“Framed for State Interest”: Professional Perspectives on Forced Medication in Outpatient Competency Restoration

Elora Yanna

A thesis

submitted in partial fulfillment

of the requirements for the degree of

Master of Social Work

University of Washington

2026

Committee:

Dr. Michelle Johnson-Jennings

James Pogue

Program Authorized to Offer Degree:

School of Social Work

University of Washington

Abstract

“Framed for State Interest”: Professional Perspectives on Forced Medication in Outpatient Competency Restoration

Elora Yanna

Chair of the Supervisory Committee:

Dr. Michelle Johnson-Jennings

School of Social Work

This research will examine the opinions of professionals working within systems related to involuntary medication, community behavioral health, and/or competency to stand trial on Sell procedures in outpatient competency restoration in Washington State. Qualitative interviews were conducted (n = 20) with participants and resulting themes were coded and analyzed by the lead researcher. Participants were recruited within Washington State beginning with convenient, key referrals that led to some snowball referrals of their colleagues. Potential participants whose primary, relevant employment was a private practice were excluded. Major findings include 1.) most participants would further explore involuntary medication in Outpatient Competency Restoration, 2.) participants' reflection of individuals who have received involuntary medication

showed that their client/patient had a co-occurring Substance Use Disorder (SUD) and/or limited insight into their mental health situation, and 3.) legislative effort and program development in this field should include attention to person-centered assessment and intervention planning and further development of comprehensive, accessible mental health care in jails. A significant relationship was found between a participant's personal history of themself or a family member being diagnosed with a Serious Mental Illness (SMI) or detained for psychiatric reasons and the decision outcome to remove involuntary medication in OCRP. Participants reported that their personal background with SMI had a neutral or positive affect on their career or approach to working with individuals with an SMI.

Acknowledgements

I would like to extend my deepest gratitude and respect to the participants who gave their time and effort to this research and my committee members, Dr. Michelle Johnson-Jennings and James Pogue, for their support and expertise. I could not have completed this work without my mom, husband, and friends; thank you for your ceaseless tolerance of this passion project.

I'd also like to acknowledge that this research was conducted and written on the traditional lands of the Cayuse, Umatilla, Walla Walla, Puyallup, and Steilacoom Nations and thank them for the care they have and continue to provide for this land.

Lastly, I want to thank my clients past and present for inspiring this work. I hope to be part of a system that provides the care you deserve.

Background

Introduction to Outpatient Competency Restoration

The U.S. Supreme Court's interpretation of the Constitution established in *Dusky v. United States* and *Pate v. Robinson* that for a criminal trial to proceed, a defendant must possess "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding–and rational as well as factual understanding of the proceedings against him" (Ladds et al., 1993). An individual facing criminal charges may be subject to a psychological assessment to determine their competency to stand trial. Should that individual be adjudicated incompetent to stand trial, the court may order them to competency restoration, which has traditionally been carried out in a psychiatric hospital. The aim of competency restoration is to allow a defendant to communicate effectively with counsel which generally includes management of symptoms in a courtroom and psychoeducation on understanding court processes. In the last few decades, states have begun to explore outpatient competency restoration to reduce the demand on hospital beds and the timeframe in which restoration may occur. A majority of the states operating a program for outpatient competency restoration have found positive outcomes in financial savings, increased inpatient bed capacity, maintenance of public safety, and high rates of restoration (Gowensmith et al., 2016).

Washington State established its Outpatient Competency Restoration Program (OCRP) following the *Trueblood v. Department of Social and Health Service* lawsuit, which challenged unconstitutional delays in competency evaluation. As of April 2026, Washington has six OCRP contractors across the Spokane, Pierce, Southwest, King, Salish, and Thurston/Mason regions covering 16 counties (*Trueblood et al v. Washington State DSHS | DSHS*, n.d.). The January 2026 court monitor report stated that OCRP has served 397 unduplicated individuals from July 1,

2020, through September 30, 2025, with 62 cases active at the time of the report (Office of Forensic Mental Health Services, 2026). An individual ordered into OCRP will begin with up to 90 days of restoration for a misdemeanor or up to a year for a felony followed by another competency evaluation. If they are judged incompetent to stand trial again, they may be ordered into two or three more rounds of restoration (RCW § 10.77.645, n.d., RCW § 10.77.650, n.d.).

Involuntary Medication in OCRP

Washington State permits involuntary medication in OCRP citing *Sell v. United States*, which ruled that the government may administer antipsychotic medication for the purposes of competency restoration. The involuntary medication of someone undergoing competency restoration for a serious offense requires a Sell hearing to weigh the government's interest against the individuals on a case-by-case basis (*Sell v. United States*, 2003, RCW § 10.77.65, n.d.). The Sell test consists of four prongs.

1. A court must find that important government interests are at stake—that is, bringing a serious crime to trial.
2. A court must find that the medication is both substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense.
3. A court must find that any alternative, less-intrusive treatments are unlikely to achieve substantially the same results.
4. A court must conclude that administration of the drugs is medically appropriate—that is, in the patient's best medical interest in light of his medical condition (Etheridge & Chamberlain, 2006).

With the ability to seek a Sell hearing, OCRP nonetheless requires participants to "be willing to adhere to medications or to receive a prescribed intramuscular injection" (RCW § 10.77.645, n.d.). This structural tension challenges the reasonableness of complying with an outpatient program over continued incarceration. Potential OCRP participants must also be "clinically appropriate," which is undefined by the statute. This provides subjective gatekeeping authority to practitioners. OCRP participation may be terminated if an individual "is no longer clinically appropriate for outpatient competency restoration" (RCW § 10.77.645, n.d). While the Sell case establishes constitutional guidelines for involuntary medication, its application in OCRP raises unique ethical and procedural concerns that are not explicitly addressed in statute.

Antipsychotic Medications

"Using medications is one of the most powerful tools we have to reduce or eliminate psychiatric symptoms and prevent relapses," says the Office of Forensic Mental Health's Breaking Barriers Competency Restoration patient workbook in use for restoration in Washington State (Office of Forensic Mental Health Services, 2019). Similarly, some research argues that antipsychotic interventions are the cornerstone of managing patients with schizophrenia and other psychotic disorders (Sampogna et al., 2023; Faizi et al., 2025). Long-acting injectables (depot) have shown to be more effective at maintaining symptom control and reducing relapse rates than their oral counterparts (Luecht et al., 2011). This is attractive for those interested in medication adherence. Limiting a study to outpatient clients has produced similar decreased risk of relapse and, additionally, lowered hospitalization (Fang et al., 2020). Further, receiving an injectable antipsychotic has shown to improve treatment adherence in involuntary outpatient commitments, like OCRP, for individuals with SMI (Swartz et al., 2001).

The state has released a data report on their forensic housing program that gives some idea about the potential diagnostic demographics of OCRP. The report showed that of the state-wide program participants with a competency order history over a twelve-month period, 66% had a psychotic diagnosis, and 51% of them had been prescribed an antipsychotic (Becker et al., 2024). There are no similar, public data available regarding any other Trueblood programming participants, including OCRP. The available data do not report if the prescribed antipsychotics were given orally or as a long-acting injectable (LAI). The September 2025 Semi-Annual Trueblood report detailed ten goals for addressing the continuing increase in demand for pretrial competency services. One of these goals is "investigating and removing barriers to using long acting injectables" (Office of Forensic Mental Health Services, 2025).

