

**Washington's Dangerous
Mentally Ill Offender Law:
Program Selection and Services
Interim Report**

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and
Gregg J. Gagliardi, Ph.D.**

May 2003

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EXECUTIVE SUMMARY

The 1999 Legislature enacted SSB 5011¹ to improve the process of identifying mentally ill offenders being released from the Department of Corrections (DOC) who pose a threat to public safety, and provide these offenders with additional treatment and services for up to five years in the community. 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 or herself or others.

The legislation assigned the responsibility of identifying DMIOs to DOC. DOC uses a computer program to identify mentally ill offenders nearing prison release, and then reviews each offender’s psychiatric and criminal information to assess the severity of the disorder and dangerousness. DOC, in cooperation with the Department of Social and Health Services (DSHS), organized a multi-agency Statewide Review Committee (SRC) to make the final decision on whether an offender should be classified as a DMIO.

The legislation assigned the responsibility for DMIO treatment and support service planning and delivery to a team of representatives that includes the following:

- DOC;
- DSHS Mental Health Division (MHD);
- Other DSHS divisions as necessary, including the Division of Alcohol and Substance Abuse (DASA) and the Division of Developmental Disabilities (DDD);
- Mental Health Regional Support Networks (RSN); and
- Treatment providers.

This planning team is charged with recommending whether a DMIO should be referred for evaluation under state mental health involuntary treatment laws (RCW 71.05) or should receive voluntary or supervised treatment in the community. In the community, a DMIO is assigned a mental health case manager who is responsible for obtaining all necessary services and treatment.

This interim report describes the ongoing process of identifying and selecting DMIOs; provides a profile of DMIOs; and documents the type of pre- and post-release services, treatment, and supervision received by DMIOs. Finally, it focuses on process improvements that have been accomplished and summarizes continuing program challenges.

¹ Chapter 214, Laws of 1999.

Findings

Identifying and Selecting DMIOs

The process of identifying and selecting DMIOs has improved considerably since 2002:

- The computer program used by DOC to identify candidates continues to be improved.
- Offenders are reviewed monthly instead of quarterly, resulting in better identification of DMIO candidates, particularly those with short prison stays.
- More offenders are reviewed by the SRC:
 - From April 2000 through December 2002, the SRC reviewed 252 offenders and selected 171 as DMIOs; and
 - Over half these offenders were reviewed and selected in 2002.

Treating DMIOs: Mental Health and Drug and Alcohol Services

From September 2000 through June 2002, 72 DMIOs were released from confinement. Data on these DMIOs have been collected from DOC, MHD, and DASA. Whenever possible, services provided to DMIOs are compared with services provided to mentally ill offenders released from prison in 1996 and 1997 (the Community Transition Study or CTS).² These CTS subjects form the comparison group for evaluating the effectiveness of the DMIO legislation; earlier analyses indicate that DMIOs are generally comparable to the CTS subjects.³

The following results show that DMIOs are receiving pre- and post-release services as the legislation envisioned. In addition, the results indicate that a much higher proportion of DMIOs are receiving services compared with CTS subjects, and the services provided to DMIOs are of much greater intensity.

Pre-Release Mental Health Services

- *81 percent* of DMIOs have received “pre-release” mental health services from community providers compared with *10 percent* of the CTS subjects.
- The DMIOs receiving services averaged *6.6 hours* per service month, while the CTS subjects averaged only *2.5 hours* per service month.

Post-Release Mental Health Services

- *87 percent* of DMIOs received community mental health services in the first three months “post-release” compared with *29 percent* of the CTS subjects.
- DMIOs receiving services in the first three months post-release averaged *10.7 hours* of services per month, while the CTS subjects averaged *4.7 hours* of services per month.

² David Lovell, Gregg Gagliardi, and Paul D. Peterson, *Community Transition Study: Mentally Ill Offenders* (Seattle: Washington Institute for Mental Illness Research and Training, University of Washington, November 2001).

³ Polly Phipps and Gregg Gagliardi, *Implementation of Washington’s Dangerous Mentally Ill Offender Law: Preliminary Findings* (Olympia: Washington State Institute for Public Policy, March 2002).

- *93 percent* of DMIOs received community mental health services in the first 12 months “post-release” compared with *45 percent* of the CTS subjects.
- DMIOs receiving services in the first 12 months post-release averaged *8.6 hours* of services per month, while the CTS subjects averaged *3.8 hours* of services per month.

Post-Release Drug and Alcohol Services

- Approximately *29 percent* of released DMIOs received drug and alcohol treatment post-release. No comparison data on the CTS subjects are available at this time.

Program Challenges

Consistent with the intent of the legislation, new connections are being built between correctional and social service systems at the state and local levels. Increased communication across systems assists in identifying individuals who may benefit from treatment in the DMIO program. In addition, the connections across systems are critical in providing for coordinated discharge and community treatment planning, such as expediting Medicaid eligibility, mental health and chemical dependency treatment, housing, and supervision. However, developing a system for better identification, treatment, and management of DMIOs is a lengthy process.

DOC continues to work on the following issues in identifying and selecting DMIOs:

- Improving linkages with state hospitals, community providers, and jails to assist in identifying candidates as early as possible; and
- Improving the quality and timeliness of mental illness information available to the SRC.

The DMIO program faces a number of challenges in treating DMIOs, including the following:

- Encouraging more RSNs to participate in the MHD contract to serve the DMIO population; and
- Developing resources, such as housing and medical care.

State and local agencies currently participating in the DMIO program openly discuss program issues. Action plans have been developed on issues critical to the success of the program. A new oversight board has been approved, with representatives from DOC, DSHS (MHD, DASA, DDD), an RSN, a county designated mental health professional (CDMHP), and mental health and alcohol/chemical dependency treatment providers. This board will assist in developing an administrative structure to oversee action plans, approve procedures, and tackle new issues.

Future reports will provide more detailed information about DMIOs. Another interim report scheduled for publication in December 2003 will focus on factors that affect service use and criminal recidivism, including substance abuse, attitudes toward treatment, types of services offered or received, housing needs, and coordination between criminal justice and social services agencies. The final report, due in December 2004, will focus on whether the program reduces criminal recidivism, and, if so, whether the program is cost-effective, and which characteristics of DMIOs predict success and failure in the community.

I. BACKGROUND

Few states have procedures in place to identify and treat mentally ill offenders being released from prison. In 1999, the Washington State Legislature passed Substitute Senate Bill 5011 (SSB 5011),⁴ which mandates 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.⁵ 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 or herself or others.⁶

The legislation assigned the responsibility of identifying DMIOs to DOC. DOC uses a computer program to identify mentally ill offenders nearing prison release, and then reviews each offender’s psychiatric and criminal information to assess the severity of the disorder and dangerousness. DOC, in cooperation with the Department of Social and Health Services (DSHS), organized a multi-agency statewide review committee (SRC) to make the final decision on whether an offender should be classified as a DMIO. DOC presents cases to the SRC monthly for a decision on DMIO status.

The legislation assigned the responsibility for DMIO treatment and support service planning and delivery to a team with representatives from the following:

- DOC;
- DSHS Mental Health Division (MHD);
- Other DSHS divisions as necessary, including the Division of Alcohol and Substance Abuse (DASA) and the Division of Developmental Disabilities (DDD);
- Mental Health Regional Support Networks (RSN); and
- Treatment providers.

The planning team is charged with recommending whether a DMIO should be referred for evaluation under state mental health involuntary treatment laws (RCW 71.05) or should receive voluntary or supervised treatment in the community. In the community, a DMIO is assigned a mental health case manager who is responsible for obtaining all necessary services and treatment.

⁴ Enacted May 17, 1999, Chapter 214, Laws of 1999.

⁵ Prior to this legislation, DOC had no systematic procedures in place to identify mentally ill offenders released from prison who were a public safety threat. However, the RSNs and DOC did have a 1996 written agreement on procedures for referring mentally ill offenders to community treatment and evaluations for involuntary commitment under RCW 71.05. Yet, only a small proportion of offenders released in 1996 and 1997 received community mental health services after release; see Lovell et al., *Community Transition Study*.

⁶ Throughout this report, the term “DMIO” refers to all individuals selected into the DMIO program, regardless of their legal status or level of participation in the program. Many individuals completed their criminal sentence prior to release; thus, they are not legally an “offender” upon release. In addition, individuals with no remaining supervision on their criminal sentence can refuse to participate in the treatment program.

The legislation directs the Washington State Institute for Public Policy (Institute), in conjunction with the Washington Institute for Mental Illness Research and Training (WIMIRT) at the University of Washington, to conduct an evaluation of SSB 5011 (see Appendix A). A 2002 report described the legislative requirements and evaluation research design and focused on the implementation in substantial detail.⁷

This report describes the ongoing process of identifying and selecting DMIOs, provides a profile of DMIOs, and describes the amount of pre- and post-release treatment, focusing on program improvements and describing continuing challenges.

- Section II outlines how DMIO candidates are identified and provides summary statistics on the selection process.
- Section III describes the program and the DMIO population, including their background characteristics, the amount of pre- and post-release treatment, criminal justice supervision, and criminal convictions.
- Section IV summarizes the DMIO program, reports on program improvements that are underway, and describes the next steps in the evaluation.

⁷ Phipps and Gagliardi, *Implementation of Washington's Dangerous Mentally Ill Offender Law*.

