Implementation of Washington's Dangerous Mentally Ill Offender Law:
Preliminary Findings

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EXECUTIVE SUMMARY

In 1999, the Legislature enacted SSB 5011[1] to improve the process of identifying and providing additional mental health treatment for mentally ill offenders being released from the Department of Corrections (DOC) who pose a threat to public safety. A "Dangerous Mentally Ill Offender" (DMIO) is identified in the legislation as a person who has a mental disorder and has been determined to be dangerous to himself, herself, or others.

The legislation directed:

- DOC to identify DMIOs by using research-based factors that are linked with an increased risk of dangerousness, including an offender's chemical dependency or abuse;
- DOC, the Department of Social and Health Services (DSHS), the Regional Support Networks (RSN), and treatment providers to develop a plan for delivery of support services and treatment for the offender upon release (the "planning team");
- The planning team to recommend evaluation by a Community Designated Mental Health Professional (CDMHP) for involuntary civil commitment, DOC supervised community treatment, or voluntary community mental health or chemical dependency/abuse treatment;
- DOC and DSHS to develop rules and agreements to facilitate Medicaid eligibility decisions prior to release;
- DSHS to contract for DMIO case management and other services with RSNs or any other qualified and appropriate entities; and
- The Washington State Institute for Public Policy, in conjunction with the Washington Institute for Mental Illness Research and Training, to conduct an evaluation of SSB 5011 (the Act) to determine:
  - If there is a reduction in criminal recidivism or inpatient hospitalization;
  - Whether there are increases in and improvement of delivery and effectiveness of mental health, drug/alcohol, case management, housing assistance, and other services;
  - The validity of the risk assessment tool used to assess dangerousness;
  - If there are any cost savings due to early Medicaid enrollment or reduced use of DOC bed spaces.

This report provides a description of the research completed to date and focuses on the implementation of the Act in substantial detail. We assess how the process of defining, identifying, and selecting DMIOs has been carried out, and we describe the treatment and services provided to an early group of released DMIOs. Whenever possible, we compare DMIOs to mentally ill offenders (MIOs) released from prison in 1996 and 1997 (the Community Transition Study or CTS), who form the comparison group from which we will ultimately evaluate the effectiveness of the DMIO legislation.

[1] Chapter 214, Laws of 1999.

Findings

Identifying and Selecting DMIOs

The process of defining, identifying, and selecting "dangerous mentally ill offenders" for the program is a critical first step in implementing the Act. Our findings indicate that the systematic identification and selection of DMIOs is not proceeding as planned, although there are ongoing efforts to improve the process.

The identification and selection process was originally envisioned as a rigorous and scientific process, involving clear definitions of what constitutes "mental disorder" and "dangerousness," a formal assessment and selection process, the use of empirically based risk assessment instruments, and final review by a statewide committee.

The uneven quality of DOC and other mental illness documentation has caused difficulties in identifying mentally ill offenders in prison. It has also proven to be an obstacle for the statewide review committee, which must make decisions based on existing documentation. In addition, formalized methods for decision-making and documenting decisions are lacking. There has not been a clear consensus on the definitions of mental disorder and dangerousness, and there is little evidence to suggest that research-based risk assessment instruments are used in the decision-making processes. We provide suggestions for the improvement of this process in Section VI.

Treating DMIOs—Insurance Liability

The second implementation problem is an insurance crisis involving the question of the burden of DMIO liability. Insurers have informed RSNs and community treatment providers that if they continue to serve the DMIO program, their insurance will be canceled. In the case of community providers, their major insurer is withdrawing from the behavioral health provider and physician market. Thus, most community providers will be searching for a new insurer. Eight of the 14 RSNs have not signed or have already withdrawn from the DSHS Mental Health Division (MHD) DMIO contract. While the MHD is attempting to contract with a community mental health provider to serve DMIO clients in affected regions, it is a time-consuming endeavor and has not been successful in all cases. This is an issue that needs to be discussed among all parties and resolved quickly.

Treating DMIOs—Mental Health and Drug and Alcohol Services

Our analyses indicate that DMIOs are generally comparable to the CTS subjects; this ensures the development of a reasonable comparison group for evaluation purposes. We have collected DOC, MHD, and Division of Alcohol and Substance Abuse (DASA) data on the first 36 DMIO participants released from confinement. The results show that the DMIO program is making a dramatic improvement in providing pre- and post-release mental health and post-release chemical dependency services to offenders.

Pre-Release "Transitional" Mental Health Services

- *83 percent* of DMIO program participants have received "pre-release" mental health services from community providers compared with *10 percent* of the CTS offenders.

- The 83 percent of DMIO program participants receiving pre-release mental health services averaged *7.3 hours* per service month, while the 10 percent of CTS offenders receiving services averaged only *2.5 hours* per service month.

Post-Release Mental Health Services

- *94 percent* of DMIO program participants received community mental health services in the first three months "post-release" compared with *29 percent* of CTS offenders.
- The DMIO program participants receiving services in the first three months post-release averaged *11.8 hours* of services per month, while the 29 percent of CTS offenders receiving services averaged *4.7 hours* of services per month.

Post-Release Drug and Alcohol Services

- *45 percent* of DMIO program participants received drug and alcohol services post-release compared with *25 percent* of CTS offenders.

It is too early to tell whether these services result in reduced criminal recidivism. That will be the focus of our comparative research study, due to the Legislature in 2004. In the meantime, we are continuing to follow program implementation and will report to the Legislature on its progress. In December 2002, we will also provide the Legislature with updated findings on services and treatment provided to DMIOs.

Recommendations

- Insurance liability issues undermine the intent and implementation of SSB 5011. These problems are severe and need to be resolved immediately to prevent program failure.

- DOC needs to improve its ability to identify mentally ill inmates. As part of this process, DOC needs to establish and maintain more detailed electronic mental health records.

- DOC needs to adopt standardized methods to assess the dangerousness risk of mentally ill offenders.

- The DMIO selection process needs to be conducted in two stages: first, decide whether an offender suffers from a qualifying mental disorder, and then determine the offender's risk for future dangerousness. DOC and committee processes on these two matters need to be formalized, and decisions need to be well documented in an electronic database for both rejected and accepted cases.

I. BACKGROUND

Few states have procedures in place to identify and treat mentally ill offenders being released from prison confinement. This population, many of whom have co-existing substance abuse and dependence problems, are of great concern to society.

In 1999, the Washington State Legislature passed Substitute Senate Bill 5011 (SSB 5011),[2] which requires improving the process of identifying and providing additional mental health treatment for mentally ill offenders being released from the Department of Corrections (DOC) who pose a threat to public safety. A "Dangerous Mentally Ill Offender" (DMIO) is identified in the legislation as a person who has a mental disorder and has been determined to be dangerous to himself, herself, or others.

A legislative subcommittee was created in 1998 to address issues surrounding mentally ill offenders being released from prison into the community. Public meetings of this subcommittee provided a forum for state and local policymakers, as well as mental health, corrections, and law enforcement representatives to discuss the issues and investigate solutions. Many topics were raised: identification of and treatment for mentally ill offenders who pose serious safety risks; offender supervision, including apprehension of those who violate supervision conditions; coordination of services between DOC and the Department of Social and Health Services (DSHS); and barriers to information sharing between agencies.

A major goal of the subcommittee was to weigh the costs and benefits of alternative approaches to supervision and treatment of this population and develop appropriate legislation.

SSB 5011 mandates the following:

- DOC to identify DMIOs using behavior known to DOC and research-based factors that are linked with an increased risk of dangerousness, including an offender's chemical dependency or abuse;
- The development of a plan for delivery of support services and treatment for the offender upon release by a planning team composed of representatives from DOC, DSHS, the Regional Support Networks (RSN), and treatment providers;
- The planning team to recommend:
  - Evaluation of DMIOs by a county-designated mental health professional for involuntary mental health commitment;
  - DOC-supervised community treatment; or
  - Voluntary community mental health or chemical dependency or abuse treatment;

[2] Enacted May 17, 1999, Chapter 214, Laws of 1999.

- DOC and DSHS to develop rules and agreements to facilitate Medicaid eligibility decisions prior to release;
- DSHS to contract for DMIO case management and other services with RSNs or any other qualified and appropriate entities; and
- The Washington State Institute for Public Policy (Institute), in conjunction with the University of Washington's Washington Institute for Mental Illness Research and Training (WIMIRT), to conduct an evaluation of SSB 5011.

The 1999–2000 biennial budget appropriated $1,676,000 to DSHS and $235,000 to DOC to implement SSB 5011. Most sections of the Act went into effect March 15, 2000.

This interim report to the Legislature describes the research evaluation being conducted by the Institute and WIMIRT and includes descriptive statistics on offenders reviewed for, selected into, and served through the DMIO program.

- Section II outlines the legislative research questions and how they are being addressed.
- Section III explains the procedures being used to identify and review offenders for the program and provides summary statistics on the statewide review committee process.
- Section IV describes offenders who have been reviewed and selected for the DMIO program from April 2000 through August 2001.
- Section V provides a description of the service program and treatment provided to offenders who were released from prison between September 2000 and June 2001.
- Section VI details challenges facing the DMIO program and discusses potential solutions to current weaknesses.
- Agency responses (DSHS and DOC) to the report recommendations are included in Appendix G.

II. LEGISLATIVE QUESTIONS AND RESEARCH DESIGN

Legislative Questions

In Section 10 of SSB 5011, the Legislature set out specific questions for the evaluation to determine the effectiveness of the Act. The legislation directed the Institute, in conjunction with the University of Washington, to determine:

(1) Whether there is a reduction in criminal recidivism as a result of this act;

(2) Whether this act has resulted in: (a) Increased treatment of, and services to, dangerous mentally ill offenders, including services at the department of corrections, and through other publicly funded services; (b) a reduction in repeated inpatient mental health treatment by the same offender; and (c) reduced length of stays at state hospitals;

(3) Whether this act improves delivery and effectiveness of the treatment and services, including mental health, drug/alcohol, case management, housing assistance, and other provided services;

(4) Whether services under this act should be expanded to include other classifications of offenders, such as: Juveniles; felons not sentenced to confinement; misdemeanants; and felons in county jails. Cost estimates for expansion of each classification shall be included;

(5) The validity of the risk assessment tool utilized by the department of corrections to assess dangerousness of offenders;

(6) Increases in early Medicaid enrollment and associated cost savings; and

(7) Any savings in bed spaces in the department of corrections as a result of this act.

Research Design

The evaluation questions cover a large number of important issues and topics. As a result, four studies have been designed to answer the legislative questions: comparative, descriptive, cost-benefit, and risk tool validation studies.

Comparative Study

The focus of the comparative study is to answer legislative questions on whether the DMIO "treatment" as implemented makes a difference in pre- and post-release services and recidivism outcomes for DMIOs. These questions are best addressed by comparing outcomes of a group of individuals who have participated in the program with an equivalent group who have not participated. An earlier study conducted by WIMIRT, the Community Transition Study or CTS (Lovell et al., 2001), of all mentally ill offenders (MIOs) released from Washington State prisons in 1996 and 1997 will provide the pool of offenders from which a matched comparison group will be selected.

The comparative study addresses those legislative questions that entail comparisons of DMIOs with other MIOs in terms of demographic characteristics, history, services provided and accessed, and criminal and psychiatric outcomes (covering questions 1, 2, 6, and 7 above). The study also examines important outcome-related, pre-existing differences in demographic and criminal, psychiatric, and correctional history between DMIOs and the CTS subjects.

The comparative study relies on existing state administrative records, including mental health, economic services, chemical dependency, and criminal justice, as sources of data on services and outcomes. The statistical analysis attempts to control for effects of pre-existing differences between groups by matching subjects, using multivariate analytical techniques, and determining the degree of selection bias. The analyses of outcomes are conducted using tests of significance, logistic regression, and survival analysis.

Descriptive Study

The descriptive study addresses those legislative questions about the quantity and quality of pre-release and post-release services that DMIOs receive, most specifically, legislative question 3. For this study, we are gathering data on a number of pre- and post-release variables that were not collected for the comparison group. Data are being collected directly from case managers through a monthly questionnaire and from institutional and community corrections officers through detailed notes that they enter into the DOC Offender Based Tracking System (OBTS) electronic database.

The data collected for this study will be used to generate descriptive statistics that characterize the kind of pre- and post-release services received by DMIOs, as well as the qualitative experiences of DMIOs and their service providers and correctional supervisors. If sample size permits, a multivariate analysis will be conducted of the relationship of the qualitative variables to recidivism outcomes, such as whether an offender was or was not hospitalized or re-incarcerated.

Cost-Benefit Study

The cost-benefit study focuses on whether SSB 5011 has any effect on benefits such as reduced criminal recidivism. The study addresses questions about the economic impact of SSB 5011 in terms of the benefits to taxpayers and crime victims compared with the taxpayer costs associated with implementing SSB 5011. It will focus on legislative question 4 and attempt to project similarly defined costs and benefits for other categories of offenders (e.g., misdemeanants, city and county jail inmates, juveniles, etc.). This study builds on existing Institute work on program cost-effectiveness for Washington State (Aos et al., 2001).

Risk Tool Validation Study

The risk tool validation study involves legislative question 5 on the validity of the risk assessment tool used by the DOC to assess offender dangerousness. The efficacy of the Level of Services Inventory-Revised (LSI-R) is evaluated. LSI-R is a risk assessment tool that is playing an increasingly greater role in DOC risk decisions for both mentally ill offenders and non-mentally ill offenders (Aos, 2002).

The validity of the LSI-R for MIOs and DMIOs will be studied using traditional psychometric methods. The internal consistency of the instrument will be examined statistically, and a factor analysis and item response analyses will be performed to study the structure and quality of LSI-R subscales and items. The predictive validity of the instrument will be tested through regression and Receiver Operation Characteristic (ROC) analyses.

III. DMIO IDENTIFICATION AND SELECTION PROCESS

The process of defining, identifying, and selecting offenders for the DMIO program is a critical first step in implementing the DMIO legislation. This section describes the identification and selection process, beginning with what was originally proposed through a quality management initiative and what has since been implemented by DOC and by the statewide review committee (SRC). We also provide a description of the SRC candidate review process from April 2000 through August 2001.

Quality Management Initiative

In the fall of 1999, DOC and the Mental Health Division (MHD) of DSHS initiated a quality management initiative to develop implementation strategies for the DMIO legislation. Out of this process, a DMIO Identification Workgroup was formed, whose members included DOC and MHD staff and outside experts in mental illness and risk assessment. This workgroup proposed criteria to identify DMIOs (see Appendix A). The criteria included definitions of mental disorders and developmental disability using DOC or MHD records as the source of data to determine whether an offender meets the definitions.[3] The criteria for dangerousness included an assessment of recidivism risk, violent crimes and infractions, chemical dependency, and involuntary medication history. After identification and screening at DOC using these criteria, candidates were to be presented to the SRC for final determination on program participation and prioritization.

These proposed criteria and the process for identification have proved difficult to implement. This section describes the implementation of the identification and selection processes at DOC during the first and second years of DMIO program operation and includes observations on implementation difficulties. A description of the SRC process over the same time period, including implementation problems, is included.

DOC Identification and Selection Processes

First Year of Program Operation

A small number of mental illness indicators are maintained in the Offender Based Tracking System (OBTS) database, including an assessment of mental illness needs conducted at prison admission, need for psychiatric medication, flag for serious mental illness set by a clinician interview, and International Classification of Diseases psychiatric diagnoses (ICD-9, ninth revision). By June 2000, based on Community Transition Study (CTS) procedures, DOC had developed an electronic program using OBTS-based criteria to identify offenders with a possible mental illness (the "algorithm").[4] This was considered the first stage of identification

[3] A decision on whether an offender has a mental disorder is to be made prior to the decision on whether the offender is dangerous.
[4] See Appendix A, II(a)(i).

for the DMIO program. Approximately 450 candidates within a year of their earned release dates were identified using this method from June 2000 to May 2001.

It was assumed this first stage of identification would produce a large pool of candidates and that further screening for mental disorder would be necessary. There was hope that detailed DOC medication data could be used to narrow the pool further, but those data did not become available in electronic form. In addition, existing OBTS electronic diagnostic data varied in quality. Thus, the next step in determining mental disorder became a manual process of reviewing OBTS chronological notes and DOC paper records. It also involved a time-consuming process of requesting and reviewing DOC institutional and state hospital mental illness paper records.

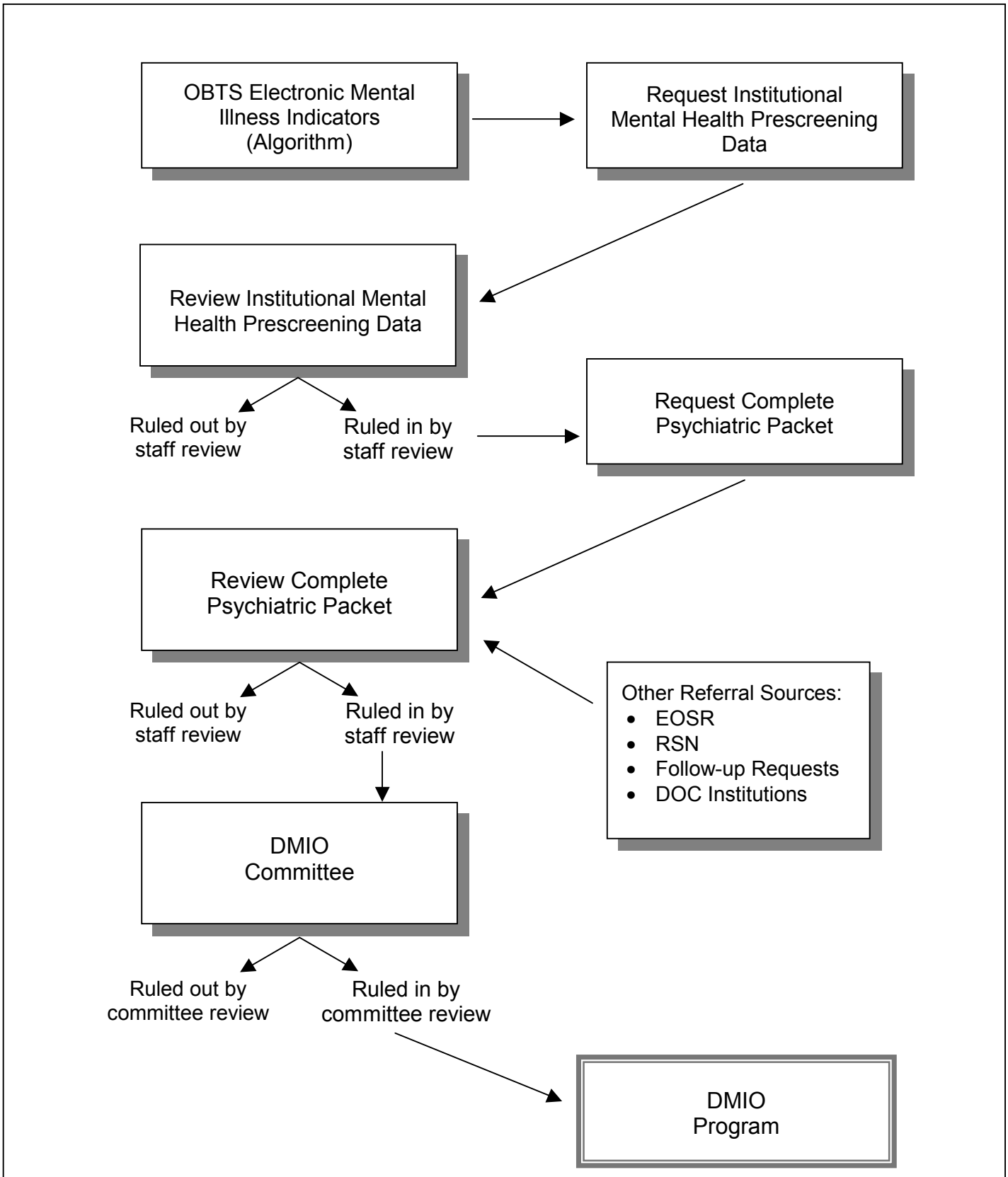
At this time, we know little about the outcomes for the first-year DOC selection process. Although decisions on all candidates identified by the "algorithm" were supposed to be documented, we have found little quantitative data on outcomes for these 450 candidates. This includes whether offenders were reviewed, the extent of the review, and why an offender was cut from or remained in the candidate pool. We found only 18 percent of the 450 candidates with a code recorded in OBTS indicating a referral to and review by the DOC program staff. This included 10 percent who were later reviewed by the SRC. For research purposes, data on the outcomes of these candidates would have been used to model the DOC selection process and to inform the process of selecting equivalent comparison group members. Anecdotally, DOC staff report that cases were cut from the candidate pool on the basis of such factors as: (1) less serious Axis I mental illness diagnoses, (2) lack of history of violence, or (3) insufficient clinical data to warrant a major Axis I disorder.