A trial of antipsychotic treatment should be predicted to last four to six weeks (Conley & Kelly, 2001, Falkai et al., 2006, Lehman et al., 2010). While a medication trial could fit within a competency restoration period, it allows little-to-no room for any barriers or delays to treatment. Both first-generation/typical and second-generation/atypical antipsychotics present potential adverse effects. Most commonly those are of the neuromuscular, metabolic, cardiovascular, and central nervous systems (Pakpoor & Agius, 2014, Willner et al., 2024). Prescribing clinicians are urged to "be vigilant for the occurrence of adverse effects, be willing to adjust or change medications as needed… and be prepared to treat any resulting medical sequelae" (Muench & Hamer, 2010). That may be hard to accomplish within the statutory timelines of competency restoration, especially if the charges are "unserious" or a misdemeanor. While an outpatient restoration period is longer than inpatient, both would institutionally favor treatment interventions that quickly reduce symptoms to align with statutory timelines (RCW § 10.77.645, n.d., RCW§10.77.655, n.d.).

There is growing research into the potential long-term outcomes of antipsychotic exposure. Whitaker (2006) recommends avoiding immediate exposure to antipsychotics in the individual's first episode and attempting a gradual withdrawal from antipsychotics for stable individuals instead of maintaining high-dosage routines. Other researchers note that further study is needed before making claims about long-term effects of antipsychotic use (Sohler et al., 2017, Goff et al., 2017). Due to the population of individuals found incompetent to stand trial, antipsychotic medications appear to take the brunt of the work in restoring someone to competency to stand trial even with concern for medications being the first line of treatment.

OCRP Programming

A competency evaluation by a Mental Health Professional in Washington State must contain non-exhaustively Relevant Clinical and Historical Data, a Mental Status Examination, Diagnostic Impressions, and an Evaluation of Competency to Stand Trial. These components especially are intended to help shape the evaluator's opinion on competency and may include information about past medication adherence, past experiences with particular pharmaceuticals, and an opinion as to the likelihood of restoration for that individual being benefitted by medication. Sample language from the Washington State Forensic Evaluation Report Guidelines by Luxton et al. (2019) looks like:

> Prior to one of those successful restoration periods, he had taken antipsychotic medications in the jail beginning before his admission and continued on clinically indicated medications in the hospital. He is not currently prescribed anything but Ibuprofen in the jail. The likelihood of successful restoration would be improved if he started taking psychotropic medications prior to admission. Mr. Smith indicated he was

> willing to do so. He also stated he would take medications at WSH [Western State Hospital] (p. 34).

This information from the competency evaluation would help the behavioral health provider in OCRP prescribe medications as appropriate. By law, OCRPs must include access to a prescriber (RCW § 10.77.655, n.d.). A Request for Information by the Health Care Authority to licensed behavioral health agencies in King County interested in implementing an OCRP stated that substantial funds would be available to clients for, "food, clothing, lodging, rent, daily living needs, transportation, medically necessary services and testing, or other items/services as appropriate for a person's success in the program" (Health Care Authority, 2021). This would ideally negate potential barriers to receiving outpatient medication management like insurance, transportation, secure storage options, etc. Additionally, any OCRP participant is eligible to enroll in Forensic Housing and Recovery through Peer Services (FHARPS) for housing and Forensic Projects for Assistance in Transition from Homelessness (FPATH) for intensive case management.

OCRP providers receiving contracts from the Health Care Authority are required to use the Breaking Barriers Competency Restoration Program as the program's methodology. This is the same methodology for inpatient restoration (DSHS Behavioral Health Administration, n.d.). OCRP participants spend approximately ten hours a week in restoration programming (*Competency Restoration, a Guide to Competency Evaluation and Restoration*, 2024). The Breaking Barriers Patient Workbook covers four main skills—courtroom knowledge, symptom management, relaxation and coping skills, and effective communication. Medication adherence is discussed as an essential component of symptom management, primarily through the lens of the Stress-Vulnerability Model (Office of Forensic Mental Health Services, 2019). There is

concern that the Stress-Vulnerability Model as a perpetuation of the medicalization of mental health may reinforce an individualized conceptualization of vulnerability rather than acknowledging systemic contributors to distress (Demke, 2022; Rudnik and Lundberg, 2012).

Decompensation

Decompensation is "a breakdown in an individual's defense mechanisms, resulting in progressive loss of normal functioning or worsening of psychiatric symptoms" (*APA Dictionary of Psychology*, n.d.). This process may occur after discontinuation of antipsychotic medications (Baldenssarini et al., 1995; Gitlin et al., 2001; Moncrieff, 2006). The current response to a behavioral health crisis in Washington State is to engage a Designated Crisis Responder (DCR) who will evaluate an individual for potential harm to self, others, or property, grave disability with imminent risk, a nonemergent substance use disorder (SUD) or mental disorder, and/or if they are in need of assisted outpatient behavioral health treatment. If the individual is deemed eligible for involuntary treatment and a bed is available, they will be detained under the Involuntary Treatment Act (*Designated Crisis Responders (DCR)*, n.d.). Many others in a behavioral health crisis, potentially because a bed was unavailable, will land in an emergency department and/or jail.

As stated above, OCRP participation may be terminated if an individual is no longer clinically appropriate. An episode of decompensation, whether caused by medication changes or environmental stressors, may trigger program termination and subsequent reinstitutionalization. This creates a legal consequence on top of the clinical harm of decompensation.

Ethical Considerations of Sell

The order to receive competency restoration is itself involuntary, and restoration is not person-centered treatment. There may be secondary benefits to the client throughout restoration programming, but the primary goal is to further a court proceeding.

Arroyo (2020) sets forth that a medical act should pass clinical and medical-legal judgments. The first two are covered in the Sell test under prongs one, two, and four, as quoted above. Arroyo highlights the necessary ethical judgement of medical acts by arguing that:

> the ethical, which is more demanding… imposes the duty to seek excellence of the medical act through personalisation, seeking the best for this particular patient, with respect for the patient's wishes about what they want for themselves, and without forgetting the principles of social justice, fairness and equality (Arroyo, 2020).

This ethical judgment is missing from the Sell test. Forced medication hearings do not require the court to affirmatively account for the individual's specific values, beliefs, preferences, or long-term wellness. Ogunwale et al. (2021) discusses cultural sensitivity in forensic mental health care:

> Culture can shape behavior (what is expected, typical deviant, taboo), how we communicate (convey pain and stress, regulate emotions), what health models we subscribe to (individualized explanations vs holistic models) and help-seeking behaviors (first point of call, how we interact with professionals, family involvement and stigma). Cultural dynamics can also impact how we interact cross-culturally as well as how we interpret and manage behaviors (Ogunwale et al., 2021).

Understanding how an individual approaches their health, communicates, and behaves in relation to their culture is vital to appropriate assessment of intervention methods such as involuntary medication.

Arroyo (2020) further argues for specific regulation of involuntary outpatient treatment, stating that sufficient scientific appraisal opens the door to person-centered treatment while precise protocol offers doctors and the legal system security and simplicity. Single (2004) states, "In Sell, the Supreme Court added a layer of protection for individuals faced with a serious threat to their significant liberty interest in remaining free of unwanted medication. However, the layer is thin at best." Single (2004) calls for clear-cut scrutiny standards in all involuntary administration of antipsychotics cases. The Sell test, as practiced in Washington State, is thin due to the missing weight of person-centered and culturally-informed practice.

