

Mentally Ill Offender Re-Entry Programs, Washington State

Two Legislatively Established Programs:

- Mentally Ill Offender Community Transition Program (MIOCTP, 1998)
 - pilot project, based in Seattle, outcome N=64
 - lower-level felony offenders with high levels of drug involvement
 - a designated residential facility
 - methods of collaboration and case management extended to DMIO program
- Dangerous Mentally Ill Offender Program (DMIO, passed 1999, began 2000)
 - statewide program, substantial agency investment, outcome N=172
 - DMIO population lower risk, higher stakes
 - Used existing network of local correctional & social service offices
 - independent mental health providers: in Seattle, same program as MIOCTP, integrated mental health-CD Tx (one chart, all mh staff CD-certified)
- Both programs passed after random public murder of a retired firefighter by a severely ill man just released from jail
- Both programs applied a Community Transition Study (Lovell et al., 2002)

Major Program Elements

- Prerelease identification of participants, interagency task force & case teams
- Medicaid eligibility waivers, pre-release pre-authorization
- Prerelease contact by community mental health providers in prisons
- Supplemental funding per participant: DMIO=\$6000 transition (3 months pre-release, 3 months post-release), then \$700/month (\$900 for non-Medicaid-eligible)

Outcome Studies

1. *Did programs affect recidivism?*

- Comparison of 172 DMIOs released 1999 thru 2003 with 172 MIOs, drawn from a pool of 1,356 released 1996 – 2000, matched case-by-case on eight predictors of recidivism and DMIO group membership (MIOCTP, N=64, same control pool)

- Three-year felony recidivism of DMIOs=27%, matched controls = 43%
Two-year felony recidivism of MIOCTP=23% vs. matched controls, 42%
Two-year any new offense recidivism of MIOCTP=41%, matched controls 61%¹
- For DMIOs, no statistically significant effects on recidivism for combined felony or misdemeanor offenses or for violent felony recidivism²
- Washington State Institute for Public Policy benefit-cost model indicates \$1.24 in benefits per dollar of program costs

2. *Did programs affect access to mental health and other social services?*

- Comparison of first 100 DMIOs (released 1999 - 2002) with Community Transition Study (CTS), sponsored by the Washington Institute for Mental Illness Research and Training: 287 MIOs released 1996 – 1998
- Among DMIO participants, 59% were seen within one week of prison release vs. 14% of CTS subjects
- Steady community mental health treatment (nine or more months in the first year) was provided to 76% of DMIO participants compared with 15 % of CTS subjects
- In first year, DMIOs averaged 9 billed hours per month of service vs. 2.5 for CTS; MIOCTP, 25 hrs/month
- Summary: far more rapid access to more intensive services

3. *How much did the program cost and how were funds expended?*

- Two-year follow-up study of 114 DMIOs released July 2002 thru December, 2003
- DMIO program costs averaged 80% of possible total costs, per participant
- Of goods and services purchased with DMIO program funds, 82% went to housing, 11% for personal expenses, and 6% for clinical intervention (sex offender and chemical dependency treatment)
- Non-Medicaid eligible participants, who depended on DMIO program funds, averaged 121 hours of service
- Medicaid-eligible participants averaged 424 hours of mental health service, largely supported by other sources
- Summary: DMIO program funds filled gaps in services

¹ McNemar Test: (1) $\chi^2=11.5$, $p<.001$, odds =0.37; (2) $\chi^2=5.5$, $p=.01$, odds=0.3; (3) $\chi^2=6.05$, $p<.01$, odds=0.24

² 24 violent felonies for DMIOs vs. 30 for matched controls; because these are rare events, we had no robust set of predictors of violent felonies that could be used to match DMIOs with controls. Therefore, we cannot say that DMIOs and matched controls were equivalent in risk for violent felonies.

4. *How did the DMIO program affect case management in the community?*

- Intensive study of case management narratives, service records, and treatment provider notes: 48 CTS followed for 18 months, and 45 DMIOs followed for 14 months
- Substantial improvements in quality of supervision, collaboration between DOC and mental health providers, management of housing issues

Case Management Study (N=48 CTS, 45 DMIOs)

1. *Quantitative Summary*

	DMIO	CTS
Pre-release DOC – soc svc contacts	4.8	2
Post-release contacts	14	7
First-year CD Treatment	53%	19%
Illegal drug abuse	14%	60%
Became homeless (N)	4	12

2. *Case Management Narratives*

- In CTS, lack of system support a factor in 40% of cases; not an issue for DMIOs
- DOC case managers much better informed
- with few exceptions, active outreach efforts by mental health case managers

3. *Transition Issues*

- Drug and alcohol abuse: severe obstacles despite case management efforts
- Mental health breakdowns required supervision & intervention, new felonies in only 4 out of 12 cases
- Brain damage & developmental disability clients: no new felonies
- Decompensating in jail (7 cases): discontinued medication, increased agitation due to confinement
- Use of hospitalization an issue in 8 cases: on release from prison, transfers between hospital and jails, attempts at civil commitment

Methods

Recidivism Predictors for MIOCTP Subjects, Matched Control Mates, and All Controls

<i>Variable</i>	DMIO (n=172)	Mates (n=172)	All controls ^a (n=1356)	p DMIO vs. all controls
1. + Past felonies (avg)	3.67	3.3	4.20	.021
2. – Mental health residential time (days, avg)	429	392	169	.000
3. + Past drug offenses (avg)	.67	.56	1.35	.000
4. + African American or Native American, Asian, Pacific Islander (pct) ^a	30%	26%	30%	1.00
5. – Index Violent Offense (pct)	72%	72%	38%	.000
6. – Age of Release (avg)	37.3	35.3	34.4	.000
7. + Annual Infraction Rate	4.0	3.36	2.8	.098
8. – Female (pct)	13%	11%	32%	.000

Note. Plus or minus signs indicate whether higher values (or positive values, for yes/no variables) were associated with increased or decreased rates of recidivism. Average values between DMIO participants and mates differ because continuous variables (past felonies, past misdemeanors, mental health residential time, age of release) were recoded as ordinal variables for matching, and a small group of subjects were matched on overall risk probability rather than individual variable scores. Variables are listed in order of the univariate correlations with felony recidivism of the recoded ordinal or categorical variables.

a. Hispanic origin not a control variable.

- Felony recidivism rate of control pool=53%; DMIO matched controls, 43%
- Risk vs. Stakes
- Methods represent an application of Gagliardi et al., 2004

Issues

- Making a bright line distinction between seriously mentally ill and others
 - Recidivism predictors largely overlap
 - To what extent are needs specific to a population defined by diagnosis?
 - Who is missed by standard medical necessity criteria?
 - Relationship of mental health, chemical dependency, & issues of neglect, abuse & loss
- Concept of Entitlement
 - Serious mental illness & medical necessity are predicates for entitlements
 - What is included in benefit-cost analysis?

References

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