

# **Mentally Ill Offender Community Transition Program**

---

## **Annual Report to the Legislature December 1, 2006**

*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

## TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY .....</b>	<b>5</b>
<b>MIO-CTP EVALUATION OUTCOMES.....</b>	<b>7</b>
Enrolled Participants .....	7
Exhibit 1 - Characteristics of MIO-CTP Participants .....	8
Diagnostic Information .....	9
Exhibit 2 - MIO-CTP Participant Diagnoses .....	9
Treatment Service Modalities.....	10
Exhibit 3 - MIO-CTP Treatment Services .....	10
Comparison of Treatment Services Received.....	10
Exhibit 4 - Percentage of Subjects Receiving Outpatient Services.....	12
Exhibit 5 - Average Monthly Outpatient Mental Health Service Hours .....	13
Hospitalization for Psychiatric Reasons .....	12
Re-Offense.....	13
Exhibit 6 - Survival Curves .....	14
Exhibit 7 - Felony Recidivism Prediction and Actual Rates .....	15
Exhibit 8 - Comparison Rates of Recidivism.....	16
Exhibit 9 - Types of Most Serious New Crime .....	17
Correlates to Felony Recidivism .....	17
Exhibit 10 - Symptom/Behavioral Correlates of Felony Recidivism .....	18
<b>PROCESS EVALUATION AND PROGRAM REVIEW .....</b>	<b>20</b>
Process Evaluation .....	20
Program Review.....	20
Subsequent Program Changes.....	22
<b>SUMMARY AND CONCLUSIONS .....</b>	<b>24</b>
<b>APPENDIX A: PROGRAM INFORMATION.....</b>	<b>26</b>
Background RCWs 71-24-450 through 71-24-460.....	26
<b>APPENDIX B: PROGRAM IMPLEMENTATION.....</b>	<b>28</b>
Oversight Committee .....	28
Program Administration.....	28
Program Staffing .....	28
Participant Referral and Selection.....	29
<b>APPENDIX C: PROGRAM COMPONENTS .....</b>	<b>30</b>
Coordinated Pre-release Planning .....	30
Intensive Post-release Case Management .....	30
Outreach and Engagement.....	30
Structured Programming .....	31
Crisis Response .....	31
Residential Support Services .....	31
Community Safety.....	33
Community Supervision .....	33
Treatment for Co-occurring Disorders of Mental Health and Substance Abuse .....	34
Employment Services .....	35
Transitions.....	37
<b>APPENDIX D: PROGRAM SUCCESSES AND INNOVATIONS .....</b>	<b>38</b>
Successes.....	38
Innovations.....	38



# Mentally Ill Offender - Community Transition Program 2006 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. The target population 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 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-CTP is accomplishing the goal of reducing recidivism as follows:

- New violent felony crimes have been committed by only 6.1 percent of the MIO-CTP participants.
- The largest proportion of new felony crimes were drug related and less serious crimes against property.

Interviews of program participants who re-offended were conducted. Commonalities contributing to their recidivism were identified and included:

- Psychiatric symptoms including depression, attempted suicide, and auditory hallucinations.
- Self reported substance use.

**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, inmate's 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 service delivery system, 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 supports the effectiveness of intensive mental health case management services in reducing the likelihood of subsequent felony recidivism and reducing the seriousness of new crimes committed.

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 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 **Appendix A**.

This report includes information on one-hundred two (102) individuals who were enrolled in the program and have received pre-release mental health services. The large majority of participants has been released from prison and has also received post-release mental health services in the community.

Mental health service levels and recidivism outcomes for participants in the Mentally Ill Community Transition Program (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. This study tracked a cohort of mentally ill offender individuals 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. It 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 **Appendix A**. The information presented here reflects data on one-hundred two (102) participants enrolled between September 1998 and June 30, 2006.

Demographic information on program participants is presented in **Exhibit 1 - Characteristics of MIO-CTP 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 (77.5%) 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. The Index Offense is the most serious offense for which the individual was incarcerated just prior to release for the respective studies. MIO-CTP participants were more likely to have committed a drug offense as their Index Offense. While these comparisons are useful, predictive data is presented later in this report comparing the two groups on likelihood of committing a new felony.

The mean length of time spent in prison for the Index Offense for all program participants is 25.6 months (SD = 19.2)<sup>1[1]</sup> versus an average 28 months for CTS subjects.

