Washington's Dangerous Mentally Ill Offender Law:
Program Costs and Developments

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with

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EXECUTIVE SUMMARY

In 1999, legislation was passed to better identify and provide additional mental health treatment for mentally ill offenders who were released from prison, who pose a threat to public safety, and agree to participate in the program.[1] A "Dangerous Mentally Ill Offender" (DMIO) is defined by the legislation as a person with a mental disorder who has been determined to be dangerous to self or others. Through interagency collaboration and state-funded mental health treatment and support services, the legislation intends to promote the safe transition of these individuals to the community.

In 2005, as required by the DMIO legislation, the Washington State Institute for Public Policy (Institute) completed the first evaluation of the program.[2] The 2005 report demonstrated that the DMIO program significantly reduced recidivism after 1 1/2 years. Overall, the program appeared to be accomplishing its other principal objectives, such as improved delivery of social services and improved living situations. The benefit-cost analysis in that report indicated that the reductions in DMIO recidivism generated financial benefits to taxpayers that were less than program costs. A January 2007 update of the recidivism analysis showed that reductions in criminal recidivism attributed to the "Dangerous Mentally Ill Offender" (DMIO) program are sustained at the 2 1/2-year mark and that benefits exceed program costs.[3]

Several questions about program implementation and costs remained unanswered in previous studies due to the short follow-up period and limitations in program administration and cost data. This supplemental report focuses on three questions:

1) What is the actual cost of the program per participant?

2) What goods and services are purchased with program funds?

3) How has the program changed since its inception?

Findings

Per-Person DMIO Program Costs Two Years After Release From Prison. The cost study was based on the records of 114 DMIO participants who were released between July 1, 2002, and December 31, 2003, and for whom cost data were available. For pre-release transitional services and two years of post-release services, costs averaged $19,390 per person. Expenditures were highest in the first six months then declined in each successive six-month period.

[1] SSB 5011, Chapter 214, Laws of 1999.
[2] D. Lovell, G. Gagliardi, & P. Phipps. (2005). *Washington's dangerous mentally ill offender law: Was community safety increased?* Olympia: Washington State Institute for Public Policy, Document No. 05-03-1901, available at <http://www.wsipp.wa.gov>.
[3] J. Mayfield. (2007). *The dangerous mentally ill offender program: Cost effectiveness 2.5 years after participants' prison release*. Olympia: Washington State Institute for Public Policy, Document No. 07-01-1902, available at <http://www.wsipp.wa.gov>.

Treatment and Other Supports Provided to DMIO Participants. In addition to defraying the additional costs of interagency collaboration and pre-release planning, DMIO funds are intended to support housing, mental health treatment for participants ineligible for Medicaid, and other clinical services such as chemical dependency and sex offender treatment. Expenditure patterns described in this report are based on a small group of individuals for whom detailed expenditure data were available.

For the pre-release period and two years after prison release,

- DMIO participants who were ineligible for Medicaid averaged 121 hours of mental health services funded by the program; and
- Medicaid-eligible participants averaged 424 hours of mental health services, largely supported by other funding sources.
- DMIO participants averaged 24 hours of chemical dependency treatment paid for by the DMIO program or other funding sources.

Expenditures for other goods and services provided to DMIO participants were distributed as follows:

- 82.4 percent for housing,
- 11.1 percent for personal expenses, and
- 6.5 percent for other clinical interventions such as sex offender and chemical dependency treatment.

Participation in the DMIO Program Has Grown Steadily. Monthly referrals have grown from four per month in the first year of implementation to an average of 12 to 14 monthly referrals in succeeding years. Because some participants are reincarcerated, move, or decide not to participate, participation rates were estimated using billing records. According to billing records, program participation rose from 112 enrollees in July 2003 to 165 enrollees in 2005, when enrollment levels appear to have stabilized.

Continued Collaboration Among Corrections and Social Services Staff. Informants working with the program since its implementation describe the constructive and collegial working relationships that have developed among members of the Statewide Review Committee, the interagency group that selects DMIO participants. Since the DMIO program began, there have been substantial improvements in collaboration and the extent to which field staff in corrections and social services understand each others' roles.

Changes in Organization and Policy That May Affect the DMIO Program. Informants expressed concerns that working relationships may be disrupted by organizational changes and shifting priorities. Issues cited by informants include the following:

- Federal restrictions on the use of Medicaid funds may increase the strain on limited state funds available for DMIO participants.

- Due to provider and insurance carrier concerns about the liability of working with a population labeled as “dangerous,” the number of Regional Support Networks (RSNs) accepting DMIO contracts fell from 13 to four.

- Coordination of services and accountability for overall program operations has been hampered by the withdrawal of RSNs, which normally supervise and track mental health services provided in their regions.