Second Year of Program Operation

DOC implemented new procedures during the second year of program operation. The results are being documented electronically and should provide a better understanding of the selection process within DOC. Figure 3.1 shows the new procedures operating for offenders with earned release dates beginning in October 2001. The first procedure is the same as described above: the use of the electronic algorithm program based on OBTS criteria to identify offenders with a possible mental illness. Through this program, approximately 775 candidates have been identified with earned release dates between October 2001 and December 2002. Second, DOC staff will request "prescreening" information from DOC institutional mental health representatives on present diagnosis and medications for all candidates identified by the algorithm (see pre-screening form, Appendix B). Third, the institutional information will be reviewed by DOC DMIO staff, and in cases where there is evidence that the candidate may meet the mental disorder and dangerousness criteria, a full psychiatric packet will be requested from the institution and reviewed by staff.[5] Fourth, other groups may refer candidates for the DMIO program, e.g., a Regional Support Network (RSN), a service provider, or the DOC End of Sentence Review Committee. In these cases, a full psychiatric packet will be requested from the institution. Finally, fully screened DMIO candidates will be reviewed by the DMIO SRC.

[5] No scoring or formal assessment process, such as that set out in Appendix A, is utilized in this review process.

Figure 3.1
DMIO Selection Process*
Department of Corrections



WSIPP 2002
** For offenders with early release dates beginning October 2001.*

Statewide Review Committee Selection Process

Committee Review Procedures

After identification and screening by DOC, offenders are reviewed by a statewide review committee (SRC)[6] that meets monthly. DOC provides SRC members a packet of materials on each candidate. After reviewing the materials, the SRC discusses each candidate and votes on whether it judges an offender to have a mental disorder. If an offender is determined to have a mental disorder, the SRC then votes on whether it judges an offender to be dangerous. The SRC defines a mental disorder as any organic, mental, or emotional impairment that has substantial adverse effects on an individual's thinking or decision-making. Criteria for determining whether an offender is dangerous to others include risk scores, criminal history, and other research-based items known to be associated with criminal offending.[7] Full committee definitions for mental disorder and dangerousness criteria are provided in Appendix C.

The packet of materials provided to SRC members includes whatever information is available from DOC or the state hospitals on a candidate's mental illness and criminal history. The extent of this information is variable. In some cases, there is extensive documentation on mental illness, including DOC psychiatric evaluations, current and past medications, and state hospital evaluations. In other cases, mental illness documentation is insufficient. The SRC may request additional documentation, but they are sometimes required to base their decision on limited information if further documentation is unavailable or difficult to access. This variability of information cannot help but contribute to variability in decision-making.

Committee Review Statistics

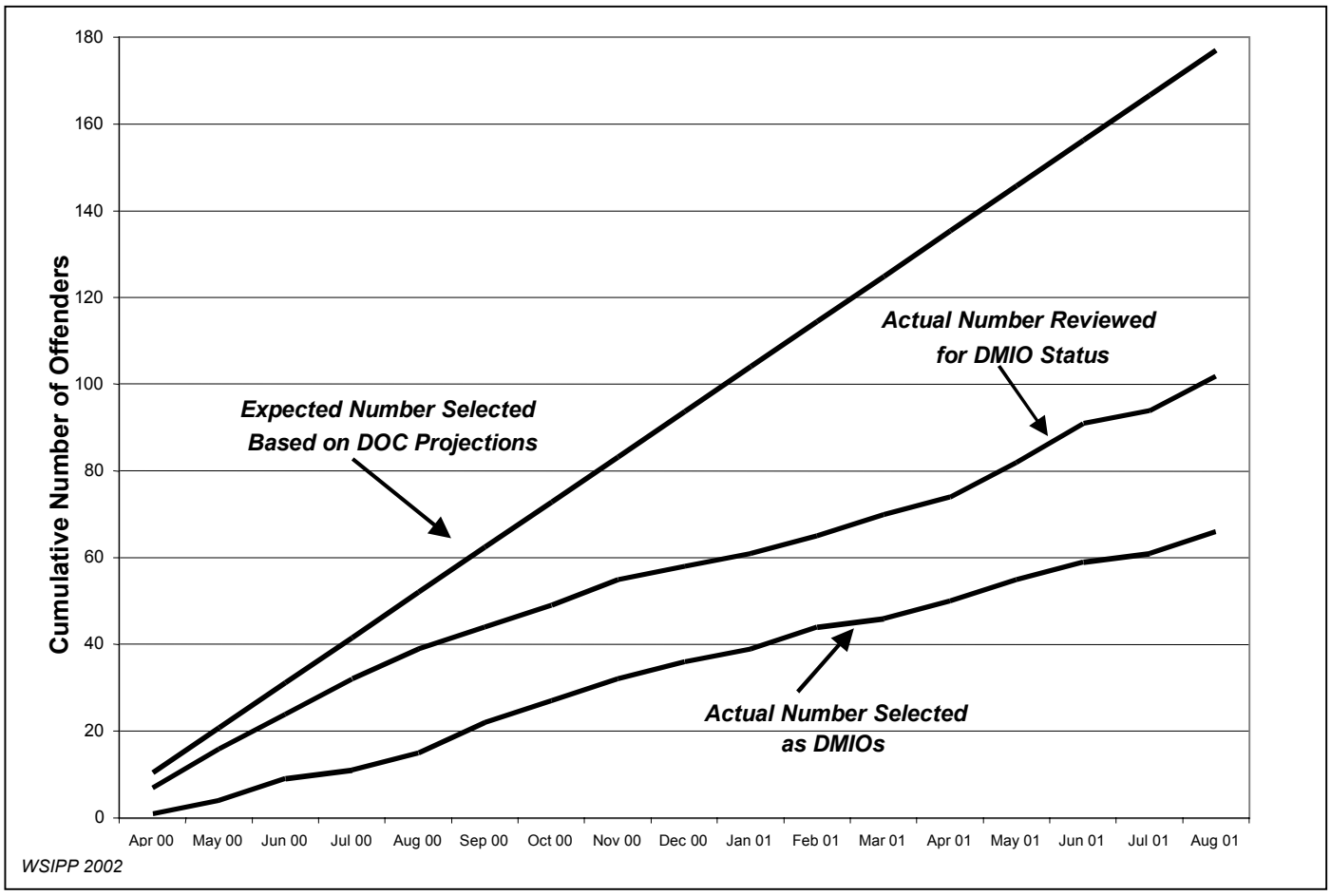
The SRC began reviewing candidates in April 2000. The cumulative number of offenders reviewed by the SRC is shown in Figure 3.2. From April 2000 through August 2001, 102 offenders were reviewed, an average of six per month. The SRC selected 66 offenders into the DMIO program, an average of 3.9 per month.

The estimated program projections are also shown in Figure 3.2. These projections, based on DOC estimates provided to the legislative subcommittee, indicate approximately 125 offenders per year would be selected into the DMIO program, an average of 10.4 offenders per month. The actual number selected has been much lower, less than half the estimated amounts. As Figure 3.2 indicates, as of August 2001, approximately 170 offenders were projected for selection into the DMIO program, compared with 66 offenders actually selected. This small number of program participants poses a research obstacle, as the effect of the program treatment will have to be quite large for such a small population.

[6] The SRC includes 12 representatives: four from DOC (Community Protection Unit, Mental Health Services, Regional Corrections, and one unspecified); three from DSHS (MHD, the Division of Alcohol and Substance Abuse, and the Division of Developmental Disabilities); one from an RSN; one community mental health treatment provider; one county designated mental health professional; one county alcohol and drug coordinator, and one law enforcement representative. Members or alternatives attend the meetings.

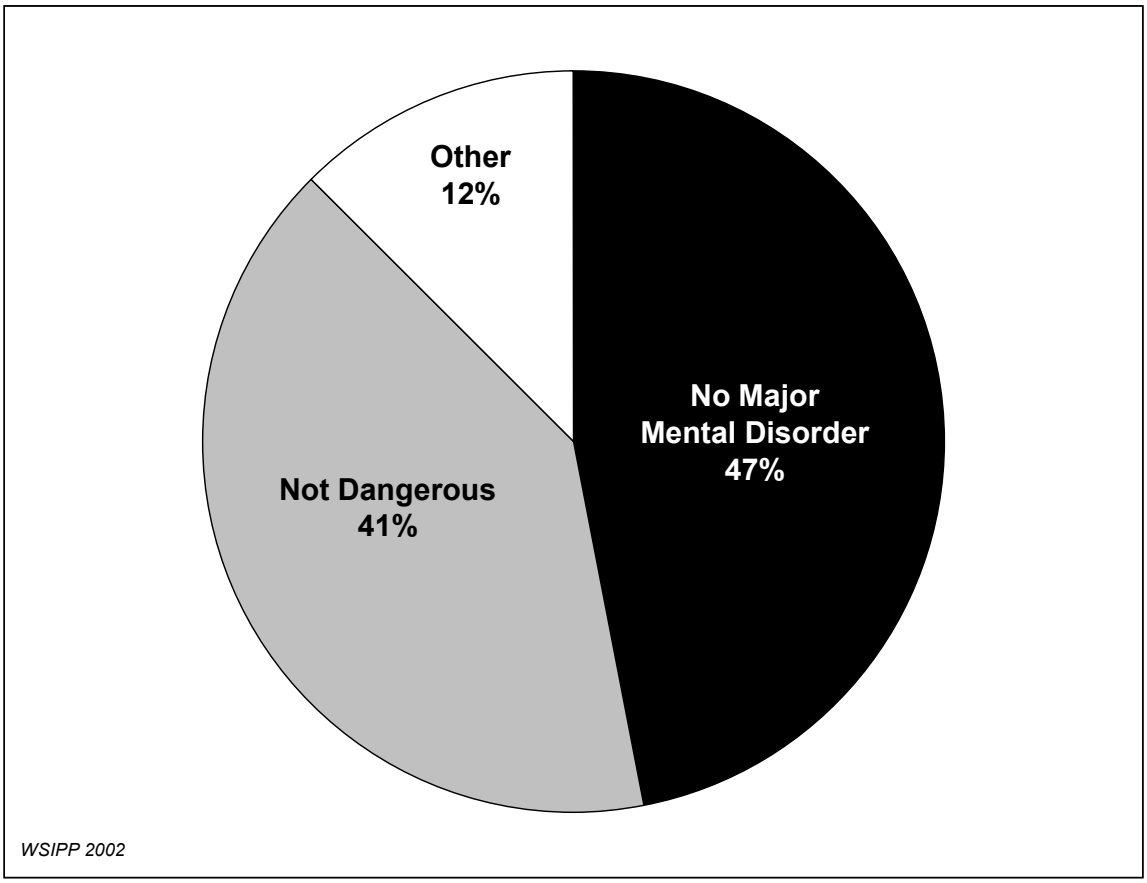
[7] SRC definitions do not include any formal scoring criteria or values/cut-off points for items they consider in determining danger to self or others.

Figure 3.2
DMIO Statewide Committee Review and Selection



As noted, of the 102 offenders reviewed, the SRC selected 66 and rejected 32 for the program and has not made a final decision in four cases. Figure 3.3 shows the SRC's recorded reasons for rejecting the 32 offenders: 47 percent (15 offenders) were rejected because the SRC found no mental disorder, 41 percent (13 offenders) because a mental disorder existed but the offender was not determined to be dangerous, and 12 percent (four offenders) for miscellaneous reasons.

Figure 3.3
Reasons for DMIO Program Rejection, April 2000–August 2001



RSN Assignment and Contract Issues

Offenders selected for the DMIO program are assigned to a mental health Regional Support Network (RSN) based on the expected county of release and other factors. There are 14 RSNs in Washington: Chelan-Douglas, Clark, Grays Harbor, Greater Columbia, King, North Central, North Sound, Northeast, Peninsula, Pierce, Southwest, Spokane, Thurston-Mason, and Timberlands.

Table 3.1 indicates the number and percentage of all DMIO participants assigned to individual RSNs through August 2001, with 11 of the 14 RSNs assigned at least one DMIO program participant. King, Pierce, and North Sound[8] RSNs have been assigned approximately 70 percent of selected DMIOs. As would be expected, King RSN has been assigned the largest number, 24 DMIO participants (36 percent); Pierce has been assigned 13 (20 percent); and North Sound, nine (14 percent). In general, the distribution of DMIO program participants follows the RSN population distribution.

[8] North Sound RSN includes Island, Skagit, Snohomish, and Whatcom Counties.

Table 3.1
Distribution of DMIO Program Participants by Regional Support Network, April 2000–August 2001

Regional Support Network	Number of Offenders	Percent
King	24	36%
Pierce	13	20%
North Sound*	9	14%
Greater Columbia*	5	8%
Thurston-Mason*	4	6%
Spokane*	3	5%
Clark	3	5%
Peninsula*	2	3%
Grays Harbor*	1	2%
North Central*	1	2%
Southwest	1	2%

N = 66
*Indicates RSNs with DMIOs that are not participating in the fiscal year 2001-02 contract.

All of the RSNs, with the exception of Peninsula, signed the MHD contract to serve DMIOs in fiscal year 2000–2001. Kitsap Mental Health agreed to serve DMIOs on a case-by-case basis in the Peninsula region. In fiscal year 2001–02, a number of RSNs did not sign the MHD DMIO contract. The MHD and several RSN representatives have indicated that the decision not to sign was made after the insurer informed covered RSNs that insurance rates would increase if they provided services to this population.[9] The RSNs not signing the contract include Grays Harbor, Greater Columbia, North Central, Northeast, Peninsula, Spokane, and Thurston-Mason. North Sound RSN recently requested to be withdrawn from the contract due to the same issue, and the MHD agreed. In addition, some community mental health providers were notified by their insurance company that contracts would be canceled in 60 days if they served the DMIO population, and contracts would not be renewed at expiration, regardless of whether they served the DMIO population.[10]

The Washington Community Mental Health Council indicates that issues involved in insurance liability coverage at the provider level are broader than DMIO coverage, as the insurer is dropping coverage for all behavioral health providers and physicians.[11] A Washington Casualty Insurance Company representative[12] indicated that the company has decided to concentrate on its core market, hospitals. Based on the company's analysis of exposure, they have determined that the risk is too great to insure most community mental health providers and all physicians. Due to the withdrawal of this company from the behavioral health market, most community mental health providers in the state will need to find a different source of liability insurance coverage.

[9] The insurer of the involved RSNs is the Washington Risk Entity Pool.
[10] The insurer of the community mental health providers is Washington Casualty Insurance Company.
[11] Telephone conversation with Cathy Gaylord, Chief Executive Officer, Washington Community Mental Health Council, 12/4/01.
[12] Telephone conversation with Debra Samples, Washington Casualty Insurance Company, 12/13/01.

In regions where the RSN did not sign the contract, the MHD is attempting to contract with a community mental health provider to serve DMIO clients. This has been accomplished in all but the Spokane and North Sound RSNs. These contractual and insurance liability issues pose a very serious problem for the DMIO program, and a potential public safety threat if DMIOs are refused needed services.[13] For research purposes, we will be able to assess how DMIO services are affected by the contractual changes using state administrative records to track service hours.

Summary

The DMIO identification and selection process used by DOC and the SRC is still a work in progress. Through a DOC/MHD joint quality management initiative, the DMIO Identification Workgroup developed procedures to identify the DMIO population. While the identification process has not proceeded as the workgroup originally envisioned, the task has been more difficult than anticipated, and there is some ongoing effort to work toward more systematic identification and documentation. The system and documentation that has been put into place at DOC in the second program year should provide better information on offenders reviewed for the program and reasons for referral, or lack of referral, to the SRC.

DOC staff struggle with the lack and uneven quality of mental illness data in the identification and selection process. The original assumption that easily accessible data, primarily in electronic format, would be available to identify DMIOs has proven incorrect. In reality, the OBTS database has only a few mental illness indicators, which are of variable quality. Other relevant data, such as DOC clinical records or state hospital and community mental health records, are not accessible electronically. Thus, much of the process of identification has involved manual searches for mental illness information.

The SRC began reviewing offenders for selection into the DMIO program in April 2000. While the SRC is provided with much information, it is of variable quality, contributing to difficult decision-making. As of August 2001, 102 offenders had been reviewed for the program, and 66 had been selected into the program. Based on original DOC estimates, we would have expected 170 offenders to have been selected into the program during this time frame.

Once an offender has been selected into the program, the SRC assigns him or her to an RSN for mental health services. Approximately 70 percent of offenders have been assigned to King, Pierce, or North Sound RSNs; the remaining 30 percent have been assigned to Greater Columbia, Thurston-Mason, Spokane, Clark, Peninsula, Grays Harbor, North Central, and Southwest RSNs. In the second program year, a number of RSNs have not signed the DSHS-MHD DMIO contract because their insurance rates would increase as a result of serving the DMIO population. Some community providers are also facing insurance liability challenges, as their major insurer is permanently leaving the behavioral health provider market.

[13] Program staff report that pre-release services have begun to be affected by these contract issues.

