Washington's Senate Bill 6610 on Transferring Provisions for Persons Found Not Guilty by Reason of Insanity

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In Washington state, public concern about the potential dangerousness of mentally ill offenders has led to increasing legislative efforts to contain them in secure settings. A recently enacted law authorizes the transfer of persons found not guilty by reason of insanity from state psychiatric hospitals to prison facilities. The authors review the recent legislation and discuss some of the legal, policy, and clinical ramifications of the law.

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Washington state law has long distinguished between individuals who are criminally convicted and those found not guilty by reason of insanity (NGRI). Individuals found NGRI are not held legally responsible for their crimes. Those who remain a danger to public safety are typically committed to one of the state's psychiatric hospitals for treatment. In the aftermath of several high-profile cases involving mentally ill individuals and persons found NGRI, legislators in Washington have responded with legislative efforts to address mentally ill offenders. A recently enacted law, which was initiated as Engrossed Senate Bill 6610 (ESB 6610),[1] may change the landscape of the insanity defense in Washington by authorizing the transfer of insanity acquittees from psychiatric hospitals to correctional facilities. Under the law, a person found NGRI may be transferred upon a finding that he cannot be managed in the hospital because of security concerns.

This law puts at the forefront society's need for public safety versus the individual rights of mentally ill offenders to recover and seek community reintegration. Drafters and proponents of ESB 6610 defend the law's attention to the safety of the general public. In contrast, opponents of the law and certain disability rights advocates assert that persons found NGRI belong in a hospital, not behind bars. To some, the new law is inconsistent with the goals of the insanity defense.

In this article, we examine the current status of the insanity defense in Washington and ESB 6610 § 2 (now codified as Wash. Rev. Code § 10.77.091), enacted in June 2010.[2] We then discuss some of the legal, policy, and clinical considerations relating to ESB 6610 § 2. Central to the discussion is the distinction between mental health treatment afforded individuals in the state hospitals compared with that available in the prison system. Also addressed is whether the transfer of insanity acquittees to a correctional facility is essentially a punitive tool for this class of individual. It is questionable whether transfer of these insanity acquittees increases public safety, given data on the recidivism of individuals coming out of NGRI programs and mentally ill offenders coming out of prison. It is clear that the legislature faces difficult challenges in responding to community security concerns as well as the needs of individuals with mental illness.

Insanity Defense in Washington State

A person found legally insane is not criminally responsible for the crime committed. In the United States, two primary standards govern defendants seeking the insanity defense: the M'Naughten test and the American Law Institute test.[3,4] Both tests

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require that the individual have a mental illness, that the illness impair psychological functioning, and that such impairment affect the individual's understanding or behavior.

Washington utilizes a M'Naughten-like insanity test. The defendant must establish, by a preponderance of the evidence, that as a result of a mental disease or defect, he was "unable to perceive the nature and quality of the act" or that he was "unable to tell right from wrong with reference to the particular act charged."[5] The defendant concedes that he committed the act the legislature deemed unlawful, but argues that he should not be punished.

The procedural framework in Washington is illustrative of the consequences of the insanity defense in other states. When a defendant is successful in his defense on a ground of insanity, he is committed to a psychiatric institution if the court considers that his release into the community would be dangerous to public safety and security.[6] The insanity acquittee may petition for periodic review, at six-month intervals, to assess whether continued commitment and treatment is necessary. The Department of Social and Health Services (DSHS) submits a petition to the court with its recommendations regarding release. The court determines whether the individual should be conditionally released.

In 2010, there were 365 beds designated for forensic patients at the two state-operated psychiatric hospitals in Washington.[7] The average daily census of patients hospitalized after being criminally acquitted by reason of insanity was 194.[7] Approximately 22 individuals found NGRI enter one of the state mental hospitals per year.[7] Previous statistics from the state's Division of Behavioral Health and Recovery reveal that, of committed individuals who are NGRI, approximately 27 percent had committed homicides, 34 percent had committed acts that included an assault, and the remainder had committed other offenses.[8] An average of 16 to 24 insanity acquittees are granted conditional or final release from commitment annually.[8] The remaining forensic beds at the state hospitals are occupied by individuals being assessed for competency to stand trial or mental state at the time of the offense or by those committed for treatment to restore competency; a limited number of beds are occupied by civilly committed patients who have been found to need the secure treatment setting of the forensic units.

