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Risk Management for Persons with Serious Mental Illness: A Process Analysis of Washington State Department of Corrections' Tools

Martin J. Tobin
Antioch University Seattle

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RISK MANAGEMENT FOR PERSONS WITH SERIOUS MENTAL ILLNESS: A PROCESS

ANALYSIS OF WASHINGTON STATE DEPARTMENT OF CORRECTIONS' TOOLS

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RISK MANAGEMENT FOR PERSONS WITH SERIOUS MENTAL ILLNESS: A PROCESS

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This dissertation, by Martin James Tobin, has been
approved by the committee members signed below
who recommend that it be accepted by the faculty of the
Antioch University Seattle at Seattle, WA
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Dissertation Committee:

_____

Jude Bergkamp, PsyD
Chairperson

_____

Wendi Wachsmuth, PhD

_____

Angela Sauer, MS

_____

Carl Foreman, PhD

_____

Date

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ABSTRACT

RISK MANAGEMENT FOR PERSONS WITH SERIOUS MENTAL ILLNESS: A PROCESS

ANALYSIS OF WASHINGTON STATE DEPARTMENT OF CORRECTIONS' TOOLS

Martin James Tobin

Antioch University Seattle

Seattle, WA

Although many evidence-based techniques are outlined in the literature, systems often assess, plan, and mitigate risk for Persons with Serious Mental Illness (PSMI) in significantly divergent ways. For more than 20 years now, the Washington State Department of Corrections has relied on the Offender Reentry Community Safety Program (ORCSP) to appraise dangerousness and presence of mental disorder, utilizing a staged process that considers a wide-ranging set of criminogenic and non-criminogenic variables. A growing body of research suggests that the ORCSP is effectively decreasing recidivism through collaborative reentry planning and mitigation between mental health and criminal justice professionals; however, whether ORCSP participant screening methods are valid or reliable remains untested. Without a cohesive assessment theory or comprehensive exploration of recidivism trends, increased scrutiny must be given to findings. In an effort to clarify these issues, this dissertation evaluates current and historical ORCSP assessment processes, overviews national standards and best-practices for PSMI risk management, and provides a set of practical recommendations to improve selection efficiency. This dissertation is available in open access at AURA: http://aura.antioch.edu/ and Ohio Link ETD Center, https://etd.ohiolink.edu/etd

Keywords: violence risk assessment, risk management, recidivism, violence prevention, severe mental illness, reentry, Offender Reentry Community Safety, ORCSP, DMIO

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.

Second Substitute Senate Bill 6002 (RCW 71.24.450, 1997, p. 1)

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List of Abbreviations

2SSB	Second Substitute Senate Bill
ACT	Assertive Community Treatment
AMA	American Medical Association
APA	American Psychiatric Association
APHA	American Public Health Association
ARD	Actual Release Date
ASPD	Antisocial Personality Disorder
AUC	Area Under the Curve
BHO	Behavioral Health Organization
BJS	Bureau of Justice Statistics
CBT	Cognitive Behavioral Therapy
CBT4CBT	Computer-Based Training for Cognitive Behavioral Therapy
CCO	Community Corrections Officer
CCR	Criminal Convictions Record
CDMHP	Certified Designated Mental Health Professional
CIAP	Community Integration Assistance Program
CIT	Crisis Intervention Team
CPA	Community Protection Act
CS	Construction Sample
CTI	Critical Time Intervention
CTS	Community Transition Study
DBT	Dialectical Behavioral Therapy

DCR	Designated Crisis Responded
DMIO	Dangerous Mentally Ill Offender
DSHS	Department of Social and Health Services (Washington)
DSM-5	Diagnostic and Statistical Manual of Mental Disorders (5th ed.)
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders (4th ed., Text Revision)
E&T	Evaluation and Treatment facility
EMDR	Eye Movement Desensitization and Reprocessing
ERD	Earned Release Date
HCA	Washington State Health Care Authority
HD	High Drug
HP	High Property
HV	High Violent
HVPD	High Violent, Property, and Drug (Criminally Diverse)
ICC	Intraclass Correlational Coefficient
IRR	Interrater Reliability
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
KCJ	King County Jail
LTPP	Long-Term Psychoanalytic Psychotherapy
MAR	Medication Administration Records
MFM	Motivational-Facilitation Model
MI	Motivational Interviewing
MIO-CTP	Mentally Ill Offender - Community Transition Program
MRT	Moral Conation Therapy