II. IDENTIFICATION AND SELECTION OF DMIOS

The first step under RCW 72.09.370 is to identify individuals who meet the statutory definition of a DMIO: offenders nearing prison release who have a mental disorder and pose a threat to public safety. The identification of DMIOs is an important task: the state will provide DMIOs with increased treatment and services, under the assumption that those receiving the additional resources will be less likely to commit new crimes.

The legislation assigns DOC the responsibility of identifying DMIOs. DOC releases approximately 6,000 offenders from prison each year. The task facing DOC is how to most efficiently review the records of offenders nearing release to identify the approximately 75 to 125 offenders per year who meet DMIO criteria.⁸

This section describes the identification and selection process used by DOC, beginning with internal DOC procedures and ending with final selection by a multi-agency statewide review committee (SRC).⁹ Statistics on SRC decisions from April 2000 through December 2002 are also provided.

DOC Identification and Screening

Step 1. To determine if an offender meets DMIO criteria, DOC first uses mental illness indicators maintained in the Offender Based Tracking System (OBTS) to identify offenders with a possible mental illness. These indicators include the following:

- Assessment of mental illness conducted at prison admission;
- Need for psychiatric medication;
- Residence in DOC mental health units;
- Serious mental illness as determined by a DOC clinical interview; and
- Psychiatric diagnoses.¹⁰

Each quarter since July 2000, DOC has used a computer program based on these indicators to identify individuals within a year of prison release for review into the DMIO program. In April 2002, DOC changed from quarterly to monthly use of the computer program to make use of the most current mental illness information available on each offender. Current data are important, as most indicators can be updated at any time during an offender's prison stay. This change allows DOC to better identify all possible mentally ill offenders, and in particular,

⁸ In 1999, as part of the legislative fiscal note process, DOC projected that 125 persons per year would meet the DMIO definition. In 2002, the SRC selected 91 offenders as DMIOs.

⁹ The SRC includes 12 representatives: four from DOC (Community Protection Unit, Mental Health Services, Regional Corrections, and one unspecified); three from DSHS (MHD, DASA, and DDD); 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.

¹⁰ DOC uses the International Classification of Diseases diagnoses (ICD-9).

those with short prison stays who may not have been identified using the quarterly program. Currently, this program identifies 70 offenders per month for further review.¹¹

Unfortunately, the available mental illness indicators are general, and the reliability of the indicators varies, so the program identifies many offenders who upon later review are found not to have a major mental disorder.¹² For example, the assessment at prison admission identifies offenders who have a variety of mental health “needs.” Some mental health problems at prison admission, such as depression, can diminish as an individual adjusts to confinement. In addition, psychiatric diagnosis and medication are likely to change as clinicians observe and treat an individual. DOC is considering refinement of the indicators and the addition of new indicators (such as electronic psychiatric medication data) to reduce the number of cases that do not have a major mental disorder.¹³

Step 2. The next step in identification and screening is for DOC program staff to review OBTS mental health data screens and chronological notes for all offenders identified by the computer program.¹⁴

Step 3. If offenders appear to have a major mental disorder, information is requested from DOC institutional mental health representatives on present diagnosis and medications.

Step 4. Where evidence exists that the offender has a major mental disorder and is dangerous to himself, herself, or others, DOC program staff request and review a complete file of psychiatric information from DOC institutions. DOC staff also request and review state hospital mental illness records for those offenders with a state hospital admission.

Step 5. Other groups may refer offenders to the DMIO program; e.g., an RSN, a service provider, or the DOC End of Sentence Review Committee. In these cases, a complete psychiatric file is requested and reviewed, as in Step 4.

Step 6. The DOC DMIO program administrator/psychologist makes the final decision on which offenders to present to the SRC, the SRC then determines if the DMIO criteria are met.

¹¹ Legislative documents indicate that approximately 400 offenders per year (33 per month) were projected to be screened for DMIO status; thus, DOC is screening more than twice the amount projected (70 per month).

¹² RCW 71.05.020 defines mental disorder as “any organic, mental, or emotional impairment which has substantial adverse effects on an individual’s cognitive or volitional functions.”

¹³ DOC has taken initial steps to bring medication records together with other OBTS indicators to produce a substantially more selective initial pool of candidates, based on recently developed procedures to count the seriously mentally ill in DOC institutions. See: David Lovell, *Identification of Offenders with Serious Mental Illness in Washington Department of Corrections Facilities* (Seattle: University of Washington-Department of Corrections Mental Health Collaboration, 2003).

¹⁴ Individuals with developmental disabilities are not always identified by the computer program. DSHS maintains a list of individuals eligible for DDD services who are in prison, which DOC uses at this step in the identification process.

Beginning in October 2001, DOC began documenting its internal decisions on all offenders identified by the computer program or referred by any internal or external group. This information is entered into OBTS and indicates decisions on eligibility and SRC decisions, including whether an offender:

- Was screened and did not have a mental disorder;
- Had a mental disorder but was not considered dangerous;
- Was presented to the SRC; and
- Was accepted or not accepted by the SRC.

Statewide Review Committee Selection Process

Committee Review Procedures

Offenders identified as potential DMIO candidates by DOC are reviewed monthly by the SRC. DOC provides SRC members with a packet of materials to review on each candidate. Based on this review of documents, the SRC discusses each candidate and votes on whether an offender has a mental disorder. If an offender is determined to have a mental disorder, the SRC then votes on whether it views an offender as dangerous. (Full committee definitions for mental disorder and dangerousness criteria are provided in Appendix B. The committee checklist for case review is provided in Appendix C.)

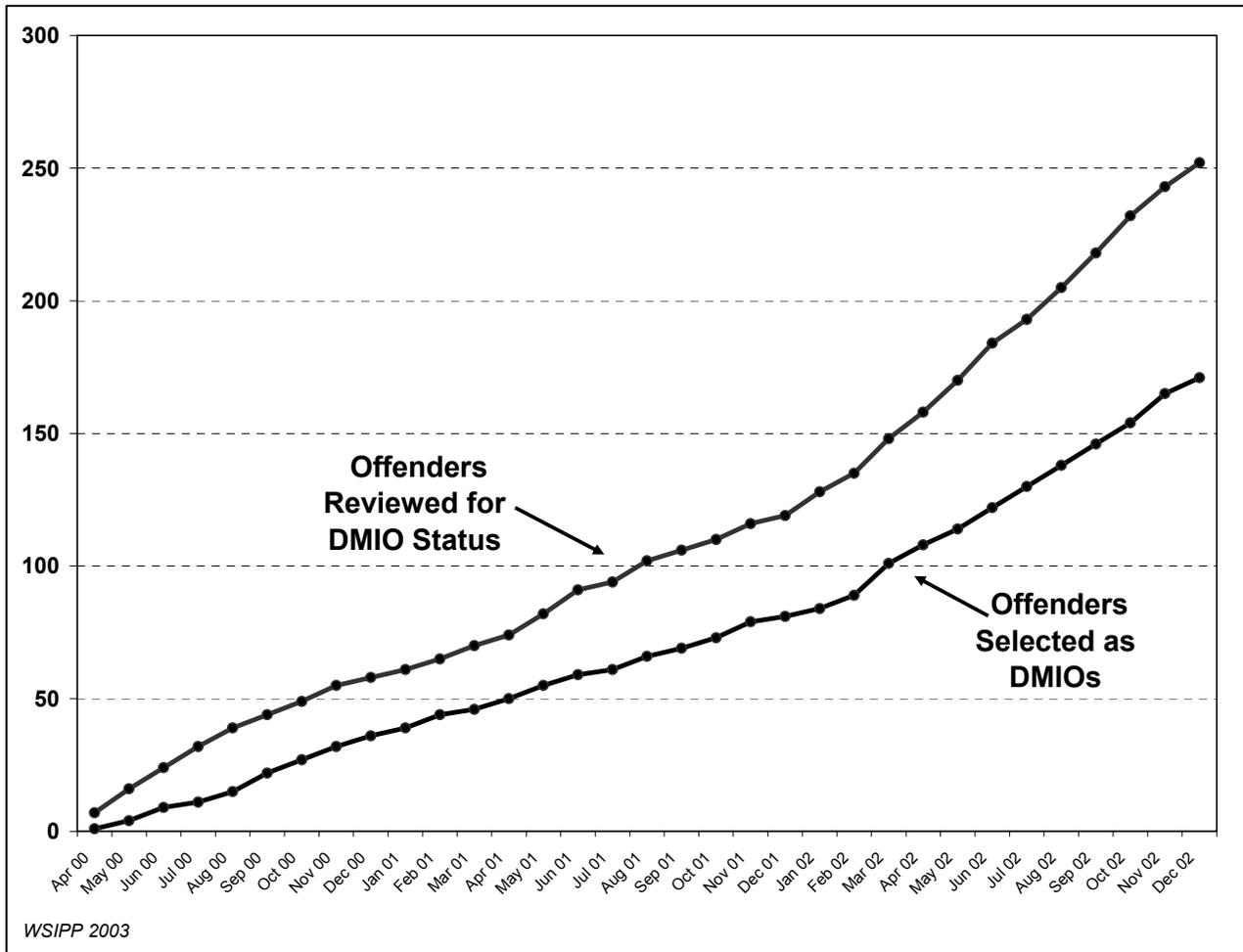
The materials provided to SRC members include information from DOC, state hospitals, and, in some cases, community mental health providers on a candidate's mental illness (e.g., psychological evaluations, case notes) and criminal history. There are still cases, however, where DOC and other mental illness documentation is insufficient or not up-to-date. In these cases, the SRC may request additional documentation, but it must base its decision on limited information if further documentation is unavailable or difficult to access.