Conclusions

This review indicates that, where records were reasonably complete, the assistance provided to DMIO participants corresponds with billing levels and that funds are being spent according to the original design of the program. The process of compiling this report, however, revealed that it may be useful to develop a more consistent approach for recording participation, services provided, and expenditures for individual DMIO participants.

Key informants described the cooperative relationships among social service and corrections agencies have been built over the course of the program. They note, however, that continued collaboration among social service and correctional agencies could be undermined by state and federal policies affecting organizational responsibilities, funding, and eligibility. The reluctance of RSNs to participate in the program was also a source of considerable concern.

I. INTRODUCTION

In 1999, legislation was passed to better identify and provide additional mental health treatment for mentally ill offenders who were released from prison, who pose a threat to public safety, and agree to participate in the program.[4] A "Dangerous Mentally Ill Offender" is defined by the legislation as a person with a mental disorder who has been determined to be dangerous to self or others. Through interagency collaboration and state-funded mental health treatment and support services, the legislation intends to promote the safe transition of these individuals to the community. The legislation directs the following:

- The Department of Corrections (DOC), the Department of Social and Health Services (DSHS), the Regional Support Networks (RSNs), and treatment providers shall plan and deliver support services and treatment for the offenders upon release; and

- DSHS shall use supplemental funding to contract for DMIO case management and other services with RSNs or any other qualified and appropriate providers.

The legislation also directed the Washington State Institute for Public Policy (Institute) and the Washington Institute for Mental Illness Research and Training (WIMIRT) to determine if DMIO participation reduced criminal recidivism or inpatient hospitalization; access to mental health, drug/alcohol, case management, housing assistance, and other services was improved; whether the risk assessment tool assessing dangerousness was valid; and if the state saved money because of early Medicaid enrollment or reduced use of DOC beds.

The Institute has issued several reports addressing these issues. The principal findings are as follows:

Community Safety. Two-and-a-half years after prison release, recidivism rates were lower for DMIO participants than for a similar group of mentally ill offenders who did not participate in the program:[5]

- Fewer DMIO participants (40 percent) were reconvicted for a new offense (felony or misdemeanor) compared with a similar group of non-participants (64 percent);

- Fewer DMIO participants (22 percent) were reconvicted of felonies compared with a similar group of non-participants (40 percent).

Cost Savings for Taxpayers and Crime Victims. An analysis comparing the program's costs to the benefits (to taxpayers and crime victims) of lower criminal recidivism indicates participation in DMIO has a positive net economic impact:[6]

- The reductions in felonies associated with the program is valued, by taxpayers and crime victims, at approximately $820 per participant minus program costs;

- For every dollar spent on a program participant, there is a return of about $1.03.

[4] SSB 5011, Chapter 214, Laws of 1999.
[5] Mayfield (2007).
[6] Ibid.

Social Services. DMIO participants were connected more quickly to community social services and received more intensive services than a similar group of mentally ill offenders who did not participate in the program:[7]

- DMIO participants were more likely to begin receiving mental health services immediately upon release (59 percent compared with 14 percent);
- Community mental health treatment in the first year after release was provided to 76 percent of DMIO participants compared with 15 percent of a similar group of non-participants, averaging 9 and 2.5 billed hours per month of service, respectively;
- DMIO participants received faster access to Medicaid and other social services; and
- DMIO participants received more drug and alcohol treatment.

Study Objectives

The primary purpose of this study is to develop a more precise measurement of per-person program costs for DMIO participants and to describe how funds were spent. Previous studies were limited by the low number of participants who entered the DMIO program during its initial years, the relatively short follow-up periods, and missing data on program costs for many participants. An additional study objective was to identify factors that may have affected program implementation since it began in late in 2000. This report answers the following two questions:

- What were the actual program costs per participant, and how were these funds used?
- How has the program changed since its inception?

[7] Lovell (2005).

II. FINDINGS

DMIO Program Costs

Agencies participating in the DMIO program bill DSHS-Mental Health Division (MHD) based on the number of clients served each month (capitation), rather than fee-for-service.[8] RSNs are responsible for supervising service contracts with local service providers in each region. If an RSN did not participate in the program, DSHS-MHD contracted directly with service providers. Capitation rates are as follows:

- Contracting agencies are allowed to bill $6,000 for transitional costs, covering services and engagement of participants before their release from prison and for the first three months afterwards.

- Thereafter, DSHS-MHD pays a fixed fee to agencies with DMIO contracts: $700 per month for Medicaid-eligible participants and $900 per month for those without Medicaid eligibility.