MTC	Modified Therapeutic Community
NGRI	Not Guilty by Reason of Insanity
OAA	Offender Accountability Act
ORCSP	Offender Reentry Community Safety Program
ORCS-PCA	Offender Reentry Community Safety Pre-screening Computer Algorithm
PACT	Program of Assertive Community Treatment
PSMI	Person(s) with Serious Mental Illness
PSMI-N	Person(s) with Serious Mental Illness and supported Needs
R/O	Rule(d) Out
R&R2M	Reasoning and Rehabilitation
RCT	Randomized Control Trials
RCW	Revised Code of Washington
REMS	Clozaril Risk Evaluation and Mitigation Strategy Program
RLC	Risk Level Classification
RMI	Risk Management Implementation
RNR	Risk-Needs-Responsivity
RSN	Regional Service Network
SAC	Swift and Certain
SAMHSA	Substance Abuse and Mental Health Services Administration
SDMH	State Department of Mental Health
SHB	Senate House Bill
SMI	Serious Mental Illness
SOAR	SSI/SSDI Outreach Access and Recovery

SRA	Static Risk Assessment
SRC	Statewide Review Committee
SSA	Social Security Administration
SSB	Substitute Senate Bill
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
STRONG	Static Risk and Offender Needs Guide
STRONG-R	Static Risk and Offender Needs Guide - Revised
SUD	Substance Use Disorder
SVP	Sexually Violent Predator
T4C	Thinking-4-a-Change
TC	Therapeutic Community
TF-CBT	Trauma Focused CBT
UCJ	Unstructured Clinical Judgment
VRA	Violence Risk Assessment
VS	Validation Sample
WADOC	Washington State Department of Corrections
WSIPP	Washington State Institute of Public Policy
WSU	Washington State University
WSSORLC	Washington State Sexual Offender Risk Level Classification

INTRODUCTION

People with mental illness are cycling in and out of Washington's criminal justice

system. (Joplin, Sihler, Enslow, Chambers, & Griffith, 2016, p. 1)

Higher rates of mental illness have been observed in the criminal justice system

compared to the general population (Bonta, Blais, & Wilson, 2014; Council of State

Governments, 2002; Fazel & Danesh, 2002; Joplin et al., 2016; Lamb & Weinberger, 2017). It is

estimated that anywhere from 6% up to 16% (Lovell, Gagliardi, & Peterson, 2002), 20%

(Lurigio & Harris, 2007), or 25% (James & Glaze, 2006) of those incarcerated live with a

Serious Mental Illness (SMI). To provide some comparison, Washington State estimates of SMI

in non-forensic settings are 4.72% for all adults over 18 years of age (Substance Abuse and

Mental Health Services Administration [SAMHSA], 2017). The most alarming realization is that

there are now more individuals with mental illness in jails and prisons in America than are in

psychiatric hospitals (Morgan et. al, 2012). Correctional institutions "have become de facto the

largest treatment setting for the mentally ill" (Lurigio & Harris, 2007, p. 147); yet, extreme

ineptitudes in funding, staffing, and services often hinder adequate care (Human Rights Watch,

2003; National Sheriffs' Association, 2014).

Although there appears to be a direct correlation between mental illness and arrest rates

in general (Andrews & Bonta, 2017), how and to what degree SMI impacts serious and violent

criminal activity is less understood. Research approximates that 18-20% of all homicides are

committed by Persons with Serious Mental Illness (PSMI; Fazel & Grann, 2006; Hartvig &

Kjelsberg, 2009). Higher odds ratios and population-attributable risk fractions also exist for

PSMIs compared to those without SMI. For example, Fazel and Grann (2006) examined

recidivism trends for patients discharged from inpatient psychiatric settings and found that only

5% of study participants committed new violent felony offenses. When accounting for population effects, however, it was noted that violence within a general population sample was 45 per 1000, compared to 215 per 1000 in a PSMI sample (Fazel & Grann, 2006). In other studies, an inverse relationship between SMI and violence has been reported (Andrews & Bonta, 2010; Bonta, Law, & Hanson, 1998; Harris, Rice, Quinsey, & Cormier, 2015), suggesting a mixed relationship between mental illness and future risk; with the vast majority of PSMIs more likely to be victims of crime than perpetrators (Engrossed Second Substitute House Bill [E2SHB] 1114, 2013; Swartz & Bhattacharya, 2017).

Regardless of whether or not an individual's mental health influences dangerousness, it is clear that many PSMIs are treated differently throughout their involvement with the criminal justice system (Applegate, 2018). In Washington State, it was found that PSMIs serve longer sentences for their offenses, compared to their non-mentally ill counterparts (Lovell et al., 2002). Of Washington State jails, "fewer than 10 percent use a formal screening tool to identify incoming inmates for mental illness, and only 20 percent use a formal pretrial risk assessment tool to assess inmates' risk of (1) failing to appear for court hearings, or (2) committing a new crime if they are released before trial" (Joplin et al., 2016, p. 5). Limited mental health screening at jail intake likely restricts treatment and jail diversion by incarcerating some PSMIs for "low-level nuisance crimes" (Joplin et al., 2016, p. 5). Biased practices that welcome PSMIs into the justice system, may just be the tip of the iceberg. Although beyond the scope of this project, many additional barriers surface throughout extended prison stays, including: inconsistent or insufficient treatment and skill development, negligible discharge planning, one-size-fits-all educational opportunities that are sometimes inaccessible to individuals with disabilities, and restricted reentry programming and resource allocation. Generally speaking, the PSMI

experience is couched in prejudice, where systems often "reinforce hierarchies in society based on race, class, gender, and other sociodemographic characteristics" (Spohn, 2015, pp. 52-53). Although this dissertation attempts to deliver an objective review of processes, it is recognized that the PSMI experience is situated within a landscape of disproportionate justice strategies.