IV. CHARACTERISTICS OF OFFENDERS REVIEWED AND SELECTED FOR THE DMIO PROGRAM

This section presents findings regarding important characteristics of mentally ill offenders (MIOs) presented to the statewide review committee (SRC) who are accepted or rejected for the DMIO program. These two groups (accepted or rejected) are compared with MIOs from the Community Transitions Study (CTS) where possible. It is important to note that these comparisons are limited to those variables that could be collected for both the CTS and DMIO groups. Without exception, these were electronic records items that include basic offender characteristics, such as demographics and criminal history, and few mental health items. Because DOC does not keep electronic clinical records, this limits the ability to contrast these groups in terms of their clinical characteristics.

Variables are grouped together into several classes: demographic variables, mental health indicator variables, index crime, recidivism risk factor variables (as previously determined from the CTS), and summary risk scores from the CTS risk equations and the Level of Services Inventory-Revised (LSI-R). A comparison of MIOs presented to the committee provides information on the *DOC selection process*, while a comparison of MIOs selected versus rejected for the DMIO program provides information on the *SRC process.*

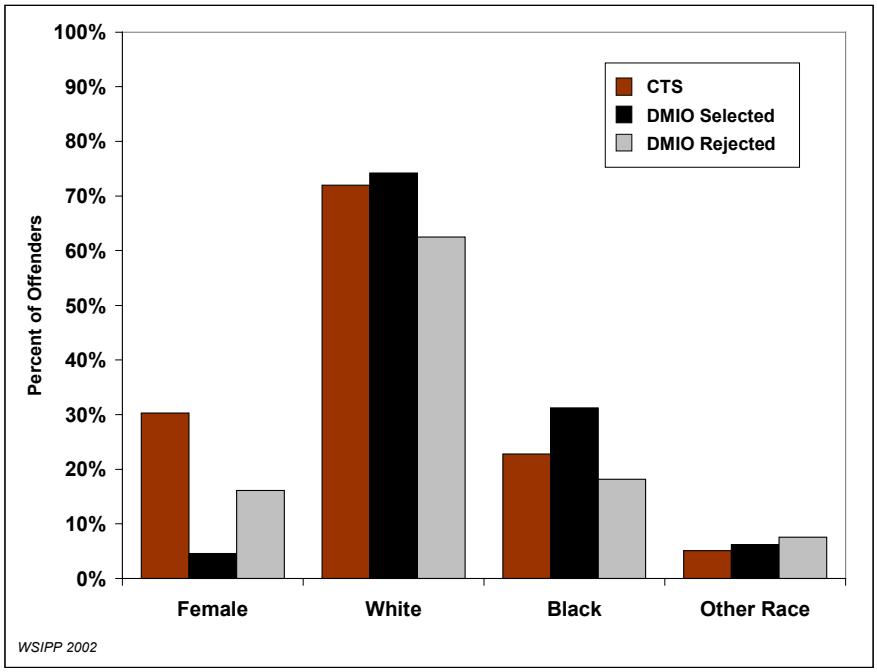
Demographic Comparisons

Figure 4.1 presents a comparison of DMIO selected, DMIO rejected, and CTS subjects.[14] As can be seen by inspecting the figure, there were no significant differences in race. However, there was a highly significant difference in the percentage of women in the three groups. DOC selected fewer women for presentation to the SRC compared with the percentage of women in the CTS population.[15] Of those cases presented to the SRC, women inmates also tended to be underrepresented among those selected for DMIO services, with just 5 percent being selected versus 16 percent that were rejected.[16]

The reasons for the gender differences in DMIO selection are presently unknown, but it is possible that both DOC and the SRC rejected more women than men on the basis of the prevalence of less serious Axis I diagnoses among women (e.g., mood disorders as opposed to psychotic disorders). It is also possible that women were less often selected due to beliefs that they are less dangerous than men, a fact that is supported by the empirical literature and which is, in part, supported by findings from the CTS, which showed that female gender is a relative protective factor for violent recidivism.

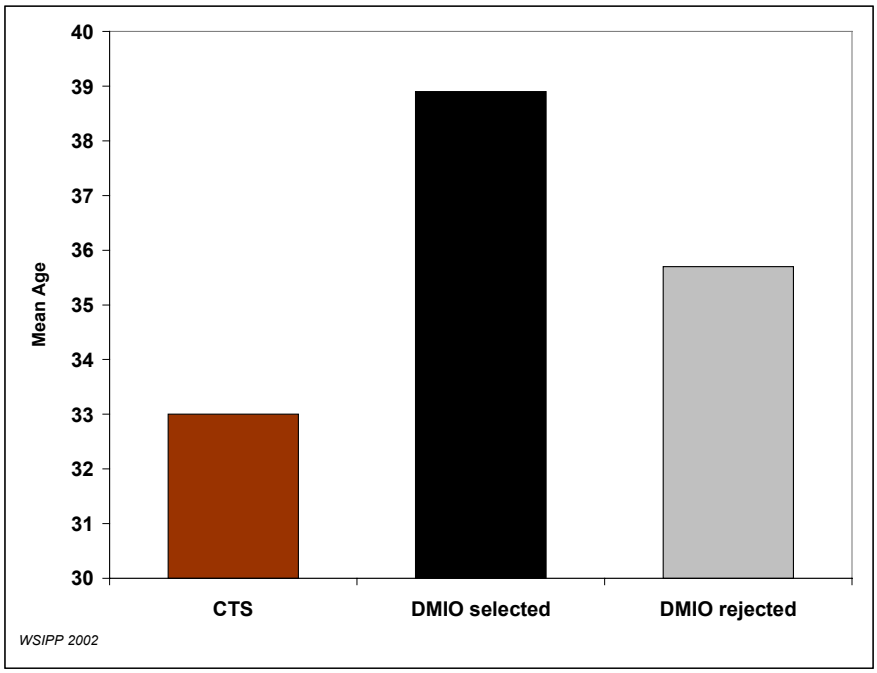
[14] The sample size is 98 DMIO candidates, with 66 selected and 32 rejected (the four not yet determined are not included); the CTS sample size is 333.
[15] $Z = 4.40$, $p < .0001$.
[16] $Z = 1.93$, $p < 06$.

Figure 4.1
Gender and Racial Characteristics



The three groups also differed from one another in age, with the CTS group being on average a few years younger (mean = 33.0) than the combined DMIO selected group and DMIO rejected group. Cases rejected for the DMIO program, however, did not differ significantly in age from those selected for DMIO services.

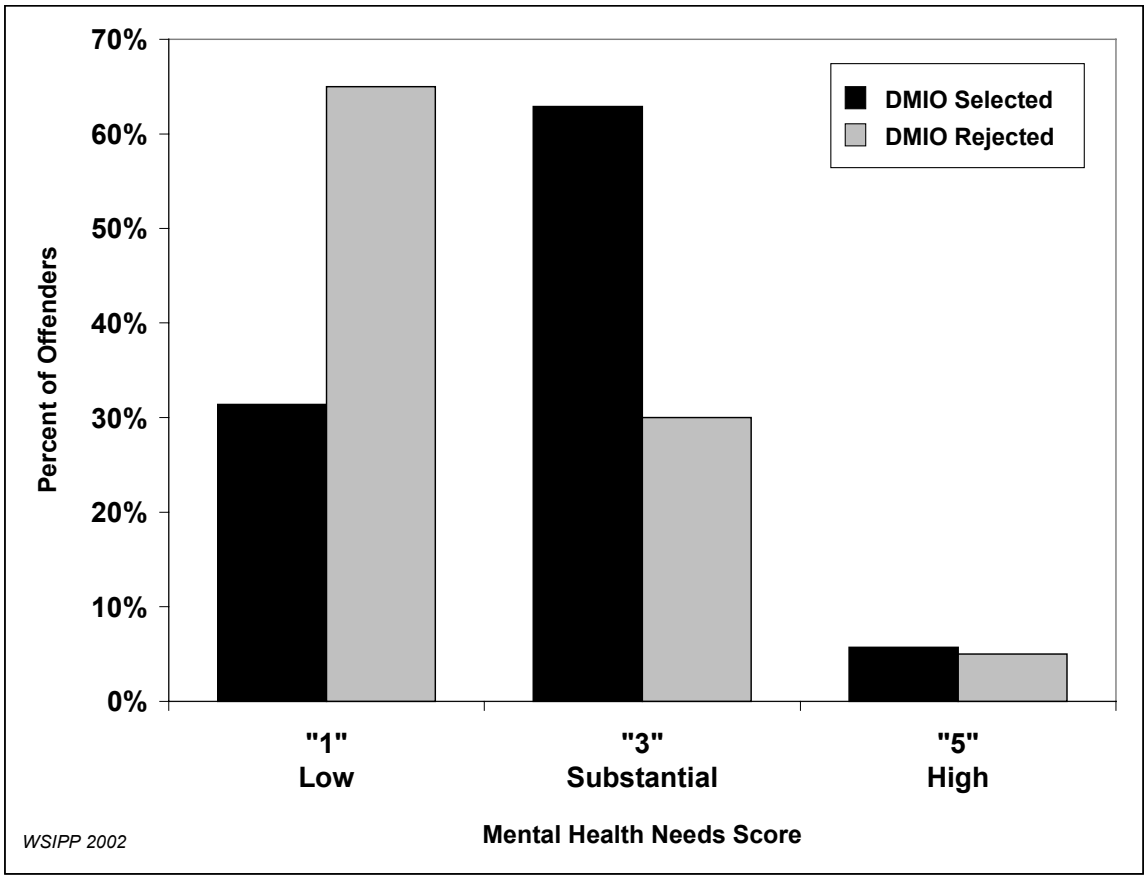
Figure 4.2
Age



Mental Health Indicator Variables

Comparison data are examined for several basic DOC mental illness indicator variables for the DMIO candidate group: Mental Health Needs score, PULHES "S" code, and behavioral management problem indexes such as "Days in Administrative Segregation" and "Days in an Intensive Management Unit" (IMU).

Figure 4.3
Mental Health Needs Scores



An offender's Mental Health Needs score is assigned by a DOC mental health professional after intake into prison and is based on the intensity of mental health needs. As shown in Figure 4.3, the groups differed significantly in their Mental Health Needs scores,[17] with the selected DMIOs having fewer low needs scores of "1" and more needs scores of "3" than the rejected DMIO group. There were too few offenders with scores of "5" to permit comparison (only three total in both groups). Thus, the SRC appears to be selecting more offenders with substantial needs into the program. It is important to point out that Mental Health Needs scores were recorded for only 55 of the 98 inmates that comprise the two DMIO candidate groups used in most of the data analyses reported here. We do not know whether the missing Mental Health Needs score is the result of random errors as opposed to systematic bias in

[17] χ^2 [2] = 5.99, p< .05.

recording. Consequently, the Mental Health Needs score differences need to be interpreted with caution.

The PULHES code is used by DOC for classification and movement purposes. The "S" score on the PULHES (ranging from 1 to 5) is used to profile an inmate's ongoing mental health management needs. An S code of 1 indicates no mental disorder; an S code of 2 indicates a mental disorder with mild residual symptoms; an S code of 3 indicates a mental disorder with moderate impairment and the need for treatment, including medication; an S code of 4 indicates a need for long-term treatment (more than 60 days) in a DOC residential care facility; and an S code of 5 designates a serious acute mental disorder with serious impairment and need for treatment in a DOC inpatient mental health unit.

PULHES "S" score was analyzed both as a quantitative variable (magnitude of score) and a categorical variable (differences in the proportions of inmates at each level of "S" score). No statistical differences between groups were found for either method of analysis.

Both "Days in an Intensive Management Unit" (IMU) and "Days in Administrative Segregation" were highly variable regardless of group, with values ranging from zero to 635 days (segregation) and zero to 1,623 days (IMU). Differences between the two groups were not statistically significant due largely to the tremendous variation in the number of days in these restrictive settings.

Index Crime

The Washington criminal code contains statutory definitions of dozens of different felony crimes. DOC codes these into a smaller number of 47 crime categories. For the purposes of the present study, these codes were further categorized into a smaller number of important but overlapping categories. See Appendix D for detailed category descriptions.

- Most Serious Violent Crime (murder, manslaughter, vehicular homicide, all rapes, indecent liberties, robbery, kidnapping, assault 1).
- Any Violent Crime (most serious violent crimes and other serious violent felonies; e.g., arson, all other assault, extortion 1).
- Serious Sex Offense (contact felony sex offenses; e.g., rape, indecent liberties, violent sex-child).
- Any Sex Offense (serious sex offenses and all other DOC sex offenses; e.g., non-violent sex-child and other sex crime).
- Non-violent Offense (includes all other DOC felony codes; e.g., theft, burglary, non-violent and other sex offenses, forgery, drug crimes, and "felony other").

The percentage of CTS, DMIO selected, and DMIO rejected cases in each of these crime categories is presented in Figure 4.4.

Figure 4.4
Index Offense Category by Group

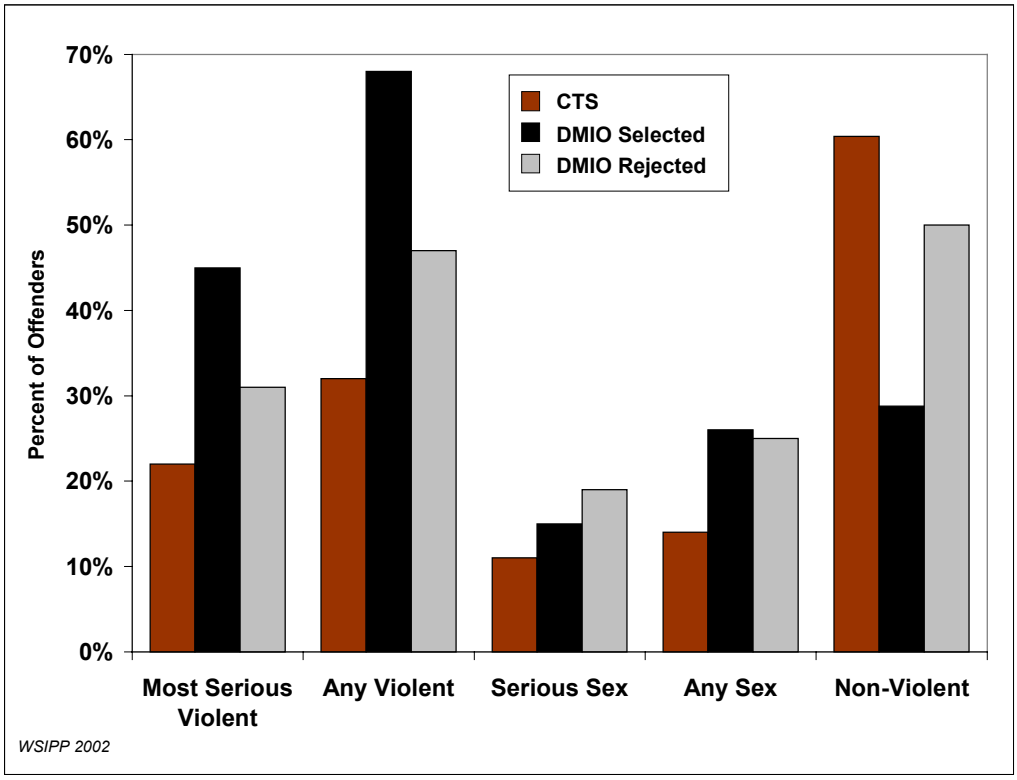


Figure 4.4 displays the category of the index offense, which is the crime associated with an offender's current prison admission. Offenders presented to the SRC more often had a "Most Serious Violent" or "Any Violent" offense.[18] Those selected for presentation to the SRC also less often had a "Non-Violent" offense.[19] There were no statistically significant differences between the groups in the percentages of those with "Serious Sex" offenses, but there was a small increase in the proportion of "Any Sex" offense among those selected for presentation.[20]

Among those selected by the SRC to receive DMIO services, there were no statistically significant differences in the proportion of offenders with a "Most Serious Violent" offense, "Serious Sex" offense, or "Any Sex" offense. However, those selected for DMIO services more often had "Any Violent" offense and less often had a "Non-Violent" offense.[21]

DOC has endeavored to screen cases prior to presentation to the SRC based on two major criteria: (1) presence of major mental disorder, and (2) dangerousness. We cannot describe how DOC conducted the first task as the necessary clinical information does not exist or is unavailable for analysis. Our evaluation is, therefore, limited to the second task, DOC's pre-selection of cases based upon an assessment of dangerousness.

[18] $Z = 3.74$, $p < .0002$, "Most Serious Violent" offense; $Z = 5.32$, $P < .0001$, "Any Violent" offense.
[19] $Z = 5.69$, $p < .0001$.
[20] $Z = 2.26$, $p < .03$.
[21] $Z = 2.03$, $p < .04$, "Any Violent" offense; $Z = 2.61$, $p < .009$, Non-violent" offense.

For both DOC and the SRC, a major rejection factor appears to have been possession of a "Non-Violent" index crime. Factors contributing to DOC's selection of cases for presentation to the SRC appear to have been either (a) possession of a "Most Serious Violent" index crime, or (b) "Any Violent" index crime. The SRC's major selection factor for DMIO services appears to have been possession of "Any Violent" index crime. While these findings might otherwise suggest that DOC and the SRC tried to select the most dangerous mentally ill offenders for DMIO services, research indicates that severity of index crime is generally not related to future violence.[22]

Risk Factor Variables

The findings presented here regarding MIO recidivism risk are limited to LSI-R scores, CTS-determined risk factors, and CTS risk equation scores. An analysis of the relationship between the CTS-based risk scores and LSI-R scores is also presented.

The CTS identified sets of variables for predicting violent recidivism and felony recidivism by MIOs (Lovell et al., 2001). Logistic regression equations using these risk factor sets were developed for the CTS group and then later used to generate risk estimates for MIOs presented by DOC to the SRC for possible selection for the DMIO program.[23] The scores on these risk factor variables are presented below.

The CTS violent and felony recidivism risk factors are presented in Appendix E. The best predictors of new felony recidivism are number of prior felonies (+),[24] number of drug felonies (+), age at first offense (-), status as a first-time sex offender (-), and felony versatility (+). The best predictors of a crime against a person are number of prior violent felonies (+), age at prison release (-), felony versatility (+), female gender (-), status as a first-time sex offender (-), and yearly prison infraction rate (+).

Figure 4.5 shows age-based risk factors, such as age at first known offense and age at release from prison, for the CTS and DMIO groups. As discussed earlier, CTS subjects were on average a few years younger than those presented by DOC to the SRC. However, there was not a statistically significant difference in age or age at first offense of those selected by the SRC for DMIO services. Offenders selected for DMIO services tended not to differ on age-based risk factors.

[22] Quinsey and colleagues (1998) report that severity of index crime actually tends to be associated with a reduced likelihood of future violence. New analysis of the CTS data (Lovell et al., 2001) using our method of categorizing offenses show that having a "most serious violent" crime as an index offense is associated with a *reduced* likelihood for violent recidivism and felony recidivism. Also, having "any violent" crime as an index offense is associated with a *reduced* likelihood for felony recidivism, and there is a trend toward it being associated with a reduced likelihood for violent reoffense. CTS data also show that having a "non-violent" felony as an index offense is positively associated with felony recidivism and there is a trend toward it also being positively associated with violent recidivism.