Neither DSHS-MHD nor the participating agencies anticipated the data requirements of a benefit-cost analysis, and recordkeeping methods evolved during the start-up phase of the program. Therefore, we estimated per-person costs based on the experiences of individuals who entered the program after the start-up phase; those released from prison between July 1, 2002, and December 31, 2003, formed the basis of our cost estimate. Two years of follow-up data on costs were available for this cohort.[9] Cost data were available for 114 of the 127 program participants released from prison during this period.[10] Agencies providing cost data are listed in the Appendix.

Exhibit 1 describes total and per-participant costs for the first two years after release from prison. The largest expenditures occur over the first six months, partly because they include an additional allowance for transitional costs.[11] Per-person expenditures continue to decrease in succeeding periods because some clients stop participating, for a variety of reasons: loss of interest, relocation, or incarceration for supervision violations or new offenses.

On average, total billings per participant summed to $16,670 over the entire two year follow-up period. Including administrative costs, per-person expenditures totaled $19,390, about 80 percent of total possible billings; if there had been billings for every participant tracked in the cost study over every month of the follow-up period, the average costs per participant would have been $24,690.

[8] Some DMIO funds are allocated to the Division of Developmental Disability (DDD) for DMIO participants assigned to its Community Protection Program; those funds are not included in this analysis.
[9] Data for this cohort were requested in January 2006.
[10] Cost records were missing for 13 participants: two were released to U.S. Immigration, four were served by a different program, and for seven there was no cost information in the files we retrieved.
[11] The $6,000 for transitional costs were collected for 86 of those tracked in the cost study.

Exhibit 1
Total and Per-Capita Costs for Two Years After Prison Release

Period	Total Billings (N=114)	Per Capita Costs: Billings Only	Per Capita Costs: Admin Costs	Per Capita Costs: Combined Per Capita
First Six Months*	$750,430	$6,580	$680	$7,260
Months 7–12	$419,250	$3,680	$680	$4,360
Months 13–18	$384,860	$3,380	$680	$4,060
Months 19–24	$345,090	$3,030	$680	$3,710
Two-Year Total	$1,899,630	$16,670	$2,720	$19,390

*First six months include special transition costs for pre-release and post-release planning, engagement, and services.

How Are DMIO Funds Spent?

The 2005 evaluation demonstrated that participation in the DMIO program improved access to mental health services, cash support programs and social services, chemical dependency treatment, and stable housing. This section provides more detail about the services provided to DMIO participants.

As described earlier, the $6,000 allocation for pre-release planning and the first three months after prison release is used for interagency planning and to engage participants in treatment before they leave prison. The monthly allocations thereafter are used to provide DMIO participants the additional support necessary to maintain their stability in the community. That support includes the following:

- Social services and coordination,
- Mental health treatment,
- Housing,
- Clinical services including sex offender or chemical dependency treatment,
- Medical care, and
- Living and personal expenses.

Challenges to Identifying Services Provided. One objective of this study is to describe in detail how DMIO funds are used to support participants in the community. What specific services and other assistance are being provided DMIO participants and at what relative intensity? This task is greatly complicated by several factors:

- Services and other assistance provided to DMIO participants are purchased by DSHS-MHD primarily through capitation rather than fee-for-service. Thus, there is no consistent way to link payments with the specific services provided to program participants.

- For payments made on a capitation basis, accounting systems that tracked billings for specific participants were not established for the first few years of the program.

- There is considerable diversity of accounting practices and recordkeeping among the DMIO service providers.

- In addition to DMIO funds, services are funded by a variety of other sources: state and federal living expense payments, Medicaid, and other state agencies such as the Division of Developmental Disabilities (DDD) and the Division of Alcohol and Substance Abuse (DASA). It is not always possible to distinguish between DMIO-funded services and services provided under other programs.

These issues do not allow for a comprehensive description of the level of DMIO-funded services and other assistance provided to participants. We are limited instead to several "snapshots" based on a limited number of clients for whom sufficient documentation is available. Even these cases fail to provide a comprehensive picture of all services provided to DMIO clients, as they are limited to specific categories such as hours of mental health services.

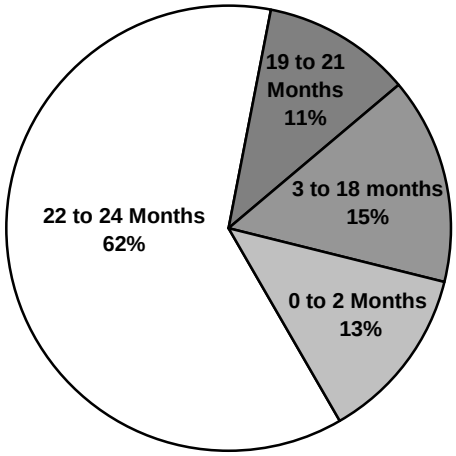
Fortunately, enough data are available to provide a basic impression of the program as it is actually being implemented in the field. And where accounting records are reasonably complete, as they were in King and Pierce Counties, this review indicates that the services and other assistance that are being provided correspond with billing levels, and that funds are being spent according to the program's original design.

