





STATE OF WASHINGTON

December 1, 2005

The Honorable James Hargrove, Chair  
Senate Human Services and Corrections Committee  
Post Office Box 40482  
Olympia, Washington 98504-0482

Dear Senator Hargrove:

Enclosed is the annual report to the legislature regarding the Mentally Ill Offender Community Transition Program (MIO-CTP). This report is a collaborative effort by the Department of Social and Health Services, the Department of Corrections, and the King County Regional Support Network as required by RCW 71.24.460.

The MIO-CTP program was created in 1998 and charged with creating a pilot program to provide for post release mental health care and housing for a select group of mentally ill offenders entering community living, in order to reduce incarceration costs, increase public safety and enhance the offender's quality of life. This report provides information on the program's successes, innovations and challenges, as well as service outcomes. It also offers conclusions regarding the program's effectiveness.

We are available to respond to any of your questions or comments.

Sincerely,

Robin Arnold-Williams  
Secretary  
Department of Social and Health Services

Harold Clarke  
Secretary  
Department of Corrections

Jackie MacLean  
Director  
King County Department of Community and Human Services

Enclosure





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December 1, 2005

Rich Nafziger, Chief Clerk  
House of Representatives  
338B Legislative Building  
Olympia, Washington 98504

Dear Chief Clerk Nafziger:

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STATE OF WASHINGTON

December 1, 2005

The Honorable Al O'Brien, Chair  
House Criminal Justice and Corrections Committee  
Post Office Box 40600  
Olympia, Washington 98504-0600

Dear Representative O'Brien:

Enclosed is the annual report to the legislature regarding the Mentally Ill Offender Community Transition Program (MIO-CTP). This report is a collaborative effort by the Department of Social and Health Services, the Department of Corrections, and the King County Regional Support Network as required by RCW 71.24.460.

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Enclosure



# **Mentally Ill Offender Community Transition Program**

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Annual Report to the Legislature  
December 1, 2005

*Washington State  
Department of Social and Health Services  
Robin Arnold-Williams, Secretary*

*Washington State  
Department of Corrections  
Harold Clarke, Secretary*

*The King County  
Regional Support Network  
Jackie MacLean, Director  
Department of Community and Human Services*

Additional copies of this report are available from:  
Washington State Department of Social and Health Services  
Health and Recovery Services Administration  
Mental Health Division - MIO-CTP Program  
P. O. Box 45320  
Olympia, WA 98504-5320  
360-902-8070

# MENTALLY ILL OFFENDER - COMMUNITY TRANSITION PROGRAM

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# Mentally Ill Offender - Community Transition Program 2005 Annual Report to the Legislature

## EXECUTIVE SUMMARY

The goal of the *Mentally Ill Offender – Community Transition Program* (MIO-CTP) is to reduce incarceration costs through reduction of recidivism, and increase public safety while improving a mentally ill offender's chances of succeeding in the community.

The MIO-CTP was initiated in 1998 with RCW 71.24.455 as a five-year pilot program charged with developing post release mental health care and housing, through intensive case management. Its target was a participant group of 25 seriously mentally ill offenders. Administration of the program is provided by the Department of Social and Health Services (DSHS), under contract with the King County Regional Support Network (KC-RSN) and its subcontractors. DSHS collaborates with the Department of Corrections (DOC) to ensure cross-agency communication.

### **Selecting Program Participants:**

Program participants are selected for inclusion in the program utilizing specific selection criteria based on the statutorily mandated elements, and good clinical practice. Candidates are referred from four correctional facilities, or "launch sites" and screened by DOC for program appropriateness. A multidisciplinary selection committee reviews all candidates and makes selection decisions.

### **Major Program Components:**

The major program components include:

- Coordinated pre-release planning
- Intensive post-release case management
- Treatment for Co-occurring disorders (mental health and substance abuse)
- Residential support / Employment services
- Community supervision by DOC

### **Program Success:**

MIO-CPT is accomplishing its goal of reducing recidivism by engaging the participant in pre-release transition planning through collaboration between DSHS, DOC, KC-RSN and community provider agencies, as follows:

- Felony recidivism of participants was 275 percent less than predicted by comparison group measures.
- Felony recidivism of participants is 13.9 percent two years following their release versus 40.8 percent in a comparison group.
- There are no new felony crimes against persons. Subsequent new offenses were the less serious drug crimes and crimes against property.

Interviews of program participants who were re-offenders were conducted three months following their release. Commonalities contributing to their recidivism were identified, and included:

- Increased psychiatric symptoms of depression, attempted suicide, and auditory hallucinations was associated with subsequent felony conviction, and
- Self reported substance use was also found to be related to subsequent felony recidivism.

**Program Innovations:**

Innovative improvements in multi-system pre-release planning increased the range, availability and appropriateness of services while improving continuity in documentation of Pre-Release Care Plans. With the improved documentation, inmates concerns and issues were readily addressed and continuity was maintained across agencies.

Collaboration and multi-system communication between the federal Social Security Administration and state DSHS Economic Services Administration, fostered by efforts of the MIO-CTP, developed efficient access to benefits for participants. This supported the more vulnerable participant's return to increased success in community living and increased health and safety.

**Conclusion:**

The evidence strongly supports the effectiveness of intensive mental health case management services in reducing the likelihood of subsequent felony recidivism. Treatment of psychiatric symptoms, particularly depression, suicidal ideation, auditory hallucinations, and substance abuse appears effective in preventing further criminal activity among offenders with serious mental illness.

## MIO-CTP 2005 ANNUAL REPORT to the LEGISLATURE

### EVALUATION OUTCOMES

**The Mentally Ill Offender - Community Transition Program (MIO-CTP)** was established in 1998 by the Washington State Legislature to evaluate the effectiveness of an intensive case management program in reducing recidivism among mentally ill offenders released from state prisons. A full description of program components and developments is included in the Appendices.

This report includes information on 80 individuals who were enrolled in the program and received pre-release mental health services. The large majority of the 80 participants have been released from prison and have also received post-release mental health services in the community.

Mental health service levels, and recidivism outcomes, for participants in the MIO-CTP are compared to those in the ***Mentally Ill Offender Community Transitions Study (CTS)*** conducted by the Washington Institute for Mental Illness Research and Training<sup>1</sup>. This study tracked a cohort of mentally ill offenders released from Washington correctional facilities in 1996 and 1997, and gathered data on mental health services utilization and criminal recidivism over a three to four year period. The study represents baseline data, or a comparison group, of mentally ill offenders in Washington State prior to the implementation of specifically designed and coordinated interventions.

#### ***Enrolled Participants***

Mentally ill offenders accepted and enrolled as active participants in the intensive outpatient case management program are profiled. Details of the program are provided in the Appendix. The information presented here reflects outcome data on 80 participants enrolled between September 1998 and June 31, 2004.