Committee Review Statistics

The SRC began reviewing offenders for DMIO status in April 2000. Exhibit 1 shows the cumulative number of offenders reviewed.

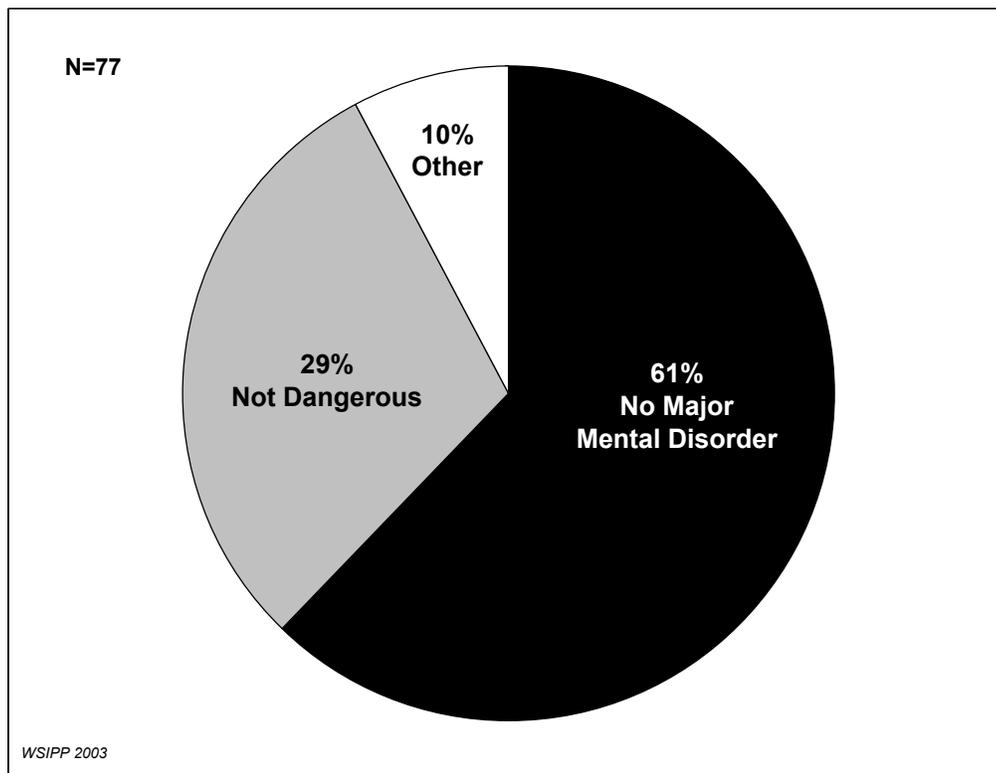
- From April 2000 through December 2002, 252 offenders were reviewed, an average of 7.6 per month.
- During the same time frame, the SRC selected 171 offenders for the DMIO program, an average of 5.2 per month.
- Since January 2002, the number of offenders reviewed and selected has increased substantially.

Exhibit 1
Statewide Committee Review and Selection of
Offenders to DMIO Program



From April 2000 through December 2002, the SRC did not select 77 offenders; a final decision was not made in four cases. Exhibit 2 shows the SRC's recorded reasons for not selecting the 77 offenders: 61 percent (48) were found to not meet the statutory and operational definitions of mental disorder, 29 percent (23) were not selected because, although a mental disorder existed, the offender was not determined to be dangerous, and 10 percent (6) were not selected for other reasons.

Exhibit 2
Reasons for DMIO Program Non-Selection, April 2000–December 2002



RSN Assignment and Contract Issues

After selection as a DMIO, the SRC assigns each offender to a local service area, based on his or her expected county of release. The law requires DSHS to contract for DMIO case management and other services with RSNs or other qualified and appropriate entities. However, RSNs—which have the primary responsibility for administering mental health care in the state—can choose whether or not to participate in the MHD contract to serve the DMIO population. Many RSNs have decided not to participate. In regions where an RSN has not signed the DMIO contract, the MHD has attempted to contract with a community mental health treatment provider. In regions where no community mental health provider has agreed to participate in the contract, the MHD has attempted to put a protective payeeship¹⁵ into place for chemical dependency, sex offender, or other treatment or services.

Since the law does not require RSNs to sign the MHD contract, a major challenge for the DMIO program continues to be how to persuade RSNs and other providers to serve the DMIO population. It remains unclear why RSNs have chosen not to participate in the MHD contract. Early concerns were raised by RSNs and providers about liability and insurance costs; however, House Bill 2672, signed by the Governor in May 2002, provided limited immunity to RSNs and mental health providers serving DMIOs. Despite this legislation, no additional RSNs have signed the MHD contract.

¹⁵ A protective payeeship is a vendor with whom MHD contracts to manage participants' DMIO funds, including paying for services; maintaining account and case records; and working with community mental health, DOC, and other treatment staff.

There are 14 RSNs in Washington State: Chelan-Douglas, Clark, Grays Harbor, Greater Columbia, King, North Central, North Sound, Northeast, Peninsula, Pierce, Southwest, Spokane, Thurston-Mason, and Timberlands. The second column in Exhibit 3 indicates whether there is a DMIO contract with the RSN, a community mental health provider contract, a protective payeeship for services, or “no special arrangements” in place to serve the DMIO program population. In RSNs with no special arrangements or with a protective payeeship in place, DMIOs who qualify for services are served under the regular mental health contract with the MHD.

Exhibit 3 shows that six RSNs have signed the contract to serve DMIOs, accounting for 53 percent of the state population (the state population distribution is displayed in column 3). The MHD has negotiated a provider contract in three regions, accounting for 32 percent of the state population. In two regions, accounting for 5 percent of the state population, there is a protective payeeship in place for treatment and services other than mental health. In three regions the MHD has no special arrangements in place to serve the DMIO population; these regions account for 10 percent of the state population.

Exhibit 3 also displays the number and percentage of DMIOs assigned to each regional area through December 2002 (columns 4 and 5). The numbers range from two in Chelan-Douglas to 51 in King. In general, the distribution of DMIOs follows the RSN state population distribution. However, Pierce County RSN is an exception as it has 23 percent of all DMIOs, while the region accounts for 12 percent of the state population.

Exhibit 3
Offenders Selected Into the DMIO Program by Mental Health Region

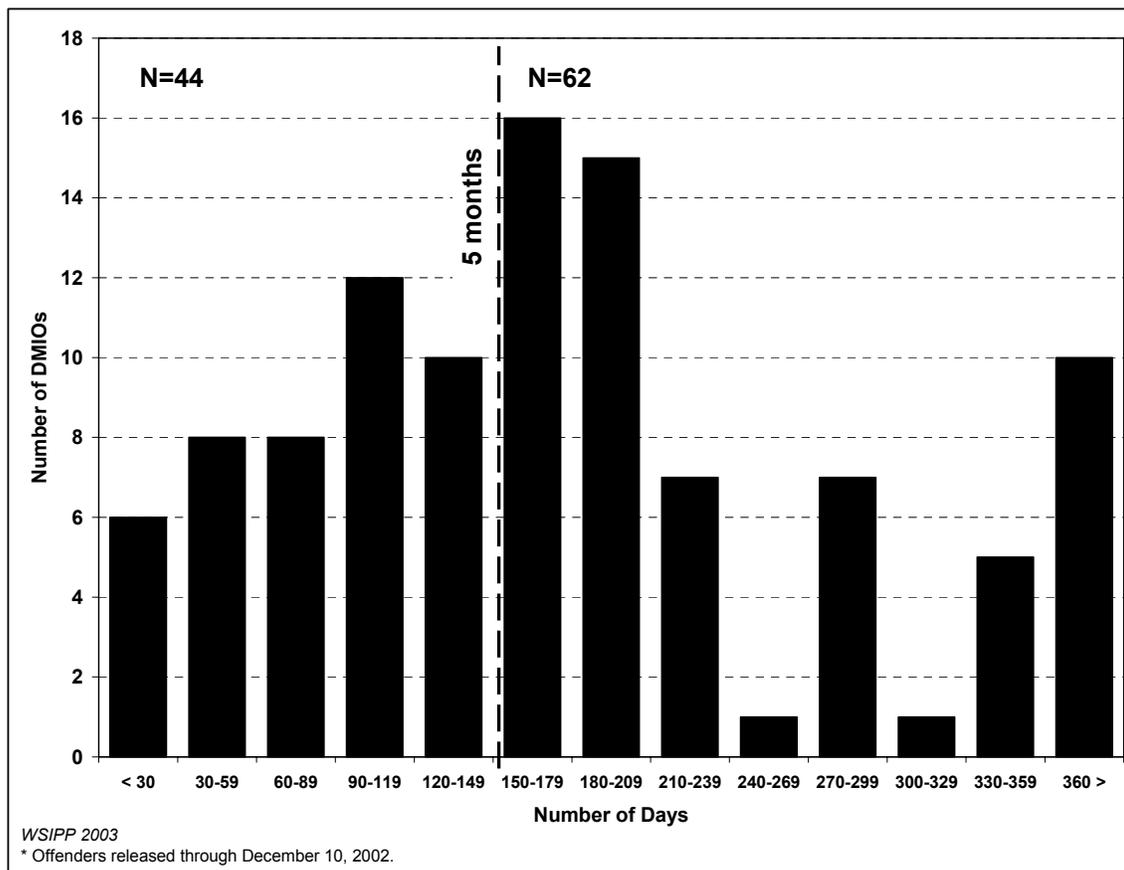
RSN	Service Contract Type	RSN Percent of State Population	Number Selected Through December 2002	Percent of DMIO Total
Chelan Douglas	RSN contract	2%	2	1%
Clark	RSN contract	6%	10	6%
Grays Harbor	Payeeship	1%	2	1%
Greater Columbia	Provider contract	10%	10	6%
King	RSN contract	30%	51	30%
North Central	No special arrangements	2%	3	2%
North Sound	Provider contract	16%	20	12%
Northeast	No special arrangements	1%	2	1%
Peninsula	Provider contract	6%	12	7%
Pierce	RSN contract	12%	40	23%
Southwest	RSN contract	2%	3	2%
Spokane	No special arrangements	7%	5	3%
Thurston Mason	Payeeship	4%	7	4%
Timberlands	RSN contract	1%	4	2%
Total		100%	171	100%