**Exhibit 1 - Characteristics of MIO-CTP Participants**

<b>MIO-CTP Participant Characteristics</b>			
<b>Characteristic</b>		<b>MIO-CTP N=102</b>	<b>CTS Comparison (N=333)</b>
<b>Gender</b>	Male	70.6%	70.0%
	Female	29.4	30.0
<b>Race</b>	White/Caucasian	48.0%	72.0%
	Black\African American	31.4	23.0
	Other	20.6	5.0
<b>Age</b>	Mean	37.0 years	33.0 years
	Standard Deviation	8.2 years	-----
<b>Number Prior Felonies</b>	One	22.5%	16.8%
	2-4	46.1	31.8
	5-7	20.6	19.2
	8-10	5.0	8.6
	11+	5.9	20.7
<b>Index Offense</b>	Homicide/Manslaughter	2.0%	3.0%
	Sex	8.8	15.0
	Robbery/Other Violent	28.4	26.0
	Burglary/Other Property	16.7	24.0
	Drug	43.1	31.0
	Other	1.0	1.0

While all program participants received mental health treatment while incarcerated, the majority (84.8%) required residential mental health treatment some time during their incarceration. The remaining 15.2 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 Department of Corrections mental health unit was 12.8 (SD = 11.8) months.

---

<sup>1[1]</sup> Three extreme cases of 340 mo, 285 mo, and 229 mo were dropped from the MIO-CTP averaging. The next longest length of incarceration included in the calculation was 100 mo.

## **Diagnostic Information**

Exhibit 2 - MIO-CTP Participant Diagnoses displays the primary psychiatric diagnostic categories of participants at the time of enrollment. The diagnosis was made 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 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>MIO-CTP Participant Diagnosis</b>		
<b>Diagnosis</b>		<b>N=97*</b>
<b>Principal Axis I Diagnosis</b>	Psychotic Disorder	53.6%
	Depression	22.7
	Bi-polar Disorder	21.6
	Other Disorder	----
	Substance Abuse Primary	2.1
<b>Co-occurring Substance Abuse</b>		90.7%
<b>Personality Disorder Dual Diagnosis</b>		55.7%

\*Does not include data on 5 individuals who refused to authorize a release of their healthcare information.

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

- A vast majority of program participants have been dually diagnosed with a substance abuse disorder in addition to the principal Axis I disorder.
- 90.7 percent of participants have been diagnosed with a co-occurring substance abuse disorder.
- Just over half (55.7%) 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.

## **Treatment Service Modalities**

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 and 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, while others spend more of their treatment contacts in a group setting.

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

<b>MIO-CTP Treatment Services</b>	
<b>Treatment Modality</b>	<b>N = 30329 hours (September 1998 – June 2006)</b>
Individual Treatment	47.2%
Group Treatment	26.1
Day Treatment	14.8
Treatment Planning (Includes Consult with DOC staff)	7.7
Special Evaluation/Consult	2.1
Medication Management	2.1
Total	100%

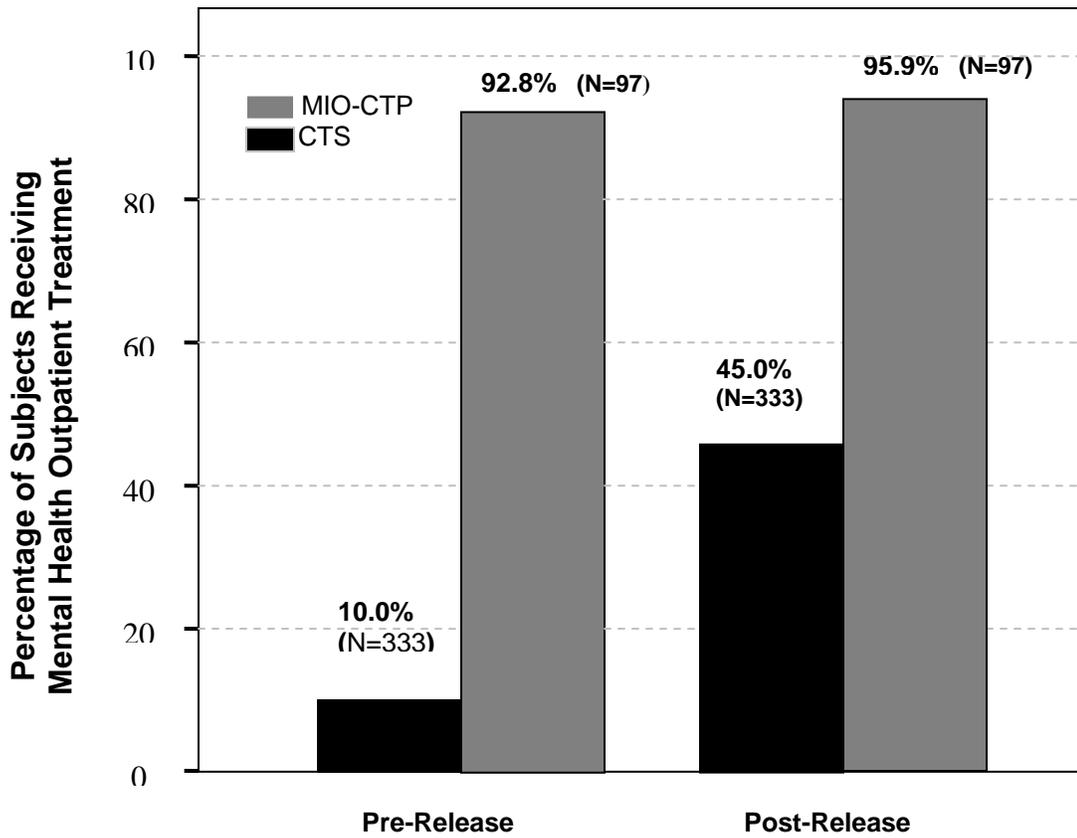
\*Does not include data on 5 individuals who refused to authorize a release of their healthcare information.