Impetus for ESB 6610

Two recent cases of violent individuals with mental illness were highly publicized in the media. These cases provoked negative public opinion and evoked reform within the state, having attracted the attention of state legislators. This information is in the public record and was derived from media sources.

Isaac Zamora

On September 2, 2008, Isaac Zamora began a shooting spree in rural northwest Washington. He killed six people, including a man who had accused him of trespassing, a woman who lived near him, two construction workers, a motorist on the highway, and a deputy sheriff. He wounded four others. After his capture, he informed investigators that he killed for God. Earlier, he had displayed signs of mental illness and had been diagnosed with schizophrenia and bipolar disorder.

Mr. Zamora was charged with 20 felony counts, including 6 counts of aggravated first-degree murder. He reached a plea agreement of NGRI for two aggravated-murder counts and guilty to the other four counts of murder. He was sent to Western State Hospital (WSH), one of Washington's two state-operated psychiatric hospitals. Under the terms of his plea agreement, if released from WSH, he would be sent to prison for the four aggravated-murder counts to which he pleaded guilty.

Phillip Paul

In 2009, Phillip Paul had been a long-term forensic patient at Eastern State Hospital (ESH) in Washington. On September 17, 2009, he eloped while on a day trip to the county fair. He was taken back into custody by local law enforcement three days after eloping from the fair. There were no reports that Mr. Paul had harmed others or property during his elopement, but at his capture he was carrying a sickle with a nine-inch blade.

In 1987, Mr. Paul had been charged with murder and found NGRI. He was diagnosed with schizophrenia. While psychotic, he strangled and slit the throat of his elderly neighbor and then buried her outside her home, later telling others that he believed her to be a witch and heard voices ordering him to kill her. He was sent to ESH for treatment. In 1990, he eloped from ESH and injured a law enforcement officer while he was being taken into custody the following day. Between 1990 and 2009, he had sev-

eral periods outside the hospital on conditional release during which he attended community college, pursued employment, and resided intermittently with his family and at a residential housing facility. He also incurred significant credit card debt and declared bankruptcy. He returned to the hospital several times when his mental illness worsened in the community.

In the aftermath of these and other incidents, Washington state officials responded with several measures: The Secretary of the DSHS suspended all off-ward privileges at ESH and WSH and convened a State Psychiatric Hospital Safety Review Panel to evaluate and suggest modifications to DSHS policies.[7] Some legislators sponsored a bill aimed at creating a category of "guilty and mentally ill," which would serve as an alternative verdict option for juries when defendants plead NGRI and would result in a prison sentence rather than commitment to a hospital.[9] Some states have enacted similar legislation.[10] The proposal has not passed in Washington.

Engrossed Senate Bill 6610

In March 2010, Washington Governor Christine Gregoire signed into law ESB 6610 relating to "improving procedures relating to the commitment of persons found not guilty by reason of insanity."[1] Among the provisions of ESB 6610 is the establishment of an independent public safety review panel to advise the DSHS Secretary on matters concerning change in commitment status, hospital leaves, or movement about a treatment facility for persons found NGRI.[11] More controversial, and the subject of this article, it also authorizes the DSHS Secretary to move any hospitalized insanity acquittee who presents an "unreasonable safety risk" to any facility operated by DSHS or the Department of Corrections.[2] The law went into effect in June 2010 for a trial period until 2015.

The portions of ESB 6610 § 2 of interest to this discussion are the following:

> (1) If the secretary determines in writing that a person committed to the custody of the secretary for treatment as criminally insane presents an unreasonable safety risk which, based on behavior, clinical history, and facility security is not manageable in a state hospital setting, the secretary may place the person in any secure facility operated by the secretary or the secretary of the department of corrections. Any person affected by this provision shall receive appropriate mental health treatment governed by a formalized treatment plan targeted at mental health rehabilitation needs and shall be afforded his or her rights under RCW 10.77.140, 10.77.150, and 10.77.200. The secretary of the department of social and health services shall retain legal custody of any person placed under this section and review any placement outside of a department mental health hospital every three months, or sooner if warranted by the person's mental health status, to determine if the placement remains appropriate.
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> (2) Beginning December 1, 2010, and every six months thereafter, the secretary shall report to the governor and the appropriate committees of the legislature regarding the use of the authority under this section to transfer persons to a secure facility. The report shall include information related to the number of persons who have been placed in a secure facility operated by the secretary or the secretary of the department of corrections, and the length of time that each such person has been in the secure facility.
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> (3) This section expires June 30, 2015.[2]