Demographic information on program participants is presented in **Exhibit 1 - Characteristics of Participants**, along with equivalent data on the CTS comparison group. The MIO-CTP group has a smaller percentage of white/Caucasian individuals and is slightly older than the CTS group. MIO-CTP participants have a history of fewer felonies than the comparison group. Three-fourths, 74.4 percent of program participants have been convicted of more than one felony. This compares to 83 percent of CTS comparison group subjects having more than one felony conviction.

Within **Exhibit 1 - Characteristics of Participants**, the "Index Offense" category meant to identify the most serious offense for which the individual was incarcerated, just prior to release for the respective studies.

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<sup>1</sup> <http://www.wsipp.wa.gov/pub.asp?docid=05-03-1901>

MIO-CTP participants were more likely to have committed a drug offense as their Index Offense. The mean length of time spent in prison for the Index Offense for all program participants is 25.1 months (Standard Deviation {SD} = 20.6)<sup>2</sup> versus an average 28 months for CTS subjects.

### Exhibit 1 - Characteristics of Participants

Participant Characteristics			
Characteristic		MIO-CTP N=80	CTS Comparison (N=333)
<b>Gender</b>	Male	63.4%	70.0%
	Female	36.6	30.0
<b>Race</b>	White/Caucasian	50.0%	72.0%
	Black/African American	31.7	23.0
	Other	18.3	5.0
<b>Age</b>	Mean	37.3 years	33.0 years
	Standard Deviation	8.0 years	
<b># Prior Felonies</b>	One	25.6%	16.8%
	2-4	50.0	31.8
	5-7	18.8	19.2
	8-10	3.8	8.6
	11+	1.3	20.7
<b>Index Offense</b>	Homicide/Manslaughter	2.5%	3.0%
	Sex	8.8	15.0
	Robbery/Other Violent	28.8	26.0
	Burglary/Other Property	18.8	24.0
	Drug	41.3	31.0
	Other	--	1.0

While all program participants received mental health treatment during their incarceration, the majority 83.8 percent required residential mental health treatment some time during their incarceration. The remaining 16.2 percent lived in the general population throughout their incarcerations. This figure is somewhat higher than the 70 percent of CTS subjects who were treated in mental health units. For participants who required residential mental health treatment, the mean number of months in a DOC mental health unit was 12.9 (SD = 13.2) months.

<sup>2</sup> Two extreme cases of 240 mo and 360 mo were dropped from the MIO-CTP averaging.

## **Diagnostic Information**

**Exhibit 2 - MIO-CTP Participant Diagnoses** reports the primary psychiatric diagnostic categories of participants at the time of enrollment as diagnosed by the local mental health service provider. Comparison with CTS subjects is limited. The source of the CTS diagnosis is DOC personnel. The decision tree for diagnostic categories may differ somewhat, and the CTS study was unable to locate a diagnosis for approximately one quarter of its subjects.

Many MIO-CTP participants carry multiple Axis I<sup>3</sup> diagnoses. The principal Axis I diagnosis was determined by the following decision process: psychotic disorders, primarily schizophrenia, took first priority, followed by depression, bi-polar, and other disorders. In other words, if a client had an Axis I diagnosis of schizophrenia and depression, the principal diagnosis was considered to be a psychotic disorder.

### **Exhibit 2 - MIO-CTP Participant Diagnoses**

<b>Participant Diagnosis</b>		
<b>Diagnosis</b>		<b>N=80</b>
<b>Principal Axis I Diagnosis</b>	Psychotic Disorder	55.0%
	Depression	21.3
	Bi-polar Disorder	20.0
	Other Disorder	2.5
	Substance Abuse Primary	1.2
<b>Co-occurring Substance Abuse</b>		86.3%
<b>Personality Disorder Dual Diagnosis</b>		52.5%

A vast majority of program participants, 86.3 percent, have been dually diagnosed with a co-occurring substance abuse disorder in addition to the principal Axis I disorder. Just over half, 52.5 percent of program participants have an Axis II personality disorder in addition to their Axis I disorder. All persons dually diagnosed with a personality disorder also have a co-occurring substance abuse disorder.

The majority of MIO-CTP participants have complex and severe mental health problems.

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<sup>3</sup> American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000; Multiaxial Assessment, pp 27-38.

## **Treatment Services**

Program participants receive a variety of services during their involvement in the program. The range and balance of services is presented in **Exhibit 3 - MIO-CTP Treatment Services**. This table includes pre and post-release services. Not all participants receive all services. The blend of services received is tailored to the needs of the individual. For example, only a portion of the participants require the intense supervision of day treatment services. Some participants require, and/or benefit from, more individual treatment; others spend more of their treatment contacts in a group setting.

**Exhibit 3 - MIO-CTP Treatment Services**

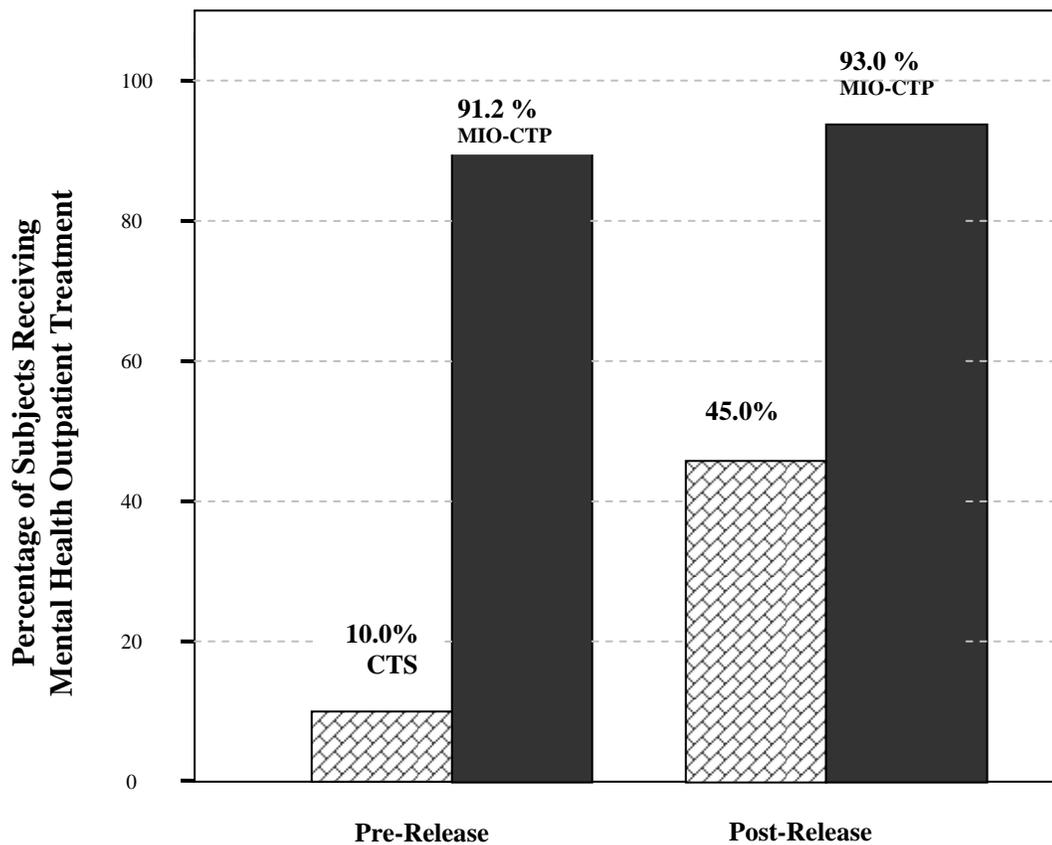
<b>Treatment Services</b>	
<b>Treatment Modality</b>	<b>N = 26258 hours (September 1998 – June 2004)</b>
Individual Treatment	45.2%
Group Treatment	26.4
Day Treatment	14.8
Treatment Planning (Includes consultation with DOC staff)	9.6
Special Evaluation/Consult	2.1
Medication Management	1.9
<b>Total</b>	<b>100%</b>

Mental health treatment services received by program participants are compared to treatment services received by the CTS group in **Exhibits 4 and 5**.