Selection and Release Timing

The time between selection as a DMIO and release into the community is a critical issue for the SRC, RSNs, and community providers. As is discussed in Section III, service planning takes time, and pre-release contact with an offender is considered critical in encouraging him or her to participate in treatment. The SRC has generally agreed that five months between the time of selection as a DMIO and release is necessary for optimal release planning. As a rule of thumb, the SRC does not review cases that are inside the five-month time frame without agreement of the RSN, if there is a RSN contract in place.

Exhibit 4 shows the number of days between committee selection and release for 106 DMIOs released through December 10, 2002. Exhibit 4 also includes a marker (dotted line) beyond which indicates the number of DMIOs with the optimal treatment planning time of five months prior to release.

Exhibit 4
Time Between Committee Selection and DOC Release*



Approximately 58 percent of all DMIOs had five or more months between selection and release (62 out of 106), while 42 percent (44 out of 106) were selected with less than five months prior to release. Exhibit 5 shows this trend remains fairly stable.

Exhibit 5
Time Between Committee Selection and
DOC Release by Selection Time Period

Selection Time Period	Number of Offenders	5 or More Months	Median Days
April 2000 to December 2000	34	59%	170
January 2001 to October 2001	34	59%	171
November 2001 to July 2002	38	55%	158
Total	106	58%	167

N=106; offenders released through December 10, 2002; 150 days equals 5 months.

Summary

The DMIO identification and screening process used by DOC continues to be refined, and improvements continue to be made in the identification process. However, the original assumption that easily accessible electronic data would help to identify individuals suitable for DMIO consideration has proven incorrect. In reality, DOC's OBTS database has a small number of mental illness indicators, and the reliability of these indicators varies. Other relevant data, such as DOC clinical records or state hospital and community mental health records, are not accessible electronically, so the documents must be requested and reviewed.

The SRC began reviewing offenders for the DMIO program in April 2000. As of December 2002, 252 offenders were reviewed, and 171 were selected into the program. Once an offender has been selected, the SRC assigns him or her to a local service area for mental health treatment and other services. Over half of the RSNs have not signed the MHD contract for DMIOs, but, in many of those regions, local community providers have agreed to serve this population.

Continuing issues in the identification and selection process include improving the quality and timeliness of mental illness information available to the SRC; improving linkages with state hospitals, community providers, and jails to assist in identifying candidates as early as possible; and encouraging all RSNs to serve DMIOs.

III. PRE-RELEASE AND COMMUNITY SERVICES FOR DMIOS

Once an offender has been selected as a DMIO, the legislation requires the following:

- 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, RSNs, and treatment providers;
- Recommendation by the planning team for:
 - Evaluation of the DMIO by a county-designated mental health professional for involuntary mental health commitment;
 - DOC-supervised community treatment; or
 - Voluntary community mental health or chemical dependency treatment;
- Development by DOC and DSHS of 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.

Treatment Planning Process

The planning team process usually begins soon after an offender is identified by the SRC as a DMIO. At this time, the MHD sends background information to the RSN and to the contracted mental health treatment provider in areas with no RSN contract.¹⁶ DASA sends background information to the local county alcohol and drug coordinator. If an offender is eligible for DDD services, a DDD representative sends information to the local provider.

An initial meeting is held with agencies that may be involved in working with the offender to determine roles and responsibilities. In most cases, the RSN or community provider takes the leadership role and sets up the initial and subsequent planning team meetings. When there is no contract in place, DOC undertakes the leadership role.

Service planning usually begins approximately three to five months prior to release. The mental health treatment provider is required to develop the community treatment plan; a mental health case manager has overall responsibility to obtain necessary services and treatment. DOC community risk management specialists draw up a detailed plan for the first 48 hours after release from prison, which is a difficult and vulnerable time for a mentally ill individual.

In the three to five months prior to release, the following additional tasks are undertaken:

- A review of safety issues for the provider and community;
- Coordination with prisons, including DOC mental health staff;
- Meeting with the offender to gain his or her participation in treatment;

¹⁶ The MHD sends the background information to the RSN regardless of whether they have a DMIO contract.

- Identification of a multi-agency treatment team, including community corrections, mental health, chemical dependency, developmental disability, sex offender treatment providers, and others;
- Development of a prison discharge and community treatment plan, including assessments, treatment components, housing, and witness notification; and
- Development of resources such as housing, a stable environment, and medical care.

There are many challenges in treating DMIOs. Research indicates that mentally ill individuals who have committed crimes are likely to have a history of resistance to psychiatric treatment, including a lack of willingness to take medications. In addition, DMIOs are likely to be intimidating because of previous violent behavior. Structured treatment activities, continuous care and regular monitoring, measures to ensure staff safety, and close mental health and criminal justice collaboration are all components of successful treatment.¹⁷ The importance of DMIO treatment planning cannot be understated. It is necessary to ensure continuous care between the criminal justice and mental health systems and to provide the DMIO in the community with the support needed to stabilize his or her illness and environment.

DMIOs Released From Prison

From September 2000 through June 2002, 72 DMIOs were released from DOC institutions. Most of these individuals received service planning through the DMIO program. This section examines these 72 DMIOs, providing background data, criminal sentence and release characteristics, prison and post-release services, supervision, and criminal justice events.¹⁸ Whenever possible, services provided to DMIOs are compared with services provided to mentally ill offenders released from prison in 1996 and 1997 (the Community Transition Study or CTS).¹⁹ These CTS subjects form the comparison group for evaluating the effectiveness of the DMIO legislation; earlier analyses indicate that DMIOs are generally comparable to the CTS subjects.²⁰

DMIO Characteristics

Exhibit 6 presents demographic, criminal history, duration of prison confinement, and risk assessment characteristics of the released DMIOs. Most are men; approximately 72 percent are white, 21 percent are black, and 7 percent are of another race. The average age at first offense is 25 years, and the average age at release is 38 years. DMIOs have a fairly extensive criminal history, with an average of four previous Washington felonies, and 78 percent have at least one Washington violent felony offense. About 29 percent have a Washington felony sex offense in their criminal history.

¹⁷ H. Richard Lamb and Linda E. Weinberger, "Persons with Severe Mental Illness in Jails and Prisons: A Review," *Psychiatric Services* 49 (1998): 483-492; Arthur Lurigio, "Effective Services for Parolees with Mental Illness," *Crime and Delinquency* 47 (2001): 446-461.

¹⁸ The cutoff of June 2002 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 released DMIOs.

¹⁹ Lovell et al., *Community Transition Study*.

²⁰ Phipps and Gagliardi, *Implementation of Washington's Dangerous Mentally Ill Offender Law*.

Exhibit 6
Characteristics of DMIOs*

Characteristic	
Total Number	72
Percent Male	94%
Race	
Percent white	72%
Percent black	21%
Percent other race	7%
Criminal History	
Average age at first Washington offense	25 years
Average age at release	38 years
Average number of previous Washington felonies	4
Percent with Washington felony violent offense	78%
Percent with Washington felony sex offense	29%
Prison Stay	
Mean prison length of stay	5 years
Prison admission date	
1980–89	14%
1990–94	13%
1995–99	33%
2000	40%
Average number of prison infractions per year	3
Risk Assessment Scores	
Average LSI-R score	36
LSI-R risk level	Medium-high

*Released September 2000 through June 2002.

Prison stay characteristics are also shown in Exhibit 6. The mean length of stay in prison for released DMIOs is five years, with the largest proportion of offenders entering prison from 1995 through 2000. DMIOs average three major infractions per year of prison. Major DOC infractions encompass a variety of behaviors, such as violent acts, weapon possession, theft, drug or alcohol possession, gambling, refusal to work, and lying to staff (see Appendix D for a complete list of major prison infractions).

To assess the risk of recidivism for each offender, DOC staff complete a risk assessment instrument called the Level of Services Inventory-Revised (LSI-R). The LSI-R includes questions on an individual's criminal history, employment, family/marital status, alcohol/drug use, emotional problems, attitudes, and other items that have a relationship to criminal behavior. DMIOs have an average score of 36 on the LSI-R, as seen in Exhibit 6. This score puts DMIOs in the 91st percentile of all released prisoners, indicating that by this assessment they are medium-high risk and have over a 57 percent chance of reoffending.