Mental Health Services. The amount of mental health services provided to DMIO participants depended in part on their Medicaid eligibility status. DMIO participants ineligible for Medicaid averaged 121 hours of mental health services, funded entirely by the DMIO program. Medicaid-eligible DMIO participants averaged 424 hours of mental health services, which were largely supported by non-DMIO funds.

Recall that monthly billings for DMIO participants served are $700 for Medicaid-eligible clients and $900 for ineligible clients. Records available for 95 clients permitted an examination of the pattern of $700 or $900 monthly payments.[12] They revealed that over the two-year follow-up only 13 percent of participants were Medicaid-eligible for two months or less (Exhibit 2). Sixty-two percent of participants were Medicaid-eligible 22 to 24 months over the follow-up period.

[12] Does not include 12 developmentally disabled DMIO participants who were served by DDD.

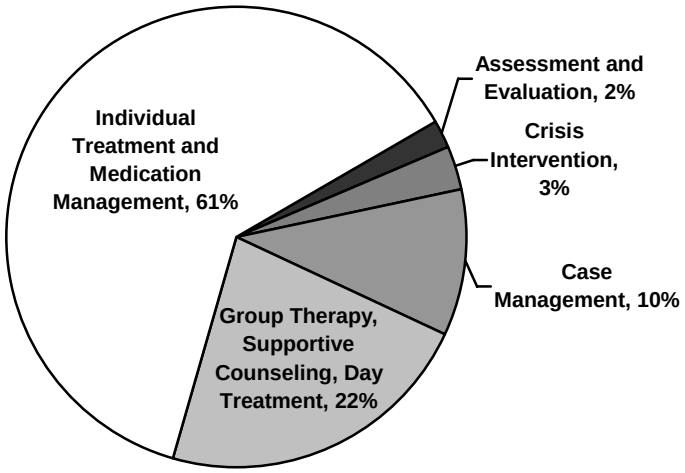
Exhibit 2
DMIO Participants' Medicaid Status:
Months of Eligibility Over the Two-Year Follow-up Period (N=95)



WSIPP, 2007

Some records were sufficiently complete to describe the type of mental health services provided to DMIO participants. We were able to compile the percentage of "contact hours" of mental health services provided to 56 DMIO participants who were served through the King and Pierce Counties' RSNs. Exhibit 3 shows that the majority of hours (61 percent) provided by mental health staff were for individual treatment and medication management. Eighty-three percent of mental health contact hours were allocated to some kind of treatment activity. The balance of the mental health services provided included assessment and evaluation, crisis intervention, and case management.

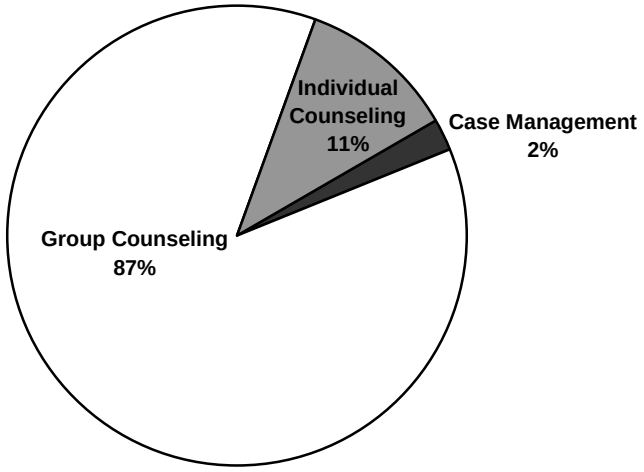
Exhibit 3
The Mix of Mental Health Services Provided to DMIO Participants
(as percentage of total contact hours) (N=56)



WSIPP, 2007

Chemical Dependency Treatment. Approximately one-third of participants in the cost study received chemical dependency treatment during the two years following prison release. Records from the Division of Alcohol and Substance Abuse show that these clients received a total of 3,095 hours of chemical dependency services over two years. The distribution of services received (group counseling, individual counseling, and case management) is described in Exhibit 4. We are unable to determine the extent to which chemical dependency services were paid for with DMIO program funds or from other funding sources.