Despite increasing awareness of sociohistorical influences on correctional systems, to Cullen (2012) "mass incarceration still is the elephant in the room, it's reality dominates corrections" (p. 98). The US prison population boomed from approximately 300,000 to over 2 million over the last 35 years, with much of this upsurge tied to dogmatic political campaigns and national funding that expanded America's war on drugs and toughened sentencing laws, while simultaneously deflating the infrastructure to treat drug addiction (Alexander, 2012). PSMIs were not unscathed by this era. Skeem, Steadman, and Manchak (2015) claim that 75% to 80% of acute PSMIs admitted into jails each year in the United States have some sort of comorbid chemical dependency issue. With prevalence rates of substance abuse double that of the general population (National Institute on Drug Abuse, 2010), it is unclear how far reaching the impact of mass incarceration has been on PSMIs.

Researchers speculate that mass incarceration of the mentally ill was instigated in the 1950s by the use of psychotropic medications (Lurigio, 2013) and later propelled by the deinstitutionalization movement of the 1960s (Grob, 1991; Hartvig & Kjelsberg, 2009). Prior to this, PSMIs were often quarantined from society in almshouses, jails, or asylums with insufficient oversight to ensure that patients received proper care (Appleman, 2018). *Least Restrictive Options* (O'Connor v. Donaldson, 1975; Talbott, 1975) became a promising endeavor. Unfortunately, the establishment of comprehensive and coordinated outpatient mental health systems was stifled by shifts in funding streams, from states to the federal government (Lurigio

& Harris, 2007). Because "there was no obligation on the federal government to provide universal comprehensive medical and mental health care" (Kerr & Lockshin, 2010, p. 4), expansive services went underfunded, resulting in constrained resource options and inadequate care. Many gross inefficiencies endure to this day, prompting such assertions:

> Every criminal justice professional would agree that the system has inherited a problem of enormous scope and complexity. Police, courts, and corrections' officers feel they're boxed in. Resources are stretched to the limit: they're tight on money and even tighter on time. Under the circumstances, many have tried to find a way to serve people with mental illness more efficiently. But with limited options and resources, especially in rural areas, many criminal justice practitioners are frustrated because they know what they're doing isn't enough. (Council of State Governments, 2002, p. 10)

The Washington State Department of Corrections (WADOC) has an estimated daily population of 50,000 (Assessments.com, 2008), with roughly 16,000 individuals housed within 12 Washington State prisons (Blackstone & Westinghouse, 2016). In the interest of long-term maximization of resources, efforts to decrease recidivism must not be too shortsighted. Higher costs associated with serious violent, serious nonviolent, and sexual offenses have been noted in legal settings (Hunt, Anderson, & Saunders, 2017; Martin, 2005). Lengthier detention periods for these types of crimes often strain mental health and correctional systems. After serving time, many individuals are released into the community with little transitional support. In the worst cases, innocent victims are harmed and those who recidivate return into the system to incur more debt. Taxpayer dollars are wisely spent on research aimed at developing efficient, risk detection and management models, including the refinement of early intervention strategies.

The Offender Reentry Community Safety Program (ORCSP) represents an intentional effort to thwart such serious recidivism among PSMIs in Washington State. Research suggests that the ORCSP alters the trajectory of many of its participants through multi-system risk mitigation and community safety efforts (Phipps & Gagliardi, 2003). Although encouraging findings support the economic utility of the ORCSP (Bitney, Drake, Grice, Hirsch, & Lee, 2017), the extent to which we understand the underlying mechanisms that influence program effectiveness remain relatively unexplored. In particular, a lack of comparative research and limited post-release treatment data, make optimistic contentions vulnerable to empirical skepticism. Furthermore, validity of assessment methods used to screen program participants has never been studied (despite the program being operational since 1998, with multiple restructuring periods), prompting a more in-depth examination of ORCSP processes. The purpose of this dissertation is multifaceted, but ultimately intended to augment an understanding of how best to administratively classify and manage high-risk PSMIs reintegrating into society from a prison setting.

CHAPTER I

BRIEF HISTORY OF THE 'MENTALLY ILL OFFENDER' IN WASHINGTON STATE

The shortsighted nature of our criminal justice and medical institutions exemplifies the country's reactive orientation toward public health and social problems. (Lurigio & Harris, 2007, p. 158)

A Reactionary Process

The origins of risk assessment in Washington State can be traced to the Community Protection Act (1990; Revised Code of Washington [RCW] 4.24.550), which pushed for increased public identification and monitoring of individuals who commited dangerous and non-dangerous sexual offenses (Hsieh & Hamilton, 2014). Since then, there have been a variety of strategies employed to catalogue, not only those with sexual-offense risk, but the entire WADOC prison population. Of particular interest to the Offender Reentry Community Safety Program (ORCSP) is how to best classify, what is referred to in this document as Persons with Serious Mental Illness and supported Needs (PSMI-N; Lurigio, 2011; this term was formerly known as Dangerous Mentally Ill Offenders, DMIO). As you will see, there is no simple solution to accomplish this undertaking.