DOC Institutional Treatment

Exhibit 7 shows the number of DMIOs in mental health units while in prison. Most mentally ill offenders reside in the DOC general population. Separate mental health units treat offenders with different needs: extremely disordered individuals, those unable to cope in other settings, and those who need intermediate care.²¹ Approximately 73 percent of the DMIOs were treated in a mental health unit during their incarceration.²² The median length of stay in a prison mental health unit was approximately 214 days.

Exhibit 7
Prison Mental Health Unit Residency of DMIOs*

Total	72
Percent With Mental Health Unit Residence	73%
Median Days in Mental Health Unit	214

*Released September 2000 through June 2002.

Chemical dependency (CD) treatment for drug or alcohol addiction was a possible treatment option during incarceration. At the time of prison admission, offenders completed a screening instrument that was used to identify whether they had an alcohol or drug problem. If the screening indicated a problem, the next step included a CD assessment to establish a diagnosis and type of treatment needed. As Exhibit 8 shows, of the 72 DMIOs, 35 had results indicating further assessment was warranted and 17 did not; 20 offenders had no screening results recorded. Of the 35 DMIOs considered to need further assessment, 15 received a CD assessment. Seven of the DMIOs received non-residential CD treatment during incarceration, and four completed that treatment.²³

²¹ David Lovell, Clark Johnson, Ron Jemelka, Victoria Harris, and David Allen, "Living in Prison After Residential Mental Health Treatment: A Program Follow-up," *Prison Journal* 81 (2001): 473-490.

²² Approximately 9 percent of the total prison population spends time in a mental health unit.

²³ Traditional chemical dependency 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 the mentally ill.

Exhibit 8
Prison Chemical Dependency Treatment of DMIOs*

Treatment Status	Number of DMIOs
Total Number	72
Chemical Dependency Screening	
Results indicate substance problem	35
No problem indicated	17
No screening	20
Chemical Dependency Assessment	15
Prison Chemical Dependency Treatment	
Completed	4
Not completed	3

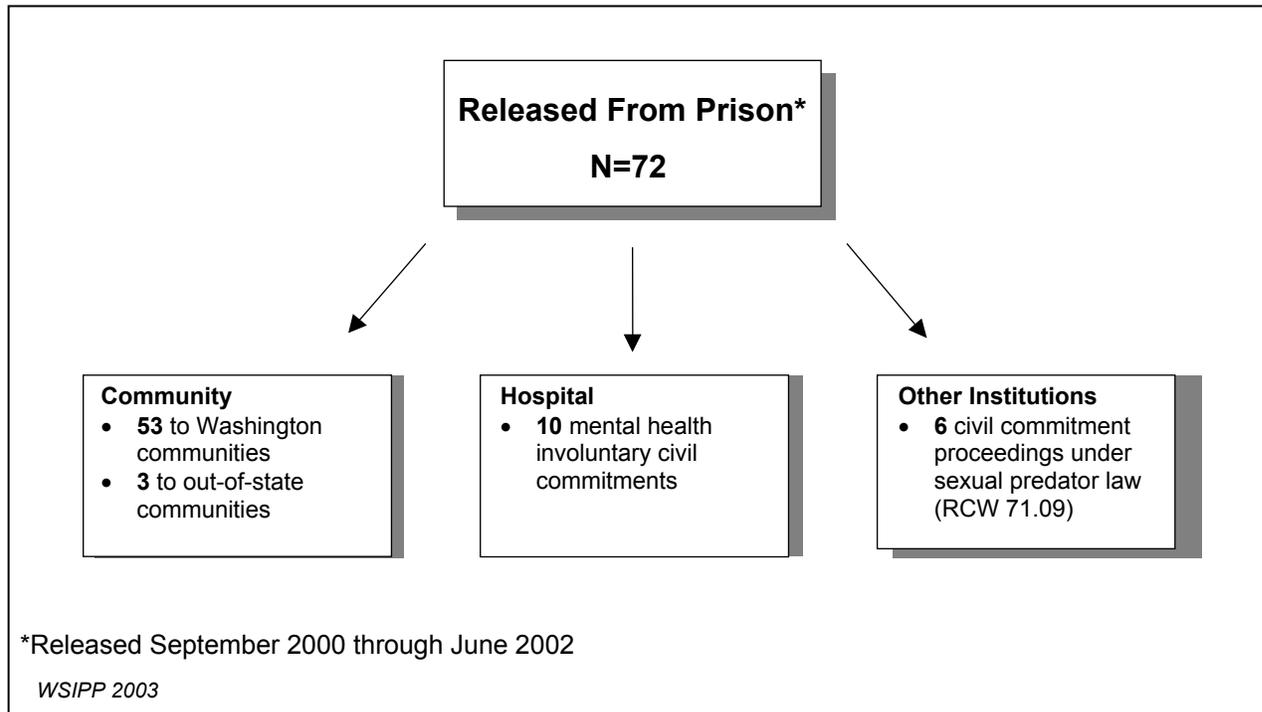
*Released September 2000 through June 2002.

Characteristics of Release

The legislation provides for the local planning team to refer any DMIO to a community designated mental health professional (CDMHP) for evaluation under involuntary mental health commitment laws. If committed, the DMIO will be released to a state or community hospital for involuntary mental health treatment. The legislation also provides two post-release treatment options for DMIOs: release to the community with DOC-supervised treatment or voluntary treatment. At this time, whether community treatment is supervised or voluntary is based on the conditions set at the time an offender is sentenced. For example, a judge may include a requirement that an individual participate in mental health treatment during community supervision. The Offender Accountability Act (applicable for offenses committed after July 1, 2000) allows DOC to set affirmative treatment conditions and provides another option for release to the community with DOC-supervised treatment. However, only one of the DMIOs released through June 2002 has been sentenced under this act.

Exhibit 9 shows the release location of the 72 DMIOs released from September 2000 through June 2002. Fifty-three DMIOs were released into Washington communities, and three were approved to move out-of-state. Ten DMIOs were committed to the state hospitals under the mental health involuntary commitment law (RCW 71.05). Six DMIOs 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; none were released as of September 2002.

**Exhibit 9
DMIO Location After Release**



DOC supervision is considered an important component of the DMIO program. Newly released offenders may resist treatment and services, particularly when participation in treatment is voluntary.²⁴ DOC supervision includes monitoring, and may include sanctions when offenders violate release conditions. Exhibit 10 shows the supervision status of the 72 DMIOs at the time of release. Most DMIOs (69 percent) had some DOC supervision time after release. Approximately 33 percent were released into community custody status, indicating at least one year, and, depending on the index crime, up to three years of active DOC supervision. Another 32 percent had post-release supervision; thus, they could have legal or financial obligations requiring some DOC supervision after prison release. About 4 percent of DMIOs had continuing supervision by the Indeterminate Sentencing Review Board (ISRB). However, 31 percent of DMIOs had no active DOC supervision after release.

**Exhibit 10
DOC Supervision Status of DMIOs***

Supervision Status at Release	Number of DMIOs	Percent
Community Custody Supervision	24	33%
Post-Release Supervision	23	32%
Parole Board (ISRB) Supervision	3	4%
No Active Supervision	22	31%
Total	72	100%

*Released September 2000 through June 2002.

²⁴ Council of State Governments, *Criminal Justice/Mental Health Consensus Project* (New York, June 2002).

Mental Health Services

To assess the extent of past mental health treatment, public mental health services provided to the 72 DMIOs *prior* to their incarceration are examined. In addition, mental health services received through the DMIO program through September 2002 are described. This includes DMIO program pre-release or “transitional” services and services in the community once an individual is released from prison.

Publicly Funded Mental Health Services Prior to Incarceration. Exhibit 11 shows that the majority of DMIOs received publicly funded mental health services prior to their prison incarceration. MHD service data are only available from 1994 onward; thus, 18 DMIOs with admission dates prior to 1994 are not included in these analyses. Approximately 83 percent of DMIOs received mental health services, with 69 percent receiving inpatient and 67 percent receiving outpatient services. As might be expected for individuals facing criminal charges, forensic days were the most common type of hospitalization prior to incarceration. Approximately 50 percent of DMIOs were hospitalized in a forensic unit prior to incarceration. The median length of hospitalization was 29 days. In addition, about one-third of DMIOs were hospitalized for psychiatric treatment in a community hospital sometime prior to incarceration. On average, two-thirds of DMIOs received outpatient mental health services prior to incarceration, averaging 4.4 hours per month for each month they received services.

Exhibit 11
Public Mental Health Services, 1994 to Incarceration

Mental Health Services	Number of DMIOs	Percent	Service Length
Any Mental Health Services	43	83%	
Inpatient Mental Health Services	36	69%	29 days (median)
State Hospital Forensic	26	50%	29 days (median)
State Hospital Civil	7	13%	9 days (median)
Community Hospital	16	31%	9.5 days (median)
Emergency/Treatment	6	12%	15.5 days (median)
Outpatient Mental Health Services	35	67%	4.4 hours per service month

N=52; 18 excluded with admission dates prior to 1994; 2 individuals with missing data.

DMIO Mental Health Services. 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 encourage an offender to participate in treatment when he or she leaves prison.