Exhibit 4
The Mix of Chemical Dependency Services Provided to DMIO Participants (as percentage of total service hours) (N=43)



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Other Goods and Services Purchased With DMIO Funds. In addition to mental health services, DMIO funds provide other forms of assistance to participants, such as housing, personal expenses, and clinical interventions such as sex offender and chemical dependency treatment. Expenditure information available for 70 participants is summarized in Exhibit 5.[13] Note that the dollar amounts shown apply only to records that could be found and classified; they do not necessarily represent all goods and services purchased. Among the identifiable DMIO expenditures, the great majority (82.4 percent) were used to provide housing assistance.

Exhibit 5
Goods and Services Purchased With DMIO Funds (N=70)

Category	Amount	Percent
Housing	$473,878	82.4%
Personal Expenses	$63,945	11.1%
Clinical Intervention	$37,138	6.5%
Total	$574,961	100%

[13] Does not include 12 developmentally disabled DMIO participants who were served by DDD.

Based on a small sample (n=24) of detailed records from Pierce County, we know that 95 percent of housing assistance went toward rent, but also included repairs (for the few participants who owned homes), utilities, and deposits. Forty-five percent of personal expenses went toward toiletries and household items, but also included food, clothing, transportation, and fees (such as fines and legal penalties). Clinical intervention expenses funded education (39 percent), chemical dependency treatment (26 percent), sex offender treatment (22 percent), and medical care (14 percent).

The expenditure patterns observed in Pierce County are not necessarily representative of the whole. In King County, for instance, DMIO chemical dependency treatment is not purchased separately, because it is integrated into the participant's mental health services. Also, in limited cases, DMIO participants who qualify may receive chemical dependency treatment through DASA.[14] For these reasons, and due to the considerable diversity among providers in how costs and expenses are reported, generalizations to all DMIO participants should be resisted.

Conclusions. Based on available records, we estimate the average cost of services and other assistance provided for DMIO participants totaled $19,390 over the two years after their release from prison. Where records were reasonably complete, as they were in King and Pierce Counties, our review indicates that the assistance provided to DMIO participants corresponds with the billing levels, and that funds are being spent according to the original design of the program.

A January 2007 recidivism analysis indicates that the economic benefits of the program narrowly outweigh the costs.[15] If the level of program expenditures needed to achieve these benefits becomes a concern to policymakers and planners, it may be useful to develop a more consistent approach for recording services, billings, and other expenditures.

How Has the DMIO Program Changed?

Here we describe changes in the number of program participants, developments in the participant selection process, issues regarding RSN participation and cross-system collaboration, and funding and eligibility policies affecting program participants.

Data collected for the cost analysis, along with participant-selection records, were reviewed to assess changes in program population and participant selection. To provide information relevant to the other issues, interviews were conducted with eight program administrators from state and local organizations who have filled leadership roles in the DMIO program since its inception.

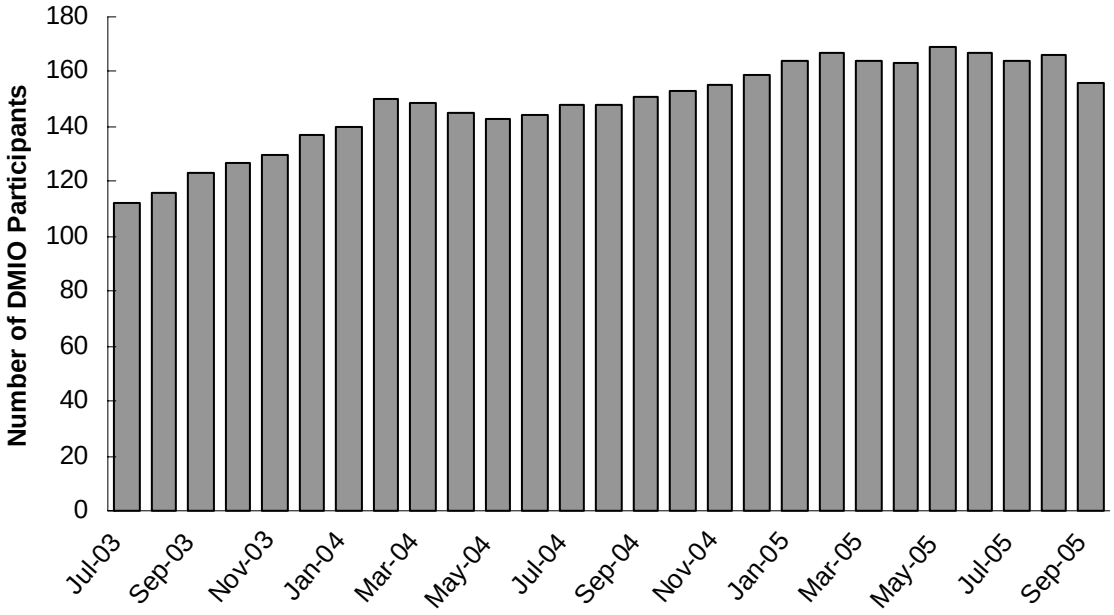
Changes in the Number of Program Participants