## ***Comparison of Treatment Services Received***

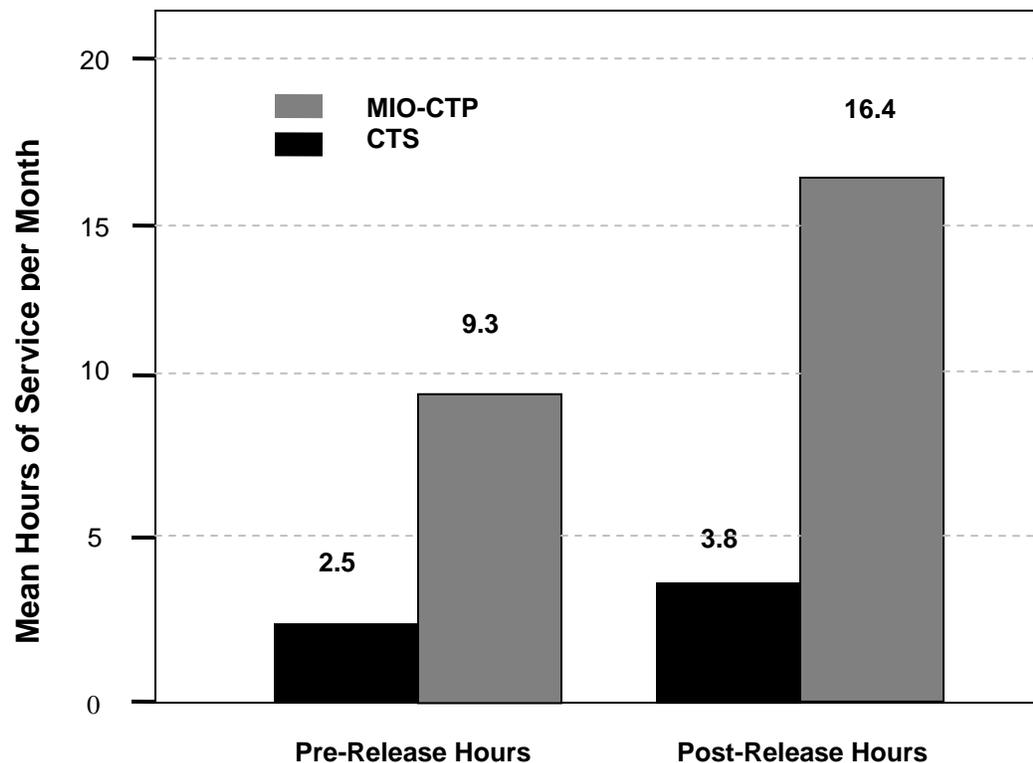
Mental health treatment services received by program participants are compared to treatment services received by the CTS group in **Exhibits 4 Percentage of Subjects Receiving Outpatient Services** and **Exhibit 5 Average Monthly Outpatient Mental Health Service Hours**.

The percentage of clients receiving pre-release and post-release mental health services is represented in **Exhibit 4 - Percentage of Subjects Receiving Outpatient Services**. Only 10 percent of CTS subjects received pre-release services, compared to 92.8 percent of MIO-CTP participants (N=97.) Only 45 percent of CTS subjects received any post-release services, while 95.9 percent of MIO-CTP clients received post-release services.