Approximately 81 percent of the DMIOs released in Washington State received mental health services from community providers prior to release (see Exhibit 12). In the six months prior to release, DMIOs received approximately 2.4 months of transitional service, with an average of 6.6 hours per service month.

Exhibit 12
**Pre- and Post-Release DMIO Community Mental Health Services,
 Through September 2002**

Community Mental Health Services	Number of DMIOs	Percent	Service Intensity
Pre-Release			
6 months prior to release	54	81%	2.4 service months 6.6 hours per service month
Post-Release			
Outpatient Mental Health Services			
3 months after release	58	87%	10.7 hours per month
12 months after release	40*	93%	8.6 hours per month

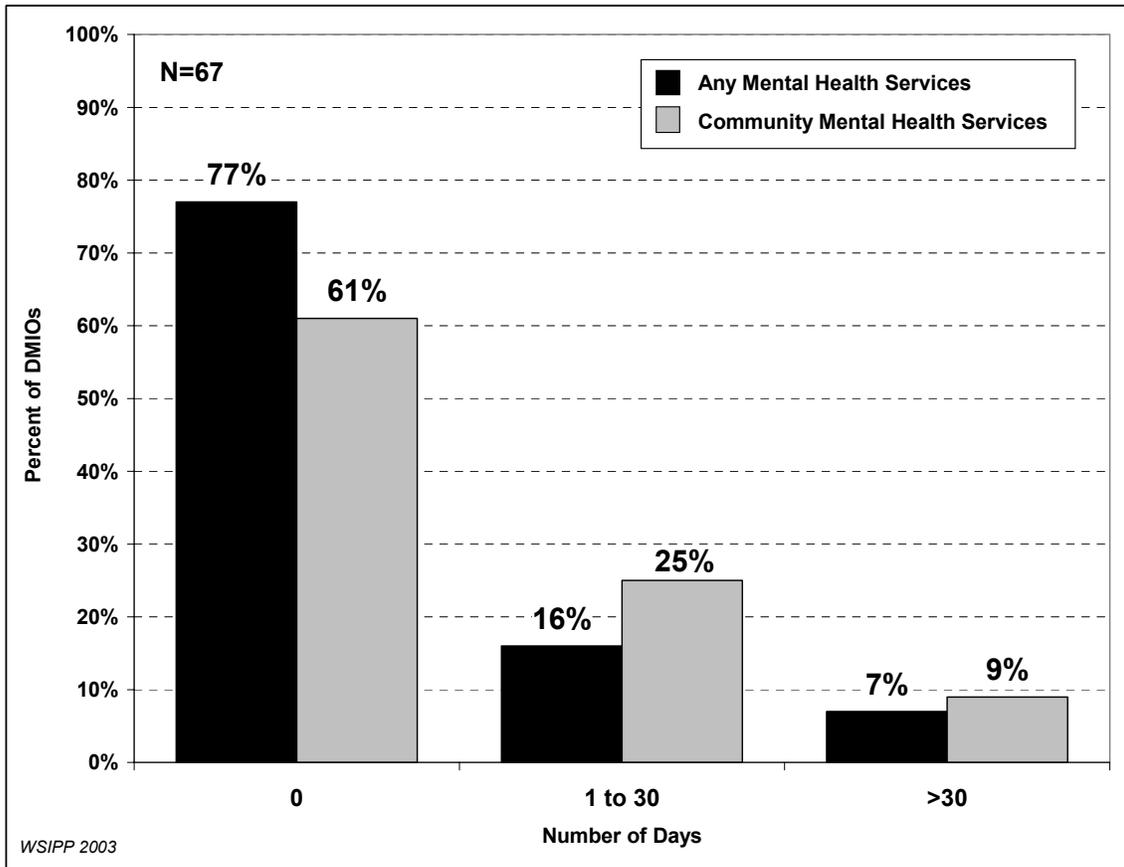
N=67; 2 individuals with missing data, 3 out-of-state excluded.

*N=43 released for 12 months or more; 1 individual with missing data; 3 out-of-state excluded.

Post-release community outpatient mental health services were provided to nearly all DMIOs released in Washington, with the exception of a few individuals whom providers were unable to persuade to participate in voluntary treatment. Exhibit 12 also shows that DMIOs received an average of 10.7 hours of outpatient services per month during the three months immediately following release. The number was slightly lower for a 12-month follow-up: 8.6 hours per service month. Thus, there was greater intensity of service in the first three months, as would be expected.

Post-release mental health services were delivered to DMIOs on a timely basis, helping to ensure a continuous treatment and medication regimen at the time of community entry (see Exhibit 13). Approximately 77 percent of DMIOs had no gap between prison release and some type of mental health services (hospital or community), 16 percent received services within 1 to 30 days, and 7 percent received services after 30 days. Approximately 61 percent of DMIOs were provided community mental health services immediately after release, with 25 percent receiving services between 1 to 30 days after release, and 9 percent receiving services after 30 days.

Exhibit 13
Time Between Prison Release and Mental Health Services



Exhibits 14 and 15 compare the experiences of the CTS subjects and DMIOs in receiving pre- and post-release community mental health services. Overall, a much larger proportion of DMIOs received services than CTS subjects, and the service hours were greater. The differences between CTS subjects and DMIOs are highly significant, indicating the DMIO program is providing significantly more pre- and post-release community mental health services to DMIOs.

Exhibit 14 indicates that only 10 percent of CTS subjects received any services prior to release compared with 81 percent of the DMIOs. In the community, only 29 percent of the CTS subjects received services in the first three months after release compared with 87 percent of all DMIOs. In the first full year after release, approximately 93 percent of all DMIOs received services compared with 45 percent of the CTS subjects.

Exhibit 14
Pre- and Post-Release Community Mental Health Services,
Through September 2002

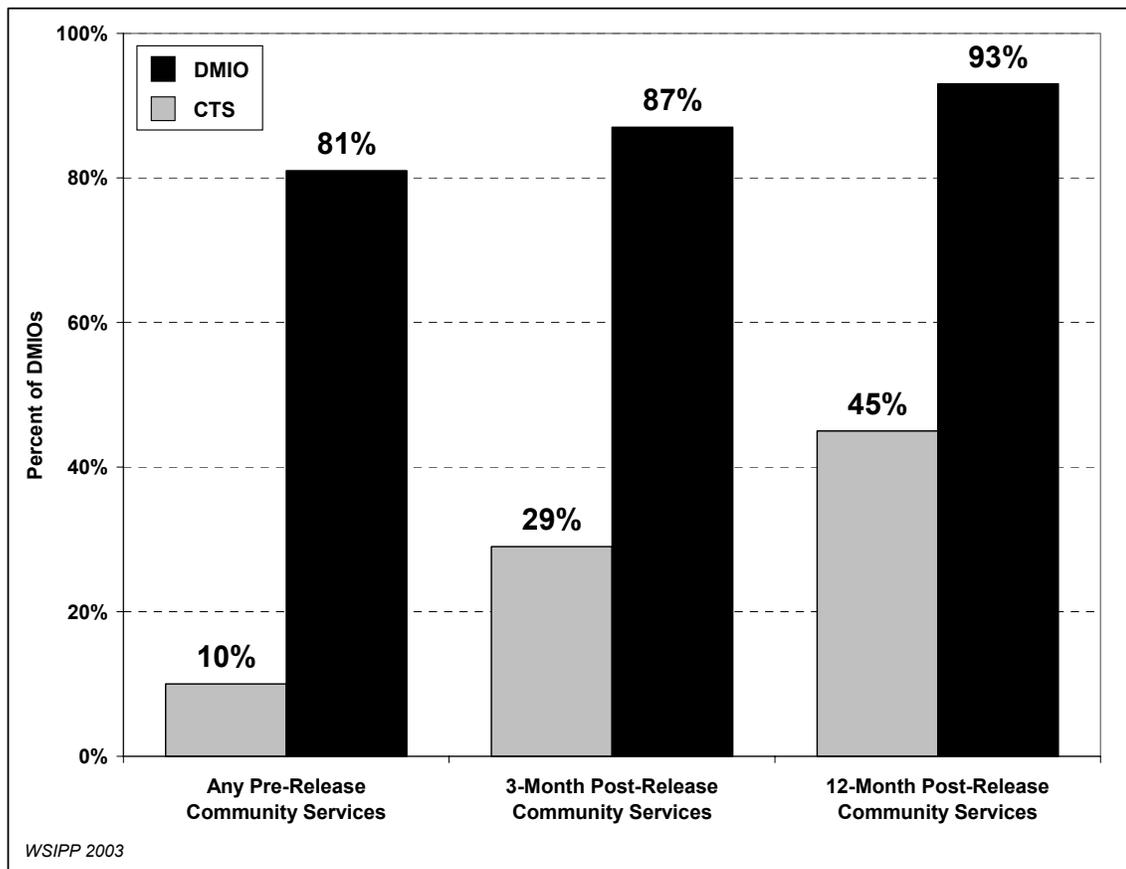
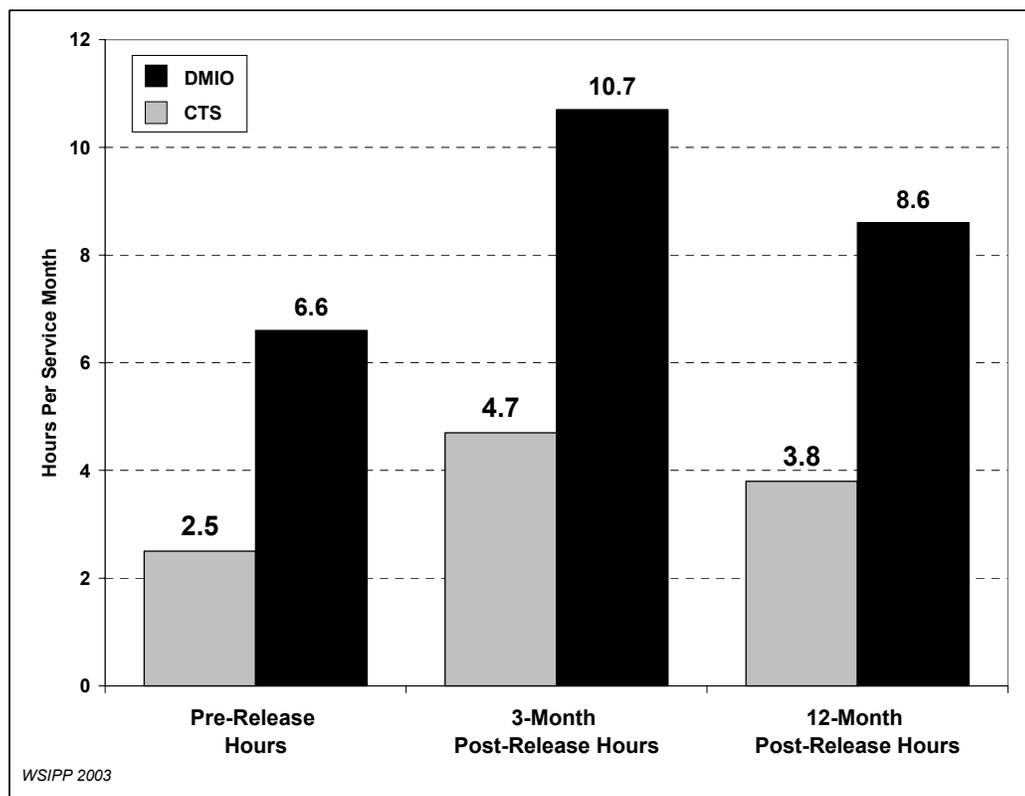