[23] The CTS risk scores for DMIO candidates were available to the SRC for use beginning in November 2000.

[24] The "+" and "-" signs denote whether the factor is associated with higher risk (+) or lower risk (-).

Figure 4.5
Age-Based Risk Factor Scores

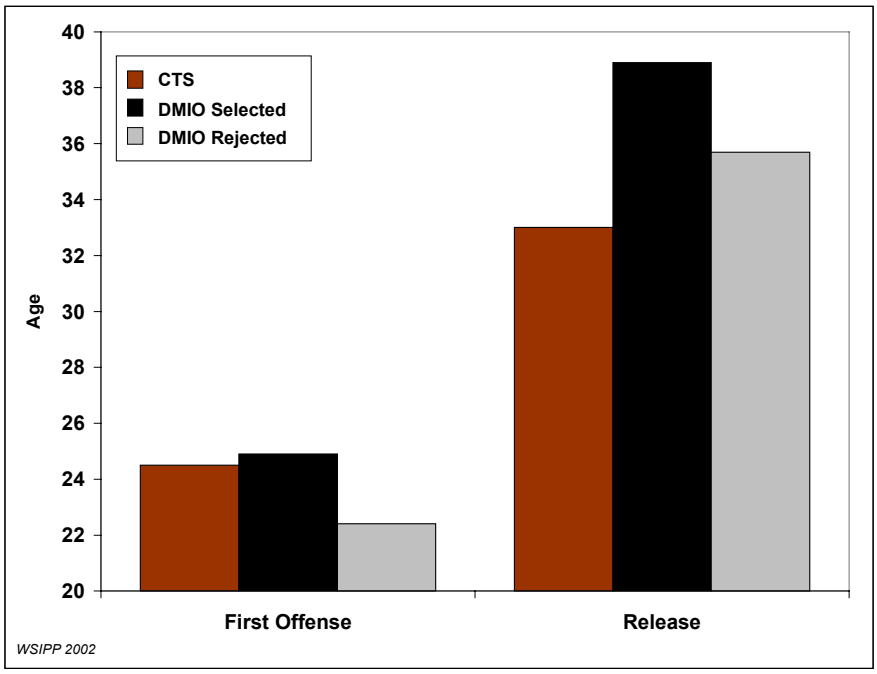
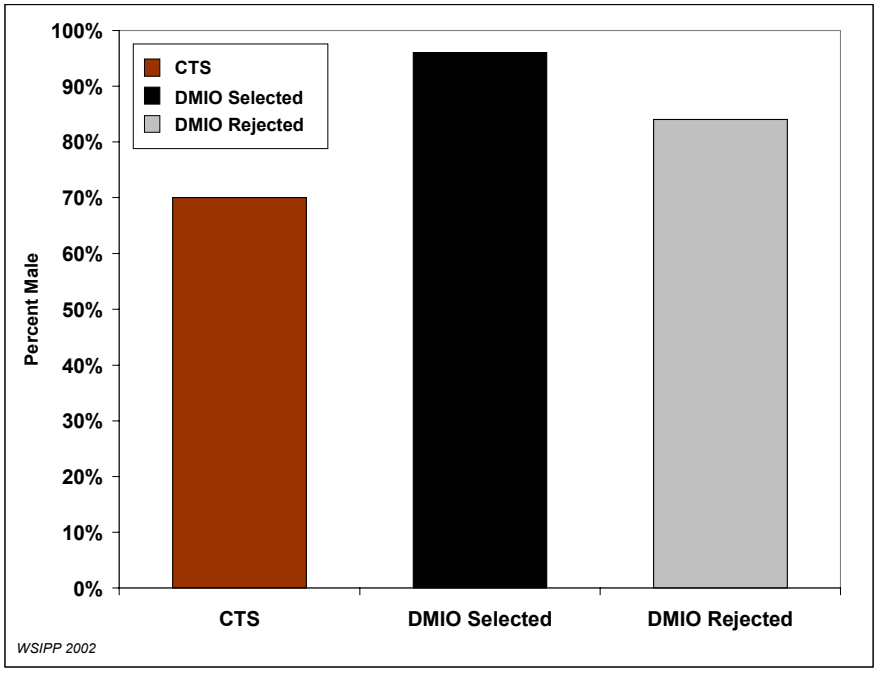


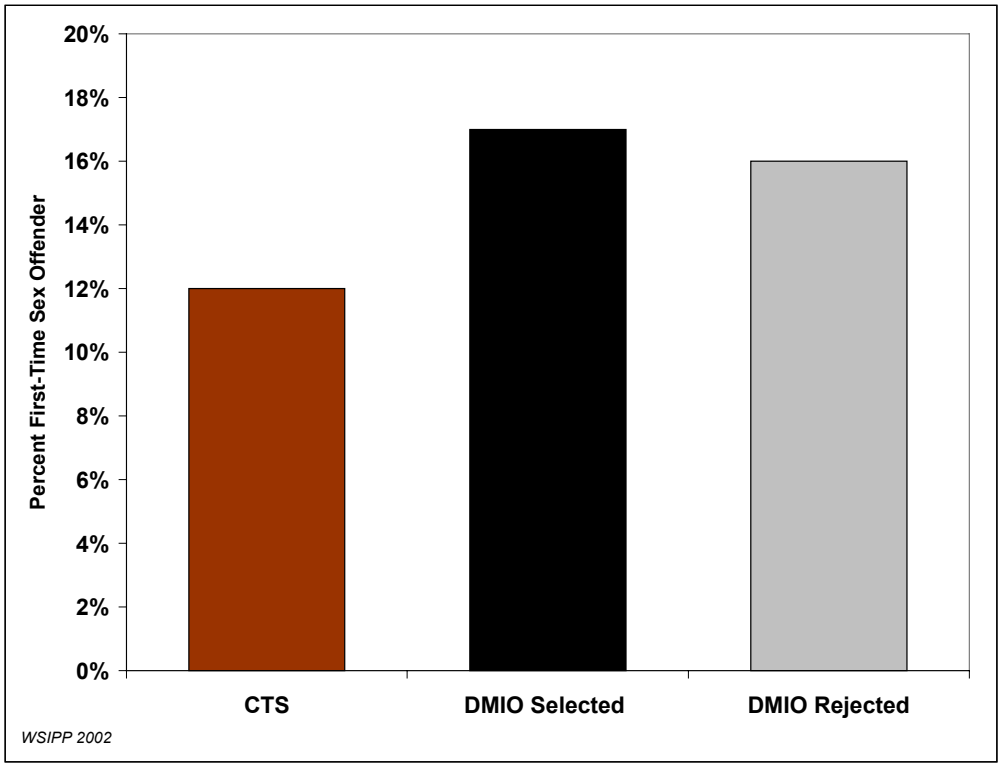
Figure 4.6 shows gender-based factors for risk, as male gender was a risk factor for reoffense for violent crimes among CTS subjects. (Alternately, female gender is a relative protective factor.) As discussed earlier, there were fewer women selected for presentation to the SRC and for DMIO services. Offenders defined as DMIOs were at higher risk in terms of gender-based (male) risk for violent recidivism.

Figure 4.6
Gender-Based Risk: Percent Male



Figures 4.7 and 4.8 present comparisons of the three groups on the remaining risk factors: whether the index offense was a first-time sex offense, felony versatility, yearly serious infraction rate in prison, number of prior drug felonies, number of prior felonies, and number of prior violent felonies.

Figure 4.7
Status as a First-Time Sex Offender



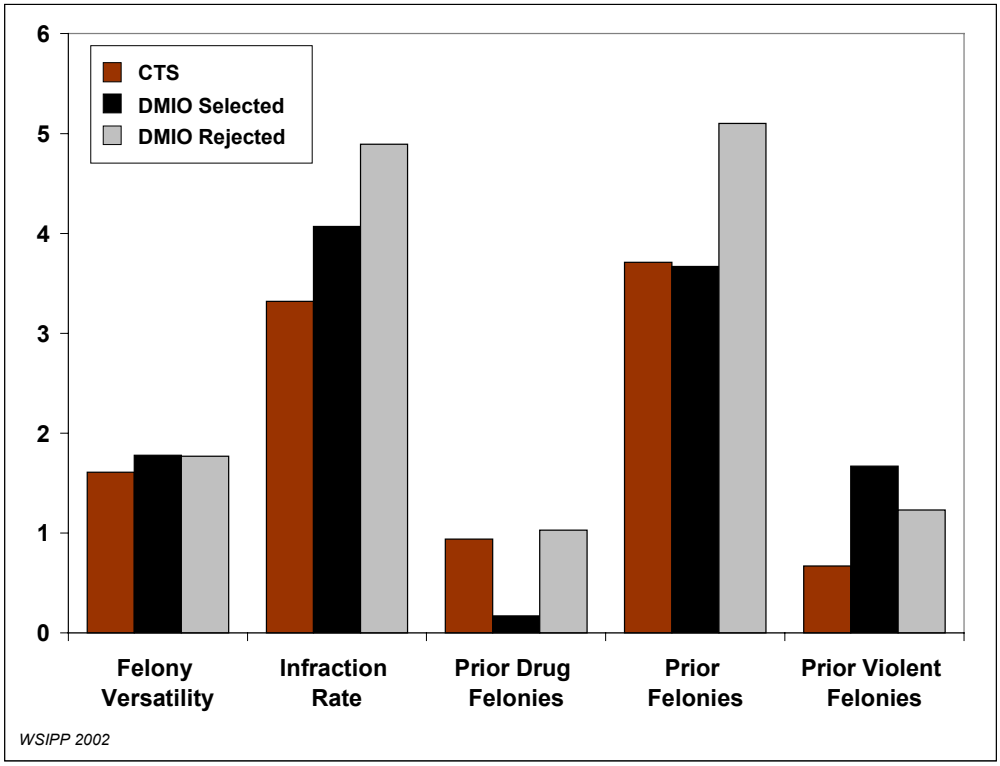
The CTS found that for MIOs, status as a first-time sex offender was a relative protective factor that lowered both felony and violent recidivism. Figure 4.7 shows no significant differences between any of the groups in terms of the percentage of first-time sex offenders.[25]

Figure 4.8 compares the three groups on the remaining CTS-determined risk factors, all but one of which is measured as a simple count. The exception, Infraction Rate, is the number of serious infractions per year of incarceration.

Studies of psychopathy using the Hare Psychopathy Checklist (PCL-R) show that psychopaths offend frequently in diverse crime categories. While PCL-R scores were not reliably available for either the CTS or the DMIO study, the CTS found that a proxy measure of psychopathy, labeled felony versatility, was associated with increased risk for recidivism. Felony versatility is measured on a 4-point scale. One point is given for each of four major categories of felonies in which an inmate has been convicted: violent non-sex crime, sex crime, drug crime, or property crime. The groups did not differ on the felony versatility risk factor. Neither did the groups differ in terms of yearly serious infraction rate.

[25] There were too few sex reoffenses in the CTS to reliably report sex offense recidivism.

Figure 4.8
Additional CTS Risk Factors



Drug abuse is one of the best predictors of recidivism in mentally ill populations as well as general offender populations (Steadman et al., 1998). A history of drug crimes is one index of the presence of a drug problem. The CTS found that past drug crime convictions were related to increased recidivism for MIOs. The present groups did differ from one another in terms of numbers of prior drug convictions. But, CTS subjects averaged *more* drug convictions than inmates selected by DOC for presentation to the SRC.[26] Moreover, of those presented to the SRC, cases selected for DMIO services actually had far fewer past drug convictions (mean = .17) than rejected cases (mean = 1.03).[27]

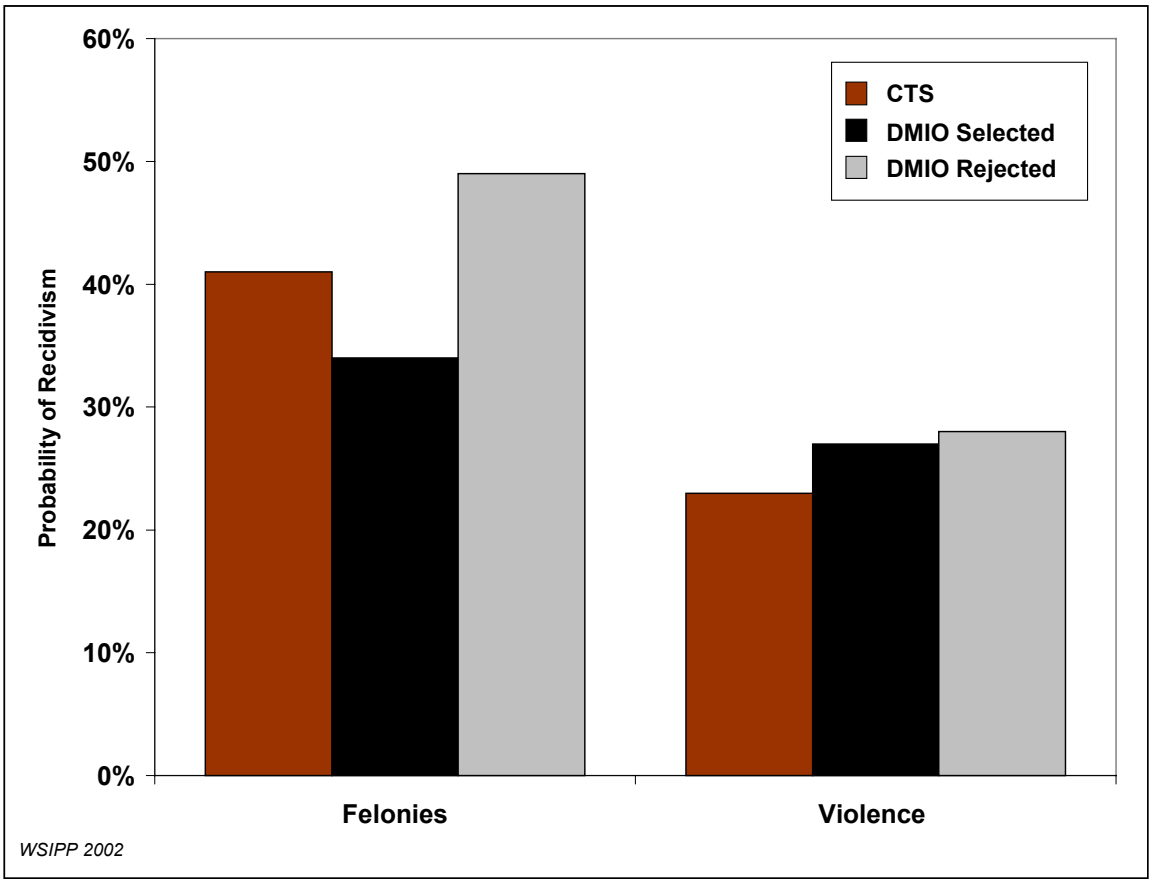
Another well established predictor of future recidivism is number of prior felony convictions (Gendreau et al., 1996). The CTS found that the number of past felony convictions was a robust predictor of felony recidivism. No differences were found in numbers of prior felonies between the CTS and offenders selected for presentation to the SRC, but of those MIOs presented to the SRC, cases selected for DMIO services had a significantly *lower* number of prior felony convictions (mean = 3.67) than rejected cases (mean = 5.1).[28] This is a surprising finding since the CTS report showed that number of prior felony convictions was the best predictor of felony recidivism, and the SRC was presented with information about past felony convictions via a specially constructed table that tallied inmates' scores on all of the CTS-identified risk factors (see Appendix F).

[26] $F(1, 93) = 4.21$, $p < .05$.
[27] $F(1, 93) = 17.10$, $p < .0001$.
[28] $F(1, 93) = 4.21$, $p < .05$.

Criminology studies support the common sense notion that persons with higher numbers of violent crime convictions are more likely to recidivate violently (Aos et al., 2001). Indeed, the CTS found that the number of prior violent felony convictions was the best predictor of future violence. Compared with the CTS group, the two DMIO groups were higher in terms of prior violent felony convictions (mean of 1.53 prior violent convictions versus .67).[29] However, cases selected by the SRC for DMIO services did not differ from rejected cases in terms of numbers of prior violent felony convictions. Thus, although the number of prior violent felonies seems to have been a factor used by DOC to select MIOs for presentation to the SRC, the number of prior violent felony convictions seems not to have been a factor used by the SRC to select inmates for DMIO services. It is possible the reason that cases accepted by the SRC for DMIO services had histories with no more violence than rejected cases is because DOC had already screened out the less violent MIOs, leaving the committee with a relatively homogeneous group of higher-risk MIOs.

Figure 4.9 shows how the groups compared in terms of overall risk for felony and violent reoffense as determined by the CTS risk equations (Lovell et al., 2001).

Figure 4.9
CTS Risk Equation Scores and Selection for DMIO Services

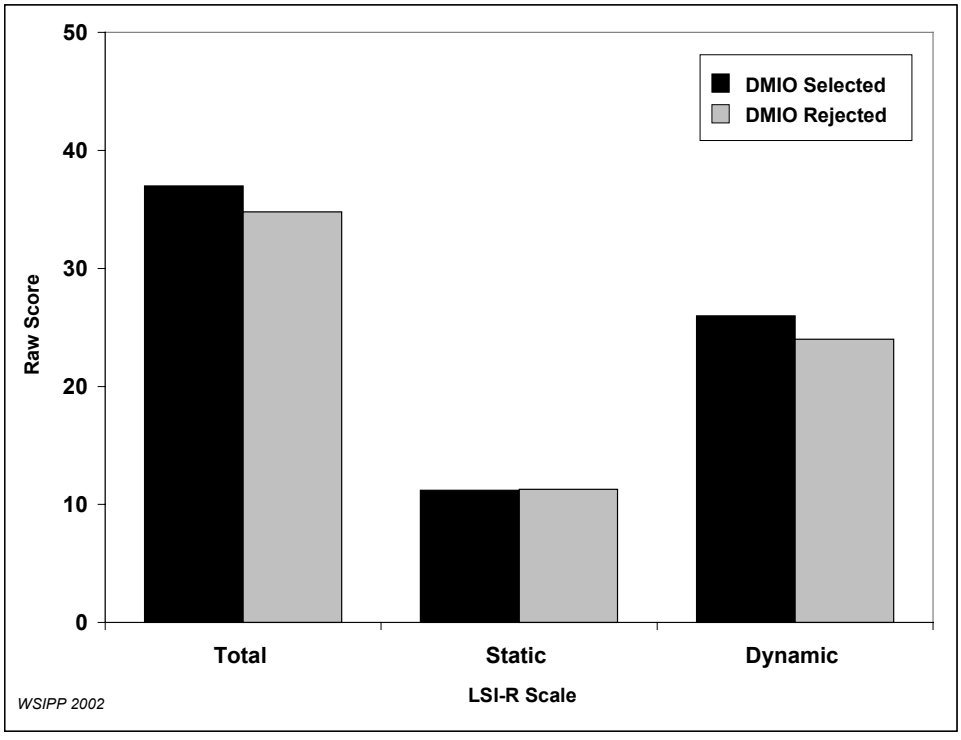


[29] F (1, 426) = 41.79, p <.0001

Analysis of the CTS *violence* risk equation scores failed to reveal significant differences between the CTS group, the group selected by the SRC for DMIO services, and the group rejected by the SRC. These three groups did, however, differ in terms of the CTS *felony* risk equation score.[30] Subsequent analysis of the CTS felony risk equation scores revealed that those selected for DMIO services by the SRC actually had a *lower*, not higher, estimated risk for felony recidivism.[31] Thus, it appears that the SRC actually gave little weight to the CTS risk prediction data provided them, and, in the case of felony recidivism, their decisions were the opposite of those recommended by the actuarial risk equation.