### Exhibit 4 - Percentage of Subjects Receiving Outpatient Services



## Exhibit 5 - Average Monthly Outpatient Mental Health Service Hours



### ***Hospitalization for Psychiatric Reasons***

Nineteen of the 95 (20.0%) MIO-CTP participants who have been in the community have been hospitalized for psychiatric reasons during the period of program involvement. This compares to 23 percent of CTS subjects. One individual has been hospitalized twenty-one times, one person hospitalized six times, 2 persons five times, 4 persons twice, and eleven participants have been hospitalized once. Of the fifty-six hospitalizations, 25.0 percent have been involuntary.

With the exception of one hospitalization that lasted approximately 30 months, the mean length of stay was 10.2 days (SD = 10.6.)

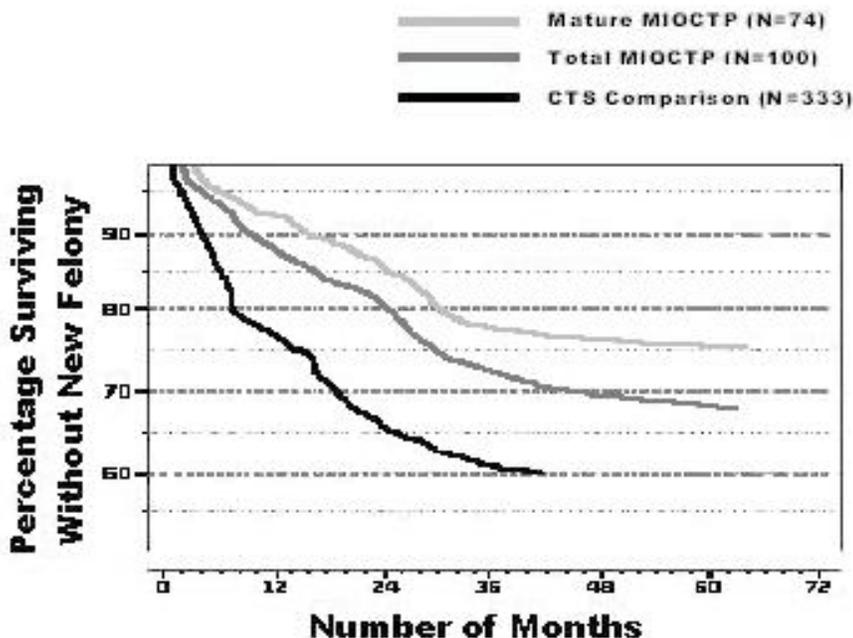
### ***Re-Offense***

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, 2006. Results reported in this section include the 100 participants who were released into the community as of June 30, 2006.

Attention is focused on the 74 subjects who were enrolled after the first year. This group is referred to as the Mature Program group. The first year is considered to be a start-up phase for the program. A number of program changes were made during the first year in participant selection, diagnostic criteria, pre-release planning, and most importantly treatment options reflecting an unexpectedly large percentage of participants who have co-occurring substance abuse disorders. Persons enrolled during years II – VI were much less likely to commit a new felony than persons enrolled during year I ( $X^2=9.69, p<.002.$ ) Substance use in the three months following release was found to be a significant factor in recidivism, as reported below.

New felony activity is well represented in **Exhibit 6 - Survival Curves** in the form of a survival curve. This representation includes the post-release criminal activity of all persons enrolled in the MIO-CTP program who have been released into the community. A survival curve represents the percentage of individuals who survive in the community over time following release from prison without a new felony. The MIO-CTP Mature Program group, the total MIO-CTP group, and the CTS comparison group are presented in this manner.

**Exhibit 6 - Survival Curves**



The best comparison of MIO-CTP with the CTS group is at the 39 month point where the CTS curve ends. The MIO-CTP Mature treatment group felony rate, at this point, is approximately 23 percent versus the total MIO-CTP treatment group felony rate at 30 percent. Both rates are compared to the 40 percent new felony rate of the CTS comparison group.

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.

The vast majority of those who will commit a new felony do so within two years after their release and a minimum two year period of release was set as the exposure standard. The CTS recidivism rate was based on a study period ranging from 27 – 55 months, with an average of 39 months. As of July 2006 forty-nine (49) participants of the Mature program have been in the community for more than two years or had committed a new felony within the first two years after release. Because many of the MIO-CTP participants have been in the community for several years, an accurate comparison with the CTS group will consider only crimes committed within the 39 month window that was the average exposure for the CTS group.