WADOC first introduced "mental health status" (Lovell et al., 2002, p. 1291) into their classification system in 1997. Prior to this, much of the risk assessment and treatment for PSMIs relied on the discretion of psychologists, psychiatrists, and mental health workers embedded within correctional institutions. Referrals and treatment decisions were likely made as complications arose or came to the attention of professionals; however, no large-scale, coordinated effort to consistently screen for and treat SMI appears to have been in place.

On July 27th, 1997, Second Substitute Senate Bill (2SSB) 6002 amended Washington State Law (RCW 71.24) and launched a wave of cross-system programming for PSMIs. The legislative intent of 2SSB 6002 decreed the creation of a pilot program dedicated to the post-release supervision of PSMIs. It was among one of the first US programs that obliged cooperation between correctional and mental health systems (Theurer & Lovell, 2008). In turn, the Washington State Department of Social and Health Services (DSHS), WADOC, and King County Regional Support Network (RSN) partnered to develop the Mentally Ill Offender Community Transition Program (MIO-CTP).

While WADOC conceptualized how exactly they would identify and manage PSMIs, Dan Van Ho was released from King County Jail (KCJ) custody on August 13th, 1997. His original criminal charges were dismissed after being found not competent to stand trial under RCW 10.77 (WA competency statute). Although recommendations to have Mr. Ho hospitalized were proposed by treating mental health professionals while in custody, warning that he was "dangerous and in need of confinement" (Keene, 1997, online publication), Mr. Ho was discharged from KCJ without a Certified Designated Mental Health Professional (CDMHP; equivalent to Designated Crisis Responder [DCR] in 2019) evaluation, follow-up care, or supervision.

Eleven days after Mr. Ho's release (August 24, 1997), Stanley Stevenson, a retired Seattle Firefighter Captain, watched the Seattle Mariners beat the New York Yankees, 5-3 (Baseball Almanac, 2018). After leaving the Kingdome, Capt. Stevenson, "his wife, Rose, one of the couple's five daughters and the daughter's future husband" (Wolf, 2013, online publication) came to the corner of Sixth Avenue and Jackson Street in South Seattle. As they waited for the crossing light to change, Mr. Ho wielded a large butcher knife and stabbed Capt. Stevenson to

death without provocation. Another victim, Richard Bourke, had also been wounded just prior to this attack, but survived (The Associated Press, 1997). Mr. Ho was charged with first-degree murder (Keene, 1997), second-degree assault, and third-degree assault (The Associated Press, 1997). He was later found not guilty by reason of insanity (NGRI) on March 27, 1998 (Superior Court Case Summary, no. 97-1-07028-3) and remitted to Western State Hospital, where he remains to this day.

In response to this tragic slaying, House Bill (HB) 2844 (1998) expanded the courts' ability to treat and confine individuals with mental health symptomatology, and shifted the type of evidence relevant to mental health cases by including behavioral observations, in addition to criminal history (The Associated Press, 1998). Washington State legislature also enacted a taxing authority to help expand mental health services aimed at triaging PSMIs. By 1998, the MIO-CTP was operational on a part-time basis in King County, with their mission to "increase public safety, reduce incarceration costs through reduction of recidivism, and to improve an offender's chances of succeeding in the community" (Arnold-Williams, Veil, & MacLean, 2008, p. 5). For a thorough overview of the MIO-CTP program structure and implementation procedures, please reference the annual legislative reports by Braddock, Lehman, and Gliene (2001); Braddock, Lehman, and MacLean (2002, 2003); Arnold-Williams, Clarke, and MacLean (2005, 2006, 2007); and Arnold-Williams et al. (2008). To briefly summarize these documents, the MIO-CTP established intensive and comprehensive reentry services that included: pre-release planning (beginning ideally 3 months before release), intensive post-release case management, structured programming (mental health and substance abuse), assistance applying for entitlements, housing subsidies ($6,600 per year), crisis intervention, residential support, and community supervision, among other strategies. Researchers have highlighted that the MIO-CTP significantly decreased

substance abuse relapse rates (up to 50%) and felony recidivism (35% – 40% decrease reported for felony recidivism) compared to individuals in the Community Transition Study (Braddock et al., 2003; see below for more information on the CTS).