The Level of Services Inventory Revised (LSI-R) is an instrument used to assess and manage offender risk. Its use has recently been extended to MIOs, where it has also been shown to forecast recidivism risk for that group of special offenders (Girard, 1999). DOC relies in large measure on the LSI-R to make important risk decisions about its inmates.[32] In 1996 and 1997, the LSI-R had not yet been administered to many MIOs incarcerated in Washington prisons. Consequently, we cannot compare CTS subjects with DMIO candidates in terms of LSI-R scores. LSI-R scores were available for all the inmates who were potential DMIO candidates. Figure 4.10 shows the LSI-R scores for DMIO selected versus DMIO rejected cases.

Figure 4.10
LSI-R Scores and Selection for DMIO Services



[30] F (2, 425) = 3.27, p< .04.
[31] F (1, 93) = 5.28, p < .03
[32] One SRC member has shared with the researchers a lack of confidence in the LSI-R as a measure of offender risk. Other SRC members may have similar skepticism about the LSI-R. It is possible that the SRC and DOC have strong differences of opinion regarding the validity of LSI-R scores. If so, this would certainly be an obstacle to DMIO selection and would suggest that DOC and the SRC ought to redouble their efforts to reach a practical consensus regarding what measures of risk they are going to rely on to select DMIOs.

Although LSI-R scores were quite high for both selected and rejected cases (92nd and 87th percentiles, respectively, based upon LSI-R manual norms), there were no significant differences between selected and rejected MIOs on any of the main LSI-R scales.[33] It would appear that the SRC gave little weight to LSI-R scores when deciding who should be selected for DMIO services (see footnote 31). The LSI-R scores of cases referred to the committee by DOC may have been so high on average as to possess little discriminating value for risk assessment. Our finding that the average MIO sent to the committee had an LSI-R score of 36.3 (90th percentile based on male norms) tends to support this conjecture. There were moderate correlations between the LSI-R scores and CTS risk equation scores as shown in Table 4.1 (all r's, $p < .0005$), which shows reasonable convergent validity between these two different measures of risk.

Table 4.1
CTS/LSI-R Score Correlation Coefficients

CTS	Total Score	Static Scale	Dynamic Scale
Violent Recidivism Score	.45	.49	.38
Felony Recidivism Score	.43	.49	.37

Summary

In this section, we have presented a comparison of the CTS MIOs, MIOs screened by DOC for presentation to the SRC, and MIOs selected by the SRC for DMIO services. Our comparisons are based upon available data, not clinical file information. Here we discuss our findings in greater detail.

A major issue of discussion at SRC meetings was whether an offender submitted for screening suffered from a serious mental illness. Approximately half (15) the rejected cases were rejected because the SRC believed the offenders were not seriously mentally ill. A related issue was the quality of clinical information available to the SRC in the DOC medical files, which were often incomplete and sometimes contained inconsistent, even contradictory, clinical information. Without comprehensive assessment data, it is impossible for any clinician or panel to make good clinical diagnoses. The relative absence of high quality, comprehensive mental health data for DOC inmates is a problem for DOC, as well as the professionally diverse committee, few or none of whom have had any personal clinical experience with the inmate under consideration for DMIO services. Finally, the SRC did not record the actual reasons for its decisions about whether an inmate suffered from a major mental disorder. Consequently, we cannot assess the clinical aspects of DMIO selection.

More information was available to the researchers about possible criteria used by DOC and the committee for determining dangerousness among those believed to be mentally ill. Again, it is important to remember that the comparisons are limited to the available electronic data, which include mainly criminal history variables. Also, the comparison group is the CTS population, which is a group of 333 MIOs released in 1996–97, not 2000–2001. The CTS population may not be equivalent to the pool of cases identified by the electronic algorithm

[33] $p > .10$ for all comparison.

early in the DMIO selection process, nor is it likely equivalent to the smaller group of inmates screened by DOC for presentation to the SRC. DOC selected the latter group on the basis of simultaneously meeting two criteria: presence of serious mental illness *and* perceived dangerousness risk. Also, the SRC may have made some of its dangerousness determinations on the basis of qualitative case data. For the above reasons, comparisons with the CTS subjects need to be interpreted cautiously.

Although the SRC rejected 13 cases based on its determination that these inmates were not dangerous, the reasons for their decisions were not documented in committee minutes. In an attempt to gain insight into the possible basis of these dangerousness decisions, we conducted a preliminary analysis of cases rejected for lack of dangerousness versus other reasons (such as lack of a major mental disorder). These analyses were necessarily based on a relatively small number of cases (13 rejected due to lack of dangerousness versus 19 rejected for other reasons). Consequently, these findings must be considered very tentative.

The analyses suggest that cases rejected as not dangerous did not have lower CTS violence or felony risk equation scores. Moreover, their LSI-R scores were not lower than those rejected for reasons other than insufficient dangerousness. Also, cases rejected by the SRC for lack of perceived dangerousness risk did not have fewer convictions for violent felonies nor fewer numbers of past felony convictions. Cases rejected for lack of dangerousness did, however, marginally differ from other rejected cases in having a smaller percentage with any sex offense.[34] Offenders with past convictions for drug offenses were also slightly more likely to be rejected.[35]

If we can assume that the CTS subjects are a fairly representative sample of DOC's mentally ill inmates, then we can draw some tentative inferences about the current DMIO selection process with respect to the dangerousness issue:

DOC risk assessment

- DOC is making most of the decisions about MIO dangerousness. By the time cases reach the SRC, they are a small, select subgroup of MIOs screened by DOC with regard to DOC's assessment of an inmate's increased risk for violence. This is clearly evident in DOC's decision to select for SRC presentation cases that have higher numbers of prior convictions for violent offenses and relatively high LSI-R scores (average LSI-R total score = 36.3, 90th percentile according to male norms). It is also supported by the observation that cases selected by DOC for SRC presentation have significantly more violent felony convictions (1.53) than CTS MIOs (.67).
- DOC appears to base its dangerousness selection decision on two factors: severity of the index crime and number of prior violent felony crimes.[36] As reported earlier, only the second factor has an established association with future violence. We were unable to evaluate the possibility that DOC also used the LSI-R score to select cases for SRC presentation.

[34] Z -1.87; $p < .07$.
[35] $t(29) = -1.81$, $p < .09$.
[36] DOC-selected offenders were older and included more men than women. Although the decision to include more men may have been part of an effort to select more dangerous MIOs, women may have also been rejected for other reasons, such as absence of a major psychotic mental disorder. It is doubtful that DOC knowingly selected older MIOs. The latter difference is probably artifactual.

Committee risk assessment

- In making their dangerousness determinations, the SRC appears to have given primary weight to the general severity of the index crime. SRC decisions seem not to distinguish those MIOs with violent index offenses or serious index sex offenses, possibly because the DOC-selected subset of cases already contained a high number of cases with these kinds of index crimes.
- The SRC does not appear to make violence risk decisions based on empirically validated factors such as those embodied in the CTS recidivism risk equations or LSI-R scores.[37] The only major exception to this may be male gender, which is a violence risk factor that distinguishes cases the selection committee selected versus those they rejected.

[37] This is not a surprising finding; research shows that committees do not base their decisions on empirically established risk factors but instead give greatest weight to clinical opinion, even though it is well established that clinical opinion is a weak predictor of future violence (see Hilton et al., 2001).

V. PRE-RELEASE AND COMMUNITY SERVICES FOR DMIO PROGRAM PARTICIPANTS

Planning Process

Thus far, our discussion has concerned how persons are identified and selected for the DMIO program. This section discusses another important component of the program, transition from prison to community services. The legislation establishes a multi-agency release planning process for DMIOs to coordinate and provide for post-release supervision, support services, and treatment, including case management, mental health treatment, drug/alcohol treatment, and housing assistance. Both the agency collaboration and service provision are considered essential to the program. Research shows that strong connections between mental health and criminal justice systems are necessary for program success (Lovell et al., 2000; Lurigio, 2001).

Once an offender has been selected for the DMIO program, the multi-agency planning process begins. Existing DOC background information on the offender is sent to the RSN, the county alcohol and drug coordinator, and other potential service providers.[38] An initial meeting is held with agencies that may be involved in working with the offender to determine roles and responsibilities. This meeting includes representatives from DOC, DSHS, RSNs, community designated mental health professionals, community mental health and drug/alcohol treatment providers, and law enforcement. Through this process, a "planning team" is formed. Service planning begins approximately three to five months prior to release and often includes meetings with the offender in order to assess needs and engage the offender in his or her treatment prior to release. The planning team is required to develop a full transition plan, including a detailed plan for the first 48 hours after release from prison.

DMIO Program Participants Released From Prison

From September 2000 through June 2001, 36 DMIO program participants were released from DOC institutions. Most of these offenders received transitional and community service planning that was carried out by a multi-agency planning team. We report on the 36 DMIO participants released through June 2001, providing descriptive data on the offenders, criminal sentence and release characteristics, as well as prison and post-release services, supervision, and criminal justice events.[39] When data are available, we compare the services received by DMIO participants with those of the CTS subjects.

Offender Characteristics

Table 5.1 presents demographic, criminal history, prison stay, and risk assessment characteristics of the released DMIO participants. On key measures, the 36 DMIO participants examined in this section are similar to the DMIO-selected offenders described in Section IV. Most participants are men; approximately 75 percent are white, 17 percent are black, and 8

[38] The information provided to the team is the same information provided to the review committee; thus, the uneven quality of information poses difficulties for the team and potential service providers.

[39] The cutoff of June 2001 was necessary to gather data from a number of state agencies, including DASA, DOC, and MHD, and to provide a three-month minimum follow-up period for all DMIO releases.

percent are of another race. The average age at first offense is 23.9 years and the average age at release is 39 years. Offenders have a fairly extensive criminal history, with an average of 3.4 previous felonies, and 72 percent have at least one violent felony offense. About 44 percent have a serious violent offense, and 11 percent have a serious sex offense in their criminal history.

Table 5.1
Characteristics of Released DMIO Participants*

Characteristic	
Total Number	36
Percent Male	94%
Race	
Percent white	75%
Percent black	17%
Percent other race	8%
Criminal History	
Average age at first offense	23.9 years
Average age at release	39.2 years
Average number of previous felonies	3.4
Percent with any violent offense	72%
Percent with serious violent offense	44%
Percent with serious sex offense	11%
Prison Stay	
Median prison length of stay	2.8 years
Prison admission date	
1980–89	14%
1990–94	14%
1995–99	36%
2000	36%
Yearly serious infraction rate	3.1
Risk Assessment Scores	
Average LSI-R score	38
CTS felony probability	35%
CTS violent probability	25%

* Released September 2000 through June 2001

Prison stay characteristics and risk assessment scores are also shown in Table 5.1. The median length of stay in prison for released DMIOs is 2.8 years, with the largest proportion of offenders entering prison from 1995 through 2000. The group has an average yearly serious infraction rate of 3.1. An average LSI-R risk score of 38 puts the offenders in the 94th percentile of all released prisoners, indicating they are medium-high risk and have over a 50 percent chance of reoffending. The CTS probability scores of 35 percent for felony and 25 percent for violent reoffense indicate that offenders are at moderate risk for new offenses, as compared with CTS subjects, using LSI-R probabilities as a frame of reference.

DOC Institutional Treatment

Table 5.2 shows the mental health treatment status of offenders while in prison. This group of offenders was well known to mental health service units within DOC institutions. Approximately 78 percent of the released DMIO participants spent time in a DOC mental health unit during their incarceration, slightly higher than CTS offenders, of whom 70 percent spent time in mental health units.[40] The length of time in mental health units for DMIO participants ranged from eight days to about 7.5 years.[41] The midpoint or median was approximately 1.8 years, indicating half the offenders spent less and half spent more than 1.8 years of their prison stay in a mental health unit. On average, the offenders spent about a third of their prison stay in mental health units.

Table 5.2
Prison Mental Health Treatment Status
Released DMIO Participants*

Prison Mental Health Treatment Status	
Total number	36
Percent with mental health unit residence	78%
Median years in mental health unit	1.8

* Released September 2000 through June 2001

Table 5.3 indicates that the Sex Offender Treatment Program (SOTP) reviewed ten of the 36 offenders for treatment consideration during their incarceration. Of the four offenders who started treatment, one successfully completed and three others were terminated. This compares with a treatment completion rate of over 90 percent for all offenders treated at SOTP. Five of the ten offenders considered for the SOTP either declined treatment or were rejected by the program. One offender appeared to be awaiting treatment, but was never admitted prior to his release date.

[40] Approximately 9 percent of the total prison population spends time in a DOC mental health unit.
[41] One offender at the extreme end of the scale spent nearly 15 years in prison mental health units.

Table 5.3
Prison Sex Offender and Chemical Dependency Treatment Status of Released DMIO Participants*

Treatment Status	Number of Offenders
Total Number	36
Sex Offender Treatment*	
Completed treatment	1
Terminated	3
Waiting acceptance	1
Declined treatment	3
Rejected for treatment	2
(**Number with a felony sex conviction)	10
Chemical Dependency Treatment	
CD screening	
Results indicate substance problem	18
No problem indicated	4
No screening	14
CD assessment	7
Prison CD treatment	
Completed	2
Not completed	1

* Released September 2000 through June 2001

Chemical dependency (CD) treatment was another possible treatment option during incarceration. However, none of the offenders were sentenced under the drug offender sentencing alternative, which would have given them CD treatment priority. At the time of admission, offenders completed a screening instrument that was used to determine if a full CD assessment should be undertaken. As Table 5.3 shows, of the 36 participants, 18 offenders had results indicating further assessment was warranted, and four did not. (There were 14 offenders who did not have any screening results recorded.) Of the group of offenders with recorded results, 80 percent had a possible CD problem compared with approximately 60 percent of the overall DOC population. Of the 18 offenders considered to need further assessment, seven received a full CD assessment. Three of the DMIOs received non-residential CD treatment during incarceration, and two completed that treatment.[42]

Release Characteristics

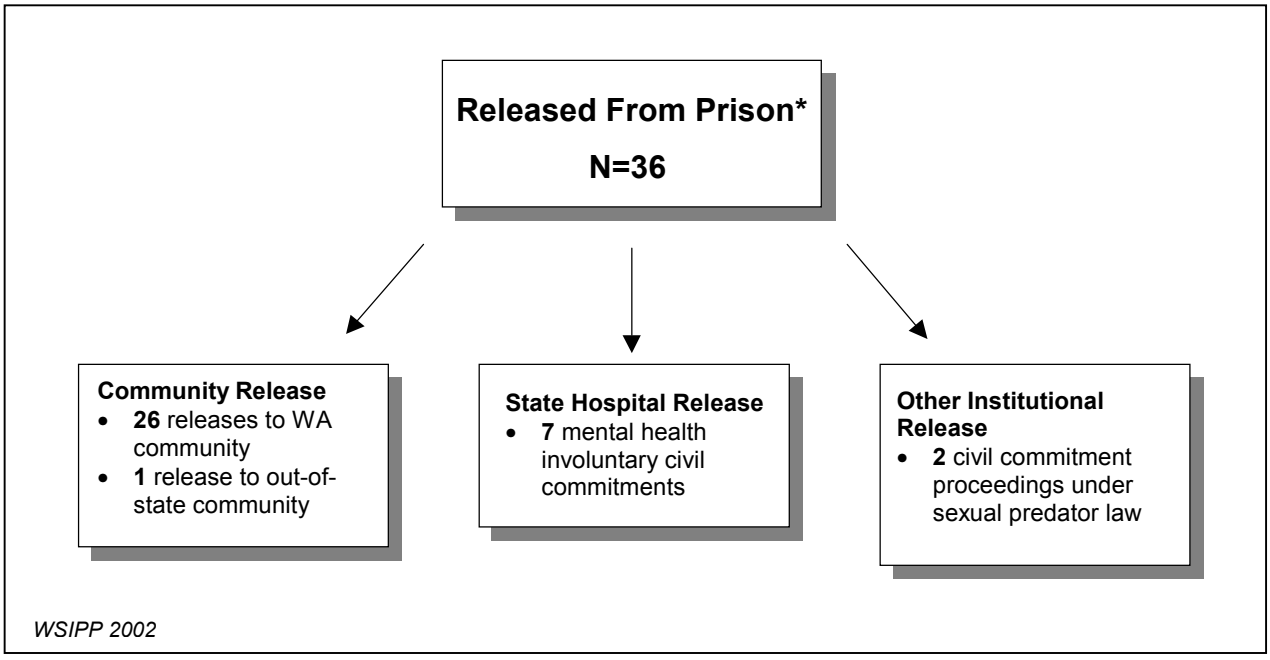
The legislation provides several post-release options for offenders selected as DMIOs, including release to the community with DOC supervised or voluntary treatment and referral to a community designated mental health professional for evaluation for involuntary mental health commitment. Currently, the distinction of supervised versus voluntary treatment is primarily based on the supervision conditions set at the time an offender is sentenced. In many cases,

[42] Traditional CD treatment may not be the best treatment option for the mentally ill. There has been some discussion at DOC of providing treatment programs specifically designed for mentally ill offenders.

an offender will be released before his or her maximum sentence is served and is subject to some DOC supervision. In over half the current cases, the offender has community placement, giving DOC additional active supervision time. However, if an offender has served his or her maximum sentence and has no community placement, voluntary treatment is the only available option. At this time, few offenders have been sentenced under the Offender Accountability Act (applicable for offenses committed after July 1, 2000), which allows DOC to set affirmative treatment conditions.

Figure 5.1 shows the release location of DMIO program participants. Of the 36 offenders released from September 2000 through June 2001, 26 were released into the community, and one offender was approved to move out-of-state. Seven offenders were committed to the state hospital under the mental health involuntary commitment law (RCW 71.05). Four of these offenders remained in state hospitals as of September 2001; of the three released on least restrictive alternatives, one has been readmitted. Finally, two offenders had involuntary civil commitment petitions under the sexually violent predator law (RCW 71.09) filed at the time of release and were transferred to a jail or other secure institutional setting; neither had been released as of September 2001.

