who have co-existing mental health issues or challenging behaviors, and who are at risk of state psychiatric hospitalization. Intensive case management is provided by

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4 case managers who carry significantly smaller case loads than average, have more frequent  
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6 client contact, and review client status more often.

7           B.       Within 30 days of entry of this Order, defendants will issue a Management  
8  
9 Bulletin establishing statewide guidelines for the use of intensive case management services.

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11                                   **IX.ADDITIONAL DATA COLLECTION**

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13           A.       Within 60 days of entry of this Order, defendants will add the categories of  
14  
15 Homelessness and Incarceration to the quarterly report.

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17           B.       Within 60 days of entry of this Order, defendants will provide WPAS with  
18  
19 DSHS' plan to implement the collection of quarterly community hospital data. The plan will  
20  
21 include the collection of data related to length of stay and discharge disposition, and will specify  
22  
23 a timeline for implementation.

**X. WPAS ACCESS AND PARTICIPATION**

          A.       Defendants will share all data and documents provided to the Independent  
Monitor with WPAS.

          B.       WPAS will be provided with all comprehensive reviews at the time the results are  
reported to the DDD and MHD Program Administrators. WPAS will also be provided with all  
documents produced by the IORT as set forth in Sections I.B. & C., above, except those  
documents that are considered attorney-client communications or attorney-work product, until  
the termination of the this lawsuit.

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4 C. Nothing in this Order shall be deemed to limit the ability of the Washington  
5 Protection and Advocacy System (“WPAS”) to fulfill its federal mandates pursuant to the  
6 “Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act,” 42 U.S.C. § 10801,  
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10 *et seq.* and the regulations promulgated thereto, 42 C.F.R. § 51 and the “Developmental  
11 Disabilities Assistance and Bill of Rights (DD) Act,” 42 U.S.C. § 15041, *et seq.* and the  
12 regulations promulgated thereto, 45 C.F.R. § 1386, *et seq.*  
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15 D. During the term of this Order, WPAS will be provided access upon request to all  
16  
17 *Allen* class members’ medical, psychological, and psychiatric records, and all reports of  
18  
19 incidents concerning *Allen* class members generated, collected, or possessed by the defendants.  
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21 Since a class has been certified in this case, no release of information or probable cause letter  
22  
23 will be required. The parties agree that the terms of access to class members’ records and related  
information shall be the same as those specified in the December 28, 1999, letter from Assistant  
Attorney General, Edward Dee, to Deborah Dorfman.

E. During the monitoring period, plaintiffs’ counsel, at their own expense, may  
consult with the Independent Monitor.

#### XI. ATTORNEY FEES & COSTS

A. Defendants will bear all costs of the notice of the settlement to the class and the  
fairness hearing required for the implementation of this Settlement Agreement.

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4 B. In addition, defendants will pay \$34,500 to plaintiffs in full settlement of all  
5 attorney fees and remaining costs incurred under this Settlement Agreement and in the  
6 community portion of this case.  
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10 **XII.ENFORCEABILITY, DISPUTE RESOLUTION AND NON-WAIVER OF**  
11 **CLAIMS AND DEFENSES**  
12

13 A. Enforceability of Settlement Agreement  
14

15 Sections I through X herein are enforceable subject to the dispute resolution provisions  
16 and requirements set forth below in paragraphs B.1. through B.6. of this Section.  
17

18 B. Dispute Resolution  
19

20 1. If at any time during the monitoring period, plaintiffs' counsel believes  
21 that defendants are not substantially in compliance with this Order, plaintiffs' counsel shall  
22 contact defendants' counsel to request a meeting with defendants and their counsel to attempt, in  
23 good faith, to informally and timely resolve the dispute. Consultation with the Independent  
Monitor may be requested by either party.

2. If a timely and informal resolution cannot be reached by the parties, the  
parties shall participate in formal mediation to resolve the issue. Mediation of the disputed  
matters shall occur within 30 business days of a party's formal written request for mediation,  
unless otherwise agreed in writing by the parties or the mediator is unavailable. A formal  
request for mediation in the form of a letter shall be submitted by the party requesting mediation.

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This request shall be served on all counsel for the parties, the Independent Monitor and the mediator.

3. The Honorable J. Kelly Arnold shall be appointed as the mediator for any dispute arising out of this Order. If Judge Arnold is unavailable, the parties shall mutually agree upon alternative mediators. Each party shall bear its own costs associated with mediation.

4. If, after participating in good faith at the mediation, no resolution is reached, plaintiffs may file a motion with United States District Court in this matter requesting the Court to hold a "show cause" hearing ordering defendants to show cause why they are not in substantial compliance with this Order. Plaintiffs shall provide the appropriate notice to defendants' counsel of such action.

5. In the event that plaintiffs have reasonable cause to believe that there is a risk of imminent harm to a class member as a result of defendants' failure to comply with this Order, plaintiffs will make a good faith effort to consult with defendants' counsel and defendants to discuss the issue or issues before filing a motion requesting a show cause hearing. Consultation with the Independent Monitor may be requested by either party, at the requesting party's expense. If the matter is not resolved, plaintiffs may proceed directly to the Court and request a show cause hearing without first going through mediation or may take any other necessary legal action. Plaintiffs will provide at least one business day's written notice to defendants' counsel via facsimile or e-mail and first class mail prior to initiating court action.

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4 6. In the event that the Court grants plaintiffs' motion requesting a show  
5 cause hearing, the parties will brief the issues with the Court's approval, present oral arguments  
6 and/or present evidence at a show cause hearing on the issues of defendants' substantial  
7 compliance with the agreement.  
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11 C. Nothing in This Order Shall Be Deemed to Limit

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13 1. The Court's powers of contempt or any other power possessed by the  
14 Court.  
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16  
17 2. The ability of any class member to seek relief of any kind to which they  
18 would be otherwise entitled under state or federal law other than the claims for systemic  
19 injunctive relief adjudicated in this action.  
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22 3. By agreeing to the entry of this Order, defendants have waived no  
23 defenses to the allegations in plaintiffs' Complaint and have admitted no liability regarding  
plaintiffs' claims as set forth in their Complaint.

4. By agreeing to the entry of this Order, plaintiffs have waived no claims  
raised in their Complaint.

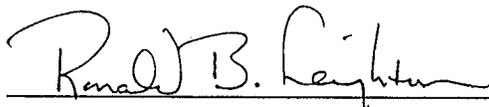
**XIII. TERMINATION OF ORDER AND DISMISSAL OF LAWSUIT**

This Order shall terminate and plaintiffs' claims relevant to services provided to class  
members in the community shall be dismissed without prejudice thirty days following receipt of

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the final monitoring report, or ninety days following the conclusion of the independent monitoring period, whichever is earlier.

DATED this 6<sup>th</sup> day of April, 2007.



RONALD B. LEIGHTON  
UNITED STATES DISTRICT JUDGE

Presented by:

/s/Deborah A. Dorfman  
Deborah Dorfman, WSBA #23832  
Washington Protection & Advocacy System  
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/s/Morgan Pate  
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Attorneys for Defendants

Attorneys for Plaintiffs

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