Exhibit 6 describes the number of individuals participating in the DMIO program during each month from July 2003 through September 2005, the period for which billing records were

[14] Many DMIO participants do not fit within DASA's priority populations: women who have children or are pregnant, youth, and intravenous drug abusers.
[15] Mayfield (2007).

requested for this study. Beginning with 112 participants in July 2003, the caseload rose to 165 in the following 1 1/2 years, after which monthly program participation levels stabilized. There were no new enrollments after May 2005, resulting in a downward trend in monthly participation through September 2005.

Exhibit 6
DMIO Program Participants Based on Billing Data
July 2003 – September 2005



WSIPP, 2007

There are no central records indicating whether or when an enrolled participant leaves the DMIO program. Some records furnished by agencies provided indicators of participant status (such as "terminated," "returned to custody," or "left state"). Such records, however, are not consistently maintained and provided no reliable basis for establishing overall program participation. In the absence of a reliable system-wide indicator of DMIO participation status beyond enrollment, billing records provided the best indication of program participation. For our purposes, we used the following guidelines to determine participation status:

- Clients receiving transitional services (as reflected by payments of $6,000) were counted as participants for three months before and after prison release.

- Thereafter, subjects were counted as participants during every month for which a $700 or $900 payment was billed.[16]

- If gaps in billings lasted three months or less, participants were included in the program caseload during the intervening months.

[16] Lump sum payments billed for several months of service were distributed evenly over the prior months (e.g., a $2,100 payment would be allocated over three months at $700 per month).

Participant Selection Process

We are unable to describe changes in the clinical profiles of DMIO participants selected since the program was implemented. It appears, however, that the overall selection process has improved and stabilized. During the first year of the program, an average of only four candidates a month were referred to the Statewide Review Committee. In subsequent years, 12 to 14 candidates were referred every month.

DMIO participants are selected by a Statewide Review Committee according to two principal criteria: diagnosis of serious mental illness and evidence of potential danger to society. The process by which candidates for the program are identified by DOC, and how relevant information is provided to the Statewide Review Committee was examined in previous evaluations by the Institute.[17]

Informants interviewed for this study[18] reported several challenges during the first years of operations. First, there were extended controversies among Statewide Review Committee members regarding definitions of dangerousness and mental illness. Second, records provided to the Review Committee by DOC were considered a glut of information, not all of which were relevant to committee decision-making. The most consistent theme among study informants was improvement in the workings of the Statewide Review Committee:

- Over years of working together, Review Committee members have developed good working relationships and a better understanding of the methods and missions of the other members' agencies; testimony about a shared spirit of collaboration was offered by almost all informants.

- DOC now provides more detailed information on client symptoms so that committee members no longer need to review thick packets of records to find relevant information.

Despite this progress, struggles over diagnoses and interpretation of mental health records remain a characteristic of the DMIO selection process.

[17] P. Phipps & G. Gagliardi. (2002). *Implementation of Washington's dangerous mentally ill offender law: Preliminary findings*. Olympia: Washington State Institute for Public Policy, Document No. 02-03-1901; P. Phipps & G. Gagliardi. (2003). *Washington's dangerous mentally ill offender law: Program selection and services, interim report.* Olympia: Washington State Institute for Public Policy, Document No. 03-05-1901. Both reports are available at: <http://www.wsipp.wa.gov>.

[18] The DMIO Program Oversight Committee was formed in 2003 to address policy issues that affect the work of the Statewide Review Committee. Members of this committee were key informants for this report.

Coordination Across Agencies

The DMIO program calls for considerable coordination among agencies, communities, and service providers. Setting the stage for the DMIO program were a series of initiatives undertaken in Washington State over the past 15 years, including the following:

- The University of Washington-Department of Corrections Mental Health Collaboration;
- Agreements among RSNs about responsibility for assessing and treating persons with mental illness when leaving prison;
- WIMIRT's Community Transition Study;
- Revisions in the competency evaluation and restoration process;
- New regulations on the sharing of mental health treatment information between DOC and MHD; and
- The Mentally Ill Offender Community Transition Program (MIOCTP).[19]

MHD and DOC Collaboration. Informants agreed that the process of implementing these initiatives, the results of the Community Transition Study, and the early experience of the MIOCTP, exposed a widespread lack of understanding between staff in correctional and mental health agencies. However, informants also described how "system learning" has resulted from the interagency planning built into the DMIO program:

- Mental health providers better understand correctional operations and motives (e.g., DOC is not "dumping clients" by releasing offenders at the end of their terms).
- Relationships built between correctional and mental health staff in the field have fostered prompt and informed responses to the challenges posed by DMIO participants; opinions corroborated a review of case management narratives in the 2005 evaluation.[20]
- Mental health professionals are increasingly willing to work with correctional clientele as evidenced by a growing number of applications for employment with this program.