Figure 5.1
DMIO Release Location



* Released September 2000 through June 2001

DOC supervision is considered an important component of the DMIO program: it provides for monitoring and for sanctions when offenders violate release conditions. The supervision status of the 36 DMIO participants at the time of release is shown in Table 5.4. Most offenders (83 percent) had some DOC supervision time. Approximately 55 percent had community placement at the time of release, indicating at least one year, and, depending on the index crime, up to three years of active DOC supervision. Another 28 percent had post-release supervision and had not reached their maximum sentence length; thus, they could have legal or financial obligations providing for some DOC supervision after prison release. Seventeen percent of offenders had no supervision at the time of release. Of this group, three were committed to the state hospital and three were released into the community.

Table 5.4
DOC Supervision Status of Released DMIO Participants*

Supervision Status at Release	Number of Offenders	Percent
Community Placement	20	55%
Post-Release Supervision	10	28%
No Active Supervision	6	17%
State hospital commitment	3	(8.5%)
Community release	3	(8.5%)
Total	36	100%

* Released September 2000 through June 2001 (N=36)

Mental Health Services

First, to assess the extent of past mental health treatment in the community, inpatient and outpatient public mental health services provided to the 36 DMIO participants prior to their incarceration are examined. Second, we report on mental health services received through the DMIO program through September 2001. This includes pre-release or "transitional" services for DMIO participants and services in the community once an offender is released from prison.

Publicly Funded Mental Health Services Prior to Incarceration. Table 5.5 shows that the majority of DMIOs received publicly funded mental health services prior to their prison incarceration on the index crime. The MHD service utilization data we use go back to 1994, thus, ten offenders with admission dates prior to 1994 are not included in these analyses. Approximately 77 percent of the 26 offenders received services, with 62 percent receiving inpatient and 62 percent receiving outpatient treatment services. For those receiving inpatient treatment, the median number of inpatient hospital days was 22, indicating half had days above and below that midpoint. On average, outpatient service recipients received 3.31 hours per month for each month they received services; services were received in approximately 25 percent of the months prior to incarceration. While the majority of offenders received outpatient services prior to incarceration, these services were not extensive.

Table 5.5
Public Mental Health Services, 1994 to Incarceration

Mental Health Services	Number of Offenders	Percent	Service Length
Any MH Services	20	77%	
Inpatient MH Services	16	62%	22 days (median)
Outpatient MH Services	16	62%	3.31 hours per service month

N=26

DMIO Mental Health Services. As described earlier, the DMIO program includes transitional services provided by community mental health providers immediately prior to prison release. Transitional services are considered an important program component and are used to assess an offender's needs and to attempt to engage him or her in treatment prior to release. The time between selection into the DMIO program and prison release for these offenders averaged 4.1 months, less than the six months set by the SRC as necessary for optimal transitional and community service planning. Even with the shorter time period, 83 percent of the DMIO participants received mental health services prior to release (see Table 5.6). In the six months prior to release, DMIOs received approximately two months of transitional service, with an average of 7.3 hours per service month.[43]

Table 5.6
Pre- and Post-Release DMIO Community Mental Health Services, Through September 2001

Community Mental Health Services	Number of Offenders	Percent	Service Intensity
Pre-Release			
6 months prior to release	30	83%	2.0 service months 7.3 hours per service month
Post-Release			
Outpatient MH Services			
3 months after release	34	94%	11.8 hours per month
All months after release	35	97%	9.2 hours per service month

N=36

Community mental health services have been provided to nearly all the DMIOs released into the community, with the exception of one offender who refused all services. As Table 5.6 shows, DMIO participants received an average of 11.8 hours of outpatient services a month during the three months immediately following release. The number was slightly lower for the full time period, 9.2 hours per service month, from release through September 2001. Thus, there was greater intensity of service in the first three months, as would be expected.

[43] This is likely an underestimate of actual time, as some of the early transitional service work may not be included as service hours. Correctional officers appear to be recording all visits and contacts with mental health and other providers; thus, the descriptive study will provide more detail of transitional services.

Figures 5.2 and 5.3 compare the experiences of the CTS subjects and DMIO participants in receiving pre- and post-release community mental health services. Figure 5.2 indicates that only 10 percent of CTS subjects received any services prior to release, compared with 83 percent of the DMIOs. In the community, the CTS subjects fared similarly, with 29 percent receiving services in the first three months after release compared with 94 percent of all DMIOs.

Figure 5.2
Pre- and Post-Release Community Mental Health Services, Through September 2001

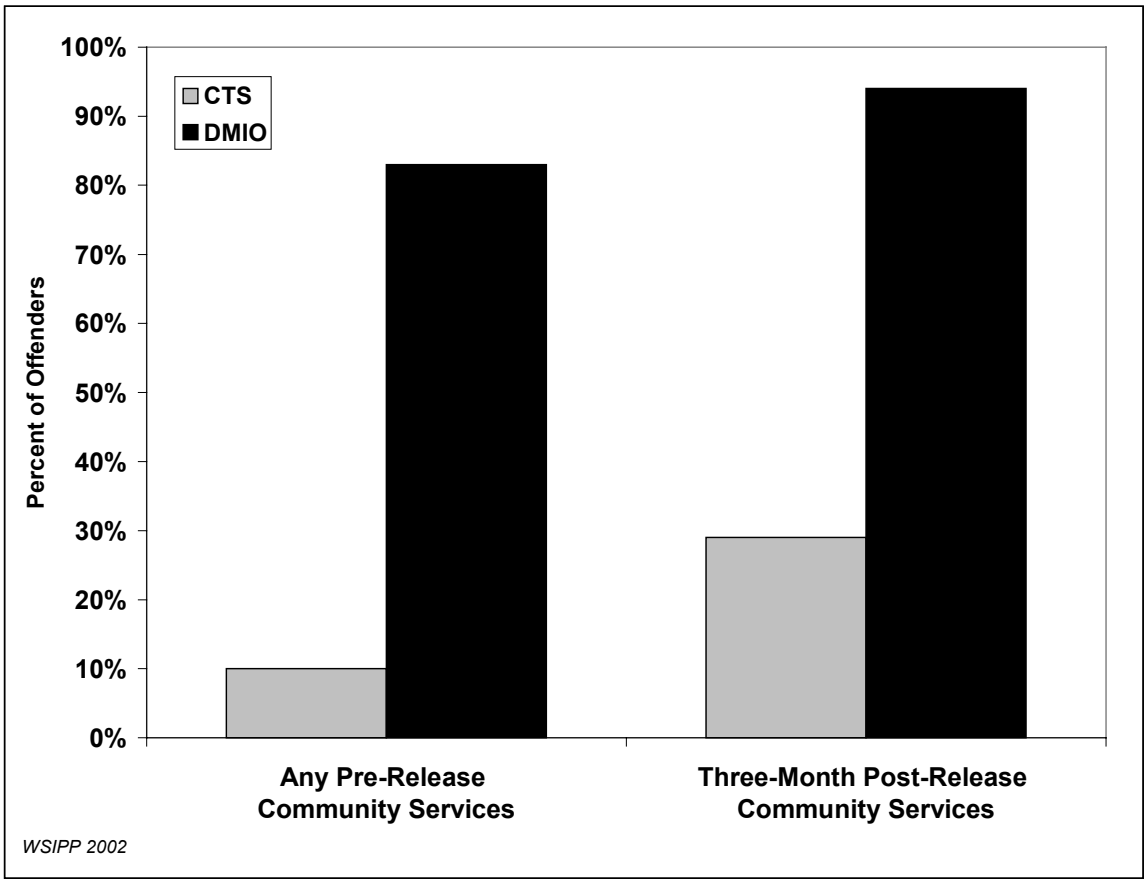
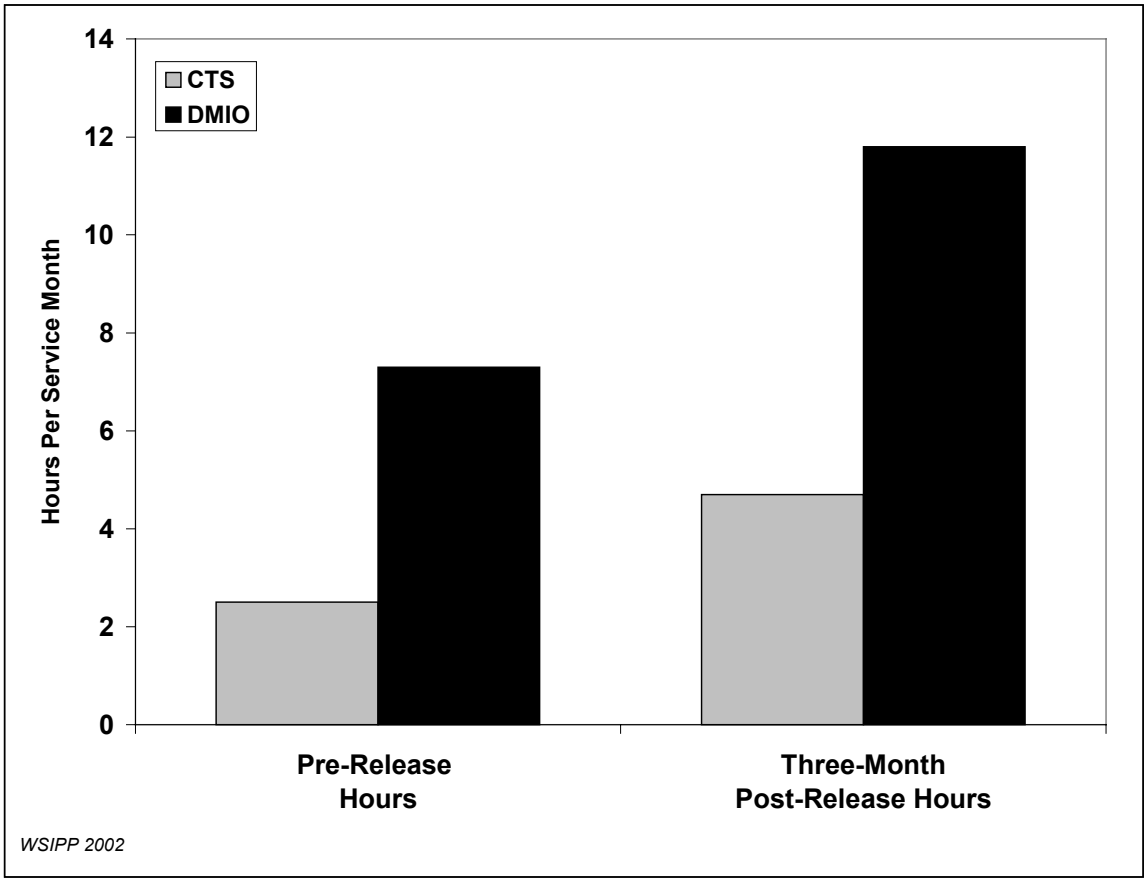


Figure 5.3 shows the community mental health outpatient service hours for CTS and DMIOs during prison transition and in the first three months after release. During prison transition, the 10 percent of CTS subjects receiving services averaged 2.52 hours per service month, while the 83 percent of DMIOs receiving services averaged 7.3 hours per service month. In the community, the 29 percent of CTS subjects receiving services averaged 4.7 hours per month for the first three months after release, while the 94 percent of DMIO participants receiving services averaged 11.8 hours. All of these differences between CTS subjects and DMIO

participants are highly significant, indicating the DMIO program is making a considerable difference in providing pre- and post-release community mental health services to DMIOs.[44]

Figure 5.3
Pre- and Post-Release Community Mental Health Service Hours, Through September 2001



Mental health inpatient stays for DMIO participants are shown in Table 5.7.[45] Overall, eight offenders have had an inpatient hospital stay after prison release. As mentioned earlier, seven DMIO participants were committed to a state hospital at the time of prison release under the involuntary mental health civil commitment law. Two of the seven have had a short stay in residence; the others have had longer stays, including four offenders who are still in residence as of September 2001, and one who was released and has returned. Overall, state hospital days for the participant ranged from three to 326, with an average of 126 days. Five offenders per year were projected by the MHD budget to be placed in a state hospital; thus, the projections were fairly close to what has occurred. One offender was admitted to an Evaluation and Treatment inpatient setting for a six-day period post-release.

[44] This report does not examine service problems in the community. In spite of these strong numbers, RSN and community provider staff report problems, including a need to streamline the Medicaid eligibility process and difficulties in obtaining housing for DMIOs.
[45] Data with an equivalent follow-up time period are not yet available to compare DMIO and CTS inpatient treatment.

Table 5.7
Post-Release Inpatient Treatment, Through September 2001

Type	Number of Offenders	Percent	Average Length of Stay
Inpatient MH Services	8	22%	
State hospital	7	19%	126 days
Evaluation and Treatment	1	3%	6 days

N=36

Community Drug/Alcohol Treatment

Figure 5.4 and Table 5.8 display the chemical dependency treatment provided to released offenders through the Division of Alcohol and Substance Abuse (DASA) contractors through September 2001. Twenty-nine offenders could have been considered for assessment and treatment (offenders who remain institutionalized under RCW 71.05 or RCW 71.09 are excluded as is the one offender who moved out-of-state). Overall, 13 of the 29 offenders received some type of chemical dependency (CD) services through September 2001 (approximately 45 percent). Figure 5.4 shows the difference in post-release CD services between the DMIO and CTS groups. The proportion of DMIO participants receiving CD services is considerably greater than that of the CTS subjects, of whom only 25 percent received any CD services after release.

Figure 5.4
Post-Release Drug and Alcohol Services, Through September 2001

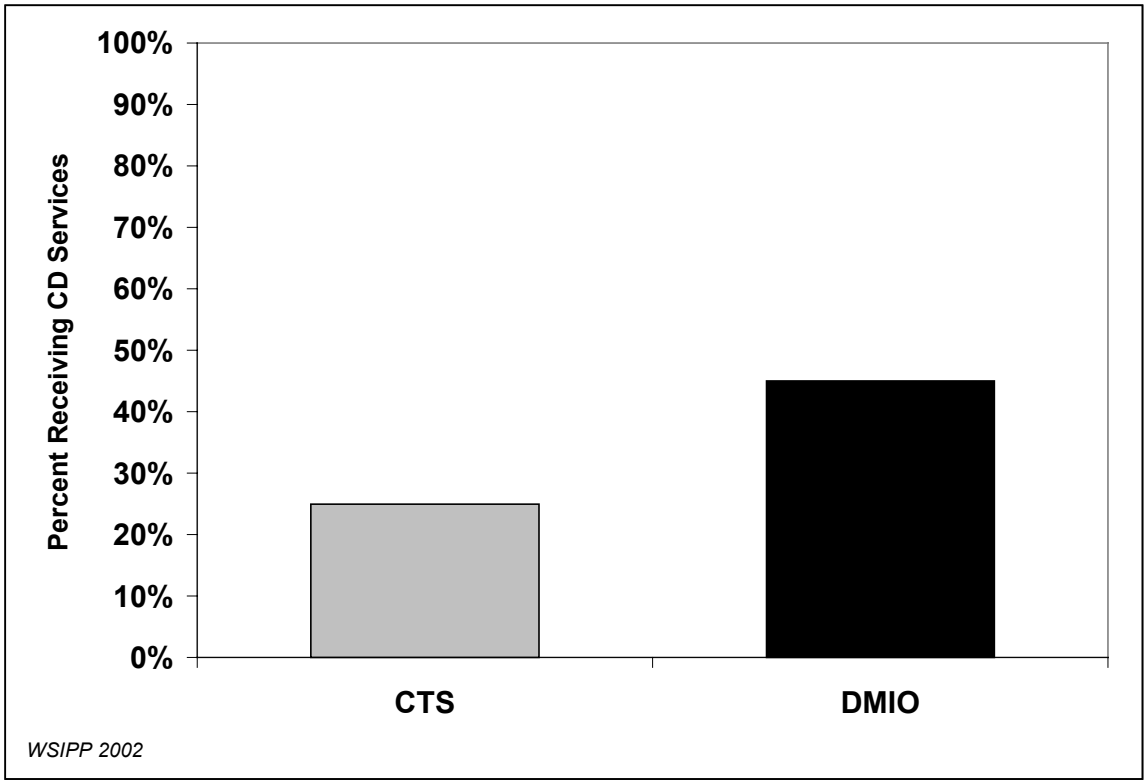


Table 5.8
Community Drug/Alcohol Services Received Under DASA Contract, Through September 2001

Service Type	Number of Offenders	Percent	Status as of 9/2001
Total eligible	29		
Any CD services	13	45%	
CD assessment	9	31%	
CD treatment	10*	34%	
Outpatient	6		Ongoing
Intensive outpatient	1		Completed
Intensive inpatient	2		1 completed; 1 ongoing
Long-term	2		1 completed; 1 ongoing

*One offender received both inpatient and outpatient treatment

As shown in Table 5.8, nine DMIOs were assessed for CD treatment immediately prior to or after release. Ten offenders have received CD treatment (approximately 34 percent). Outpatient treatment is most common: six offenders continue to participate in this treatment as of September 2001. One offender has completed an intensive outpatient program; and two offenders have been treated in intensive inpatient programs, one having completed treatment and another in treatment as of September 2001. Finally, two offenders have been admitted to long-term treatment: one offender has completed treatment and one continues in this program as of September 2001. It is likely that a few offenders are receiving treatment through providers not under contract to DASA, so we may not be capturing the full extent of CD treatment.[46]

Post-Release Criminal Justice Events

Table 5.9 shows the post-release criminal justice events of 29 DMIO participants who have been in the community at some time and "at-risk" to reoffend. Overall, offenders have been in the community for an average of 6.7 months through September 2001. While it is too early to formally evaluate criminal recidivism, these statistics provide an early look at how DMIO participants are faring in the community.

An offender may have conditions set by the court at the time of sentencing that he or she is required to abide by during post-confinement supervision. In addition, there are general DOC supervision requirements for community supervision. When an offender violates any of the conditions, he or she can receive a supervision violation, and sanctions may be imposed.

Approximately 48 percent of DMIO participants have received a supervision violation after release. Given the short time-at-risk for these offenders, this is a relatively high rate.[47]

[46] Federal confidentiality laws prevent the collection of CD treatment information from mental health providers; thus, we rely entirely on the DASA TARGET database for information. The TARGET database includes treatment information for those persons who are receiving services under a DASA contract. One major mental health provider in this study provides CD treatment services not funded by DASA.
[47] Less than 42 percent of Risk Management Level A (RMA) offenders released from prison had a violation within six months of release.

However, this is not unexpected; DMIO participants are considered the highest-risk management level and should receive a high level of supervision, which appears to be the case. Of the 14 offenders receiving violations, the most common violation was use of alcohol or a controlled substance and failure to comply with treatment. But there were a wide range of other violations, from failure to pay or appear, unapproved residence or employment changes, contact with the crime victims, or escape. The violation sanction for 31 percent of the offenders included confinement time in a DOC facility or county jail.