Two years after Stevenson's death, in March 1999, King County established the second mental health court in US history (Pulkkinen, 2009). That same year, the Offender Accountability Act (OAA; 1999) called for increased risk classification, and the Washington Institute for Public Policy (WSIPP) began implementing the Risk Management Identification (RMI) model on the entire WADOC population (Aos, 2002). The RMI model contained two elements: (1) risk of reoffending in the future, measured by risk score on the Level of Services Inventory Revised (LSI-R; Andrews & Bonta, 1995); and (2) projected negative impact to society based on past behaviors, measured by the *Risk Management Identification Form* (Aos, 2002). The LSI-R, as discussed by Phipps and Gagliardi (2002), was used extensively by WADOC and played a central role in risk decisions for years to follow (for a list of LSI-R cutoff scores and Risk Management Levels, please reference Appendix B.1).

Origins of the 'Dangerous Mentally Ill Offender' Designation

Washington State's Substitute Senate Bill 5011 (SSB 5011) intended to improve classification and management of persons who are "(1) determined to be dangerous to themselves or others as a result of a mental disorder or a combination of a mental disorder and chemical dependency or abuse; and (2) under, or being released from, confinement or partial confinement of the department of corrections" (SSB 5011, 1999, p. 1; this was later amended to read: "(a) Are reasonably believed to be dangerous to themselves or others; and (b) have a mental disorder," 3ESSB 6151, 2001, p.85). The Dangerous Mentally Ill Offender (DMIO) Program, as it came to be known, allowed WADOC to "develop a plan for delivery of treatment

and support services" (SSB 5011, 1999, p. 2). It was assumed that hazard and recidivism,

especially more serious violent offenses, could be mitigated by granting additional triage

services and resources to PSMI-Ns. To support this effort, "the 1999-2000 biennial budget

appropriated $1,676,000 to DSHS and $235,000 to the WADOC to implement SSB 5011"

(Phipps & Gagliardi, 2002, p. 6; DMIO Program total budget [1999-2000] = $1,911,000).

WADOC and DSHS partnered to create the first DMIO Program administrative,

procedural, and implementation framework, which they based largely on the MIO-CTP design.

The DMIO Program established operational guidelines that were hoped to maximize assessment

efficiency and minimize screener bias. As part of this work, they adapted an assessment from the

Community Transition Study (CTS), titled *MIO Transition Study: Worksheet for Case*

Assessment and Medical Chart Data (AKA-'*DMIO Algorithm*;' internal WADOC document,

1999), to govern the DMIO selection process. This assessment protocol conceived operational

definitions, decision trees for *Mental Disorder* and *Dangerousness*, and fashioned an algorithm

for scoring based on static risk variables.

It is well established that assessment measures must undergo proper scientific

investigation, validation, and reliability testing (Daubert v. Merrell Dow Pharmaceuticals, Inc.,

509 U.S. 579, 1993; Harris et al., 2015). As Brown and Singh (2014) highlight, "adding or

removing additional items on actuarial risk assessment tools or using them with unintended

populations or to predict unintended outcomes has been found to weaken their predictive

validity" (p. 53). Despite these limitations, the Statewide Review Committee (SRC) began

screening DMIO candidates in April 2000 using the *'DMIO Algorithm'* as an administrative tool

in selection decisions.

An additional component of SSB 5011 was the recruitment of WSIPP and the University of Washington to evaluate the DMIO Program's ability to deter recidivism, conduct a comparative program cost analysis, and examine "the validity of the risk assessment tool utilized by the department of corrections to assess dangerousness of offenders" (RCW 72.09.370, 1999, p. 10). The initial assessment of the DMIO Program by Phipps and Gagliardi (2002) examined the outcomes of the first 36 participants designated as DMIO. With regard to selection processes, researchers opined the following: "the SRC does not appear to make violence risk decisions based on empirically validated factors such as those embodied in the CTS recidivism risk equations or LSI-R scores" (p. 32). It was also reported that there were insignificant differences between LSI-R scores for those designated as DMIO vs. not designated, with both groups averaging in the 90th percentile (average total LSI-R score = 36.3; Phipps & Gagliardi, 2002). Given the lack of discriminatory ability, the SRC often made decisions based on "severity of the crime and number of prior violent felonies" (p. 31), with higher rejection rates for cases that involved sex offenses and/or drug offenses. Since researchers were unable to establish validity of screening processes, it is unclear if the legislative intent to use empirically supported tools for PSMI-N selection is fulfilled. Although Phipps and Gagliardi (2002) recommended the inclusion of objective risk assessments, the DMIO Program retained an unstructured clinical judgment model that bootstrapped the *'DMIO Algorithm'* to their screening processes, deprived of validity or reliability testing. Without investigation, it is impossible to say how these methods performed over their implementation lifetime.