The percentage of clients receiving pre-release and post-release services is represented in **Exhibit 4**. Only 10 percent of CTS subjects received pre-release services, compared to 91.2 percent of MIO-CTP participants.

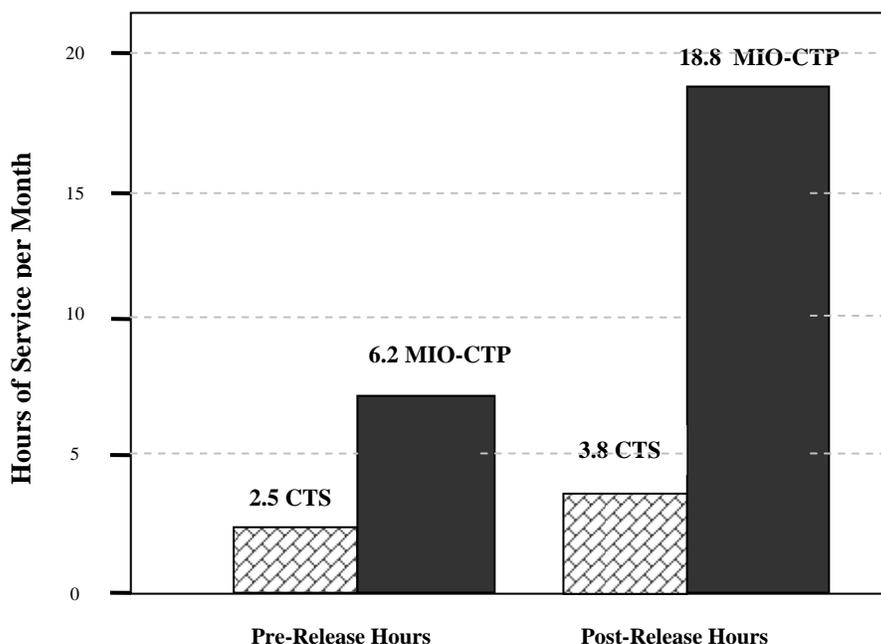
Only 45 percent of CTS subjects received any post-release services, while 93.0 percent of MIO-CTP clients received post-release services.

**Exhibit 4 - Percentage of Subjects Receiving Mental Health Outpatient Treatment Services**



Further differences in the amount of services received by the two groups is presented in **Exhibit 5 - Average Number of Outpatient Treatment Hours per Month**, which compares the average number of hours of treatment per month, per group. These figures represent the mean of those who received any services. The 10 percent of CTS individuals receiving pre-release services, received an average of 2.5 treatment hours per month and the 45 percent of CTS individuals who received services in the 12 month post-release period received an average of 3.8 treatment hours per month. This is contrasted with 91.2 percent of MIO-CTP participants who received an average of 6.2 hours of pre-release services and the 93 percent of MIO-CTP participants who received an average of 18.8 hours post-release services per month.

**Exhibit 5 - Average Number of Outpatient Treatment Hours per Month**



Fourteen of the 80 MIO-CTP participants have been hospitalized for psychiatric reasons during the period of program involvement. At 17.5 percent, this was less than the 23 percent of CTS subjects who were hospitalized for psychiatric reasons. One individual has been hospitalized 11 times, two persons hospitalized five times, three persons twice, and eight participants have been hospitalized once. Of the 35 hospitalizations, 31.4 percent have been involuntary. Excluding one hospitalization that lasted approximately 30 months, the mean length of stay was 10.4 days (SD = 12.9).

## **Re-Offense**

Data on re-offense convictions is from the Washington State Institute for Public Policy (WSIPP) database. The WSIPP database is updated quarterly and results are based on data current through June 30, 2004. Results reported in this section include the 71 participants released into the community as of June 30, 2004.

Attention is focused on the 45 subjects who were enrolled after the first year. This group is referred to as the mature program group. Year I was considered to be a start-up phase for the program. A number of program changes were made during Year I in participant selection, diagnostic criteria, pre-release planning, and most importantly treatment options reflecting the unexpectedly large percentage of participants who have co-occurring substance abuse disorders. Persons enrolled during Years II through VI were much less likely to commit a new felony than persons enrolled during Year I ( $X^2=15.4$ ,  $p<.001$ .) Substance use in the three months following release was found to be a significant factor in recidivism, as reported below.

Comparison of recidivism rates depends most specifically on a comparable risk for recidivism between groups. The CTS study found five variables which predict felony recidivism as accurately as some of the best prediction strategies reported in the literature. Four of the predictor variables (previous felonies, previous drug felonies, age of first offense, and felony versatility) were applicable to program participants. The predictors were applied to MIO-CTP participants and a predicted likelihood of a new felony was calculated. A comparison of predicted felony rates for program participants and the CTS group is presented in Exhibit 6 along with actual rates of felony recidivism.