The legislative history and basis for this provision is somewhat unclear. In a radio program, Washington's King County Prosecuting Attorney Daniel Satterberg reported that the section was precipitated by concern that individuals such as Mr. Zamora (with hybrid NGRI acquittal and prison sentence) could petition for conditional release, but that DSHS lacked authority, until now, to initiate transfer to prison once inpatient psychiatric treatment is no longer necessary and the individual is stable enough to leave the psychiatric hospital.[12] Prior to ESB 6610, Mr. Zamora and other similarly situated individuals would be sent to prison only after the court granted a conditional release or upon final discharge; ESB 6610 permits transfer of these individuals, regardless of the court's actions on the NGRI finding and regardless of whether they have been found guilty of a crime.

Others, in contrast, have suggested that the measure came in response to Mr. Paul's escape from ESH, prompting security concerns at ESH, and as a deliberate legislative scheme to limit NGRI patients' privileges.[13] Either position, both of which represent reactions to public safety concerns, has merit based on the state's response to Mr. Paul's escape and ensuing requests by the DSHS Secretary for advisory opinions regarding the state hospitals. While the safety of the hospital staff is undoubtedly of concern to the state legislature, the history of ESB 6610 suggests that public safety was the primary impetus. The provisions of ESB 6610 do not address insanity acquittees who are transferred from the state hospital because they have acquired additional legal charges while committed to the hospital.

Section 2 permits the DSHS Secretary to move persons found NGRI from a state psychiatric hospi-

tal to a prison facility operated by the state Department of Corrections. The law allows the Secretary to act at her discretion, and it does not provide the NGRI acquittee with a hearing or other means of challenging any transfer to prison. As of this writing, no individual has been transferred from one of the state psychiatric hospitals to the Department of Corrections under ESB 6610 § 2.

Discussion

Legal Challenges to ESB 6610 § 2

Both civil commitment and imprisonment represent substantial curtailments in liberty interests. However, in both scenarios, there are constitutionally protected interests. The two commitment schemes are not equal in the protections afforded to persons affected by them.

ESB 6610 § 2 has not yet been scrutinized by the courts, and constitutional challenges to the law are likely to arise in the future. One lawsuit was filed on behalf of NGRI patients, facially challenging the constitutionality of ESB 6610 § 2, but it was dismissed as not ripe for adjudication, since no one had yet been moved, and DSHS had not yet developed policies about who would be moved.[14] The legal action complained that the law would violate insanity acquittees' Fourteenth Amendment rights to substantive and procedural due process and equal protection of the law, the Fifth Amendment right to be free from being placed in double jeopardy, the constitutional prohibition against *ex post facto* punishment, the constitutional prohibition against bills of attainder, and the rights provided to people with disabilities to be free from discrimination on the basis of their disabilities under the Americans with Disabilities Act.[13]

There are some additional avenues by which the law could be challenged. As an initial matter, Washington law has very specific language to describe the authorized outcomes for persons found NGRI. Under Wash. Rev. Code § 10.77.110, if a person is found NGRI and the court determines that he remains a danger to public safety, the court must order "hospitalization or any appropriate alternative treatment less restrictive than detention in a state hospital."[6] Prisons are arguably the most restrictive setting available. Accordingly, one could argue that the statutory provisions are in direct conflict. Opponents of ESB 6610 § 2 could argue that the law undermines the purpose of § 10.77.110 by broadening the available placements for insanity acquittees and permits institutionalizing people in a setting that is more restrictive than is appropriate.

As a counter argument, although the law authorizes a change in physical location, ESB 6610 as written does nothing to alter how an insanity acquittee is treated once transferred. On its face, the law does nothing to alter insanity acquittees' status as civil detainees. Under ESB 6610, the DSHS retains legal custody of persons found NGRI and continues to oversee their treatment. Insanity acquittees retain the right to periodic review of their mental health condition and ability to petition for release.