Table 5.9
Criminal Justice Events of Released DMIO Participants Through September 2001

Event	Number of Offenders	Percent of Total at-Risk
DMIOs at-risk	29	100%
DOC violations	14	48%
Confinement	9	31%
Arrested	14	48%
Misdemeanor conviction	5	17%
Violent	2	
Drug	1	
Other	2	
Felony conviction	0	

Overall, 48 percent of those at-risk have been arrested.[48] There have been no felony charges or convictions for DMIO participants through September 2001. Five offenders have been convicted for at least one misdemeanor crime post-release. Table 5.9 shows the most serious misdemeanor convictions, including two violent offenses—Assault 4; one marijuana possession; and two other offenses—patronizing a prostitute and driving under the influence. Two offenders had multiple convictions. This included one offender with three convictions: two for driving while license suspended and one for drug possession. The second offender had two convictions: one for Assault 4 and one for Escape 2.

This amount of involvement with the criminal justice system is not unexpected for the DMIO population. Misdemeanor convictions were common for the CTS population. Prior to a felony conviction, there is usually a pattern of misdemeanant activity or supervision violations (termed "harbinger offenses"), which could be considered a warning for increased risk of felony offenses. Hopefully, these patterns have been identified by the DMIO program, and program intervention has provided the necessary treatment and supervision to reduce this risk. The final evaluation of the DMIO program will estimate the degree to which the program reduces recidivism.

[48] The arrest data are not from official records and should be considered tentative.

Summary

The 36 DMIO program participants released through June 2001 are similar to all offenders selected for the program. They have a fairly extensive felony history, which includes a violent offense. Risk assessment instruments put them at medium to high risk to reoffend. Most have received mental health services in prison, but few have received sex offender or chemical dependency treatment in prison.

The DMIO program provides several release options, including community treatment or referral for involuntary civil commitment. Of the 36 program participants, 26 offenders were released into the community, one offender was released to another state, seven were civilly committed upon release to the state hospital under involuntary mental health treatment laws (RCW 71.05), and two were institutionalized pending civil commitment proceedings under sexual predator laws (RCW 71.09). Thirty of the offenders released into the community were supervised by DOC after release; of the six that were not, three were committed to the state hospital, and three were released to the community.

Prior to incarceration, the majority of the DMIO participants received public mental health services, although the services received were not extensive. Through the DMIO program, nearly all offenders received pre- and post-release community mental health services. The service hours were much greater than those received by the CTS subjects, indicating that the program has been working as envisioned, and offenders have been receiving needed transitional and community treatment services. In addition, chemical dependency services have been provided to nearly half the DMIOs, with approximately 34 percent actually receiving some type of treatment.

About half the DMIO participants have received a DMIO supervision violation, and half have been arrested after release from prison. DMIOs are considered the highest risk level, so the high violation rate is likely a reflection of behavior and the supervision level. No new felony charges or convictions have been recorded for DMIO participants through September 2001, but five offenders have been convicted of a new misdemeanor offense.

VI. CHALLENGES FACING THE DMIO PROGRAM

It is a great program success that most DMIO offenders are receiving needed transitional and community services and the services and hours provided are significantly greater in number than those received by CTS subjects. However, there has been a substantial amount of conflict involving state and local agencies participating in the DMIO program, which needs to be openly discussed and resolved to assure the continued participation of all agencies.

One of the major lessons learned from implementing the DMIO program has been how difficult it is for state agencies and the communities to reach consensus and work together on the same team. Some of the problems include the following: disagreements over what definition of mental disorder will be used to select DMIOs, disagreement about what MIO characteristics constitute high risk to reoffend, conflict and confusion over who should bear the burden of liability if a DMIO reoffends and harms someone, how and under what circumstance should agency information systems be linked to better identify and track MIOs, and what information should be shared or tracked.

The first step in implementing a DMIO program is to identify the DMIOs, and the first step in identifying the DMIOs is to find the MIOs. A major program weakness is assuming that DOC already has an efficient, accurate method for identifying mentally ill offenders. The truth is that DOC has struggled for years with the task of identifying its mentally ill offenders and, despite much work and substantial progress, it is not providing the quality level of mental health assessment services it wishes it could provide. This is evident in the Healthcare Facility Masterplan, Report No. 1 (State of Washington, DOC, 2001), written by DOC-hired consultants. The report states unequivocally that in regard to DOC mental health care "…[t]he current delivery system does not ensure the consistent identification of offenders with mental health issues" (p. 10). Before passage of SSB 5011, DOC did not have sufficient mental health services infrastructure to select MIOs for DMIO services; largely, it still does not possess sufficient capability to do this in a routine, efficient manner.

Like many other states, Washington's DOC has not yet built sufficient infrastructure to assess the dangerousness risk of its mentally ill offenders. Although SSB 5011 encourages DOC to develop and test a risk assessment methodology to identify DMIOs, it does not create for them the infrastructure to accomplish this task. Consequently, there is still no agreed upon method to measure MIO dangerousness. Much of the responsibility to select dangerous MIOs has been delegated to a few DOC staff, and the rest has been reserved for SRC vote.[49]

With these considerations in mind, we now identify some of the principal obstacles to the successful implementation of the DMIO program and offer recommendations for improvement.

[49] Dangerousness selection, although it ought to be informed by clinical risk assessment, as well as actuarial risk assessment, is not equivalent to risk assessment nor is it a substitute for risk assessment; neither is a committee vote a risk assessment.

Identification and Selection Processes

At present, the assessment of whether an inmate is seriously mentally ill and whether the inmate is dangerous is confounded. These are two separate questions. We continue to believe, as did the DMIO Identification Workgroup, that selection should proceed in two separate stages: (1) identify offenders who are seriously mentally ill, and (2) then decide which offenders with serious mental illness pose the greatest risk for reoffense in general, and in particular, violent reoffense. These recommendations are difficult to implement since they require new DOC infrastructure. Central to both stages is the development of a more useful DOC mental health database.

The DMIO Identification Workgroup criteria for DMIO identification and selection were partially implemented. These criteria were ambitious, and limited resources, data limitations, and staff turnover appeared to have worked against full implementation. Formalized methods for decision-making are still lacking. Consequently, ordinary staff and clinical judgment remains the primary method used in the screening process to assess mental disorder and dangerousness. A formalized method should be developed and adopted.

Although the SRC has set out definitions for dangerousness (see Appendix C), there appears to be no formal scoring criteria used to assess dangerousness. While the SRC may consider the information provided by a number of factors and risk instruments, it would be useful to establish more specific criteria to standardize decision-making.

Insurance Liability Issues

Insurance liability issues pose a continuing threat to the DMIO program and need to be resolved quickly. These issues will require discussions with all involved parties, including the legislature and state and local agencies. DMIOs are a priority population that Washington State has mandated receive transitional and community mental health and other services. Research shows that the coordination of social service and criminal justice agencies in working with this population promotes better outcomes. The program needs all organizations partnering together to help this complex, challenging population of offenders.

Specific Suggestions for Improvement

The following specific suggestions are motivated by three major concerns: (1) improving efficiency and accuracy of decision-making among the parties, (2) improving accountability, and (3) ensuring accurate and comprehensive program data.

Electronic Records:

- Establish and maintain DOC electronic mental health and treatment records on psychosocial history, diagnostic and test data, medication prescription records, course and length of stay in mental health units, and use of restrictive services such as segregation and intensive management.
- Run the OBTS electronic algorithm monthly as opposed to quarterly to avoid missing offenders with shorter prison sentences.
- Create an electronic record of important risk assessment data.
- Develop formal electronic information links with DSHS databases to determine whether DOC inmates have a mental illness history and the extent of that history.
- Develop, where possible, formal electronic information links with RSN databases to determine whether DOC inmates have a history of community treatment.

Identification and Selection:

- Develop a formal, objective method or scoring system for selecting inmates from those initially screened MIO positive by the electronic OBTS indicators and electronically document the method or system for each candidate.
- DOC, DSHS, the communities, and the SRC need to come to an agreement about which objective criteria (diagnosis, functional impairment) will qualify a candidate as mentally ill for purposes of the DMIO program. Strong consideration needs to be given to adopting mental health system definitions and criteria that help establish eligibility for financial and social services in the community as has been recommended in the CTS report (Lovell et al., 2001, p. 24).

Statewide Review Committee Procedures:

- Debating diagnostic issues at the level of the SRC is problematic, especially since many of the SRC members are not legally licensed by the Department of Health to make mental health diagnoses and, even if they were so licensed, doubtlessly could arrive at a meaningful diagnosis without having personally conducted a clinical assessment of the offender under consideration. We recommend that DOC be given primary authority to decide who among their inmates is mentally ill. In addition, we recommend that DOC prepare case files to support its decision (diagnosis, clinical history, medication, and treatment history, etc.). DOC should also consider conducting additional psychological evaluations of candidates as necessary. The SRC should be allowed to override DOC's decision on who is seriously mentally ill, but only upon formal motion and only after a formal review process/hearing adopted by the SRC. An alternative would be to refer difficult cases to a subcommittee of providers licensed to make mental diagnoses, composed of representatives from DOC, MHD, an RSN, and the community.

Dangerousness Screening:

- A decision must be made about what process to follow to screen MIOs for dangerousness:
  - Who should conduct the dangerousness screening/evaluation: DOC, the SRC, or both?
  - Should there be a screening stage and a more in-depth assessment stage, or should the dangerousness evaluation be accomplished in one stage?
  - If both DOC and the SRC conduct dangerousness screening and/or evaluation, then how should the task be divided?
  - Which specific elements of the inmate file are to be considered for risk assessment and, if the risk assessment task is to be shared between DOC and the SRC, who should assess which elements of risk at which stage of risk assessment?

Documentation:

- DOC needs to work more closely with SRC members to identify documentation considered critical for review decisions. It also needs to work on standardizing the packets of information provided to the SRC. We recommend that DOC work to streamline case files to include only those clinical and risk data items that the SRC deems essential to its decision-making task. Additional file information could be made available in a secondary file for further review if the primary file has been reviewed, discussed, and found wanting in some important aspect.
- Electronically document DOC and SRC reasons for accepting or rejecting an inmate for DMIO services.

Oversight:

- Develop a formal oversight process whereby the SRC periodically reviews the status of DMIOs released to the community or to other settings, such as the state hospitals. Currently, the researchers receive requests about the status of participants, to which we cannot respond due to Human Research Review Board confidentiality agreements. A formalized process for reviewing and tracking offenders needs to be implemented at the state and local levels.

Labels:

- Consider changing the program name from “Dangerous Mentally Ill Offenders” to “High-Needs” Mentally Ill Offenders or a similar more neutral term. This label has caused difficulties, including the inability to obtain housing.

To carry out these tasks, it may be useful to go back and revisit the quality management initiative and develop or reinstate work teams as necessary.

Toward the Future

Program implementation at an inter-agency level is a challenge, but even more so when it involves a complex program with many different organizations and individuals who have not worked together in any sustained manner. Consistent with the intent of SSB 5011, new connections are being built between the correctional and mental health systems. However, this will take time and effort, as the program is still in a formative stage of development. New staff and staff/program turnover have doubtless added to the complexity of program implementation, as individuals must learn new procedures and how to navigate in organizations and committees that are new or foreign to them. A system for better identification, treatment, and management of the risks that MIOs pose for violent recidivism cannot be built in a year or two; it is at least a decade-long enterprise.

Despite understandable problems with its implementation, the DMIO program possesses a subtle, largely unrecognized strength that deserves illumination. Diverse organizations are being brought together, new channels of communication are opening, and those involved are increasing their efforts to work with this challenging population. In some respects, creating new roads to inter-agency communication has been the largest and most impressive accomplishment of the DMIO program. As a result of two years of hard work and learning, the program is now prepared to move forward to tackle the serious issues identified by the Legislature. Many challenges remain, but they are worth overcoming regardless of how daunting they may appear.

We expect in future reports to provide the Legislature with more detailed information about DMIOs as more are identified and released to the community. We especially look forward to learning more about which pre-release characteristics of DMIOs predict success and failure in the community, which community services reduce recidivism, and whether these reductions in recidivism are cost-effective.

BIBLIOGRAPHY

Aos, Steve. 2002. *Washington's Offender Accountability Act: An Evaluation of the Department of Corrections' Risk Management Identification System*. Washington State Institute for Public Policy (January).

Aos, Steve, Polly Phipps, Robert Barnoski, and Roxanne Lieb. 2001. *The Comparative Costs and Benefits of Programs to Reduce Crime, Version 4.0*. Washington State Institute for Public Policy (May).

Gendreau, Paul, T. Little, and C. Goggin. 1996. "A Meta-analysis of the Predictors of Adult Offender Recidivism: What Works." *Criminology* 34: 575-607.

Girard, L. 1999. *The Level of Services Inventory-Ontario Revision: Risk/Need Assessment and Recidivism* (pp. 142-164, 191-193). Doctoral dissertation. National Library of Canada: Ottawa, ON.

Hilton, N. Zoe and Janet L. Simmons. 2001. The Influence of Actuarial Risk Assessment in Clinical Judgments and Tribunal Decisions about Mentally Disordered Offenders in Maximum Security. *Law and Human Behavior* 25: 393-408.

Lovell, David, Pete Wood, Katrina Moore, and Genevieve Arnaut. 2000. *Mentally Ill Offender Community Transitions*. The Washington Institute for Mental Illness Research and Training, University of Washington (March).

Lovell, David, Gregg Gagliardi, and Paul D. Peterson. 2001. *Community Transition Study: Mentally Ill Offenders.* The Washington Institute for Mental Illness Research and Training, University of Washington (November).

Lurigio, Arthur J. 2001. "Effective Services for Parolees with Mental Illness." *Crime and Delinquency* 47: 446-461.

Quinsey, V. L., G. T. Harris, M. E. Rice, and C. A. Cormier. 1998. *Violent Offenders: Appraising and Managing Risk*. Washington, D.C.: American Psychological Association Press.

State of Washington, Department of Corrections. 2001. *Healthcare Facility Masterplan, Report No. 1.* Submitted by DLR Group, Pulitzer/Bogard and Associates (June).

Steadman, Henry J., Edward P. Mulvey, John Monahan, Pamela Clark Robbins, Paul S. Appelbaum, Thomas Grisso, Loren H. Roth, and Eric Silver. 1998. "Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhood." *Archives of General Psychiatry* 55: 393-401.

APPENDIX A: QUALITY MANAGEMENT INITIATIVE—PROPOSED DMIO IDENTIFICATION CRITERIA

I. Time -18 months to earned release date
II. Mentally Disordered
    a. Mentally Ill, as defined by any one of the following:
        i. Algorithm
            1. Offender profile battery mental health needs score of >=3
            2. >=30 days in prison mental health unit
            3. PUHLES score of 3 for men, 4 for women
            4. Serious mentally ill offender flag or axis I diagnosis
        ii. Previous psychiatric hospitalization, or
        iii. Clinical adjustment
    b. Developmentally disabled
        i. Meets state eligibility criteria for DDD services
III. Dangerous
    a. Risk of recidivism
        i. Sex offenders (male, female and DD): Supervision and management assessment =High (using MSOST, RRASOR and clinical evaluation)
        ii. Female (incl. DD): Multidisciplinary team assessment=High risk
        iii. Male (incl. DD) meet any one of the following:
            1. LSI-R is 50th% or higher,
            2. 8+ prior arrests,
            3. 3+ prior felony convictions, or
            4. Age at first arrest under 17 and age at release under 25
        iv. History of involuntary medications
    b. Violence
        i. Offenses
            1. No violent offense = 0 points
            2. 1 violent offense = 1 point
            3. 2 or more violent offenses = 2 points
            4. 1 or more serious violent offenses = 2 points
        ii. Selected Infractions
            1. None = 0 points
            2. 1 in the last 12 months = 1 point
            3. 1 additional in history = 1 point
            4. 2+ infractions in the last 12 months = 2 points
            5. 2+ additional in history = 2 points
    c. Chemical dependency
        i. None or one “yes” = 0 points; 2 or more “yes” = 1 point
            1. One or more prior alcohol or drug related arrests
            2. Index offense is drug or alcohol related
            3. Infractions are drug or alcohol related
            4. Self identifies as chemically dependent (SASSI, TCU)
            5. Offender profile report “+” for chemical dependency
    d. Involuntary medications
        i. Currently receiving involuntary medications = 2 points

IV. Final Prioritization
    a. Committee
        i. Function: Select/prioritize for participation from eligible ranked offenders
        ii. Composition: Multi-System Care Planning Team (recommend inclusion of forensic psychology with risk assessment expertise, and a community mental health provider)
    b. Tools
        i. Optional dynamic risk assessments: VRAG and PIC
        ii. History and rate of infractions
        iii. Victim witness enrollees

APPENDIX B: DEPARTMENT OF CORRECTIONS DMIO PRE-SCREENING FORM

Name: _____ **DOC ID:**

Institution: _____ **ERD:** _____
MAX: _____

CURRENT OR MOST RECENT DIAGNOSIS:

- **AXIS I** _____
  _____
- **AXIS II** _____
  _____

Is Developmentally Disabled: ☐ Yes ☐ No

CURRENT PSYCHOTROPIC MEDICATIONS:

☐ Involuntary ☐ Voluntary Medications

- **LIST:** _____
  _____
  _____

CURRENTLY:

Has an active mental health treatment plan: ☐ Yes ☐ No

COMMENTS:

_____
_____
_____

Reviewer:: _____ Date: _____
Please Print First/Last Name

Please mail form with **10 days** of receipt to: Tom Saltrup PhD. DMIO Program Manager, MS: 41127, Olympia, WA 98504-1127; or fax to (360) 586-9055. All questions should be directed to Tom Saltrup (360) 586-4371.

APPENDIX C: STATEWIDE REVIEW COMMITTEE'S MENTAL DISORDER AND DANGEROUSNESS CRITERIA

"**Mental disorder**" means any organic, mental, or emotional impairment, which has substantial adverse effects on an individual's cognitive or volitional functions. **RCW 71.05.020**

Operationalized definition*:*

"Organic, mental, or emotional impairment" means

- any organic brain defect, damage or injury (such as traumatic brain injury, developmental disability, and dementia)
- mental or emotional illness (thought and affective disorders such as schizophrenia, schizoaffective disorder, bi-polar affective disorder, major depression, severe mood, anxiety or dissociative disorders, borderline personality or other disorders with psychotic features. It does not include substance abuse/addiction disorders or most personality disorders.)