Classification and Screening Models

      DMIO Algorithm. In 2002, Lovell and colleagues published results from the Community Transition Study (CTS), which outlined violent recidivism trends for approximately 337 identified PSMIs released from Washington State prisons between the years 1996 and 1997. Selection criterion for this sample were constructed by researchers based on computerized correctional tracking records. Indicators included:

> Mental health bed residence, prison hospitalizations, appearance in psychotropic medication records, and intake screening flags for possible mental illness… 2 of 3 criteria: more than 30 days in prison residential mental health treatment program, prescription of listed antipsychotic, mood stabilizing, or antidepressant medications, excluding off-label and low dosages of medications administered for sleep or stress disorders, and a recorded diagnosis of schizophrenia or other psychotic disorders, bipolar disorder, major depression, dementia, or borderline personality disorder. (Lovell et al., 2002, p. 1291)

      Of note, the CTS found slightly lower rates of felony recidivism for PSMIs (37%) compared to non-PSMIs (41%). Recidivism rates for serious felony offenses were 10% for both populations, with each group at higher risk of recidivism during the first year after release. Of those who recidivated, 72% were rearrested for supervision violations and misdemeanors, with only 4.4% for felony crimes against persons. The CTS also observed a pattern of escalating lower level criminal behavior before serious recidivism. This phenomenon, known as *'Harbinger offenses'* (Lovell et al., 2002, p. 1294), complicates the risk assessment process by challenging assessors to not only consider crime type, but progression of criminal conduct and duration between crimes. Since most index offenses assessed by the ORCSP are serious, Harbinger

information is more useful to those working with program participants post-release, as a way to identify an increased need for support or sanction. The magnitude of prompt and appropriate mental health intervention in these instances cannot be underscored enough.

The *'DMIO Algorithm'* was heavily influenced by CTS data, which had a significantly less violent sample population compared to candidates reviewed by the SRC (Phipps & Gagliardi, 2002). For the CTS, PSMIs "rarely commit serious violent offenses" (Lovell et al., 2002, p. 1295). Conversely, individuals presented during SRC meetings almost always had elevated LSI-R scores and/or extensive criminal histories. As such, it may have been inappropriate to generalize CTS findings to PSMI-Ns. Whether risk factors differ for lower-risk PSMIs and PSMI-Ns remains unclear.

Static Risk Instrument. In 2006, WADOC introduced the Static Risk Instrument (SRI) into their classification system (Barnoski & Drake, 2007). The SRI was an actuarial risk tool that assessed criminal history, age, gender, and infraction history to determine risk level. The static nature of these variables made generating risk scores convenient and time efficient with the use of technology. When scoring this tool, weighted scores (see Appendix B.2 for weighting rules) subdivide individuals into five separate risk bins, constituting the Risk Level Classification (RLC) system: low, moderate, high drug, high property, and high violent (see Appendix B.3 for classification rules). Each bin represents a distinct level of categorization that quantifies static offending trends. Findings from Barnoski and Drake's (2007) examination of the SRI revealed moderate predictive accuracy, with the following Area Under the Curve (AUC) statistics reported: felony recidivism (construction sample [CS]: 0.756, validation sample [VS]: 0.742), property/violent recidivism (CS: 0.757, VS: 0.733), and violent felony recidivism (CS: 0.745, VS: 0.732). The RLC also evidenced greater utility in grouping individuals into the high violent

(HV) risk category (felony recidivism: 60%, violent felony recidivism: 24%) compared to the RMA group under the RMI system (felony recidivism: 44%, violent felony recidivism: 18%; Drake and Barnoski, 2009). Even with these improvements in classification, for individuals with violent non-sex felonies as their most serious offense, only moderate predictive values were reported (AUC=0.687; Barnoski & Drake, 2007). An arranging of the most significant SRI violent recidivism factors in this study suggests that risk increases with accumulation of offenses or persistence of criminality. Although Barnoski and Drake (2007) use this logic to outline a statistical argument for weighing scores on the SRI, they spend little time considering if or how low base rates of violence might limit their interpretations.

Given population distribution data, individuals who fall into any of the SRI higher-risk categories will be few and far between, with even sparser numbers among PSMIs. For example, using data from Barnoski and Drake (2007), 36.2% of individuals with multiple felony DV charges recidivated with violent offenses, the highest reported correlation to violent recidivism in this study. However, only 1% of the total validation sample had 2 or more DV charges (0.36% of the total sample), approximately 187 people out of 51,648, the equivalent of 1 out of every 277. It is also recognized that data for this study did not delineate participants by mental illness status, leaving PSMIs to be classified based on the needs of individuals without mental illness. Because of these limitations, among others, the SRI does not appear to be an ideal classification tool for PSMIs or the purposes of enrollment screening for the ORCSP.

STRONG. In 2008, a collaborative effort between WADOC and the company, Assessments.com, developed the Static Risk and Offender Needs Guide (STRONG; STRONG Fact Sheet, 2008). The first part of the STRONG, the Static Risk Assessment (SRA), a 26-item actuarial tool, operated almost identically to the SRI matrix, and eventually revised the RLC

classification system. WADOC also began administering an Offender Needs Assessment (ONA) on all individuals with high-risk scores, which provided a process for organizing and evaluating more complex criminogenic needs and protective factors, drawing attention to dynamic risk/change variables that could then be targeted as focal areas for mitigation. The 11 domains of the ONA were intended to assess risk and inform the creation of individualized supervision plans (Assessments.com, 2008), in accordance with the Risk-Needs-Responsivity (RNR) principles (Andrews & Bonta, 2017; Bonta, 1996).