Second, current Washington law authorizes placement of an insanity acquittee in a secure mental health facility within the confines of a prison.[15] However, the state has not identified a secure mental health facility within a prison. The correctional facility most closely resembling a secure psychiatric structure is the special offender unit (SOU) within the state's Monroe Correctional Complex. The SOU is a dedicated mental health complex for the most severely mentally ill inmates in Washington. It has approximately 400 beds and is not a psychiatric hospital. It is presumed that any transfer of male insanity acquittees to correctional facilities would be to the SOU, but this is not specified in ESB 6610 and has not been clarified by the legislature. It is further unclear where women would be transferred. The state has no SOU for women at this time. This is another instance in which statutory provisions may be in direct conflict.

Along similar lines, ESB 6610 § 2 authorizes the transfer of an insanity acquittee who presents an "unreasonable safety risk." Nowhere within the statute, however, is the term "unreasonable safety risk" defined. This term could be seen as unreasonably vague. Although the vagueness doctrine typically applies to criminal statutes, it arguably has applicability in quasi-criminal statutes like ESB 6610 § 2. Here, the law contains no guidelines for defining the term (other than basing the risk evaluation on the patient's behavior, clinical history, and facility security). It does not give any guidance as to how factors are to be weighed in determining the "unreasonable safety risk." It also fails to afford notice to those patients who could be affected by the provision or clarify which behaviors could trigger transfer. As the costs of maintaining persons in state hospitals remains higher

than those for holding them in prison, there may be administrative pressure to transfer insanity acquittees to a prison. The vagueness of the provision provides such limited guidance to the DSHS Secretary that there is no protection from biased or arbitrary decision making from the DSHS Secretary.

Policy and Clinical Considerations Relating to ESB 6610 § 2

One must be mindful that the law is more than legislation and constitutional principles. It serves as a reflection of society's attitudes. Stories such as those of the two individuals described herein often evoke strong emotional reactions from community members. On one side are those who see mentally ill offenders as violent, unpredictable criminals. To others, the notion of mentally ill offenders stirs up sympathy and concern for individuals who were unable to get needed treatment before they acted contrary to the law. The treatment of insanity acquittees highlights the conflict between community safety and individual justice.

It is a common belief that criminal defendants use the insanity defense to avoid punishment. One article reports that the general public has the impression that the insanity defense is used in 20 to 50 percent of all criminal cases.[16] Despite popular perception, empirical research reveals that the insanity defense is seldom used and is seldom successful. Studies have demonstrated that approximately one percent of felony defendants raise an insanity defense.[17] Of those that plead insanity, one-quarter are successful.[18]

Public perception and legislative efforts to reform laws around mentally ill offenders have gradually resulted in an increasing number of mentally ill individuals in the criminal justice system. According to a 1998 Bureau of Justice Statistics report, nearly one in six inmates in state prison facilities has a mental illness.[19] To some, however, placing individuals found NGRI in prison, as authorized under ESB 6610 § 2, runs counter to the policy goals of the insanity defense. The insanity defense is an exception to the fundamental criminal law premise that individuals are able to control their actions through volitional and cognitive capacities. Central to these assumptions is that the threat of punishment will influence behavior. If people know that they will be punished for breaking the law, they are less likely to break the law. Retributivists believe that individuals choose to commit crimes and therefore deserve to be punished for their actions.

The insanity defense serves to protect those individuals who, because of their mental illness, are unable to comprehend the illegality of their conduct or to obey the law. Individuals with a serious mental illness, who are unable to understand or conform to the law, are not deterred by the threat of punishment. The Supreme Court has held that insanity acquittees are exempt from criminal responsibility and may not be criminalized or punished.[20] Following this logic, some argue that insanity acquittees should never be imprisoned, as it constitutes a punitive measure. Although others could assert that the intent of ESB 6610 § 2 is not punitive, the question remains as to whether it would be punitive as applied.