Informants agreed that staff in the various agencies are highly motivated to work with staff across disciplinary boundaries and are committed to serving the challenging population of offenders with mental illness. The commitment and motivation described by informants is not necessarily permanent. Preventing a "reversion to territoriality" and maintaining gains made so far, relies on several key factors:

[19] Based in Seattle and serving a less violent and more drug-involved group of persons with mental illness leaving prison, MIOCTP had been in operation for two years when the DMIO program began.
[20] Lovell (2005).

- Maintaining the atmosphere of trust, in which administrators and staff have learned to work cooperatively on behalf of the clients, rather than protecting organizational turf; and

- Careful attention to proposed organizational changes and shifting priorities that may alter incentives for cooperation or disrupt established relationships.[21]

The Decline in Participating RSNs. The precipitous decline in the number of participating RSNs, from 13 to four in the early years of the program, was frequently cited as the most significant change in the program. As discussed in previous reports,[22] some RSNs did not participate due to the liability concerns of their service providers, concerns which stemmed more from the title "Dangerous Mentally Ill Offender" than from any actuarial analysis of risks.[23]

To serve DMIO participants released to a county or region without an RSN contract, MHD and DOC administrators were forced to find alternatives, occasionally employing protective payees. These are people who know the participant, sometimes as housing or treatment providers and occasionally as relatives, who manage program funds on behalf of participants to ensure that funds are spent wisely. Informants suggested that the counties and regions served by these alternatives lack the level of oversight provided by contracted RSNs. Informant views were consistent with the experience of researchers collecting information for this study:

- Without RSN involvement, the burden of tracking program participation and services fell upon statewide program administrators; the multiplicity of providers with diverse understandings of the program posed severe obstacles to maintaining a reliable, consistent system of reports on costs, services, or client status.

- Data on 20 percent of the clients used in the cost study (excluding DDD-administered clients) were compiled from records provided by non-RSN sources. Locating these records required extraordinary efforts, and they were far less complete than records provided by the contracting RSNs.

- With respect to questions about who is served—and where, when, and how services are provided—the difficulties encountered while compiling this report provide direct evidence of the relationship between RSN participation and program accountability.

According to informants, in addition to insufficient accountability, the lack of RSN involvement also interferes with pre-release engagement; collaborative interagency planning; support for housing stability; and access to additional services, such as chemical dependency and sex offender treatment. For these reasons, MHD has requested legislation requiring RSN participation. Some informants noted, however, that the concerns

[21] For example, some informants characterized the process of organizational change at DOC as disruptive to established relationships and problem-solving practices across agencies. Changing state or federal policies regarding funding and service eligibility may also influence levels of collaboration among correctional and social service agencies.
[22] Phipps (2002); and Phipps (2003).
[23] MHD recently proposed changing the title of the program to the Community Integration and Assistance Program (CIAP).

of local providers and their insurance carriers would still need to be addressed even if policies are changed at the RSN level.

Funding and Eligibility Policies Affecting DMIO Participants

Informants described a number of eligibility and funding policies that may contribute to service gaps for DMIO clients or limit their funding options. Specifically, they described restricted eligibility for publicly funded chemical dependency treatment, waiting periods and discontinuity of Supplemental Security Income (SSI), and restrictions on the use of Medicaid funds.

Qualifying for Chemical Abuse and Dependency Treatment. The eligibility criteria for publicly supported treatment for chemical dependency restrict the range of services and support available for people leaving prison. For instance, many DMIO participants do not fit within DASA's priority populations: women who have children or are pregnant, youth, and intravenous drug abusers. Although DMIO program funds have been used to address these service gaps, some informants stress the need for more intensive services, such as residential treatment, for those with long histories of chemical abuse or dependency.

Qualifying for SSI. Persons considered unemployable by virtue of a disability such as mental illness are provided cash support under the General Assistance-Unemployable (GAU) program, with the expectation that they will eventually qualify for the federal SSI program. Once a client qualifies for SSI, the state is reimbursed for previous GAU payments. Clients also receive a higher level of support from SSI, which reduces some of the demands on DMIO funds, such as housing assistance.

However, several eligibility issues complicate matters for DMIO participants. Outstanding warrants prevent some offenders from qualifying for SSI. Reincarceration results in a loss of SSI eligibility. For example, a client briefly incarcerated for a supervision violation loses eligibility for SSI, must reapply, and then must enter another waiting period while collecting GAU. This suggests there may be some benefit to examining alternatives to handling outstanding warrants and supervision violations for DMIO participants.