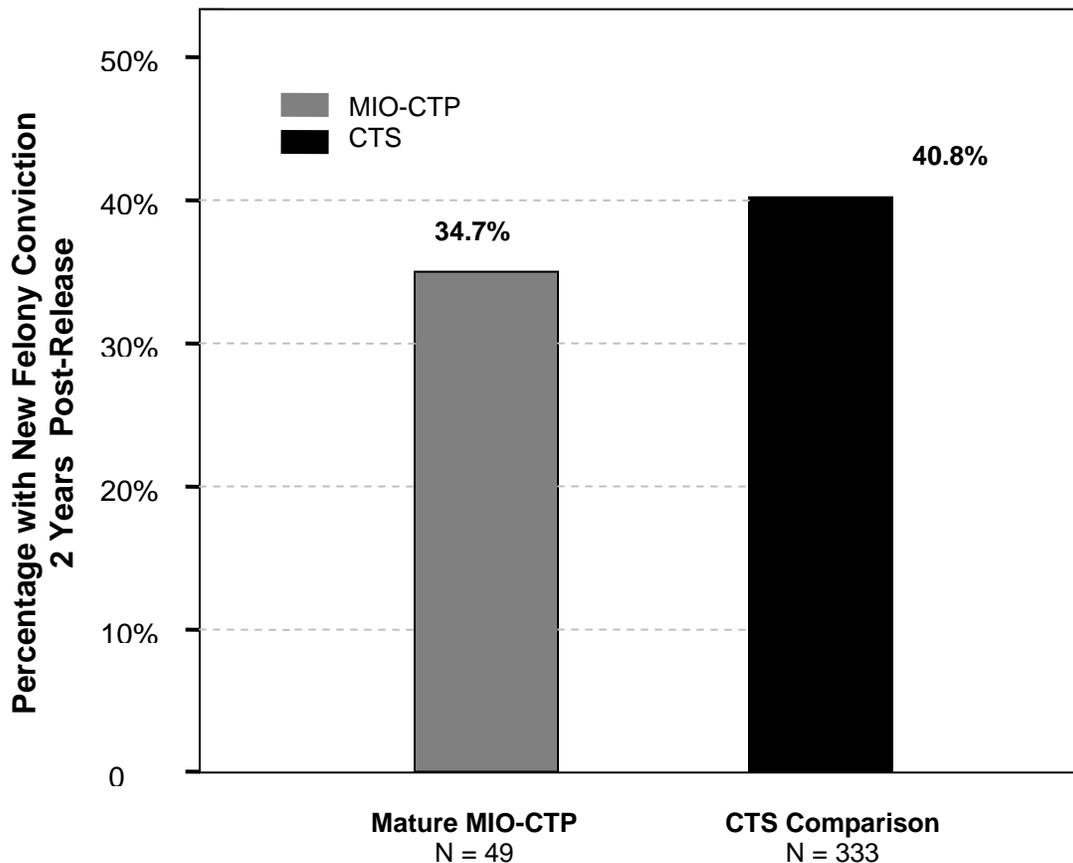
A comparison of predicted felony rates for Mature program participants and the CTS comparison group is presented in **Exhibit 7 - Felony Recidivism Prediction and Actual Rates**, along with actual rates of felony recidivism for these groups.

**Exhibit 7 - Felony Recidivism Prediction and Actual Rates**

<b>Felony Recidivism Prediction and Actual Rates</b>		
<b>Groups</b>	<b>Mean Mature Program Released (N=49)</b>	<b>Mean for CTS Comparison (N=333)</b>
<b>Felony Prediction</b>	38.0%	40.8%
<b>Actual Felony Rate</b>	34.7%	40.8%
<b>Violent Felony Prediction</b>	19.3%	---
<b>Actual Violent Felony Rate</b>	6.1%	---

MIO-CTP Mature Program participants released into the community prior to July 2006 with at least two years post release have an average predicted risk for felony recidivism (38.0%) that is very comparable to that of the CTS comparison group (40.8%).