The goals of hospitals and prisons are inherently different. By way of illustration, the Washington's Department of Corrections' mission statement differs widely from that of Washington's DSHS' statement. The Department of Corrections' mission is to "improve public safety"; one of its goals is to "punish those convicted of violating criminal laws by denying them their personal liberty."[21] In contrast, DSHS seeks to "improve the safety and health of individuals, families, and communities."[22] Specifically, WSH's Center for Forensic Services, where NGRI acquittees currently reside, provides a hospital setting to "improve active treatment opportunities for patients, their quality of life, internal safety for patients and staff, facility self-containment and community security, and residents' privacy."[23] It is a logical presumption, then, that services provided within the prisons and the state psychiatric hospitals would differ. Prison mental health services function to provide treatment to inmates within the prison culture; this contrasts with a state forensic hospital unit, which emphasizes treatment and recovery.

Under ESB 6610 § 2, NGRI psychiatric patients, if moved to prison, are likely to receive different treatment. By way of background, the U.S. Constitution, as interpreted by the U.S. Supreme Court, does not guarantee a right to mental health treatment, *per se*, but does confer an entitlement to those in state care to something more than custodial care.[24] Various federal and state statutes grant treatment rights that fall short of a constitutional mandate. In Washington, Wash. Rev. Code § 10.77.120 governs the treatment of individuals found not guilty by reason of insanity. Under the statute, the DSHS "shall

provide adequate care and individualized treatment to persons found criminally insane at one or several of the state institutions or facilities under the direction and control of the secretary."[25]

The right to treatment for convicted mentally ill offenders generally stems from different legal bases than that of individuals who are involuntarily committed to a psychiatric hospital. Treatment standards for convicted persons have historically derived from the Eighth Amendment's right to be free from cruel and unusual punishment.[26] The Supreme Court held in *Estelle v. Gamble*[27] that "deliberate indifference" to the serious medical needs of prison inmates constitutes cruel and unusual punishment in violation of the Eighth Amendment. The standard has been applied to psychiatric and psychological treatment.[28]

In contrast, for committed persons, the right to treatment is generally derived through the Fourteenth Amendment right not to be deprived of life, liberty, or property without due process.[29] The rights include freedom from punishment.[30] The Supreme Court in *Youngberg v. Romeo*[31] established a right to adequate "training" for persons in state institutions and held that the Fourteenth Amendment requires that practitioners exercise "professional judgment" in delivering treatment. "Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish" (Ref. 31, p 322).

Even if these patients are transferred to the SOU at the Monroe Correctional Facility, allocation of resources and treatment emphases will differ between prisons and hospitals. As stated above, the mission of corrections is not treatment, but rather safety and security. An emphasis on safety and security limits the range of settings and treatments that can be provided to individuals with mental illness. Research by Human Rights Watch suggests that no American prison provides the level of treatment recommended by the National Commission on Correctional Health Care.[32]

In addition, in prison, transferred insanity acquittees may be subject to regular prison policies and discipline. There is concern that once transferred, there is no guarantee that an insanity acquittee would remain in the SOU. It is possible that such individuals could be relocated to other complexes or placed in the general prison population, a further departure from the hospital environment. While this is an unsettled question, it is also possible that such individuals could be subject to removal of privileges, prison restraints, prison methods of control, or placement in solitary confinement.

Studies addressing the effect of solitary confinement on individuals with mental illness reveal that such prison conditions can be particularly severe for persons with serious mental illness, such as insanity acquittees, exacerbating an individual's symptoms or provoking a recurrence of symptoms.[33] Among other things, a prisoner in isolation may have limited access to natural light, limited access to stimulatory materials such as books or radios, and few, if any, meaningful social contacts. Further, in confinement, a person's routine is likely to be considerably disrupted. Such situations could aggravate or provoke symptoms of illness, particularly with persons diagnosed with serious mental illnesses such as bipolar disorder.

According to Metzner and Fellner,[33] individuals with mental illness, including acquittees, are more likely than others to break the rules and fall subject to prison discipline. They argue that persons with mental illness frequently have impaired abilities to adapt to a new environment and may have more difficulty adapting to the stress associated with incarceration, the prison routine, and prison rules. Some individuals may not be able to understand the rules; others may be unable to control their behaviors. Because of mental illness, they may manifest behavior that can result in disciplinary action. For example, persons who are mute, display bizarre behavior, or engage in dangerous behavior may be regarded as not conforming to prison rules. This is particularly true where prison personnel have limited training in dealing with individuals with mental illness and lack sufficient understanding of their behavior.