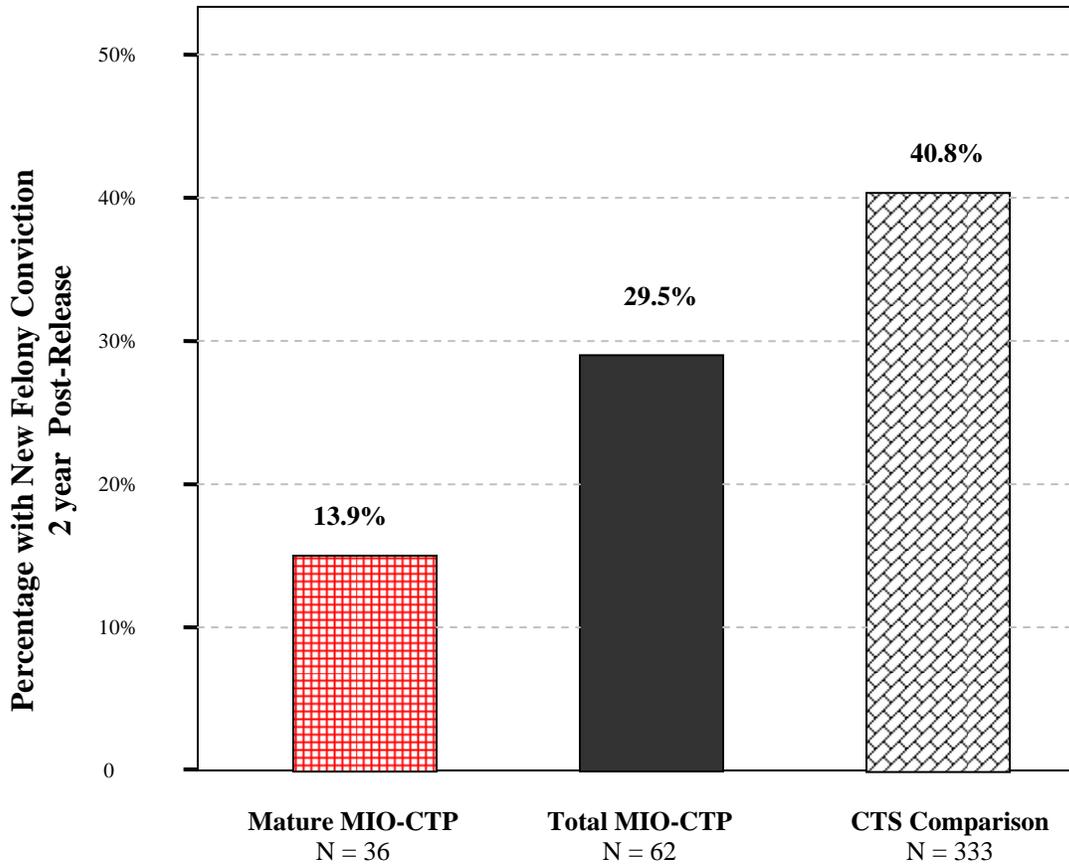
MIO-CTP program participants released into the community have a 39.5 percent average predicted risk for felony recidivism which is comparable to that of the CTS comparison group at 40.8 percent. The predicted risk for Mature Program participants is also comparable at 38.2 percent. Thirty-five participants of the Mature Program have been in the community for more than two years. The vast majority of those who will commit a new felony, do so within the two years following their release. One Mature Program participant has committed a new felony in less than two years post release and that person is included in the Mature Program felony rate, as well as the total program figures. The CTS recidivism rate was based on a study period ranging from 27 to 55 months, with an average of 39 months.

**Exhibit 6 - Felony Recidivism Prediction and Actual Rates**

<b>Recidivism Prediction</b>			
<b>Felony Recidivism Rates</b>	<b>Mean Mature Program Released N=36</b>	<b>Mean for Total Program Released N=62</b>	<b>Mean for CTS Comparison N=333</b>
<b>Felony Prediction</b>	38.2%	39.5%	40.8%
<b>Actual Felony Rate</b>	13.9%	29.5%	40.8%

A graphic comparison of felony recidivism rates is presented in **Exhibit 7 - Rates of Recidivism Compared**. Recidivism for MIO-CTP Mature Program group is one-third the rate of recidivism for the CTS comparison group. This represents a nearly 300 percent reduction in felony recidivism among severely mentally ill offenders who have been enrolled in an intensive case management program, as compared to a group of offenders who were released prior to the introduction of focused case management services.

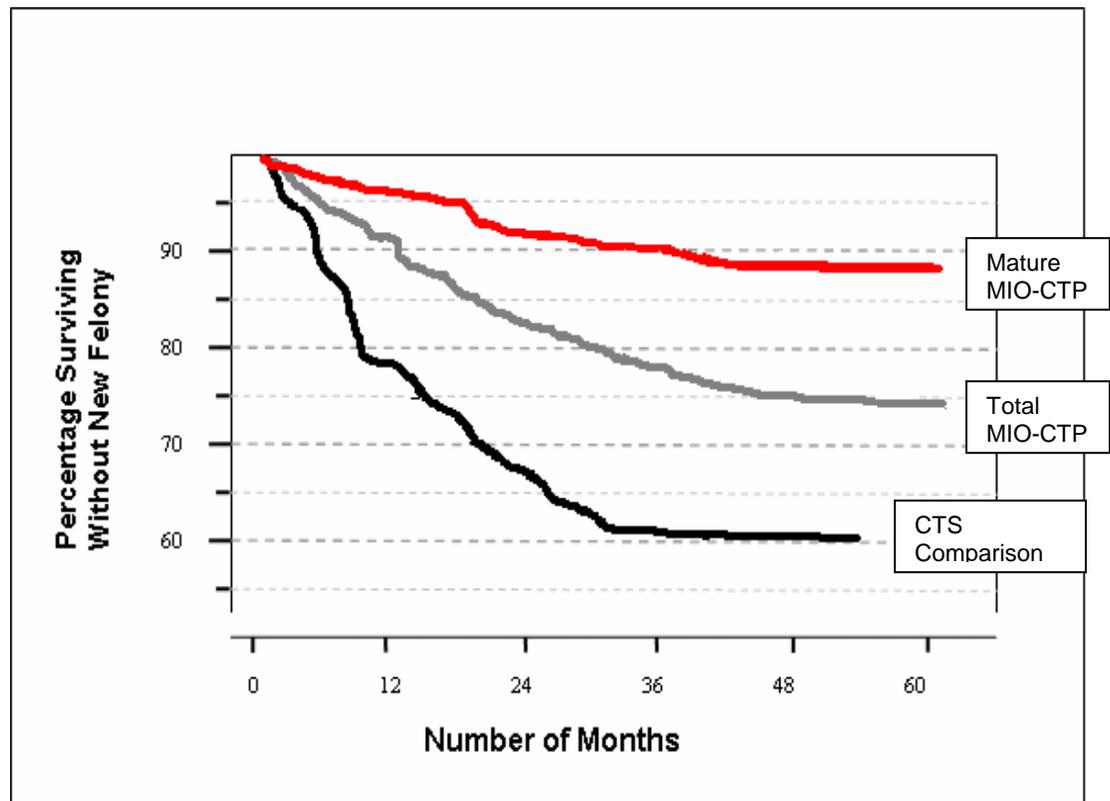
**Exhibit 7 - Rates of Recidivism Compared**



**Exhibit 8 - Survival Curves - New Felony Activity** represents new felony activity, that does not rely on a two-year post-release period to calculate a recidivism rate. A survival curve represents the percentage of individuals who survive in the community over time following release from prison without a new felony. The *Mature MIO-CTP* group, the *Total MIO-CTP* group, and the *CTS Comparison* group are presented in this manner.

The survival curves of all three groups follow a similar pattern. There is a tendency for the curve to fall steeply in the early months following release from prison, when offenders are most likely to commit a new felony. The curve begins to flatten between one and two years post release and very few new felonies occur after three years post-release.