Exhibit 15 shows the community mental health outpatient service hours for CTS subjects and DMIOs during prison transition and in the first three and 12 months after release. During prison transition, the 10 percent of CTS subjects receiving services averaged 2.5 hours per service month, while the 81 percent of DMIOs receiving services averaged 6.6 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 87 percent of DMIOs receiving services averaged 10.7 hours. At 12 months after release, 45 percent of the CTS subjects received services averaging 3.8 hours per month compared with 93 percent of the released DMIOs who averaged 8.6 hours per month.

Exhibit 15
**Pre- and Post-Release Community Mental Health Service Hours,
 Through September 2002**



Post-release mental health inpatient stays for DMIOs are shown in Exhibit 16.²⁵ Overall, one-quarter of DMIOs had an inpatient hospital stay after prison release. Ten DMIOs were committed to a state hospital *at the time of prison release* under the involuntary mental health civil commitment law; one was committed at a later date. State hospital days ranged from three to 533, with a median stay of 80 days. Early in the program, the MHD estimated approximately five DMIOs per year would be placed in a state hospital; thus the estimates are close to what has occurred. Three DMIOs were admitted to an Evaluation and Treatment inpatient setting sometime after release with a median stay of 18 days, and five DMIOs were admitted to a community hospital for psychiatric treatment sometime after release with a median stay of seven days.

²⁵ Data with an equivalent follow-up time period are not yet available to compare DMIO and CTS inpatient treatment.

Exhibit 16
Post-Release Inpatient Treatment, Through September 2002

Type	Number of DMIOs	Percent	Median Length of Stay
Inpatient Mental Health Services	16	24%	-
State Hospital*	11	16%	80 days
Evaluation and Treatment*	3	4%	18 days
Community Hospital*	5	7%	7 days

N=67; 3 out-of-state excluded; 2 individuals with missing data.

*Three DMIOs received more than one type of hospitalization.

Community Drug and Alcohol Treatment

Exhibit 17 displays the chemical dependency (CD) treatment provided to released DMIOs through DASA contractors and Seattle Mental Health (SMH) through June 2002. All DMIOs who could have been considered for treatment are included (offenders who remain institutionalized under RCW 71.05 or RCW 71.09 are excluded, as are offenders who moved out-of-state). Overall, approximately 29 percent of DMIOs received some type of CD services through DASA or SMH; the most common type of treatment was outpatient.

Exhibit 17
Community Chemical Dependency Services Received Under DASA Contract or Through Seattle Mental Health, Through June 2002

Service Type	Number of DMIOs	Status as of 6/2002
Total Receiving Treatment	17	
Chemical Dependency Treatment*	21	
Outpatient	12	6 ongoing; 2 completed; 4 not completed
Intensive outpatient	4	1 ongoing; 1 completed; 2 not completed
Intensive inpatient	3	2 completed; 1 not completed
Long-term residential	2	1 completed; 1 not completed

N=58; includes all offenders released to Washington communities any time after prison release; 2 individuals with missing data.

*Four offenders received more than one type of treatment.

Tracking the full scope of drug and alcohol services provided to DMIOs has proven difficult because a number of DMIOs participate in mentally ill chemical abuser (MICA) groups that are not recorded in DASA or MHD databases.

To obtain a better understanding of whether DMIOs are receiving alcohol and drug services post-release, we identified 31 DMIOs (approximately 53 percent of those released) who might be candidates for services with either a current diagnosis of chemical dependency or abuse or post chemical dependency treatment. Seventeen of the 31 received CD treatment services post-release. Of the 14 not receiving CD treatment, three had attended MICA groups, two were listed as in remission with one involved in AA, and nine had no indication of services received.

Post-Release Criminal Justice Events

Exhibit 18 shows the post-release criminal justice events of 60 DMIOs who were in the community at some time and at risk to reoffend.²⁶ Overall, offenders were in the community for an average of 14 months (through September 2002). While it is too early to evaluate the impact of the program on criminal recidivism, these statistics provide an early look at how DMIOs 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 follow during post-confinement supervision. In addition, there are general DOC 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. Of the 60 DMIOs at risk to reoffend in the community, 38 (63 percent) are under some type of DOC supervision, as shown in Exhibit 18.

Approximately 71 percent of the 38 DMIOs under DOC supervision violated the conditions of their release. While this is a relatively high rate,²⁷ it is not unexpected; DMIOs are considered the highest risk-management level and are likely to receive a high level of supervision. The violation sanction for 18 of the 27 offenders included confinement in a DOC facility or county jail. The most common violations included alcohol or drugs (29 percent), failure to pay or report (21 percent), treatment non-compliance (16 percent), court or DOC supervision non-compliance (15 percent), and unapproved residence or employment change (13 percent).

Exhibit 18
Criminal Justice Events of DMIOs,
Through September 2002

Event	Number of DMIOs	Percent of Total At-Risk
DMIOs At-Risk	60	100%
DMIOs Under DOC Supervision	38	63%
DOC Violations	27	71%
Confinement	18	
Any Conviction	15	25%
Felony Conviction	4	7%
Violent	1	
Property	3	
Misdemeanor Conviction	13	22%
Violent	6	
Property	2	
Drug	1	
Other	4	

²⁶ We exclude offenders released out-of-state, those in state hospitals, and those institutionalized pending RCW 71.09 sexual predator proceedings.

²⁷ Less than 42 percent of Risk Management Level A (RMA) offenders released from prison had a violation within six months of release. DMIOs are classified as RMA.

Exhibit 18 shows that 15 of the 60 at-risk DMIOs (25 percent) have at least one felony or misdemeanor conviction for a new offense post release. Approximately 7 percent (four DMIOs) were convicted of a felony; however, only one offender has been convicted of a crime involving violence (Assault 3). About 22 percent of those at risk have been convicted for a misdemeanor crime, including six offenders with convictions for simple assault. This amount of involvement with the criminal justice system is not unexpected for the DMIO population. In particular, misdemeanor convictions were common for the CTS population. The final evaluation of the DMIO program will estimate the degree to which the program reduces criminal recidivism.

Summary

The 72 DMIOs released through June 2002 have a fairly extensive felony history, which includes a violent or sex offense. DMIOs are also at medium-high risk to reoffend. Most receive mental health services in prison, but few receive chemical dependency treatment while incarcerated.

Of the 72 DMIOs, 53 were released into the community, three were released to another state, ten were civilly committed upon release to the state hospital under involuntary mental health treatment laws (RCW 71.05), and six were institutionalized pending civil commitment proceedings under sexual predator laws (RCW 71.09).

Prior to incarceration, the majority of DMIOs received public mental health services, although, on average, the services 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 is working as envisioned, and DMIOs have been receiving transitional and community mental health treatment services.

Over two-thirds of released DMIOs under DOC supervision received a supervision violation, and two-thirds were temporarily placed in confinement (jail or prison) as a sanction. DMIOs are considered the highest risk level, so the high violation rate is likely a reflection of behavior and supervision level. Approximately 25 percent of DMIOs have been convicted of a new offense, with 7 percent convicted of a felony and 22 percent convicted of a misdemeanor offense. New convictions are not unexpected for this population; currently, there are only a small proportion of felony convictions. The final evaluation, in December 2004, will estimate the degree to which the program reduces criminal recidivism.