The stigma of mental illness in the prison setting may also increase the medication refusal rate of acquittees. In the hospital setting, most acquittees receive medication, and it is an accepted part of treatment in that setting. In a prison, however, insanity acquittees may be reluctant to accept medication because they fear looking weak or different from the other inmates.

In addition to treatment considerations, it is important to recognize that, because of their illnesses, mentally ill inmates may face increased risk of physical harm while incarcerated. A mentally ill inmate is more likely than one who is not mentally ill to be

physically or sexually assaulted while imprisoned.[34] The bases for this are most likely multifactorial, attributable in part to the mentally ill inmates' behavior and their vulnerability to pressure from other inmates. It could be argued that this increased risk of harm, in addition to the different treatment standard in prison compared with psychiatric hospitals, creates *de facto* criminalization of insanity acquittees under ESB 6610.

If the focus of ESB 6610 § 2 is public safety, it is important to note that there is an emerging body of empirical literature on the recidivism rates for persons found NGRI compared with those offenders who were criminally convicted of their offenses. In Oregon, for example, a person found guilty except for insanity is placed under the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB). Recent data from the PSRB show that a small percentage of individuals under PSRB jurisdiction are rearrested for new criminal activity:

> Just over 1,200 people have been conditionally released from the state hospital by the PSRB in the last 10 years, and only 12 of those have been revoked as a result of an arrest for a new felony while on conditional release. The overall rate of recidivism for persons under PSRB jurisdiction is 2.2 percent, which is comparatively much lower than the approximately 30 percent recidivism rate in the corrections system [Ref. 35, p 3].

Although full discussion of the reasons for these differences is beyond the scope of this article, factors are likely to include better treatment, closer monitoring, and greater access to community resources after release. These statistics are at odds with public perception.

Conclusions

Legal insanity highlights the conflict between ensuring community safety and justice for the individual. The community and legislature in Washington state have reacted to this tension and recently enacted legislation in efforts to further ensure community safety. The public is concerned with community security and often finds it challenging to accept the possibility that a mentally ill offender could be hospitalized and ultimately discharged. Those advocating for individual liberty interests conversely argue that public safety concerns should be balanced by the rights of persons found NGRI. Washington's ESB 6610 § 2 brings these concerns to the forefront. Given the legal, political, and clinical implications of the law, future legal and legislative challenges to ESB 6610 § 2 are likely to emerge. In addition to constitutional challenges, opponents to ESB 6610 § 2 are likely to focus on the facts that the state currently lacks a facility appropriate or authorized by other statutes for transfer; that any transfer from the psychiatric hospital will negatively affect treatment and could lead to decompensation; that the statute lacks guidance for insanity acquittees and the DSHS Secretary to follow regarding the bases for possible transfer; and that the statute fails to afford NGRI patients any means of challenging their transfer. Public safety and the rights of individuals found NGRI are not incompatible. The goal should be to reach a balance between the state's commitment to public safety and the rights of the patient. Greater public education about mental illness and legal insanity may help to bridge the gap.

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References

1. Engrossed Senate Bill 6610, Commitment Procedures—Criminally Insane Persons. Now codified in sections of Wash. Rev. Code § 10.77 (2010). Available at http://apps.leg.wa.gov/documents/WSLdocs/2009-10/Pdf/Bills/Session%20Law%202010/6610.SL.pdf. Accessed August 1, 2010
2. Engrossed Senate Bill 6610 § 2 (codified as Wash. Rev. Code § 10.77.091 (2010))
3. M'Naughten's Case, 101 Cl. & F. 200, 8 Eng. Rep. 718 (H.L. 1843)
4. Model Penal Code § 4.01 (Mental Disease or Defect Excluding Responsibility) (1985)
5. Wash. Rev. Code § 9A. 12.010(1)(a)(b) (1975)
6. Wash. Rev. Code § 10.77.110 (1973)
7. Veith R, Bate B, Busch, C, *et al*: Final Report, State Psychiatric Hospital Safety Review Panel, December 14, 2009. Available at www.dshs.wa.gov/pdf/EA/121509SafetyReview.pdf. Accessed January 25, 2011
8. Merelle L: ESB 6610 Bill Analysis. Washington State House of Representatives, Office of Program Research, Human Services Committee. Available at https://apps.leg.wa.gov/billinfo/summary.aspx?year=2010&bill=6610. Accessed April 2, 2012
9. Senate Bill 5253. Concerning criminal defendants who are guilty and mentally ill. Available at http://apps.leg.wa.gov/billinfo/summary.aspx?bill=5253&year=2009. Accessed January 5, 2011
10. Sloat LM, Frierson RL: Juror knowledge and attitudes regarding mental illness verdicts. J Am Acad Psychiatry Law 33:208–13, 2005
11. Engrossed Senate Bill 6610 § 1 (codified as Wash. Rev. Code § 10.77.270 (2010))
12. Scher S: Not Guilty by Reason of Insanity: Balancing Public Safety With Disability Rights. Weekday. National Public Radio KUOW, Seattle, WA. May 13, 2010. Available at http://www.kuow.org. Accessed April 2, 2012