**Exhibit 8 - Comparison Rates of Recidivism**

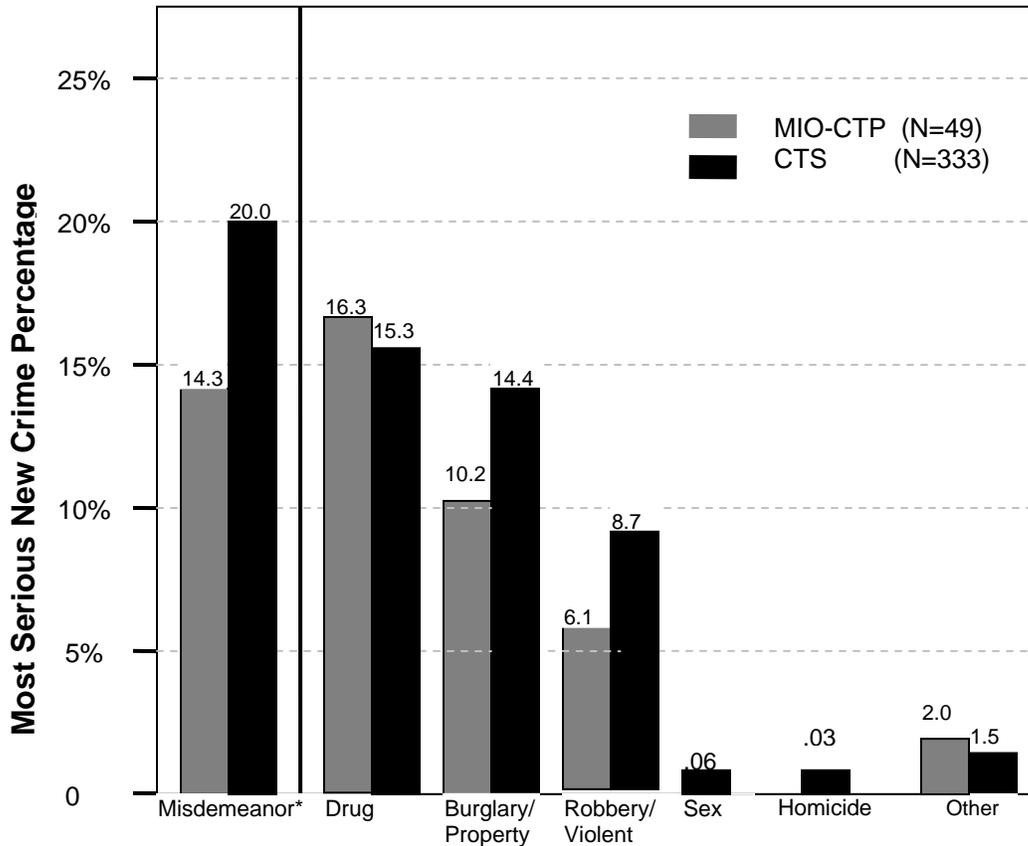


To better understand the nature of this new felony rate, it is also important to consider the kinds of new crimes being committed. Data from the previous research with the CTS Comparison group has also yielded predictors for violent felonies.

The Mature MIO-CTP group has a mean violent felony prediction of 19.3 percent. (From **Exhibit 7 - Felony Recidivism Prediction and Actual Rates** above.)

66 7A 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.

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



Comparing felony convictions, the MIO-CTP felonies are of a less serious nature. New violent felony crime has been committed by only 6.1 percent of the Mature MIO-CTP participants. This is compared to the range of index felonies. This is compared to the 19.3 percent predicted and the more than 40 percent of index crimes were violent offenses (From **Exhibit 1 - Characteristics of MIO-CTP Participants** above.) Drug offenses are the most likely new felony offense and this rate is greater than the CTS comparison rate of new felony drug 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 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. At three months post-release participants were asked 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**

Symptom/Behavioral 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. Those who reported some use of either alcohol, or illicit drugs were much more likely to be convicted of a subsequent felony. 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.



# PROCESS EVALUATION AND PROGRAM REVIEW

## ***Process Evaluation***

In April of 2006 the MIO-CTP Oversight Committee began to review the outcome evaluation reports covering 2004 and beyond. The recidivism rate presented in the December 2005 report had increased from 13.9 percent to 23.8 percent. Ongoing, informal reports to the committee suggested that new felonies were continuing among participants. While a gradual increase in this rate was to be expected, the committee expressed concern and decided to undertake a review of the program and to consider issues that may be impacting outcomes.

In conjunction with Seattle Mental Health (SMH), Northwest Resource Associates (NWRA) assembled a focus group in June of 2006 to discuss this trend, whether or not changes had occurred in the program, and conditions external to the program that may be impacting the program and its results. The group consisted of management personnel from the program, Department of Correction's risk management personnel involved in referrals, and Department of Correction's Community Corrections personnel. The following is a synopsis of that discussion.