"Substantial adverse effects" means

- untreated, has a major impairment on

"An individual's cognitive or volitional functions" means

- functions of thinking, decision-making or making choices

Dangerous to self

- Substantial risk
- Violent act

Consider:

- Suicide attempts: number, frequency, and seriousness
- Acts of self harm: number, frequency, and seriousness
- Substance abuse or addiction and its relationship to suicide attempts or acts of self harm

Dangerous to others

Consider:

- LSI-R score
- Community Transition Study Risk Levels: new felony offense and new crimes against persons
- Previous convictions: violence and number
- Age at first arrest
- Use of a weapon
- Institutional infractions: number and seriousness
- Substance abuse or addiction and its relationship to crimes

APPENDIX D: DETAILED INDEX OFFENSE CATEGORIES

Most Serious Violent	Any Violent	Serious Sex	All Sex	Non-Violent
• Murder 1 • Murder 2 • Manslaughter 1 • Manslaughter 2 • Vehicular Homicide • Child rape • Rape 1 • Rape 2 • Rape other • Rape child 2 • Indecent liberties • Violent sex, child • Robbery 1 • Robbery 2 • Assault 1 • Kidnapping 1 • Kidnapping 2	• Murder 1 • Murder 2 • Manslaughter 1 • Manslaughter 2 • Vehicular Homicide • Child rape • Rape 1 • Rape 2 • Rape other • Rape child 2 • Indecent liberties • Violent sex, child • Robbery 1 • Robbery 2 • Assault 1 • Kidnapping 1 • Kidnapping 2 • Extortion 1 • Assault 2 • Vehicular assault • Assault, DV • Arson 1 • Arson 2	• Child rape • Rape 1 • Rape 2 • Rape other • Rape child 2 • Indecent liberties • Violent sex, child	• Child rape • Rape 1 • Rape 2 • Rape other • Rape child 2 • Indecent liberties • Violent sex, child • Non-violent sex, child • Other sex • Public nuisance, sex	• Non-violent sex, child • Other sex • Public nuisance, sex • Extortion 2 • Burglary 1 • Burglary 2 • Theft 1 • Auto theft • Forgery • Welfare fraud • Property other • Theft 2 • Drug • Felony other

APPENDIX E: CTS RISK FACTORS FOR NEW FELONIES AND NEW CRIMES AGAINST PERSONS*

New Felonies	Crimes Against Persons
Number of prior felonies (+)	Number of prior violent felonies (+)
Number of prior drug felonies (+)	Age at prison release (-)
Age at first known offense (-)	Felony versatility (+)
First-time sex offense (-)	Female gender (-)
Felony versatility (+)	First-time sex offense (-)
	Yearly prison infraction rate (+)

Predictive Power Measures

Area under ROC (AUC) = .82	Area under ROC (AUC) = .77
r^2 = .29	r^2 = .18

* N=333

Note: Felony versatility ranged in value from 1 to 4 depending on how many of four major felony types—drug offenses, property offenses, sex offenses, and (non-sex) violent offenses—were found in the subject's criminal history. The statistic r^2 is the coefficient of determination, an r^2 analog in logistic regression similar to the r^2 used in ordinary least squares regression, which adjusts r^2 for the fact that the dependant variable is discrete (i.e., constricted in range from 0 to 1).

APPENDIX F: COMMUNITY TRANSITIONS STUDY (CTS) COMPARISON TABLE FOR ESTIMATING DMIO ACTUAL RISK FOR RECIDIVISM

The table below shows how the identified, candidate DMIOs compare with MIOs from the CTS in terms of recidivism risk. Care should be exercised in making these comparisons.

- The comparative risk levels in the table are actuarial, that is, they reflect rates of recidivism among CTS offenders with comparable criminal and correctional histories. There may be other factors in particular cases that the SRC should consider.
- Criminal history shown in the tables was extracted from electronic databases, which contain a small amount of error. In addition, these databases do not include crimes committed in other states. If the offender has multiple previous out-of-state offenses, these actuarial risk scores, based only on Washington data, will be invalid.
- Some candidates may be missing from this list. Risk scores are calculated for candidates in the combined Institute-DOC candidate database, which includes offenders with two or more of these OBTS mental illness indicators: prison intake interviews indicating significant mental health concerns; 30 or more days in a prison mental health unit; classified as needing continuing psychiatric medications in prison; Axis I diagnosis, or interview by DOC mental health staff confirming a serious mental illness.

Person ID Number	**000001**	**000002**	**000003**	**000004**	**000005**
Age at first offense	20	18	15	15	15
Projected age at release	36	36	31	34	23
Sex (1=M, 2=F)	1	1	1	1	2
WA violent felony convictions[1]	2	1	2	4	1
WA sex felony convictions[1]	0	1	0	2	0
WA drug felony convictions[1]	4	0	0	0	0
WA felony convictions[1]	7	2	5	6	2
Criminal versatility (1-4)[2]	3	2	2	2	2
Annual major infraction rate[3]	1.61	0	1.88	0	2.65
First WA sex felony (0=no, 1=yes)[4]	0	1	0	0	0
Probability of new felony	94%	7%	54%	59%	40%
Probability of new crime vs. person[5]	41%	8%	34%	60%	20%

[1] These include the felony conviction(s) for which the offender is currently incarcerated. Convictions are counted as the most serious offense per offense date.

[2] Versatility scored 1-4 based on the number of different types of offenses (drug, property, sex, violent) for which the offender has been convicted.

[3] Based on the number of serious infractions during the *current* DOC incarceration (if less than 6 months of data available in current incarceration, the average rate of 1 per year is used).

[4] First-time felony sex offenders *as a group* have lower rates of felony recidivism, but other factors, such as out-of-state convictions or special features of the offense, may mean that this factor doesn't apply as predicted to a particular case.

[5] For these purposes, offenses against persons include first-degree burglary and arson, misdemeanor assaults, and felony violent or sex offenses.

APPENDIX G: AGENCY RESPONSES TO REPORT RECOMMENDATIONS

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, WA 98504-5000

February 26, 2002

Steve Aos, Acting Director
Washington State Institute for Public Policy
P.O. Box 40999
Olympia, Washington 98504-0999

Dear Mr. Aos:

Thank you for the opportunity to comment on your interim report on the implementation of Washington's dangerous mentally ill offenders (DMIO) law.

Your identification of the insurance liability issue is congruent with our own concerns. Lack of insurance will undermine, if not doom, the program. The Department of Social and Health Services (DSHS), in concert with the Department of Corrections (DOC) and concerned legislators, has worked toward a legislative resolution of this program. Representative Kirby sponsored HB 2672 which will, if passed, limit liability for Regional Support Networks (RSNs) and community providers of services for persons designated as DMIO.

Prior to this liability issue arising, most RSNs and community providers were willing to sign DMIO contracts. With legislative relief, we anticipate that most of them will again be willing to sign.

We in DSHS are also working with DOC as they address the other findings and recommendations presented in your report. In particular, we are all working to more clearly and consistently define "mental disorder" and identify the use of a research-based risk assessment tool. At the same time, we are working to better understand the concept of "dangerous" with particular attention to legislative intent. While "risk-to-re-offend" is clearly included, some suggest including an element reflecting the harm or impact of re-offense even if there is a low likelihood of it occurring.

Thank you again for the opportunity to comment. We look forward to the final report.

Sincerely,

Timothy R. Brown, Ph.D.
Assistant Secretary
Health and Rehabilitative Services Administration

cc: Dennis Braddock, Secretary
Department of Social and Health Services

Joseph Lehman, Secretary
Department of Corrections

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
OFFICE OF THE SECRETARY
P.O. Box 41101 • Olympia, Washington 98504-1101 • (360) 753-2500
FAX (360) 664-4056

February 22, 2002

Steve Aos, Acting Director
Washington Institute for Public Policy
P.O. Box 40999
Olympia, WA 98504-0999

Dear Steve:

Thank you for the opportunity to provide comment on the Washington State Institute of Public Policy report on Dangerous Mentally Ill Offenders. I would like to offer the following for your review.

1. First Finding: Identifying and Selecting Dangerous Mentally Ill Offenders (DMIO)

The selection process for identifying potential candidates to be presented to the Statewide DMIO Committee is the responsibility of the Department of Corrections and while there have been difficulties during the implementation phase of this process, there have been marked changes and advances in the process in the last eighteen months.

Mental illness diagnoses are complex and often present with overlapping symptomotology. The identification of a "precise" diagnosis is not only quite difficult but is often unlikely. This is true for any specific system whether it is in the Department of Corrections (DOC), a state hospital or community mental health agency. Diagnoses are fluid and changes are more likely the rule than the exception. This is not necessarily evidence of a lack of assessment or treatment quality but is understandably part of the overall picture. It is very important to obtain collateral clinical information from as many providers as possible. The Department is actively engaged in enhancing its clinical programs and the information available needed for this program.

The committee has had a working definition of what constitutes a "Major Mental Disorder". This definition is narrow as it parallels criteria for major mental illness as defined under RCW 71.05.020. It includes the diagnoses of Schizophrenia,

Psychoses, Major Affective and Mood Disorders and such other mental disorder which have substantial adverse effects on an individual's cognitive and volitional functions (this includes Developmentally Disabled individuals). Within DOC the definition of Seriously Mentally Ill (SMI) (as entered on the Offender Based Tracking System (OBTS) database) includes a significant number of individuals who do not qualify under the Major Mental Disorder definition as adopted by the Committee. The difference in definitions generate a great deal of work to more specifically identify those individuals who were appropriate for consideration and to exclude a high number of individuals who do not meet the diagnostic criteria.

The identification of individuals based on electronic data gathering is an integral first step but has included many "false positives" for DMIO selection purposes. Most of the initial data regarding the identification and selection process of DMIO's is in hard copy and therefore is not electronically available to the Institute. DOC has implemented electronic recording of the selection process and decisions for DMIO's. The electronic "running" of the algorithm is now done on a monthly basis as compared to the quarterly basis previously used. Since there is not a shared electronic/data based system in place. Accessing information from the state hospitals and community providers continues to be performed through direct contact.

DOC has consistently utilized a distinct two step process in screening cases for DMIO committee consideration. The identification of a qualifying mental disorder is the first step. Once that determination is made, only then is the issue of dangerousness assessed. While the risks for recidivism as compared to the Committee's view of "dangerousness" may need to be further refined. DOC does use the Level of Service Inventory – Revised (LSI-R) tool and the Risk Management Identification (RMI) criteria established for the Offender Accountability Act. However, please note there is no known risk assessment instrument which has been validated by research that can accurately predict the "dangerousness" of mentally ill offenders or the nexus between mental illness and risk. If one is developed the committee would be likely to implement it as soon as possible.

2. Second Finding: Treating DMIO's: Insurance Liabilities Issues

DOC has been actively involved in discussing and addressing these issues with the community providers, Regional Support Networks (RSN) and the Mental Health Division. This has become a significant impairment to the DMIO program. DOC is actively supporting legislation providing for limited liability indemnification to RSN's and treatment providers. The implementation of collaborative inter-agency services has been a challenge for this program. The term "Dangerous Mentally Ill Offender" is emotionally laden to many individuals in the community as well as certain treatment providers. In many cases, this label has (in and of itself) presented obstacles to obtaining housing, certain treatment needs and services.

3. *Third Finding: Treating DMIO's*

DOC has an integral role to play in the DMIO program. The collaboration of several state agencies (DOC, DSHS –DASA, MHD, DDD) has been outstanding and has broken new ground in the ability to have agencies actively working together, sharing information, resources, and communications. The ability to engage this difficult population in services has been established and continues to be a focus for further development. The pre-release engagement of services has been of significant value to the individuals involved. Already preliminary data show that DMIO's are receiving services at a higher and more frequent rate than those not releasing as a DMIO. There needs to be continued work to better implement services in the community as well as internally with the DOC structure.

The Department of Corrections, Division of Alcohol and Substance Abuse and Mental Health Division personnel have provided presentations at several statewide conferences regarding the DMIO legislation, program and its implementation. These agencies continue to actively be involved in the community transitioning process and services for these designated DMIO's. This level of communication and involvement has been paramount to the successful implementation of the program. Many barriers had to be overcome and will need continued attention. DOC is committed to continuing in this effort to implement and refine the DMIO program for the benefit of all served.

Sincerely,

Joseph D. Lehman, Secretary
Department of Corrections

DOC RESPONSE TO WSIPP PRELIMINARY REPORT ON THE DANGEROUS MENTALLY ILL OFFENDER REPORT SPECIFIC SUGGESTIONS

RECOMMENDATION IN CONTINUING ITS FULL IMPLEMENTATION OF JLARC'S 1998 RECOMMENDATION	AGENCY POSITION	COMMENTS
1 - Electronic Records		
1a - Establish and maintain DOC electronic mental health and treatment records on psychosocial history, diagnostic and test data, medication prescription records, course and length of stay in mental health units, and use of restrictive services such as segregation and intensive management.	Partially Concur	The Dept currently has an electronic database which has mental health diagnoses, prescription records, length of stay, segregation, and IMU information. Psychological history, diagnostic and test data are available in hard copy. Establishing additional database information would not necessarily enhance accuracy of decision making but may make the process more efficient.
1b - Run the OBTS electronic algorithm monthly as opposed to quarterly to avoid missing offenders with shorter prison sentences.	Concur	This has been implemented effective Feb 2002.
1c - Create an electronic record of important risk assessment data.	Concur	The Dept has incorporated LSI-R data and RMI Risk Management data into its electronic database. This is partially available immediately. Institutional staff will be trained on the RMI assessment tool and the information will then be available electronically on all inmates.
1d - Develop formal electronic information links with DSHS databases to determine whether DOC inmates have a mental illness history and the extent of that history.	Concur	The Dept and MHD currently have limited information regarding clients, primarily that the client is known to both agencies. The shared database with more extensive and detailed histories would need to be established jointly.
1e - Develop, where possible, formal electronic information links with RSN databases to determine whether DOC inmates have a history of community treatment.	Concur	The information links currently are through direct contact. A formal electronic link would need to be established with the RSN, MHP, and DOC.

DOC RESPONSE TO WSIPP PRELIMINARY REPORT ON THE DANGEROUS MENTALLY ILL OFFENDER REPORT SPECIFIC SUGGESTIONS

2 - Identification and Selection		
2a - Develop a formal, objective method or scoring system for selecting inmates from those initially screened MIO positive by electronic OBTS indicators and electronically document the method or system for each candidate.	Partially Concur	The Dept agrees that the screening/selection process needs further refinement. There are many factors that are included and need to be considered which can be determined and documented. However, the development of a scoring system in and of itself is deemed overly simplistic in such a complex issue related to mental health, diagnostics, and risk/dangerousness factors.
2b - DOC, DSHS, the communities, and the Statewide Review Committee (SRC) need to come to an agreement about which objective criteria (diagnosis, functional impairment) will qualify a candidate as mentally ill for purposes of the DMIO program. Strong consideration needs to be given to adopting mental health system definitions and criteria that helps establish eligibility for financial and social services in the community as has been recommended in the CTS report. (Lovell, et al., 2002, p. 24).	Concern	The SRC has accepted the major mental disorder criteria/definition under RCW 71.05.200 as the working definition for SRC. Further refinement and review by the stakeholders involved to further develop the definition is supported by DOC.

DOC RESPONSE TO WSIPP PRELIMINARY REPORT ON THE DANGEROUS MENTALLY ILL OFFENDER REPORT SPECIFIC SUGGESTIONS

3 - Statewide Review Committee Procedures		
3a - Debating diagnostic issues at the level of the SRC is problematic, especially since many of the SRC members are not legally licensed by the Department of Health to make mental health diagnoses and, even if they were so licensed, doubtlessly could arrive at a meaningful diagnosis without having personally conducted a clinical assessment of the offender under consideration. We recommend that DOC be given primary authority to decide who among their inmates are mentally ill. In addition, we recommend that DOC prepare case files to support its decision (diagnosis, clinical history, medication, and treatment history, etc.). DOC should also consider conducting additional psychological evaluations of candidates as necessary. The SRC should be allowed to override DOC's decision on who is seriously mentally ill, but only upon formal motion and only after a formal review process/hearing adopted by the SRC. An alternative would be to refer difficult cases to a subcommittee of providers licensed to make mental diagnoses, composed by representatives from DOC, MHD, and RSN, and the community.	Mostly Disagree	This is a complex issue. As stated above, the SRC needs to further refine and clarify the current working definition of "major mental disorder" for DMIO criteria. This should be of benefit to help resolve this recommendation to some extent. It is currently the committee's responsibility to determine who meets criteria for the DMIO program and that includes assessing criteria for having a major mental disorder. If this authority is primarily given to DOC, the committee's role is greatly reduced.
4 - Dangerousness Screening		
A decision must be made about what process to follow to screen MIOs for dangerousness.		
4a - Who should conduct the dangerousness screening/evaluation: DOC, the SRC, or both? **4b** - Should there be a screening stage and a more in-depth assessment stage, or should the dangerousness evaluation be accomplished in one stage?	Concur	The Dept supports these recommendations. The Dept representation to the SRC (co-chair) and the MHD representative (co-chair) are scheduling additional SRC meetings to address these issues, format resolutions and recommendations

DOC RESPONSE TO WSIPP PRELIMINARY REPORT ON THE DANGEROUS MENTALLY ILL OFFENDER REPORT SPECIFIC SUGGESTIONS

4c - If both DOC and the SRC conduct dangerousness screening and/or evaluation, then how should the task be divided? **4d** - Which specific elements of the inmate file are to be considered for risk assessment and, if the risk assessment task is to be shared between DOC and the SRC, who should assess which elements of risk at what point of the risk assessment?		for further action.
5 - Documentation:		
5a - DOC needs to work more closely with SRC members to identify documentation considered critical for review decisions. DOC also needs to work on standardizing the packets of information provided to the SRC. We recommend that DOC work to streamline case files to include only those clinical and risk data items that the SRC deems essential to its decision-making task. Additional file information could be made available in a secondary file for further review if the primary file has been reviewed, discussed, and found wanting in some important aspect.	Concur	The Dept supports these recommendations. The Dept representation to the SRC (co-chair) and the MHD representative (co-chair) are scheduling additional SRC meetings to address these issues and format resolutions and recommendations for further action.
5b - Electronically document DOC and SRC reasons for accepting or rejecting an inmate for DMIO services.	Concur	The Dept has implemented the electronic documentation of decisions by the SRC. This is available in OBTS on both the DT07 (checkdate) screen as well as the DT37 (chronology) screen. Further classification codes on the DT07 have been requested.

DOC RESPONSE TO WSIPP PRELIMINARY REPORT ON THE DANGEROUS MENTALLY ILL OFFENDER REPORT SPECIFIC SUGGESTIONS

6 - Oversight:		
6a - Develop a formal oversight process whereby the SRC periodically reviews the status of DMIOs released to the community or to other settings, such as state hospitals. Currently, the researchers receive requests about the status of participants, to which we cannot respond due to Human Research Review Board Confidentiality Agreements. A formalized process for reviewing and tracking offenders needs to be implemented at the state and local levels.	Concur	The Dept supports these recommendations. The Dept representation to the SRC (co-chair) and the MHD representative (co-chair) are scheduling additional SRC meetings to address these issues and format resolutions and recommendations for further action.
7 - Labels:		
7a - Consider changing the program name from "Dangerous Mentally Ill Offenders" to "High-Needs" Mentally Ill Offenders or a similar more neutral term. This label has caused difficulties, including the inability to obtain housing.	Concur	
To carry out these tasks, it may be useful to go back and revisit the quality management initiate and develop or reinstate work teams as necessary.		