**Exhibit 8 - Survival Curves - New Felony Activity**

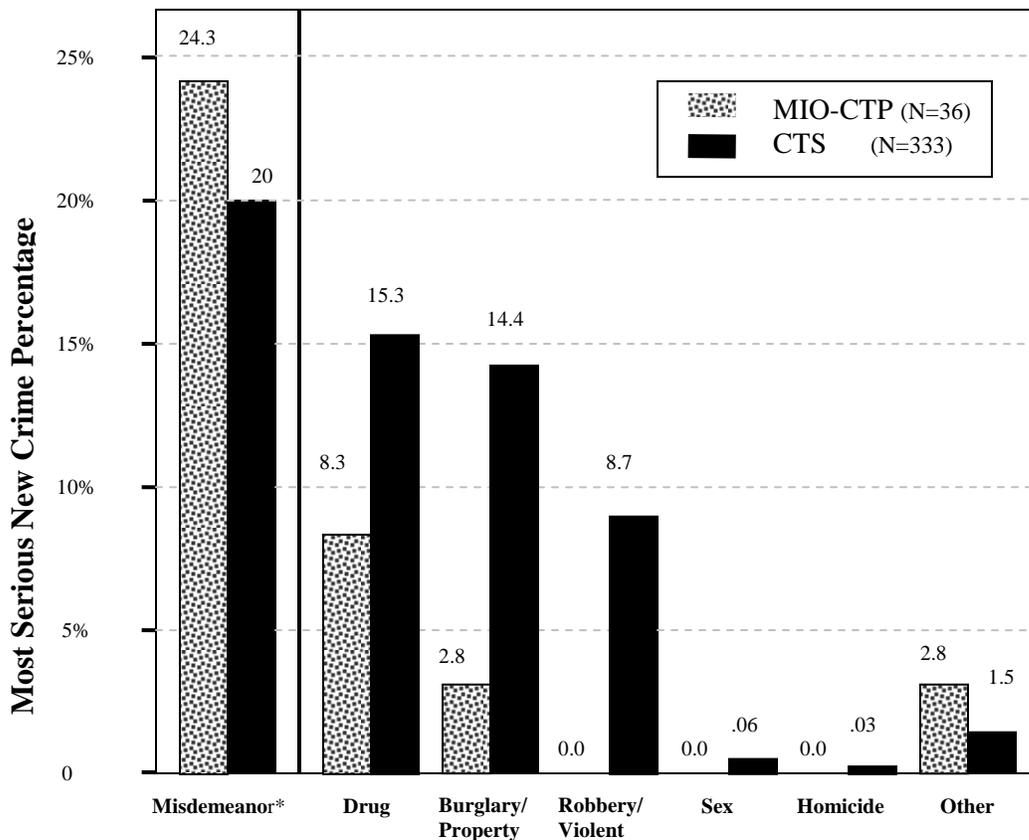


In addition to rates of new felonies, it is also important to consider the kinds of new crimes being committed. A comparison of most serious new crime committed post-release from the index incarceration is presented in **Exhibit 9 - Types of Most Serious New Crime**. This includes misdemeanor crimes for both the mature MIO-CTP and CTS comparison groups.

MIO-CTP participants have a higher rate of misdemeanor convictions represented than the CTS comparison. However, it is important to keep in mind that this exhibit represents the most serious crime for which the person was convicted post-release. Because MIO-CTP participants are less likely to be convicted of a new felony, misdemeanor convictions are less likely to be trumped by a felony conviction.

Comparing felony convictions, the MIO-CTP felonies are of a less serious nature. Among the Mature Program group who have committed a new felony, the most serious offense was a felony crime of property committed by one participant. The most serious new crime for three persons was a drug related crime, and one person's most serious offense was a felony escape. There were no new felony convictions for a crime against a person. This is compared to the range of index felonies. From **Exhibit 1** above, 40 percent of the enrollees' index crimes are violent offenses against another person.

**Exhibit 9 - Types of Most Serious New Crime**



***Correlates to Felony Recidivism***

Whether or not an MIO-CTP participant committed a new felony appears to be related to a number of characteristics evaluated at three months post-release. Three months after release a series of questions was asked of participants regarding mental health symptoms and substance abuse use. Some were found to correlate with subsequent felony convictions. Analyses are presented in **Exhibit 10 - Symptom/Behavioral Correlates of Felony Recidivism**.

Fifty-seven of the 71 participants released into the community were interviewed at three months post-release. Participants were asked if they had experienced symptoms of depression in the past 30 days. Although the correlation of responses to this question does not meet strict levels of statistical significance, a closely related symptom, having made a suicide attempt, did correlate significantly with subsequent felony conviction. Consequently, both are reported here.

One item involving psychotic symptoms was statistically related to subsequent felony conviction. Participants were asked at three months post-release how frequently they had experienced auditory hallucinations. Increased frequency of auditory hallucinations was associated with subsequent felony conviction.

### Exhibit 10 - Symptom/Behavioral Correlates of Felony Recidivism

Correlates of Felony Recidivism		
Self Reported Symptom/Behavior	Statistical Data (N = 57)	
	Statistic	Significance level
Feelings of sadness or depression for at least two weeks in the past 30 days.	$X^2 = 3.45$	$p = .06$
Suicide attempt in past 30 days	$X^2 = 10.72$	$p = .001$
Frequency of hearing noises or voices that others do not hear.	$F = 14.06$	$p = .022$
Reported alcohol use in past 30 days	$X^2 = 8.08$	$p = .004$
Recognition of drug dependency in past 30 days	$X^2 = 14.11$	$p = .022$
Use of non-prescription drugs in past 30 days	$X^2 = 6.51$	$p = .011$

Self reported substance use, at three months post-release, was found to be related to subsequent felony recidivism. Participants self reported their use of either alcohol or illicit drugs. They were much more likely to be convicted of a subsequent felony resulting from the consequences of alcohol/illicit drug use. Similarly, participants who acknowledged a drug dependence problem were also more likely to be convicted of another felony. These findings suggest that the mental health problems continue to play a role in criminal activity for these individuals. Management of psychiatric and substance abuse problems appears to be important in reducing the likelihood of further felony conviction.

## Summary and Conclusions

***This program evaluation study of mentally ill offenders supports the hypothesis that intensive mental health case management services can effectively lower recidivism in this population.***

Demographic data and diagnostic information was presented. Just over 50 percent of program participants were diagnosed with a psychotic disorder, and the overwhelming majority, at 86.3 percent, of all participants were diagnosed as having a co-occurring substance abuse disorder in addition to their primary psychiatric diagnosis.

In contrast to nearly non-existent pre-release services and inconsistent post-release mental health services for the comparison group, pre-release mental health planning and treatment services and post-release mental health services were delivered consistently by the MIO-CTP program.

This program emphasized treatment of co-occurring substance abuse disorders and close coordination with community corrections personnel from DOC. Program participants averaged 6.2 hours per month of pre-release services and 18.8 hours per month of post-release services.

Outcomes are focused on the 36 individuals who were enrolled after the program matured, and who had at least two years in the community post-release.

***Felony recidivism was 275 percent lower among program participants than was predicted.***

The prediction was made using a strategy developed among a comparable group of offenders released before the introduction of MIO-CTP services for mentally ill offenders returning to the community from prison. Only 13.9 percent of individuals in this program group were convicted of a new felony, and the offenses were less serious crimes of property and drug related activity. There were no new convictions for violent felonies against a person.