Current Policy and State Interest

Revised Code of Washington

The Revised Code of Washington (RCW) is the compilation of all permanent laws currently in force. As stated above, RCW 10.77.665 determines whether a court can authorize involuntary medication for competency restoration. RCW 10.77.525 determines that administration of antipsychotic medication without consent must follow the same procedures applicable to a civil commitment. It furthers that state interest in administering antipsychotic medication without consent under Chapter 10.77 applies when the patient's refusal, "would result in a likelihood of serious harm or substantial deterioration or substantially prolong the length of involuntary commitment and there is no less intrusive course of treatment than medication that is in the best interest of the patient" (RCW § 10.77.525, n.d.). This adds onto the parameters of the

Sell test to include reducing the risk of harm, risk of decompensation, and length of commitment/period of restoration. These additional factors appear to shift the case of involuntary medication towards person-centered treatment in a way that the Sell test alone does not. Though, the aims of restoration remain skewed toward the court's ability to prosecute the individual.

Law in Practice

In the effort of understanding current practice on this topic, the lead researcher shadowed a Sell hearing for an individual undergoing inpatient restoration at Western State Hospital (WSH) at the end of 2025. The bulk of the hearing centered on the treating psychiatrist's testimony for the provision of involuntary antipsychotic medication. Notably, the patient refused to attend or participate in the hearing. Much of the case hinged on the patient's risk of a life-threatening physical health episode because a specific delusion was presenting as a barrier to receiving care for that condition. Also important to the case was the patient's previous history responding well to the proposed medication, their previous history in competency restoration, and the undeniably serious nature of the charges. On the third prong concerning alternative, less-intrusive treatment, the psychiatrist testified that the patient was not attending classes. They stated that medication and classes were all that WSH offered for competency restoration and that medication was much more likely to restore the patient to competency than any other treatment. With this, prosecution was successful in arguing that government interest was at stake, medication would likely render the client restorable without interfering side effects, alternative, less-intrusive treatment would be ineffective, and that the medication was in the client's best medical interest.

The defense attorney noted in their closing argument that while the charges at hand were undeniably serious, they questioned the constitutionality of the "seriousness question." The most interesting part in this hearing to me was the argument of "tailoring" the order to the patient in

question. The court showed interest in restricting the psychiatrist's legal authority to prescribe a broad range of antipsychotics and dosages. The judge agreed to tailor the order down to just two medications at any time at their maximum dosage. They also agreed to allow the jail to continue to administer the medication involuntarily for the purpose of maintaining restoration up to trial, if necessary.

The testifying psychiatrist was able to provide information on the administration of involuntary medication that the lead researcher was unable to find via publicly available materials. They stated that in their time at Western State Hospital, having security staff present when offering oral/injectable medication to a patient with a Forced Medication Order (FMO) would press the patient to take their medication without use of force. They continued that it was standard for a patient with an FMO to "realize they need the medication" and agree to take it orally after the medication became effective. This practice brings forth concerns about coercion and power threats, while also potentially protecting individuals from the trauma of force and physical restraint.

While this hearing was for an inpatient restoration period, the primacy of medication over alternative treatment options carries through outpatient restoration. Outpatient restoration, however, does not have equivalent procedural safeguards for the potential of administering involuntary medication.

House Bills

House Bill (HB) 1218 was initially introduced in the last legislative session by former Washington State Governor Jay Inslee. HB 1218 seeks to make "changes to competency evaluation and restoration service provisions, including procedures in nonfelony cases, outpatient

competency restoration, duties of forensic navigators, and hearings for involuntary medication determinations" (House Bill 1218, 2025). Staff summary of the last public hearing for HB 1218 states, "There are concerns about the involuntary medication provisions in this bill… Nothing will ever be perfect, but the system can be improved." An ongoing task force was created to allow stakeholders to develop a comprehensive approach to the balance of safety and reality with regard to competency restoration (House Bill 1218, 2025).

House Bill 1359 details this task force. Their tasks are to, "consider terminology and language changes to improve clarity, reduce stigma, and improve coherence between legal and medical terminology; and make recommendations to remove barriers to diversion programs, promote effective treatment, and increase services that would facilitate safe hospital discharges" (House Bill 1359, 2025). The members include five state officials and 21 Department of Social and Health Services (DSHS) designees. Notably, that includes three individuals with lived experience of the forensic mental health systems, one designee of the Office of Crime Victims Advocacy, one designee of the National Alliance on Mental Illness (NAMI), and one designee of Disability Rights Washington, the plaintiff organization of the Trueblood lawsuit. These notable designees represent a shift towards participatory governance, but the balance remains tilted towards institutional authority.

Importance of Professional Opinions

The importance of recognizing and including lived experience within our systems cannot be understated. Practitioner opinions represent a large sample of cases and situations while including the interaction between micro-level practitioners and the larger legal/health systems. This unique experience of policy is valuable within any discussion of reform.

Simultaneously, practitioners are inseparable from their own intersectionalities and cultural lenses. Hays (2001) established the ADDRESSING model as follows—

Age and generational influence

Developmental disability

Disability acquired later in life

Religion and spiritual

Ethnic and racial identity

Socioeconomic status

Sexual orientation

Indigenous heritage

National origin

Gender

She intended for the model to be used by practitioners to recognize the impact of social identities on their clients, but it has since been used as a reflexive practice to address implicit biases and cultural complexity in practitioner-client relationships. (Hays, 2001). Those factors may influence transference, avoidance, adherence to stigma, belief in an individual's ability to change, willingness to follow best practice, willingness to integrate cultural practices, etc. These positional influences are especially critical when professional judgement and authority are the direct link to involuntary treatment and justice involvement, which opens the door for someone to be involuntarily medicated.

Methodology

Research Design

With regard to positionality, the lead researcher has experience working in community mental health, federal reentry, and houselessness as an overnight shelter aid, lead case manager, and mental health counselor. She is a White, cis-gender, young adult that has personal experience with a close family member being victimized by someone with an SMI and a family member being detained for psychiatric reasons. Discussion of these topics in relation to the research questions may have caused biases in interpretation and/or length of time spent in discussion on that topic. Her current employment is within this field, and participants were either previously established professional relationships or networked through those relationships as snowball referrals. The lead researcher strived to include the opinion of all relevant professionals. Participation in the study was voluntary. No compensation was offered or provided as this study is unfunded. Participants chose to participate in order to contribute to social work research. Potential participants were informed that study questions may cause discomfort and were reminded at the beginning of every interview that any question could be declined if they chose.

This study used constructivist grounded theory methodology to acknowledge the subjectivity and positionality of participants' opinions. The study explored the perspectives and experiences of practitioners working within systems related to involuntary medication, outpatient behavioral health, and/or competency to stand trial. These three experiences are all relevant to the study question, but participants were unlikely to have experience with all three. Participants were recruited via convenient, purposive sampling by word of mouth, phone calls, and email in order to include a variety of professions and perspectives across the behavioral health continuum within the timeframe of this project. Recruitment flyers were not used, but a document was given to all potential participants that detailed the study aim, expectation of participants, data security, and contact information. All communication about recruitment and recruitment was finalized via

email. Some participants recommended other professionals who they believed provided a unique perspective. Eligible participants included social workers, mental health professionals (MHPs), law enforcement, probation/parole officers, attorneys, and any other related position. Potential participants whose primary, relevant employment was a private practice were excluded to maintain focus on professionals most likely to come into contact with involuntary medication, outpatient behavioral health, and/or competency to stand trial. Saturation was reached when it did not appear any additional insights would emerge, as defined by method theory.

Data Collection

Data were collected by the primary researcher through individual, semi-structured interviews that lasted approximately one hour. Interviews were offered in-person or via Zoom from locations that provided confidentiality such as an office or treatment room. Transcriptions of interviews were not used in order to focus on nuance and nonverbal communication while reducing labor in quality checking transcripts.