IV. CONTINUING CHALLENGES AND NEXT STEPS

With SSB 5011, Washington State began a process undertaken by few states. It is a formidable task to systematically identify mentally ill offenders in prison who pose a public safety threat and provide them with transitional and community services. The task involves coordination between correctional and social services agencies that have differing philosophies (punishment vs. treatment) and operating rules. There are many other factors that add complexity and complications to the DMIO program: community resources vary, communities have varying experience in working across agencies, and DMIO program resources are modest.

Consistent with the intent of the legislation, new connections are being built between correctional and social service systems at the state and local levels. Increased communication across systems assists in identifying individuals who may benefit from treatment in the DMIO program. In addition, the connections across systems are critical in providing for coordinated discharge and community treatment planning, such as expediting Medicaid eligibility, mental health and chemical dependency treatment, housing, and supervision. However, developing a system for better identification, treatment, and management of DMIOs is a lengthy process.

The Institute's earlier report identified challenges facing the DMIO program and made specific suggestions for improvement.²⁸ Many of these suggestions have been implemented. New programs are difficult to implement, particularly programs with a high-needs population that poses major challenges to treatment and supervision.

State and local agencies are willing to openly discuss program issues. In November 2002, all agencies represented on the SRC met with Institute representatives to share their views and ideas regarding the program. Subsequently, two day-long meetings were held with agency representatives from DOC, DSHS (MHD, DASA, DDD), RSNs, Community-Designated Mental Health Professionals (CDMHP), community mental health providers, the Washington Community Mental Health Council, and the SRC. These meetings addressed issues that need to be resolved and set future plans.

During the first meeting, the group identified and prioritized program issues, including weaknesses in program oversight, operations, and information sharing; lack of clarity in the roles and responsibilities of participating agencies; barriers to treating DMIOs; and the need for additional or reallocation of financial resources. As part of this process, action plans were developed on topics determined to be critical to the success of the DMIO program:

- Designing an oversight board/function;
- Creating a policy and procedure manual;
- Setting minimum standards for SRC case review information packets;
- Formalizing a process for documenting transition, release, and treatment plans, including who has responsibility for different plan elements and a central location where those involved can check in;
- Developing written procedures on termination from the DMIO program;

²⁸ Phipps and Gagliardi, *Implementation of Washington's Dangerous Mentally Ill Offender Law*.

- Developing written procedures on removing an individual from the DMIO program when further clinical assessment indicates he or she does not meet major mental disorder criteria;
- Identifying methods to increase and reallocate funding for DMIOs; and
- Writing a position paper on barriers to DMIO access in the community and obstacles to DMIO oversight.

The second meeting involved a discussion on critical issues identified in the first meeting:

- Meeting DOC's need to identify DMIOs in a way that allows providers sufficient opportunity to plan and engage an offender in treatment;
- Expediting the preparation process for selected DMIOs with less than five months to release; and
- Identifying DMIO candidates earlier in order to ensure adequate planning time.

Based on these two meetings, the group took formal action on several items, including the following:

- Establish a DMIO oversight committee to act as a governing structure for the DMIO program.²⁹ The oversight committee has authority to follow up on action plans, approve procedures, and address new and ongoing program issues. Membership includes one representative each from DOC, MHD, DDD, DASA, an RSN, a CDMHP, a mental health treatment provider, and an alcohol/chemical dependency treatment provider;
- Approval for DOC to begin implementing liaisons with jails to assist in the early identification of possible DMIO candidates, particularly those with a short time period between DOC admission and release; and
- Establish an ad hoc committee for consultation on offenders with short release times and other emergency cases.

Most agency representatives indicated that establishing an oversight committee is the first step in developing a strong administrative structure, and ultimately, a stronger DMIO program.

Next Steps

Future reports will provide more detailed information about DMIOs:

- An interim report in December 2003 will focus on the factors that affect service use and criminal recidivism, including substance abuse, attitude towards treatment, types of services offered and received, housing needs, and coordination between criminal justice and social service agencies.
- The final report, due in December 2004, will focus on whether the DMIO program reduces criminal recidivism, whether the program is cost-effective, and which characteristics of DMIOs predict success and failure in the community.

²⁹ In May 2003, DSHS proposed the oversight committee have an advisory rather than a governance role to the MHD and DOC (the agencies that have statutory authority to implement the DMIO program).

APPENDIX A: LEGISLATIVE RESEARCH QUESTIONS

In Section 10 of SSB 5011, the Legislature designated specific questions for the evaluation. 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.

APPENDIX B: STATEWIDE REVIEW COMMITTEE’S MENTAL DISORDER AND DANGEROUSNESS CRITERIA

Mental Disorder

- **“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
 - ◆ 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 Scores: 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 C: STATEWIDE REVIEW COMMITTEE’S DMIO CHECKLIST

Dangerous Mentally Ill Offender Committee Review Sheet

Major Thought Disorder, Major Mood Disorder or DDD enrolled. **YES** **NO**

- a. Schizophrenia b. Schizoaffective c. Psychosis NOS
- d. Schizophreniform e. Bipolar Disorders f. DDD
- g. Major Depression h. Mood Disorder NOS _____
- i. Brief Psychotic Disorder j. Organic Brain Syndrome/Dementia
- k. Other: _____ e.g.:(Axis 1): OCD, Delusional, Paranoid, Anxiety disorders: (Axis 11) Borderline, paranoid, schizoid (must have debilitating/significant impact on functioning for either Axis 1 or 11)

Decision Justification: _____

Significant Substance Abuse/Dependency History **YES** **NO**

Dangerous. **YES** **NO**

- Convicted of a Felony Index Violent/Serious Violent Offense
- Classified as RMA
- LSI-R score 41 or greater
- Significant History of Suicide Attempts
- Use of Weapon During an Offense
- Current Threats of Imminent Risk
- Sex Offender Level III
- Significant History of Dangerous Infractions
- Significant History of Hate Crimes
- High Probability of New Felony ___% or Greater
- High Probability of New Crime vs. Person ___% or Greater

Decision Justification: _____

Decision: **Accepted as a DMIO** **Imminent Risk** **Pend**
 Rule out MMD **Rule out Danger** **RMB High Needs**

Other Comments: _____

APPENDIX D: MAJOR PRISON INFRACTIONS

- Aggravated Assault/Inmate
- Aggravated Assault/Staff
- Aggravated Assault/Visitor
- Assault
- Assault/Inmate
- Assault/Non-Hospital
- Assault/Staff
- Assault/Visitor
- Assault/Hospital
- Attempt Infraction
- Cause I/M Injury
- Cause Staff Injury
- Commit Homicide
- Communication Misuse
- Communication W/Minor
- Counterfeit/Forgery
- Dangerous Infraction
- Destroy Property
- Disease Transfer
- Drug/Alcohol Use
- Escape
- Escape Apprehended
- Escape Forced
- Escape Tools
- Escape Voluntary Return
- Escape/Attempt
- Extortion
- Fail Maintain
- Fail to Return
- Fail to Perform
- Fail to Report Income
- False Release Plan
- Feigning Illness
- Fighting
- Flooding
- Food Theft > \$5
- Four General Infraction
- Fraud
- Furlough Violation
- Gambling
- Group Demonstration
- Holding Hostage
- Homicide
- Hunger Strike
- Impersonating
- Inciting Riot
- Indecent Exposure
- Injure a Visitor
- Interfere With Count
- Interfere With Staff
- Lost Future Gct
- Lying to Hearing
- Lying to Staff
- Mail/Phone Violation
- Make Bomb Threat
- Making Drugs
- Martial Arts
- Misdemeanor
- Misuse > \$10
- Obscene Material
- Offer Bribe
- Operate Motor Veh. w/o Permission
- Operational Risk
- Organize Work Stoppage
- Other Felony/Misdemeanor
- Perform Marriage
- Poor Conduct
- Positive Drug Test
- Possess Alcohol
- Possess Ammunition
- Possess Clothing
- Possess Contraband
- Possess Controlled Substance
- Possess Marijuana
- Possess Medication Over 1 Dose
- Possess Money
- Possess Narcotic
- Possess Narcotic/Alcohol >15
- Possess Staff Clothes
- Possess Tobacco Products
- Possess Unauthorized Tool
- Possess Weapon
- Possess > \$10
- Refusal/Safety
- Refuse Breath Test
- Refuse Cell Assignment
- Refuse Medical Test
- Refuse Sanctions
- Refuse Search
- Refuse Test
- Refuse to Leave
- Refuse to Program
- Refuse to Work
- Refuse Transfer
- Refuse U/A Test
- Refuse W/Staff Injury
- Refuse Work
- Rioting
- Self Mutilation
- Setting Fire
- Sexual Acts
- Sexual Harass/Staff
- Soliciting Goods
- Staff Interference
- Strong-arming
- Tamper Fire Equipment
- Tamper With Lock
- Tattoo/Paraphernalia
- Theft
- Threatening
- Throwing Objects
- Unauthorized Contract
- Unauthorized Gang/Club
- Unauthorized Keys
- Unauthorized Meeting
- Violate Condition
- Violate Furlough
- Violate Law
- Work Plan Modify
- Wtr Gct Loss