A number of mental health symptoms/behavioral correlates were found to be related to recidivism. In interviews conducted at three months post-release, participants reported a number of psychiatric symptoms. Suicide attempts and frequency of auditory hallucinations were related to increased likelihood of felony recidivism. Similarly, participants reported a number of factors related to substance use and abuse at three months post-release. Alcohol use, non-prescription drug use, and recognition of a drug dependency problem were all associated with a higher incidence of felony recidivism. The latter is highly consistent with the experience of program administrators.

**During the first year of operation, program administrators were surprised by the number of drug and alcohol problems encountered in their initial group of mentally ill offenders.**

**A co-occurring disorders program was instituted by the end of the first year, and subsequent rates of recidivism dropped significantly from 50 percent of first year enrollees, to the 13.9 percent of Mature Program participants.**

The quasi-experimental comparison group design of this study is not as definitive as might be achieved in a random assignment experimental design. The comparison group offenders were released during a different time period than the MIO-CTP group. Also, the comparison group members were returned to communities throughout the state of Washington. MIO-CTP Program participants were released only to Seattle, and at a later date. Nevertheless, the real comparison is based on a set of predictors of recidivism developed in the CTS comparison study that are independent of both time of release and location.

**The evidence strongly supports the efficacy of intensive mental health case management services in reducing the likelihood of subsequent felony recidivism. Treatment of psychiatric symptoms, particularly depression, suicidal ideation, auditory hallucinations, and substance abuse appears effective in preventing further criminal activity among offenders with serious mental illness.**

## APPENDIX A: PROGRAM INFORMATION

### **Background**

RCW 71.24.460 required an Annual MIO-CTP Effectiveness Report, annually through 2003. The reporting requirement was suspended for the 2003-2005 Biennium, and is again statutorily required beginning December 1, 2005. This edition of the report covers the program period 1998-2004 regarding the Mentally Ill Offender Community Transition Program (hereafter referred to as the program). RCW 71.24.455 authorized this five-year pilot. Funding began July 1998.

The Act articulates the legislative intent for the pilot:

*“Many acute and chronically mentally ill offenders are delayed in their release from Washington correctional facilities due to their inability to access reasonable treatment and living accommodations prior to the maximum expiration of their sentences. Often the offender reaches the end of his or her sentence and is released without any follow-up care, funds, or housing. These delays are costly to the state, often lead to psychiatric relapse, and result in unnecessary risk to the public.*

*These offenders rarely possess the skills or emotional stability to maintain employment or even complete applications to receive entitlement funding. Nation-wide only five percent of diagnosed schizophrenics are able to maintain part-time or full-time employment. Housing and appropriate treatment are difficult to obtain.*

*This lack of resources, funding, treatment, and housing creates additional stress for the mentally ill offender, impairing self-control and judgment. When the mental illness is instrumental in the offender's patterns of crime, such stresses may lead to a worsening of his or her illness, re-offending, and a threat to public safety.*

*It is the intent of the legislature to create a pilot program to provide post-release mental health care and housing for a select group of mentally ill offenders entering community living, in order to reduce incarceration costs, increase public safety, and enhance the offender's quality of life.”*

*[RCW 71.24.450]*

Specifically the Act:

- Charges DSHS to contract with a Regional Support Network (RSN) or private provider to provide specialized services for up to 25 mentally ill offenders,
- Sets participant selection criteria,
- Specifies a set of required services,
- Creates an oversight committee composed of representatives from DSHS, DOC and a selected RSN or private provider,
- Requires DSHS, in collaboration with DOC and the oversight committee, to track outcomes and submit to the legislature a report of the services and outcomes by December 1, 1998, and annually thereafter, as necessary.

The report to the legislature is to include:

- A statistical analysis regarding the re-offense and re-institutionalization rate by the enrollees in the program
- A quantitative description of the services provided in the program
- Recommendations for any needed modifications in the services and funding levels to increase the effectiveness of the program

## **APPENDIX B: PROGRAM IMPLEMENTATION**

### ***Oversight Committee***

As authorized by statute, the oversight committee is comprised of a representative from the DSHS, DOC and KC-RSN. This committee, with a rotating chairperson, operates in a collaborative manner to develop the policies and processes necessary to implement the project. The committee meets monthly to review project activities, discuss and resolve issues raised by program staff and provide project direction and oversight. A recent example of the oversight committee's work is the development of policy to prioritize persons waiting to enter the program.

### ***Program Administration***

In August 1998, DSHS contracted with the KC-RSN to develop and implement the pilot program. In September 1998, the KC-RSN sub-contracted with Seattle Mental Health and its subcontractors, Pioneer Human Services and Therapeutic Health Services, to provide the statutory required service components. The three organizations are licensed mental health and substance abuse agencies with a history of partnership in providing an integrated program of mental health, substance abuse, residential, vocational and community-based correction services.

### ***Program Staffing***

Seattle Mental Health uses a multi-disciplinary team approach to deliver integrated treatment services to a broad spectrum of participants. The agency provides services to persons with a variety of clinical diagnoses, levels of functioning and differing degrees of mental health and substance abuse issues. The program staff include case managers, the project manager, psychiatrist, nurse practitioner, registered nurse, substance abuse assessor/counselor, and two residential house managers. Staff members have forensic and clinical experience and are skilled at exercising authority, setting limits, establishing appropriate behavioral standards and integrating supportive treatment and behavioral supervision. Most of these staff members are devoted only part-time to the pilot. The total staffing represents approximately five and one-half full time equivalents.

### ***Participant Referral and Selection***

In considering candidates for referral to the program, DOC staff evaluates mentally ill offenders against program selection criteria based on statutory mandated elements and good clinical practice. Candidates come from four correctional facilities known as launch sites. Corrections may transfer mentally ill offenders from other correctional facilities to these launch sites for review and consideration.

The four launch sites are:

1. Lincoln Park Work Release Program in Pierce County
2. McNeil Island Corrections Center in Pierce County
3. Monroe Correctional Complex in Snohomish County
4. Washington Correctional Center for Women in Pierce County

DOC institutional staff first screens potential candidates for the program and then refer candidates for an interview by program case managers. DOC staff prepare a comprehensive referral packet that includes the legal history surrounding the offender's crime, mental health assessments from psychiatrists and psychologists and associated clinical information for the KC-RSN. The selection committee, DOC and KC-RSN staff review all information, discuss the candidate with a launch site representative and make the selection decision. The selection of persons with a history of sex offenses or fire setting continues to be particularly problematic. There are limited options for appropriate housing or proprietors willing to accept these offenders.

## **APPENDIX C: PROGRAM COMPONENTS**

### ***Coordinated Pre-release Planning***

The coordinated pre-release planning component has emerged as a crucial element of a participant's successful integration into the community. This phase begins after the selection committee identifies a referred person as eligible, and while the person is still incarcerated. Ideally this phase is implemented three months before the offender's release date.