The following screening questions were answered by all participants prior to the interview:

1. Which of these labels best describes your position: social worker, mental health professional, officer, attorney? If none of those feel like a good fit, please describe your role.
2. Is the funder of your primary, relevant employment a private practice?
3. Have you worked in this field in any other state?
4. How many months/years of experience do you have working with Serious Mental Illness (SMI) in the community?

5. How many months/years of experience do you have working with individuals ordered into competency restoration?
6. How many months/years of experience do you have working with individuals ordered to receive involuntary medication?
7. Have you or a personal relation been diagnosed with an SMI or been detained for psychiatric reasons?
8. Have you or a personal relation been victimized by someone with an SMI?

They were then asked the following interview questions:

1. What does consent to treatment mean to you?
2. What is your understanding of the population's ability to give consent?
3. What is your cultural perspective? (Age, Religion, Ethnicity, Socioeconomic Status, Indigenous Group Membership, Gender)
4. How are antipsychotic medications perceived from your cultural perspective?
5. How does that perception affect your practice?
6. How does treatment change between a mental health unit at a jail, a forensic wing at a hospital, and outpatient?
7. What is your opinion on involuntary medication?
8. What is the purpose of involuntary medication?
9. In your experience, what percentage of clients who have received involuntary medication had limited insight into their situation?
10. In your experience, what percentage of clients who have received involuntary medication had a co-occurring substance use disorder?
11. What is your opinion on involuntary medication in an outpatient setting?

12. How would you envision the practice of administering involuntary medication in an outpatient setting?
13. How do you weigh the harm of decompensation while outpatient against the loss of agency associated with receiving involuntary medication?
14. If given the power, would you move to establish further guidance for involuntary medication in an outpatient setting or remove the authority to seek a *Sell* hearing from OCRP contractors?

Additional questions were asked if necessary to clarify the participant's experience or opinion.

Data Analysis

Qualitative data were analyzed by the lead researcher and supported by committee members. The data were coded by idea or concept and developed into themes for thematic analysis with the aid of a spreadsheet software. Theme 1 "it depends or case-by-base" developed sub-theme 1.1 "depends on prior history." Thematic analysis reduced objectivity of the researcher and allowed the process to adapt to emerging insight(s). Effort was taken to not over-condense themes in order to protect the contextualization of participant's responses. This data may lack replicability because it is interpretive. It will also not attempt to create explanatory claims as it is descriptive.

Artificial Intelligence (AI) Companion by Zoom was denied by the primary researcher in every virtual interview in order to protect the process of qualitative analysis as set out in this section and with concern for the sustainability and environmental impact of generative AI (Bashir et al., 2024, Davison et al., 2024). Thematic analysis was conducted through manual coding rather than qualitative analysis software incorporating generative AI. The primary

researcher intentionally used this approach to maintain close interpretive engagement with the data and to ensure that coding decisions remained grounded in participant context, relational meaning, and cultural nuance. Given the study's emphasis on cultural, practice, and community-informed interpretation, hand coding allowed the researchers to engage reflexively and iteratively with the data in ways that prioritized contextual interpretation over automated categorization. In addition, concerns regarding transparency, reproducibility, data governance, the potential for generative AI systems to misinterpret culturally specific meanings, and environmental justice informed the decision to avoid AI-assisted analytic platforms.

Screening questions and demographic answers were classified into two to three groups, depending on the range of answers, in order to segment the data for comparison. The same process was used for interview questions nine and ten for the same reason. Age groups were defined as followfollows—Young Adult (18–39 years old), Middle Age (40–59 years old) and Senior (65+ years old). No participants reported identifying as nonbinary, genderfluid, intersex, or agender, so participant responses are reflected as Male and Female. The ethnicity of participants did not need to be segmented as responses were within these four categories—Biracial, Black, White, and Hispanic. Religious beliefs were defined as Spiritual or None. Socioeconomic status/SES groups were categorized as Middle and Upper SES. Job positions were defined as client-serving, court-serving, and emergency services in order to best represent the functionality of each position. The participants' experience working in their field in another jurisdiction or state is represented as a yes/no response. Years of experience with SMI in the community, competency proceedings, and involuntary medications were categorized as ten and under years of experience, 11–19 years of experience, and 20 and over years of experience. Personal history of themselves or someone else being diagnosed with an SMI, being

psychiatrically detained, and being victimized by someone with an SMI were all represented as a yes/no response. Questions nine and ten ([9] In your experience, what percentage of clients who have received involuntary medication had limited insight into their situation? [10] In your experience, what percentage of clients who have received involuntary medication had a cooccurring substance use disorder?) asked for a percentage and responses were classified as follows—1 (not applicable to the participant's experience or no response), 2 (50% and under), and 3 (over 50%).

A Fisher test and chi-square test were conducted to examine the relationship between class type and decision outcome (further vs. remove) using the sample size of twenty.

Findings

Demographics

Table 1, on the next page, shows that these findings represent a combined 240.5 years of experience with SMI in the community, 154.5 years of experience with individuals ordered into competency restoration, and 169 years of experience with individuals ordered to receive involuntary medication. Years of experience in each area averaged at 11.64 years, 7.60 years, and 8.33 years respectively. Table 2 shows that 50% participants were young adults, 75% were female, 55% were middle class, 55% were spiritual, 45% were client-serving, and 55% were White. Further, 55% of the participants had less than ten years of experience, 50% had less than ten years of experience with individuals ordered to receive competency restoration, and 70% had less than ten years of experience with individuals ordered to receive involuntary medication. Overall, 55% of the participants have worked in another state or jurisdiction. 60% of the participants do not have a personal history of themselves or someone else being diagnosed with an SMI or being detained for psychiatric reasons and 80% did not have experience of themselves

or someone else being victimized by an individual with an SMI. No participants reported an Indigenous identity. Participants' experience comes from community psychiatry and therapy, supportive housing, competency evaluation, defense law, prosecution, judicial law, state hospital social work, court case management, mental health crisis response, law enforcement, and jail mental health.

Table 1

Years of Experience of Participants

	Years of Experience With		
	SMI	**Competency**	**Involuntary Medication**
Total	240.5	154.5	169
Average	11.64	7.60	8.33
Range	0 - 36	1 - 30	0 - 25

Table 2

Demographics of Participants

Age	n =	%	**Position**	n =	%	**Experience involuntary medication**	n =	%
Young Adult	10	50%	Client-serving	9	45%	<10 years	14	70%
Middle Aged	8	40%	Court-serving	7	35%	11-19 years	3	15%
Senior	2	10%	Emergency Services	4	20%	>20 years	3	15%
Gender	n =	%	**Ethnicity**	n =	%	**Experience in other State/Jurisdiction**	n =	%
Female	15	75%	White	11	55%	Yes	12	60%
Male	5	25%	Biracial	5	25%	No	8	40%
			Black	3	15%			
			Hispanic	1	5%			
Socioeconomic Status	n =	%	**Experience SMI**	n =	%	**Personal History of Diagnosis or Detainment**	n =	%
Middle Class	11	55%	<10 years	10	50%	No	12	60%
Upper Class	5	25%	11-19 years	6	30%	Yes	8	40%
No answer	4	20%	>20 years	4	20%			
Religion	n =	%	**Experience competency**	n =	%	**Personal History of Victimization**	n =	%
Spiritual	11	55%	<10 years	16	80%	No	16	80%
None	9	45%	11-19 years	1	5%	Yes	4	20%
			>20 years	3	15%			

Thematic Analysis

There were twenty-five themes identified in the thematic analysis as shown in Table 3, on the next page. Each participant responded that cases involving ability to give consent, purpose of involuntary medication, and/or appropriate response to decompensation in the community was dependent on the context and, or should be evaluated case-by-case. Three participants stated that the individual's prior history should be part of that evaluation. Sixteen (80%) participants stated that jail mental health services are limited or lacking. Fourteen (70%) had an initial negative reaction to question 12 (How would you envision the practice of administering involuntary medication in an outpatient setting?) which were expressed, non-exhaustively, as "I would petition against that, it's dangerous," "Do we have somebody to hold them down? That's hard to imagine," "Farfetched, unthinkable, and violent." Twelve (60%) participants indicated that the purpose of involuntary medication is to establish stability/ and/or reduce symptoms.