Additional changes came with the passing of Substitute House Bill (SHB) 1201 in 2009, which modified RCW 71.24.470 to "supplement and not to supplant" (p. 2), funding for up to five years (sixty-months) that "may include coordination of mental health services, assistance with unfunded medical expenses, obtaining chemical dependency treatment, housing, employment services, educational or vocational training, independent living skills, parenting education, anger management services, and such other services as the case manager deems necessary" (p. 1). The ORCSP has incorporated SHB 1201's five-year edict into their program structure; however, it is not a literal interpretation. A participant may access services as long as they are enrolled in the ORCSP, at minimum, for one month per year, with a maximum benefit period of up to sixty months within an eight-year period (ORCSP program guidelines, 2018).

The parameters of the sixty-month funding period are somewhat flexible, which has both pros and cons. On the one hand, reentry teams are free to tailor management plans appropriate to context, rather than implement strategies that may not be feasible within their jurisdiction or supported by an adequate funding stream. On the other hand, quality assurance may be confounded by capricious clinical options that fall short of evidence-based recommendations.

In 2013, WSIPP assessed the utility of the Static Risk Assessment (SRA) within both civil commitment (RCW 71.05) and competency (RCW 10.77) populations (Burley & Drake, 2015). Results indicated significant AUCs for each of the groups: RCW 71.05 (AUC=0.81 for violent felony, 0.80 for non-violent felony, and 0.78 for any conviction) and RCW 10.77 (AUC=0.75 for violent felony, 0.76 for non-violent felony, and 0.75 for any conviction). Although these findings offered some indication that the assessment was useful in non-WADOC settings, the SRA was not integrated into others systems.

Static-99, Stable-2007, Acute-2007. The addition of Static-99, Stable-2007, and Acute-2007 assessments (Hanson, Phenix, Hanson, & Thornton, 2003) in 2014 was a meaningful step toward improved risk assessment and management for individuals with sex offenses. The Static-99, an actuarial tool that generates risk estimates for sexual recidivism, has evidenced good discrimination among individuals released from psychiatric hospitals (Lee & Hanson, 2016) and those living with developmental delay (Hanson, Sheaham, & VanZuylen, 2013), making it an appropriately fit risk assessment for use with PSMIs that have sexual offense histories. The Stable-2007 assesses dynamic risks and needs, which are hypothesized to be deeply entrenched and would require significant time and/or effort to change. For example, access to appropriate social support, coping style, and impulsivity, among other factors are considered. When the Static-99 is combined with the Stable-2007, static scores can be adjusted to account for density of needs. The Acute-2007 attempts to capture present expressions of risk and is often used as a case management tool. Assessing acute needs over time provides a method to compare current functioning to historical evaluations, allowing professionals to track biopsychosocial and environmental factors, while also being responsive to changes in stability or warning signs of criminal escalation. A multilevel risk-detection strategy, that utilizes all of these assessments at

different stages of the program (Static-99 + Stable-2007 during enrollment process and Acute-2007 during management) may be ideal for ORCSP participants with sexual offense histories.

WAONE. In 2015, a revision of the STRONG, the Washington ONE dynamic risk and needs assessment (WAONE; originally branded as STRONG-R) was designed to classify and manage incarcerated persons in WADOC prisons and those on community supervision (Assessments.com, 2008). It strives to incorporate static and dynamic factors into meaningful interpretations of risk, while also crafting contextualized management plans that balance unique needs and strengths (Drake, 2014). According to Mei and Hamilton (2016; see also Mei, Routh, and Hamilton, 2016a, p. 3), the WAONE organizes risk based on five higher-order constructs: "*Antisocial History, Education and Employment, Antisocial Propensity, Substance Abuse Propensity,* and *Reintegration Needs*" (p. 9), and is further divided into 14 subscales.

The subscale, *Mental Health*, is positioned under the *Reintegration Needs* construct, grouped with *Employment Barriers* and *Reentry Needs*. The operational definition of *Mental Health* provided by Mei et al. (2016a) reads: "Mental Health, which contains two subscales, is the degree to which an offender's mental health condition" (p. 7). What is meant by this cryptic sentence is unclear, but given the circuitousness, authors may have adopted a partial or negligible consideration of mental health when developing the instrument. *Mental Health* is alternatively defined in the *Employment Barrier* subscale, *Physical and Mental Barrier*, as: "assesses the degree to which a person('s) mental and physical health conditions block his or her employment opportunities" (Mei et al., 2016a, p. 8). Here again, this operational definition is too broadly defined and does not adequately explain how the WAONE conceptualizes mental illness. Some indication is provided by Hamilton, Campagna, Tollefsbol, van Wormer, and Barnoski (2007), who suggest that mental health is "less important and may even be noncriminogenic" (p. 265).