Pre-release planning includes several components:

1. Convening of a multi-system team that includes the mental health provider, DOC Community Corrections Officer, prison-based DOC staff, and the chemical dependency provider (when applicable);
2. Developing comprehensive assessments and intakes that incorporate mental health and chemical dependency treatment needs and DOC community supervision requirements;
3. Creating an individualized treatment plan that includes input from the inmate and community-based providers;
4. Applying for entitlements (GAU, SSI, Medicaid) and coordinating start-up with local Community Service Offices;
5. Establishing initial appointments that coincide with the week/day of release;
6. Forming a therapeutic relationship with the offender.

After the initial meetings with the offender and prison-based DOC staff, ongoing coordination of pre-release activities is facilitated through weekly team meetings where issues such as housing needs, medication management, and chemical dependency treatment needs are discussed. The overarching goal is to provide as seamless a transition to community life as possible.

### ***Intensive Post-release Case Management***

The first week is a vulnerable time for most participants. It is well documented that participants are highly susceptible to chemical dependency relapse at this time. To mitigate this risk, participants are asked to remain at their residence during the first week, unless accompanied by a case manager or attending a nearby appointment.

On the initial release day DOC staff transports the released offender (now referred to as "the participant") to their housing. In most cases, newly released participants are initially housed at a specialized supported living facility. When the participant arrives, they are met by their case manager and introduced to the house manager. The participant's first day in the community is typically a busy one. The case manager takes the participant shopping for clothing, bedding, cooking implements, food, cleaning supplies, and

personal care items. The participant usually has an intake appointment at the DSHS Community Service Office<sup>4</sup> so that financial resources can be available immediately.

The second day usually includes an appointment with a health care provider, obtaining legal identification, having a DOC community intake appointment, and meeting the program staff members who are part of the participant's team.

During the remainder of the first week, the participant typically has initial appointments with their chemical dependency treatment provider and with psychiatric services. Some participants have significant mental health symptoms and/or compromised levels of functioning; consequently, strategies are employed to assist such participants in transition to the community at a pace that is compatible with their abilities. For participants who have limited daily living skills, such as how to shop, cook, or take care of personal hygiene needs, their case manager will immediately provide coaching and skill building. For those who become confused or get lost when trying to get to appointments the case manager will walk with them until they can find their way or are no longer overwhelmed.

The intensity of the first week's activity sets the stage for implementing the ongoing services identified in the participant's individualized treatment plan. As the participants successfully achieve treatment objectives and goals, they are encouraged to become more independent by developing a transition plan which includes:

- a mapped strategy for achieving greater self-determination,
- reduction of dependence on formal systems,
- living in a less structured housing environment,
- engagement in educational and employment activities,
- increased self-monitoring of medications.

### ***Outreach and Engagement:***

For some participants, the combination of severe mental illness, past criminal behaviors and other factors, results in significant resistance to engage in the treatment and services needed to achieve individual and community stability. Some are subject to mental health decompensation, chemical dependency lapse/relapse, and/or periods when the participants' whereabouts are unknown. In these situations, program staff provide outreach and engagement services designed to establish trust in the treatment team and acceptance of services.

Staff engage the participant whether in jail, on the streets, in shelters, in hospitals, or in detention by Immigration and Naturalization Services. For some, the intensity of the program is more than they can tolerate, so enrolling them in "mainstream" services may be the best option.<sup>5</sup>

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<sup>4</sup> Financial applications are completed while the participant is still incarcerated, but face-to-face intakes are still required before entitlements can be dispersed.

<sup>5</sup> The program is mandated to serve no more than 25 participants at a time, so moving some participants to less intensive services may provide an opening for participants who can benefit from intensive services.

***Structured Programming:***

The program design incorporates attendance at a minimum of five group sessions per week. These groups are lead/co-facilitated by mental health and chemical dependency professionals and by community correction officers. Assertive mental health treatment is tailored to individual needs, and includes at least one group and one individual counseling session weekly, home visits at least two times per month and other structured activities. Counseling sessions focus on relapse prevention, and case management addresses requirements for meeting all court-ordered conditions. The team reports any violations to the community correction officer.

For participants who receive intensive outpatient chemical dependency treatment, specialized groups are provided. Participants are also encouraged and assisted to develop natural supports through Alcoholics Anonymous and Narcotics Anonymous. If participants want a faith-based connection, program staff help the participant locate a culturally appropriate faith-based community. Program staff also help participants re-establish family connections, when appropriate.

When participants are first released, their medication compliance is monitored on a daily basis. Participants come to the clinician's office where medications are dispensed so the participant can be observed taking the medicine. Some participants are actually given a financial incentive to encourage compliance with their medication regime.

***Crisis Response:***

Program staff and DOC Community Corrections Officers have developed a 24-hour crisis response protocol for all participants, each of whom has an individualized crisis plan that identifies risk factors, strategies that address community safety concerns, and recommended interventions. This plan is electronically available to the after-hours crisis response team, and includes access to a community corrections supervisor (for those participants who have community supervision) who may provide consultation and assistance with interventions as needed.

A number of program participants have histories of rapid decompensation that can foreshadow assaultive behavior. When this appears to be occurring, program staff immediately assesses whether voluntary or involuntary hospitalization is indicated. County designated mental health professionals often provide consultation, including crisis interventions that may mitigate hospitalization or involvement in criminal behavior. In some cases, however, hospitalization is the appropriate option.

## ***Residential Support Services***

The program continues to provide a housing subsidy up to a maximum of \$6,600 per participant per year. Seattle Mental Health contracts with Pioneer Human Services, an organization specializing in providing housing to former offenders. Most participants are initially housed in a transitional housing facility when they are first released from prison.<sup>6</sup> This facility provides onsite house management, ongoing monitoring of residents, and offices for clinical services. As the participant achieves greater community stability, they may be able to move to less structured housing, which is an important step toward further independence.

Some participants are so cognitively and/or functionally impaired that full participation in program activities is not a realistic expectation. It is particularly challenging for these participants to acquire and implement the set of skills needed to live in transitional or independent housing, i.e., shopping, cooking, cleaning. Residential facilities that provide meals and other supports needed for activities of daily living may be a better option. Placement in such facilities allows the program team to focus on helping the participant to improve their mental health symptoms and address other immediate treatment needs. When participants achieve greater stability, acquiring activities of daily living and community living skills can then move to the forefront.

## ***Community Safety***

Community safety is a high priority for the program. The program team meets with participants a minimum of five times a week and regularly conducts risk assessments. When a participant experiences mental health deterioration that might indicate risk, a psychiatrist sees the participant on an emergency basis. Staff then closely monitor medication compliance and effectiveness, and coordinate with the psychiatrist to stabilize the participant.

The vast majority of program participants have a history of substance abuse or addiction. Relapse among these participants is of special concern, particularly when the participant has a history of engaging in criminal conduct while under the influence of substances. The program staff assesses risk to the community in each instance of relapse.