A cluster of subthemes– 7, 6, 8, and 9– address the cultural impact on the participants' work. Eight professionals (40%) had received negative messaging or formed a negative judgement of SMI in their childhoods, which were expressed, non-exhaustively, as "That person is crazy, stay away," "People with a mental illness were unpredictable," "They're not perceived well." Two (10%) of participants had been directed to pray for an individual with an SMI. Seven (35%) stated that they either had no exposure to SMI or it was intentionally not talked about within their families. Two (10%) had a familial exposure to SMI that positively affected their perception of SMI and their career within this field. No participant reported that their career or approach to this population is negatively impacted by the messaging or exposure they had around SMI before engaging in this field professionally.

Table 3

Themes

Code	Theme	n =	%
1	It depends/case by case	20	100%
10	Jail mental health is lacking	16	80%
12	Initial negative reaction to outpatient forced medication	14	70%
14	Involuntary medications are for stability/symptom reduction	12	60%
7	Negative judgement of SMI growing up	8	40%
11	Outpatient is better than jail/hospital	8	40%
5	Participant said they didn't know/weren't sure	7	35%
6	SMI was not talked about/participant had no exposure	7	35%
15	Involuntary medications are to restore some function	7	35%
19	Houselessness	7	35%
2	Consent is time-bound	5	25%
3	Participant mentioned a code of ethics	5	25%
13	Exposure/access in outpatient being negative	5	25%
24	Population's vulnerability to coercion	5	25%
1.1	Depends on individual's prior history	3	15%
16	Hospital programming	3	15%
17	Physical healthcare	3	15%
18	Release/discharge planning	3	15%
20	Court timelines are a restriction	3	15%
21	Participant appealed to society	3	15%
22	Participant deferred to someone/something else	3	15%
4	SUD-Medication Interference	2	10%
8	Prayer as treatment in culture	2	10%
9	Family exposure affected perception	2	10%
23	Detox before assessment	2	10%
24	Harm to property	2	10%

Limited Insight and Co-occurring SUD

Table 4 shows that 14 (70%) of the participants said that at least 50% of individuals who have received involuntary medication had limited insight into their situation and 13 (65%) said that at least 50% of individuals who have received involuntary medication had a co-occurring substance use disorder (SUD). Two (10%) of the participants cited concern for the interaction between substances and antipsychotic medications. Similarly, five (25%) of the participants were

concerned about access or exposure to substances being a stressor on the success of outpatient treatment and/or competency restoration.

Table 4

Limited Insight and Co-occurring SUD in individuals ordered to receive involuntary medication

Limited Insight	n =	%	**Co-ocurring SUD**	n =	%
Not Applicable	4	20%	Not Applicable	3	15%
≤ 50	2	10%	≤ 50	4	20%
> 50	14	70%	> 50	13	65%

Involuntary medication in OCRP

When participants were asked to consider the actual practice of administering a forced medication to someone in outpatient competency restoration, the majority had an initial negative reaction to it citing difficulty with staffing, timeline issues, client locations, violence, danger, and/or impossibility. Most of the mentions of houselessness occurred in discussion of how to locate clients for the purpose of administering a forced medication.

In between the question of actual practice and final vote, participants were asked to consider the harm of decompensating in the community and weigh it against the loss of agency associated with receiving a forced medication. Those discussions considered client history in decompensation, safety of the community, potential harm to self and/or others, grave disability, client's desire to remain in OCRP, and various codes of ethics. The center of discourse was the use of the Involuntary Treatment Act (ITA) within OCRP which is carried out by crisis responders.

Participants were split in the purpose of involuntary medication. The majority discussed stability and symptom reduction and a third discussed involuntary medication being meant to

specifically restore some function or another i.e., competency, communication ability, ability to consider medication, with some overlap between both.

The final question of the interview asked participants to definitely answer if they would move to establish further guidance for involuntary medication in an outpatient setting or remove the authority to seek a Sell hearing from OCRP contractors. Thirteen (65%) of the participants reported that they were seeking further guidance while seven (35%) stated that they would remove OCRP contractor's ability to request a Sell hearing.

Table 5

Participants response to involuntary medication in OCRP

Question 14 Answer	n =	%
Further	13	65%
Remove	7	35%

While not the intent of this research, a statistically significant relationship using the chi-square test at $p < 0.05$ was found between a participant's personal history of themselves or a family member being diagnosed with an SMI or detained for psychiatric reasons and the decision outcome to remove involuntary medication in OCRP since $p = 0.035$. The chi-square value was 4.4. The observed distribution was diagnosed or detained (three further, five remove) and no diagnosis or detainment (ten further, two remove). The same data in the Fisher test, which is more appropriate for this sample size, resulted in no significance with an odds ratio of 0.15 and *p*-value of 0.062.

Discussion

The primary researcher conducted this study to inform the ongoing development of outpatient competency restoration in Washington State from the perspectives of professionals engaged in the groundwork of the behavioral health system. This is the first known study to

address forced medication in OCRP through the eyes of active professionals with consideration of their cultural values and views. Several major themes were found surrounding person-centered assessment and intervention, need for expanded mental health support within jails, the purpose of involuntary medication, and a negative response to forced medication in outpatient care.

Qualitative Individual Interviews Major Themes: Thematic Analysis

Person-centered Assessment and Intervention is context driven

The first major findings of the thematic analysis of professionals in the field was that assessment and intervention is person-centered and varies by situation. All participants reported an understanding of consent to treatment as the individual entering an informed agreement to available interventions, with a quarter of the participants mentioning that that consent is time-bound. The individual's prior history was identified as a factor in both ability to give consent and suitability for involuntary detention while in a behavioral health crisis. There was some concern for the method of communication in all interactions being accessible to the individual i.e., language spoken, Americans with Disabilities Act accommodations. Some participants would prefer for individuals to be detoxed from substances before being assessed for consent to treatment.

Lack of Mental Health Support in Jails

Another significant theme is that professionals identified a lack of mental health support in jails. Jail mental health was described as understaffed, underfunded, and limited in both accessibility to incarcerated individuals and breadth of service. "I wouldn't call it treatment," said one professional. While another stated that mental health in jails is, "virtually nonexistent." The intended service of mental health staff in jails is penological, concerned about the management of the facility, not centered on the overall sustainable wellness of clients.

Individual Perceptions of Forced Medication

The last few questions of the interview zoomed in on the professionals' direct opinion of forced medication in OCRP. As previously stated in findings, professionals shared statements like, “I would petition against that, it’s dangerous,” “Do we have somebody to hold them down? That's hard to imagine,” and “Farfetched, unthinkable, and violent” in response to the logistic practice of administering a forced medication in the community. Other concerns were staffing difficulties, timeline issues, and client location. Between responses like the above and a majority of professionals stating they would explore Sell hearings in OCRP, the primary researcher opened a discussion about the harms of decompensating in the community.