Several changes appear to have occurred in the program that may have had an indirect effect on outcomes. In the early stages of the program, treatment personnel met regularly to discuss potential changes in the program. These discussions and subsequent decisions to institute changes resulted in many of the developments of the first year of the program that seem to have had a positive impact on outcomes; however, over the past several years these meetings became increasingly less frequent as immediate issues diminished. This kind of active program review by staff had all but ceased entirely. Over the course of several years many program personnel have changed and the institutional memory of those individuals has been lost.

Additionally, the participant selection process has changed somewhat over time. Originally, all potential referrals were interviewed by program staff prior to final selections decision. This direct personal contact was often an integral part of the assessment of motivation and capacity to benefit from the program. In addition to DOC staff having personal contact regarding the suitability of referral, a second perspective of the future treatment staff brought a fuller discussion of referral issues and consequently treatment staff had a larger input into the admission decision. This step was suspended during a period of time when enrollment was low due to uncertainty of continued funding (discussed below) and the time needed for this interview process was causing delays. The practice was suspended in the interest of moving quickly to enroll new participants, and never re-instituted.

## ***Program Review***

Broader issues have impacted the program. Twice the program has experienced the uncertainty of continued funding by the state legislature—first in 2003 and again in

2005. In January of 2003 new referrals and enrollments were suspended for six months. At this time continued funding appeared highly unlikely. While the 2005 uncertainty was not as intense, the effect was similar. Clients, as well as treatment personnel, were very aware of funding considerations and the very real possibility that the program would discontinue. While this can be somewhat demoralizing to staff efforts, effect on the stability of clients was more palpable. Disorganized persons with mental illness are much more likely to act out their anxiety over the stability of their future. Also, as noted above, the selection process was impacted by these periods of uncertainty. Some focus group members felt that the selection review process may not have been as thorough in many ways as it had been previously, all in the interest of rebuilding the number of participants in the program. Persons not ideally suited to the program may have been selected.

A number of changes have occurred within the Department of Corrections specifically related to Community Corrections over the past several years. Originally, one Community Corrections Officer (CCO) was responsible for monitoring all of the MIO-CTP clients. This facilitated communication and coordination between DOC and the treatment staff at SMH. During this time the CCO was clearly identified as a member of the treatment team. This changed at approximately the same time that the Dangerously Mentally Ill Offender program was instituted and a variety of CCOs from the Special Needs unit were assigned clients in the MIO-CTP. While there are arguably advantages and disadvantages to this arrangement, the result was a gradual eroding of the concept of the CCO as an integral part of the treatment team. Focus group participants from the CCO staff doubted that the majority of CCOs would describe themselves as treatment team members.

One result was that coordination between case management staff and CCOs has been uneven. Another result is that there has been a decrease in the use of incarceration in the King County Jail as a response to failure to comply with treatment expectations. This is due in part to cutbacks in the King County Jail and incarceration for treatment failures not being an option. Regardless, missed treatment meetings and other forms of non-compliance were no longer being met with brief incarceration.

Other recent changes in community corrections have been upsetting to the coordination and treatment process. Near the end of 2005 a different group of personnel, the risk management specialists (RMS) in the community were given responsibility for supervision of MIOs, rather than the CCOs. This lasted for several months with a steep learning curve for RMSs before the decision was made to return this responsibility to the CCO. Instability of personnel and processes would be expected to have a negative impact on treatment and the stability of clients.

Finally, discussion centered on referrals. Referring personnel within the prisons noted that the quality of referrals has, in their perspective, deteriorated within 2005 and 2006. It was explained that new programs within DOC have opened up new release options to those who are incarcerated. Other housing supports have been made available to offenders that do not require the intense programming of MIO-CTP. Consequently, many individuals with no other options would previously have shown interest in and

agreed to the program have subsequently chosen a different option. As a result, referrals have been fewer, and include a larger percentage of drug and alcohol involvement and Axis II personality issues in the clinical picture than previously the case. In other words, referrals have been less likely to meet the ideal of a primary Axis I serious mental disorder. Further, there appears to have been an increase in the number of referrals and participants with a history of sex offense and housing problems (discussed below) have been exacerbated by this feature.

Finally, housing has been another program feature that has changed over time. Initially, the vast majority of participants were housed in one facility, the Berkey House. It is in this facility that the close video monitoring of activity is possible. While the Berkey House has very strict rules about substance use violations, other facilities were used as temporary and longer term back-up when these issues arose. Increasingly, more participants have come with a history of sex offense and sex offenders cannot be housed at the Berkey. Alternative facilities with limited monitoring and less ideal conditions have become primary housing options. When problems have arisen in these facilities, homelessness has increasingly become more common among participants. The chaos and stresses of homelessness further complicate the lives of program participants.