New Restrictions on Use of Medicaid Funds. The switch, ten years ago, from fee-for-service billing to capitated payments for Medicaid-eligible patients was intended to encourage more cost-effective efficiency in service delivery. Mental health administrators assumed that savings could be used to support a broader range of services outside the previous reimbursable service schedule. Further, they assumed that anticipated savings could be used to support services for mental health consumers who meet RSN criteria for service but the Medicaid criteria of medical necessity.

As of July 2005, rulings by the Center for Medicaid and Medicare Services have limited the funding options of those providing mental health services to DMIO participants. The new rules state that Medicaid funds cannot be commingled with other funds used either to serve non-Medicaid-eligible consumers or to provide services not authorized under Medicaid as medically necessary. About 30 percent of DMIO participants are ineligible for Medicaid during substantial portions of their post-release period.[24] In addition, pre-release planning

[24] This percentage is inferred based on the billing data collected for this study.

and other assistance provided to DMIO participants are among the services for which Medicaid funds cannot be used.

It remains to be seen whether this change in mental health funding will threaten the viability of the DMIO program. The ruling may place further stress on the limited state mental health dollars that are not tied to the Medicaid system. These pressures could increase competition for limited state funds used to serve challenging clients, discourage providers from taking on such clients, and undermine the collaboration fostered by the DMIO program.

III. CONCLUDING COMMENTS

Available evidence indicates that DMIO program funds are being used as intended, and that the program has grown and fostered effective collaboration between administrators and staff in agencies with different missions and approaches. The experience of compiling data for this report and interviewing informants about program changes yields two principal recommendations:

Improve the Capacity to Track Costs and Participants. Participating agencies did not anticipate the requirements of a benefit-cost analysis, so program expenses and billing records were not always maintained in a way that permitted a full accounting of expenditures and services for individual DMIO participants.

Administrative changes and policies, in particular the rejection of contracts by most RSNs, have contributed to the lack of accountability. As a result, it was possible to account for all three of the principal components of cost analysis—billings, services, and expenses—for only the two large RSNs (King and Pierce Counties) that have remained engaged throughout the program.

Examine Organizational and Policy Changes That May Undermine Collaboration. Analysis of data and interviews with administrators who have worked with this program since its inception support the conclusion that the DMIO program has fostered the necessary collaborative relationships.

These relationships, however, may be vulnerable to federal and state administrative policies that increase pressures on limited funds and reduce incentives to work together. Conversely, collaboration may be improved by policies that reduce territorial barriers and restrictions on eligibility for clients whose needs cut across organizational boundaries.

Appendix

Cost and service data were provided, in various degrees of completeness, by the agencies listed in Exhibit A-1.

Exhibit A-1
Agencies Providing Service Records for the Cost Study Participant Sample

Agency	Clients
Associated Providers of Washington	13
Central Washington Comprehensive Mental Health	6
Clark County RSN	2
Division of Developmental Disabilities	12
King County RSN	36
Kitsap Mental Health Services	1
Peninsula RSN	3
Pierce County RSN	35
Southwest Washington RSN & Cowlitz County	3
Spokane County RSN	2
Timberlands RSN	1
Total	114

Until July 1, 2003, electronic records of the participants for whom payments were made were not maintained by DSHS-MHD. It was necessary, therefore, to contact service providers directly and ask for records of those served and their service dates. Some records needed to be retrieved from files stored in the state record archives.

- This process yielded over 60 documents from which program costs for the statewide program were compiled.
- From these documents, records were constructed of monthly costs for each study subject for two years after release from prison.

Administrative costs were based on average enrollments during 2005, which were relatively steady and averaged approximately 165 participants per month. This average enrollment number is used, rather than the number in the cost study cohort, for two reasons: administrative costs during the study years covered other participants, enrolled earlier or later; also, for benefit-cost analyses, it was preferable to use relatively stable administrative costs.

Some DMIO participants received primary services through DDD, but DMIO-related expenses were reimbursed out of DMIO program funds. A description of goods and services provided to these clients is displayed in Exhibit A-2. It is noteworthy that clinical services constituted the primary DMIO program expense for DDD clients. These services were used primarily for sex offender treatment, though the exact proportion is unknown. Similarly, housing was an important part of the living allowance for many clients, but it cannot be separated from other personal expenses.

Exhibit A-2
Goods and Services Purchased for DDD Participants (N=12)

Category	Amount	Percent
Personal Expenses	$68,700	31%
Clinical Services	$93,190	42%
Education, Employment, and Assessment	$59,460	27%
Total	$221,350	100%