Our study indicated that some professionals prefer outpatient care’s ability to establish interventions that would prevent decompensation and promote client-advocacy in a way that jails and psychiatric hospitals are reportedly unable to. In this vein, some professionals discussed a lack of effective discharge/release planning from psychiatric hospitals and jails.

The majority of professionals reported that the purpose of involuntary medication after decompensation is to establish stability/safety via symptom reduction and a third of professionals discussed the restoration of some function or another. One professional noted, individuals have “the right to decompensate in the community” to discourage practices that harm clients while trying to prevent decompensation. Another shared that they “fear that not taking action to reduce risk would cause harm" while discussing best practice around decompensation.

Professionals were not strictly questioned about why they made the choice to further or remove forced medication in OCRP. However the difference in responses about the topic before and after discussing decompensation suggests that the potential harm of decompensation to the individual, staff, and community, is enough to entertain the idea of forced medication in OCRP.

Decompensation and Property

Interestingly, multiple participants discussed the harm to property being less serious than harm to self or others in the context of trespassing, burglary, etc., i.e. broken windows or doors. RCW 71.05.020 states that a person may be involuntary detained if they are likely to inflict serious harm which includes, "physical harm…inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others" (RCW § 71.05.020, n.d.). The primary researcher believes it is worth noting that Chapter 9.08 of the RCW defines animals as property while research into animal cruelty as a psychiatric topic conceptualizes them as a being and their mistreatment as indicative of the likelihood to harm people (Gleyzer et al., 2002, Holoyda, 2018, RCW § 9.08, n.d.). Given that professionals may devalue the seriousness of harm to inanimate property in relation to the ITA, more research is needed to clarify how this relates to the classification of animals as property, especially given that animal abuse may be an indicator of severe psychological concerns, thus, more research is needed in this area.

Programmatic Considerations

Professionals indicated that the following existing programs can be supportive of outpatient care: Assisted Outpatient Treatment (AOT), Least Restrictive Alternatives (LRA), Program of Assertive Community Treatment (PACT), and Mental Health Advanced Directives (MHAD). Professionals overall found that AOT is not useful for either the client or provider as there is not enough incentive to maintain client engagement. It further has too much carceral consequence. Many professionals have used PACT to address access to medication in the community by meeting them where they are, increasing the frequency of provider-client contact,

and giving clients the opportunity to seek psychoeducation. PACT has identified challenges with coordinating referrals and engagement, rate structure, workforce development, and service area gaps (Meghan DeGallier, 2020). Meanwhile, MHADs have the potential to ensure person-centered care in crisis but lack accessibility and accountability (*Mental Health Advance Directives | Washington State Health Care Authority*, n.d., Swartz & Swanson, 2026).

Cultural Considerations and Lived Experience

Our findings indicate that exposure to SMI and cultural views of SMI prior to engaging in this field professionally have neutral or positive impacts on professionals. No professional reported that their exposure to SMI made them think negatively of individuals with an SMI, but professionals that had lived or personal experience with SMI felt it made them more compassionate and/or informed. Some participants reported a greater devotion to cultural humility and lifelong reflexive learning around SMI- as a result of their previous experience or lack thereof. This supports that lived experience strengthens the behavioral health workforce and professionals should be lifelong students of culturally-informed practices (Seetharaman, Fox, and Millar, 2023, Gottlieb, 2020).

Limited Insight and Co-occurring SUD

The majority of interviewed professionals working in relevant practice settings like forensic inpatient care, assigned counsel, and jail mental health teams reported that most individuals who have received involuntary medication had limited insight (anosognosia) into their mental health situation and/or a co-occurring SUD. Professionals were concerned about the biological interaction between antipsychotics and substances as well as the impact of substance use on outpatient engagement. These findings suggest that the impact of insight and SUD cannot

be separated from this discussion and so it should play a prominent role in any future legislative discussion on involuntary medication in OCRP.

Sell Hearing Case Study: Effects of Forced Medication Findings

Given that trauma may incur from forcibly administering medications and includes denial of individual rights, this study's findings suggest that implicit harm may occur for both clients and professionals, regardless of the purpose of the involuntary medication. Lacasse et al. (2015) recommends recovery-oriented inclusion of client's voices in psychiatric medication prescribing while challenging the portrayals of client experiences and funding ethics in previously established research. It's important to note that a professional and client's perspective of the same event will naturally differ as explored by Haglund et al. (2003). Vicarious trauma, repeated exposure to another's trauma, is acknowledged throughout literature but underresearched in forensic social work (Pirelli et al., 2020, Wiltsie et al., 2025).

The primary researcher's shadowing experience of the Sell hearing supports the participants reports of internal policies around forced medication. Clients are reportedly likely to agree to a medication when presented with staff capable of restraining them and this effect is used in practice. However, only a quarter of the professionals interviewed discussed this population's vulnerability to coercion. Our study found that any discussion around coercion only occurred in conversation around initial consent to treatment and decompensation response; indicating that professionals may not consider power differentials throughout an individual's interaction with the behavioral health and justice systems. A researcher of lived experiences of forced medication calls for an "epistemological shift towards rights-based, relational, and trauma-informed care surrounding medication use" (Abdulhussein, 2025). The Power Threat Meaning Framework (PTMF) used by the quoted researcher was developed as an alternative to

psychiatric diagnosis and considers context, sociocultural factors, meaning made, and perceived threat within a narrative framework. It is intended to step-away from the medical model of mental health and towards strengths-based approaches. PTMF has offers this lens of forced medication "(PTMF) narratives reflect the complex and non-binary nature of coercion, where perceived therapeutic benefit can coexist with psychological harm and loss of trust" (Atkinson, Nathan, and Sukhera, 2025). This radical acceptance of the ethical greyness of involuntary treatment and medication may be beneficial to both clients and professionals.

Limitations

Limitations of this research include the range of perspectives not captured in the sample, the sample size itself, and the timeframe of the project. Within the scope of convenient, purposive sampling, the lead researcher was unable to recruit participants who had experience with the Department of Corrections, Probation/Pretrial, emergency department social work, short-term stabilization facilities, AOT, FPATH, and all OCRP contractors. The sample size is unable to provide nuanced analysis of subgroups, which limits depth and scope of perspectives. As stated previously, these data may lack replicability because the research is interpretive and did not attempt to create explanatory claims as it is descriptive. A larger sample size and potential follow-up interviews may have been possible with a longer study period. This study was also unfunded, which may have limited engagement in recruitment. The study sample and methods are limited to Washington State practice. Though limited in scope, this is the first known study to examine professional attitudes towards forced medications within competency restoration in the state of Washington. Further, prior research has not explored professional cultural and lived experiences in relationship to these issues. Further research is needed into the perspectives of professions both represented and not represented in the sample. A greater

diversity of demographics, especially Indigenous perspectives, which are severely lacking, is essential to better understand the relationship between culture and practice in this field. The relationships between SUD and mental health insight and involuntary medication should be researched further in the context of outpatient competency restoration. A larger sample to examine the relationship between lived/familial experience with SMI and opinion on involuntary medication is recommended. While the study intent and methods are limited to Washington State's OCRP, the principles of forensic mental health and ethical neglect in Sell extend beyond the state's borders. Study into the replicability of Trueblood programs to address houselessness and peer support in outpatient competency restoration in other states may be beneficial.