13. Complaint, G.R. v. Gregoire, 2010 U.S. Dist. LEXIS 82882 (E.D. Wash. 2010)
14. Order to Dismiss, G.R. v. Gregoire, 2010 U.S. Dist. LEXIS 82882 (E.D. Wash. 2010)
15. Wash. Rev. Code §10.77.220 (1973)
16. Marc Rosen: Note, Insanity denied: abolition of the insanity defense in Kansas. Kan J L & Pub Pol'y 8:253, 258, 1999 (citing Frain M: Professor Says Insanity Defense Seldom Works, Telegram & Gazette, Jan. 19, 1996, B1, available in 1996 WL 2377559)
17. Blau GL, Pasewark RA: Statutory changes and the insanity defense: seeking the perfect insane person. Law Psychol Rev 18:69, 1994
18. Steadman HJ: Empirical research on the insanity defense. Ann Am Acad Pol Sci 477:58, 1985
19. Ditton P: Special Report, Mental Health and Treatment of Inmates and Probationers. Washington, DC: US Department of Justice, Bureau of Justice Statistics, July 1999. Available at http://bjs.ojp.usdoj.gov/content/pub/pdf/mhtip.pdf. Accessed January 10, 2011
20. Foucha v. Louisiana, 504 U.S. 71 (1992)
21. Department of Corrections, Washington State: About the Department of Corrections: Mission Statement. Olympia, WA: DOC. Available at http://www.doc.wa.gov/aboutdoc/default.asp. Accessed January 8, 2011
22. Department of Social and Health Services, Washington State: Mission Statement. Olympia, WA: DSHS. Available at https://fortress.wa.gov/dshs/f2ws03esaapps/onlinecso/mission.asp. Accessed January 8, 2011
23. Center for Forensic Services, Western State Hospital. Lakewood, WA: Western State Hospital, DSHS. Available at http://www.dshs.wa.gov/mhsystems/wshcfs.shtml. Accessed January 8, 2011
24. O'Connor v. Donaldson, 422 U.S. 563 (1975)
25. Wash. Rev. Code § 10.77.120 (1973)
26. U.S. Const. amend. VIII
27. Estelle v. Gamble, 429 U.S. 97 (1976)
28. Bowring v. Godwin, 551 F.2d 44 (4th Cir. 1977)
29. U.S. Const. amend. XIV, § 1, cl. 3
30. Bell v. Wolfish, 441 U.S. 520 (1979)
31. Youngberg v. Romeo, 457 U.S. 307 (1982)
32. Abramsky S, Fellner J: Ill-equipped: US prisons and offenders with mental illness. New York: Human Rights Watch Report, October 23, 2003, pp 145–68,
33. Metzner J, Fellner J: Solitary confinement and mental illness in U.S. prisons: a challenge for medical ethics. J Am Acad Psychiatry Law 38:104–8, 2010
34. Wolff N, Blitz CL, Shi J: Rates of sexual victimization of inmates with and without mental disorders. Psychiatr Serv 58:1087, 2007
35. Psychiatry Security Review Board (PSRB), Sitting Workgroup: Final Report, February 6, 2009. Available at www.oregon.gov/OHA/mentalhealth/data/2009/psrb-siting-report.pdf. Accessed January 15, 2011