## ***Community Supervision***

The Special Needs Unit of the King County DOC office has assigned a designated Community Corrections Officer to work with the project. Although community supervision is not a requirement for program eligibility, most participants have some level of supervision. This assignment has fostered cohesiveness amongst team members, and collaboration between the treatment and community corrections

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<sup>6</sup> Some participants are excluded because of their criminal history. For example, the transitional house is not accessible to those who have committed a sex offense because of its proximity to a grade school.

systems. This collaboration enables treatment plans to assist the participant in meeting community correction requirements. Community supervision appears to have positive impact on successful reintegration due to the unique role the Community Corrections Officer plays on the participant's team.

The Community Corrections Officer:

1. is an integral part of the treatment team,
2. has the authority to arrest/detain participants for infractions, which can provide a strong reminder to participants to comply with conditions of release and avoid re-offense,
3. can add a corrections perspective to crisis response,
4. has the authority to conduct random UA's for participants with histories of substance abuse, or when current substance abuse is suspected – this can lead to pre-emptive interventions that may preclude incarceration,
5. can conduct room searches to locate drug paraphernalia when there are concerns,
6. can make recommendations in disciplinary hearings that include input from the participant's team,
7. can enforce treatment compliance if this is a condition for release.

A particularly valuable role for the Community Corrections Officer is invoking disciplinary measures when a participant violates conditions. One effective strategy involves temporary incarceration at Lincoln Park, a DOC work release facility in Tacoma that has onsite mental health and chemical dependency counselors. The treatment team continues to work with the participant during temporary incarcerations, the participant experiences the placement as less punitive, and the community provider and facility staff are able to coordinate treatment strategies. The work release environment allows the participant to leave the facility for approved reasons while still providing a highly structured setting.

### ***Co-occurring Disorders (Mental Health and Substance Abuse) Treatment***

As integrated mental health and substance abuse treatment plays an ever increasing role in the program, Seattle Mental Health has provided two staff persons that are co-occurring disorder specialists to provide integrated mental health and drug and alcohol treatment. The program continues to adhere to an integrated approach, training the additional team members in developing a coordinated treatment plan and approach. The team members are primarily responsible for assessments, individual treatment and group leadership. Other team members focus on motivation enhancement, preventative intervention, trigger identification and encouraging the clients in their progress. Weekly team meetings and having on-site staff increases communication and promotes frequent treatment review.

There are special population concerns and characteristics for ex-offender addicts. Previous unsuccessful treatment efforts with chemically dependent offenders in transition have focused on general characteristics that this population shares with all

addicts. Ex-offenders present the same entrenched denial systems, lack of knowledge of the health impact of drugs, and continued emotional entanglement with active users and codependency issues that all recovering addicts deal with. It is common for ex-offenders to quickly exit treatment programs that only address these issues.

Successful work with this group of recovering individuals includes strategies that attend to the unique characteristics of ex-offenders. Treatment strategies address:

- Immediate Use Syndrome – Most offender addicts employ fantasies of using drugs immediately upon prison release to help them cope with the daily routine of prison life. Strategies such as early intervention with offenders (assessments/individual sessions) during the pre-release phase provide a bridge to a life that is not centered on the use of substances.
- Non-Incrimination Theme – Many offenders avoid discussions about aspects of their personal or family drug use history due to long standing beliefs that discussing this information will lead to incrimination (or incrimination of loved ones) in further crimes. Strategies such as milieu treatment with ex-offenders to come to terms with their past can lead to the abandonment of denial systems.
- Overt Compliance – Some offenders have familiarized themselves with recovery jargon but do not truly attempt to make lifestyle changes. Frequent urine-analysis, family involvement, peer group feedback, and the use of non-traditional counseling techniques help participants develop a deeper understanding of drug addiction recovery.

Although the program participants represent a very small sample of ex-offenders, clear trends point to the success of the specific chemical dependency treatment strategies used with participants enrolled in the program.

### ***Employment Services***

While not all of the participants have obtained employment, the involvement of specialized vocational staff increases motivation and interest in becoming more productive. Participants have worked in such varied employment settings as construction companies, dental offices, coffeehouses and restaurants. Some have worked for private industry while others have done volunteer work as a step toward gaining marketable skills. A number of clients have pursued educational programs, such as completion of their GED, dietitian programs, and musical studies. The program connects those who may not yet be able to work or attend school with Emerald House, a clubhouse program sited at Seattle Mental Health. This is a participant run day treatment program. Additional information on employment services is presented in the Innovations section of Program Successes and Innovations, later in this report.

## ***Transitions***

The pilot project design calls for participants to transition from the intensive service level of the program to the “mainstream” publicly funded mental health system, when it becomes appropriate. Timing of transitions depends on a number of factors: whether the participant continues to have community supervision requirements; the ability of the participant to manage their mental health and/or chemical dependency issues without the intensity offered by the program; whether affordable, appropriate housing can be provided without the subsidies provided by the program; and whether the person has requested less intense services.

Terminations typically occur through a process initiated by program staff. Recommended terminations are consistent with statutory requirements and may also include other circumstances, i.e., the participant has disappeared and cannot be located or the participant is Absent Without Leave from a work release facility.

The Program Manager generally presents requests for termination to the Oversight Committee for review and discussion. The Oversight Committee considers whether the request meets statutory requirements, and makes a final determination. Program staff is strongly committed to re-establishing therapeutic relationships with those participants who are willing and able to return to the program. If a terminated participant requests readmission, they are provided with priority review for reinstatement by the Selection Committee, comprised of representatives from provider agencies and DOC.

The majority of participants who terminated from the program continue to receive mental health services through the KC-RSN, regardless of whether the participant completed the program or left prior to completion.



## APPENDIX D: PROGRAM SUCCESSES AND INNOVATIONS

### ***Successes***

The enhanced ability to work across systems continues to be a major asset toward successful community transition of program enrollees. Representatives from each system have gained considerable knowledge about how other systems work – the mission, goals, regulatory requirements, and activities provided to work with participants. This knowledge, in addition to the personal connections that have been made, leads to improved continuity, unified cross-system efforts, clear communication, and a more comprehensive approach to work with participants has been achieved.

### ***Innovations***

The program developed numerous innovations this past year that improved the range, availability, and appropriateness of services to participants.

- Use of a ***Multi-System Care Plan*** for pre-release planning: The program has continued using the ***Multi-System Care Plan***, as developed for the Dangerous Mentally Ill Offender Program<sup>7</sup>, during the past year. This tool improves overall documentation of the pre-release care plan. Of particular value is input from institution-based DOC staff which provides information and concerns about inmates prior to the first pre-release meeting.
- Improved access to entitlements: The program participated in a work group, which included a local representative from Social Security that reviewed policies and procedures for access to entitlements for homeless and mentally ill people. The program continues to work with the Social Security Administration and the DSHS Economic Services Administration in ongoing efforts to address efficiencies related to entitlement access for program participants.

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<sup>7</sup> Dangerous Mentally Ill Offender Program (DMIO) is a legislative mandate administered statewide by the Mental Health Division.