Conclusion: "Framed for State Interest"

The greatest tension in this project has been the nature of competency restoration centering the outcome of a criminal case rather than the wellness of the individual and the burden carried by antipsychotic medications in that effort. As one professional stated, client wellness would have to be "framed for State interest" if it is going to be effectively and sustainably addressed in competency restoration. With ongoing legislative effort and program development in this field, this research recommends attention to person-centered assessment and intervention planning, development of comprehensive, accessible mental health care in jails, and crisis interventions that account for anosognosia and co-occurring SUD. Simultaneously, it is imperative that the cultural background and perspectives of both the professionals and clients working our systems are centered in the care we have the potential to provide.

References

Abdulhussein, M. (2025). The Subjective Experience of Forced Psychiatric Medication: A scoping review interpreted through the Power Threat Meaning Framework. *Journal of Humanistic Psychology*. https://doi.org/10.1177/00221678251396670

APA Dictionary of Psychology. (n.d.). https://dictionary.apa.org/decompensation

Arroyo, M. C. (2020). Involuntary outpatient treatment: the ethical implications. *Revista Española De Sanidad Penitenciaria*, *22*(1), 6–8. https://doi.org/10.18176/resp.0001

Baldessarini, R. J. (1995). Neuroleptic withdrawal in schizophrenic patients. *Archives of General Psychiatry*, *52*(3), 189. https://doi.org/10.1001/archpsyc.1995.03950150021002

Becker, T., Harrison, P., He, L., Henzel, P., Mancuso, D., Huber, A., & Felver, B. (2024). *The Impact of Forensic Housing and Recovery through Peer Services (FHARPS) on homelessness and housing support Access – an outcome evaluation*. Washington State Department of Social and Health Services. https://www.dshs.wa.gov/ffa/rda/research-reports/impact-forensic-housing-and-recovery-through-peer-services-fharps-homelessness-and-housing-support-access-%E2%80%93-outcome-evaluation

Bashir, N., Donti, P., Cuff, J., Sroka, S., Ilic, M., Sze, V., Delimitrou, C., & Olivetti, E. (2024). The Climate and Sustainability Implications of Generative AI. An MIT Exploration of Generative AI. https://doi.org/10.21428/e4baedd9.9070dfe7

Behavioral Health Disorders, RCW § 71.05 (n.d.). https://app.leg.wa.gov/rcw/default.aspx?cite=71.05

Conley, R. R., & Kelly, D. L. (2001). Management of treatment resistance in schizophrenia. *Biological Psychiatry*, *50*(11), 898–911. https://doi.org/10.1016/s0006-3223(01)01271-9

Competency Restoration, A guide to Competency Evaluation and restoration (DSHS 22-1837). (2024). Washington State Department of Social and Health Services. https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/24-1007-BHA-Comp-Restoration-Booklet22-1837v2.pdf

Criminally Insane—Procedures, RCW § 10.77 (n.d.). https://app.leg.wa.gov/RCW/default.aspx?cite=10.77

David Luxton, Berger, M., Yocum, R., Ronnei, M., Zolnikov, B., Golding, S., Kinlen, T., Means, J., Montaldi, D., & Strandquist, R. (2019). *Forensic Evaluation Report Guidelines: Competency to stand trial*. Washington State Department of Social and Health Services. https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/OFMHS-MAN-012-Forensic-Evaluation-Report-Guidelines-Competency-to-Stand-Trial-04SEPT2019.pdf

Davison, R. M., Chughtai, H., Nielsen, P., Marabelli, M., Iannacci, F., Van Offenbeek, M., Tarafdar, M., Trenz, M., Techatassanasoontorn, A. A., Andrade, A. D., & Panteli, N. (2024). The ethics of using generative AI for qualitative data analysis. Information Systems Journal, 34(5), 1433–1439. https://doi.org/10.1111/isj.12504

Demke, E. (2022). The Vulnerability-Stress-Model—Holding up the construct of the faulty individual in the light of challenges to the medical model of mental distress. *Frontiers in Sociology*, *7*, 833987. https://doi.org/10.3389/fsoc.2022.833987

Designated crisis responders (DCR) | Washington State Health Care Authority. (n.d.). https://www.hca.wa.gov/billers-providers-partners/program-information-providers/designated-crisis-responders-dcr

Dusky v. United States, 362 U.S. 402 (1960)

Etheridge, A. U., & Chamberlain, J. R. (2006, June 1). *Application of Sell v. United States*. Journal of the American Academy of Psychiatry and the Law. https://jaapl.org/content/34/2/248

Faizi, A., McDermott, B. E., & Warburton, K. (2025). Do antipsychotic medications work: An exploration using competency to stand trial as the functional outcome. *CNS Spectrums*, *30*(1), e29. https://doi.org/10.1017/s1092852924002372

Falkai, P., Wobrock, T., Lieberman, J., Glenthoj, B., Gattaz, W. F., Möller, H., Guide, W. T. F. O. T., Falkai, P., Wobrock, T., Lieberman, J., Glenthoj, B., Gattaz, W. F., Möller, H., & Guide, W. T. F. O. T. (2006). World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 2: Long-term treatment of schizophrenia. *The World Journal of Biological Psychiatry*, *7*(1), 5–40. https://doi.org/10.1080/15622970500483177

Fang, S., Liao, D., Huang, C., Hsu, C., Cheng, S., & Shao, Y. J. (2020). The effectiveness of long-acting injectable antipsychotics versus oral antipsychotics in the maintenance treatment of outpatients with chronic schizophrenia. *Human Psychopharmacology Clinical and Experimental*, *35*(3), e2729. https://doi.org/10.1002/hup.2729

Gitlin, M., Nuechterlein, K., Subotnik, K. L., Ventura, J., Mintz, J., Fogelson, D. L., Bartzokis, G., & Aravagiri, M. (2001). Clinical outcome following neuroleptic discontinuation in patients with Remitted Recent-Onset schizophrenia. *American Journal of Psychiatry*, *158*(11), 1835–1842. https://doi.org/10.1176/appi.ajp.158.11.1835

Gleyzer, R., Felthous, A. R., & Holzer, C. E. (2002). Animal cruelty and psychiatric disorders. In J Am Acad Psychiatry Law, *J Am Acad Psychiatry Law* (Vol. 30, pp. 257–265). https://r.jordan.im/download/psychology/gleyzer2002.pdf

Goff, D. C., Falkai, P., Fleischhacker, W. W., Girgis, R. R., Kahn, R. M., Uchida, H., Zhao, J., & Lieberman, J. A. (2017). The Long-Term Effects of Antipsychotic Medication on Clinical Course in Schizophrenia. *American Journal of Psychiatry*, *174*(9), 840–849. https://doi.org/10.1176/appi.ajp.2017.16091016

Gottlieb, M. (2021). The Case for a Cultural Humility Framework in Social Work Practice. *Journal of Ethnic & Cultural Diversity in Social Work*, *30*(6), 463–481. https://doi.org/10.1080/15313204.2020.1753615

Gowensmith, W. N., Frost, L. E., Speelman, D. W., & Therson, D. E. (2016). Lookin' for beds in all the wrong places: Outpatient competency restoration as a promising approach to modern challenges. *Psychology Public Policy and Law*, *22*(3), 293–305. https://doi.org/10.1037/law0000088

Haglund, K., Von Knorring, L., & Von Essen, L. (2003). Forced medication in psychiatric care: patient experiences and nurse perceptions. *Journal of Psychiatric and Mental Health Nursing*, *10*(1), 65–72. https://doi.org/10.1046/j.1365-2850.2003.00555.x

Hays, P. A. (2001). Entering another's world: Understanding clients' identities and contexts. In *American Psychological Association eBooks* (pp. 55–69). https://doi.org/10.1037/10411-004

Health Care Authority. (2021). *Request for Information (RFI) Outpatient Competency Restoration Program (OCRP)* (RFI NO. 2021HCA6). https://www.hca.wa.gov/assets/program/RFI%202021HCA6%20-%20OCRP.pdf

