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March 2002

Implementation of Washington's Dangerous Mentally Ill Offender Law:

Preliminary Findings

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.

[1] Chapter 214, Laws of 1999.

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.

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.

Document No. 02-03-1901