### ***Subsequent Program Changes***

A number of changes were made to the program shortly after the above review. These were changes that were obvious to the program and were within their power to effect. Program personnel now meet formally two times each week with CCOs from the Seattle Special Needs Unit. This is facilitating communication between the organizations and personnel. They are better able to keep each other abreast of changes in the client and to coordinate treatment decisions.

Program personnel have returned to the practice of interviewing program candidates prior to the selection decision.

While not directly a result of the program review, it is a change that speaks to the larger issue of treatment response for the changing clientele in the program. SMH has continued to shift its treatment focus and personnel to address chemical dependency issues. For some time all staff have been cross-trained in chemical dependency, two staff members are now Chemical Dependency Professional Trainees on goal to become accredited Chemical Dependency Professionals.



## SUMMARY AND CONCLUSIONS

This ongoing program evaluation study of mentally ill offenders continues to support the hypothesis that intensive mental health case management services can effectively reduce recidivism, and more particularly the seriousness of the crimes committed by this population. While the overall rate of recidivism for program participants has increased, it is clear that the new felony crimes have been less serious and less violent than previous offenses and less than is predicted by established factors.

Demographic data and diagnostic information were presented in the report. Just over 50 percent of program participants were diagnosed with a psychotic disorder, and the overwhelming majority of all participants (90.7%) 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 emphasizes treatment of co-occurring substance abuse disorders and close coordination with community corrections personnel from the Department of Corrections. Program participants averaged 9.3 hours per month of pre-release services and 16.4 hours per month of post-release services.

Outcomes are focused on the 49 individuals who were enrolled after the program matured, and who had at least two years in the community post-release. While total felony recidivism at this stage of the program was only somewhat lower among program participants than the comparison group and was predicted by a set of established variables, the seriousness of new crimes is much less than the type of index crimes. The current new felony offense rate is heavily influenced by a preponderance of drug offenses. New violent felonies are 200 percent less than is predicted by established factors. Only 6.1 percent of new convictions have been for violent felonies against a person, compared to the 19.3 percent predicted and the 39.2 percent of index felonies.

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 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 in a different time period and across the State of Washington. Program participants were release to Seattle only and at a later time. 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.

Because of concerns about the rising felony re-offense rate, the program underwent a process evaluation review to consider factors that may be playing a part in this rise. A number of issues were uncovered and discussed. Some were small, but important, program changes regarding the selection process and the frequency of program review within the agency. More important have been the changes that have occurred within the Department of Corrections. Internal restructuring within the Community Corrections Division have impacted the communications and coordination with mental health treatment personnel. Community Corrections and the Department of Mental Health within the Department of Corrections have been undergoing change over the past several years. Finally, changes in release planning options within DOC have changed the nature of the clientele enrolled in the program. As a result the program is working with individuals who are more likely chemically dependent and less severely mentally ill, and an increasing number of sex offenders which have compromised the housing structure of the program.

A number of recommendations and changes have resulted from the program review and process evaluation. Changes were easily made at the program level to improve the selection process and coordination with the Community Corrections Special Needs Unit.

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

## APPENDIX A: PROGRAM INFORMATION

### **Background RCWs 71-24-450 through 71-24-460**

#### **RCW 71.24.450**

This act articulates the legislative intent for the program 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]*

#### **RCW 71.24.455**

This act authorized the five-year pilot. Funding began July 1998.

#### **RCW 71.24.460**

This act required an **Annual MIO-CTP Effectiveness Report**, each year through 2003. The reporting requirement was suspended for the 2003-2005 Biennium. It became statutorily required, again, beginning December 1, 2005.

This edition, the **2006 Annual MIO-CTP Effectiveness Report to the Legislature** covers the program period 1998-2004.

### **Summary of the RCWs**

Specifically, the act:

- Charges DSHS to contract with a Regional Support Network (RSN) or private provider to deliver 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 Department of Social and Health Services, Department of Corrections and the King County 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. The Department of 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>2</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

---

<sup>2</sup> Financial applications are completed while the participant is still incarcerated, but face-to-face intakes are still required before entitlements can be dispersed.

program is more than they can tolerate, so enrolling them in “mainstream” services may be the best option.<sup>3</sup>

## ***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.

---

<sup>3</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.

## ***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>4</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

---

<sup>4</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.

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 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.

### ***Treatment for Co-occurring Disorders of Mental Health and Substance Abuse***

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>5</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.

---

<sup>5</sup> RCW 71.24.470 Dangerous Mentally Ill Offender Program (DMIO) is a legislative mandate administered statewide by the Mental Health Division.