H.B. 1218, 2025-2026 Reg. Sess. (Wash. 2015) https://app.leg.wa.gov/billsummary/?billnumber=1218&year=2025#documentSection

H.B. 1359, 2025-2026 Reg. Sess. (Wash. 2015) https://app.leg.wa.gov/billsummary?BillNumber=1359&Initiative=False&Year=2025

Holoyda, B. J. (2018). Animal maltreatment law: Evolving efforts to protect animals and their forensic mental health implications. *Behavioral Sciences & the Law*, *36*(6), 675–686. https://doi.org/10.1002/bsl.2367

Ladds, B., Convit, A., Zito, J., & Vitrai, J. (1993). The disposition of criminal charges after involuntary medication to restore competency to stand trial. *Journal of Forensic Sciences*, *38*(6), 1442–1459. https://doi.org/10.1520/jfs13550j

Lehman, A. F., Lieberman, J. A., Dixon, L. B., McGlashan, T. H., Miller, A. L., Perkins, D. O., WORK GROUP ON SCHIZOPHRENIA, Kreyenbuhl, J., American Psychiatric Association, McIntyre, J. S., Charles, S. C., Anzia, D. J., Cook, I. A., Finnerty, M. T., Johnson, B. R., Nininger, J. E., Summergrad, P., Woods, S. M., & Yager, J. (2010). *Practice Guideline for the treatment of Patients with Schizophrenia* (By R. Pyles, C. D. Cross, R. Peele, J. P. D. Shemo, L. Lurie, R. D. Walker, M. A. Barnovitz, S. H. Gray, S. Saxena, T. Tonnu, R. Kunkle, A. B. Albert, L. J. Fochtmann, American Psychiatric Association, C. Hart, & D. A. Regier). https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia.pdf

Leucht, S., Priller, J., & Davis, J. M. (2024). Antipsychotic Drugs: A concise review of history, classification, indications, mechanism, efficacy, side effects, dosing, and clinical application. *American Journal of Psychiatry*, *181*(10), 865–878. https://doi.org/10.1176/appi.ajp.20240738

Meghan DeGallier. (2020). *Program of Assertive Community Treatment (PACT)*. https://www.hca.wa.gov/assets/program/fact-sheet-programs-assertive-community-treatment.pdf

Mental health advance directives | Washington State Health Care Authority. (n.d.). https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/mental-health-advance-directives

Moncrieff, J. (2006). Why is it so difficult to stop psychiatric drug treatment? *Medical Hypotheses*, *67*(3), 517–523. https://doi.org/10.1016/j.mehy.2006.03.009

Muench, J., & Hamer, A. M. (2010, March 1). *Adverse effects of antipsychotic medications*. AAFP. https://www.aafp.org/pubs/afp/issues/2010/0301/p617.html?

Office of Forensic Mental Health Services. (2019). *Breaking Barriers Patient Workbook*. https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/OFMHS-MAN-004%20Breaking%20Barriers%20C%20O%20R%20E%20Patient%20Workbook_Large%20Print_Rev-1%2028JAN2021.docx

Office of Forensic Mental Health Services. (2025). *Cassie Cordell Trueblood, et al., v. Washington State Department of Social and Health Services, et al. Semi-Annual Report 12*. Washington State Department of Social and Health Services. https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2025-09-Semi-Annual-Report.pdf

Office of Forensic Mental Health Services. (2026). *Cassie Cordell Trueblood, et al., v. Washington State Department of Social and HealthServices, et al. Monthly report to the court appointed monitor*. Washington State Department of Social and Health Services.

https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2026Trueblood/Trueblood-Report-2026-01.pdf

Ogunwale, A., Ndegwa, D., & Shepherd, S. (2021). Cross-cultural sensitivity in forensic mental health care. In *The Handbook of Forensic Mental Health in Africa* (pp. 11–35). https://doi.org/10.4324/9781003024354-2-3

Pakpoor, J. A., & Agius, M. (2014, November 1). *A review of the adverse side effects associated with antipsychotics as related to their efficacy*. PubMed. https://pubmed.ncbi.nlm.nih.gov/25413553/

Pate v. Robinson, 383 U.S. 375 (1966)

Pirelli, G., Formon, D. L., & Maloney, K. (2020). Preventing vicarious trauma (VT), compassion fatigue (CF), and burnout (BO) in forensic mental health: Forensic psychology as exemplar. *Professional Psychology Research and Practice*, *51*(5), 454–466. https://doi.org/10.1037/pro0000293

Rudnick, A., & Lundberg, E. (2012). The Stress-Vulnerability Model of Schizophrenia: A Conceptual Analysis and Selective review. *Current Psychiatry Reviews*, *8*(4), 337–341. https://doi.org/10.2174/157340012803520450

Sampogna, G., Di Vincenzo, M., Giuliani, L., Menculini, G., Mancuso, E., Arsenio, E., Cipolla, S., Della Rocca, B., Martiadis, V., Signorelli, M. S., & Fiorillo, A. (2023). A Systematic Review on the Effectiveness of Antipsychotic Drugs on the Quality of Life of Patients with Schizophrenia. *Brain Sciences*, *13*(11), 1577. https://doi.org/10.3390/brainsci13111577

Seetharaman, R. B., Fox, J., & Millar, G. (2025). Exploring the Impact of Lived Experience Contributions to Social Work and Healthcare Programmes: A Scoping Review. *Social Sciences*, *14*(6), 367. https://doi.org/10.3390/socsci14060367

Single, G. (2004). United States v. Sell: Involuntary Administration of Antipsychotic Medication - Are You Dangerous or Not. *Cleveland State University Journal of Law and Health*, *18*(2), 297–321. https://engagedscholarship.csuohio.edu/jlh/vol18/iss2/7/

Sohler, N., Adams, B. G., Barnes, D. M., Cohen, G. H., Prins, S. J., & Schwartz, S. (2015). Weighing the evidence for harm from long-term treatment with antipsychotic medications: A systematic review. *American Journal of Orthopsychiatry*, *86*(5), 477–485. https://doi.org/10.1037/ort0000106

Swartz, M. S., Swanson, J. W., Wagner, H. R., Burns, B. J., & Hiday, V. A. (2001). Effects of Involuntary Outpatient Commitment and Depot Antipsychotics on Treatment Adherence in Persons with Severe Mental Illness. *The Journal of Nervous and Mental Disease*, *189*(9), 583–592. https://doi.org/10.1097/00005053-200109000-00003

Swartz, M. S., & Swanson, J. W. (2026). Psychiatric advance directives: challenges emerging from implementation and possible steps forward. *World Psychiatry*, *25*(1), 145–146. https://doi.org/10.1002/wps.70037

Trueblood et al v. Washington State DSHS | DSHS. (n.d.). https://www.dshs.wa.gov/bha/trueblood-et-al-v-washington-state-dshs

Willner, K., Vasan, S., Patel, P., & Abdijadid, S. (2024, May 1). *Atypical antipsychotic agents*. StatPearls - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/sites/books/NBK448156/

Wiltsie K, Jackson C, Kanani H, Grisamore S, DeMatteo D. Vicarious trauma among forensic psychologists. J Forensic Sci. 2026;71:120–131. https://doi.org/10.1111/1556-4029.70242

Whitaker, R. (2003). The case against antipsychotic drugs: a 50-year record of doing more harm than good. *Medical Hypotheses*, *62*(1), 5–13. https://doi.org/10.1016/s0306-9877(03)00293-7