Washington legislature communicates a similar perspective, with additional caveat: "persons with a mental illness or developmental disability are more likely to be victimized by crime than to be perpetrators of crime. The legislature further finds that there are a small number of individuals who commit repeated violent acts against others while suffering from the effects of a mental illness and/or developmental delay" (E2SHB 1114, 2013, p. 1). The contradiction between a safe majority and a dangerous minority, creates a requisite for highly contextualized, narrowband assessment, designed specifically for PSMIs.

Two other WAONE sub-subscales attempt to capture *Mental Health* through assessment of *Suicidal Propensity:* (1) current ("most recent 6 months"), and (2) historical ("lifetime;" Mei et al., 2016a, p. 7), revealing an interest in PSMIs with acute and chronic suicidal behaviors. For if presence of suicidality is a risk factor for danger to self (DTS), but not danger to others (DTO), one must question whether the WAONE has properly contextualized dangerousness. Since the ORCSP and WADOC do not currently count suicidal behaviors as recidivism, exploring this matter is problematic.

Although medication and treatment factors are considered during WAONE assessment (see Table 1 for a list of WAONE *Mental Health* subcategories), many other mental health issues (i.e., paranoid delusions, command hallucinations, loss of volitional control, impulsivity, energized mania, and impaired judgment) are relevant to ORCSP *Mental Disorder* eligibility criteria. Even though these issues might be assessed, it is not clear if WAONE assessors explore mental health symptoms in a consistent manner. It is recommended that creators of the WAONE clarify their definitions of mental illness and improve documentation to account for symptom-level risk factors.

Table 1. WAONE Mental Health Subcategories

WAONE Mental Health Subscales (P = Protective Factor)	
Higher Order Construct	**Subscale(s)**
Suicide	Suicide (ongoing concern) Suicide ideation/attempts (6-months)
Mental Health Treatment	Current – P Not required – P Required, but not attending
Mental Health Medication Usage	Currently compliant – P More than 6-months since last prescribed Prescribed, but not compliant
Employment barriers	Mental health issues

It has been reported that the WAONE reduces risk classification disproportionality for female and ethnic categories compared to the SRA-2 (a revision of the SRA; Hamilton et al., 2016). Despite these improvements, findings suggest only a 1% difference in violent recidivism base rates for males (6% for females). During construction of the tool, three cut-point options were explored. A gender-neutral model (*Option 3* – high-risk cutoff determined as 2 times the base rate, moderate/low cutoff set at one-fifth the base rate) was ultimately recommended, even though such broadband inclusion limits discriminatory abilities within high-risk categories. STRONG-R documentation also tested a cut-point option that identified a lower proportion of individuals at the high-risk level (*Option 2* as outlined by Hamilton, et al., 2016; high-risk designation determined by 2.5 times the base rate and moderate/low cutoff set at one-half; *Option 2*: HV=11%, HVPD=5%; *Option 1*: HV=17%, HVPD=22%; Option 3: HV=20%, HVPD=23%). Without reporting recidivism data for *Options 1 or 2*, researchers have not presented all the data needed to conclude that the use of *Option 3* (gender-neutral model)

provides better discrimination for serious recidivism. It is hypothesized that individuals classified as HV and HVPD under *Option 2* (*Option 1* had similar risk category proportions as *Option 3* and SRA-2) possess higher violent recidivism rates than those reported for *Option 3*. It is also uncertain if other cut-point scenarios have been explored, but possible that multiple thresholds could be calibrated over time to address specific risk assessment tasks. Currently, the ORCSP is not able to access WAONE raw scores to investigate cut-point alternatives or customized weighing of individual items for PSMI-N identification.

Although it appears that some enhancements have been made to classification for females, whether these changes have meaningfully enriched assessment for males or improved the quality of correctional programming remains less clear. Because the WAONE retained similar cut-points to the STRONG and SRA-2, the status quo of operations may have remained relatively unaffected. It is recommended that WADOC examine how the WAONE has impacted programming trends based on new classification rules.

In addition to recalibration of cut-points, the WAONE specified a criminally diverse category, known as *High Violent, Property, and Drug* (HVPD), a label given to those who meet criteria for each high-risk level. Three-year recidivism findings from the *STRONG-R Pilot Assessment Study* (Hamilton et al., 2016) showed increased risk for the HVPD group, possessing a 43% felony recidivism rate. In 2015, Burley and Drake reported 49.9% (two-year) felony recidivism rates for SRA high-risk categories and 62.4% for individuals classified into SRA highest-risk category (additional cut-points were delineated that were outside of SRA classification rules). For violent felonies, HVPD classification was associated with 17% violent recidivism, while the HV category was slightly higher at 18% (Hamilton et al., 2016). Again, Burley and Drake (2015) reported higher recidivism rates for high-risk (24.7%) and highest-risk

(26.5%) categories using their SRA model. Table 2 provides violent recidivism rates reported in

previous Washington studies. These figures suggest that the WAONE has similar, but not

superior, predictive abilities for high-risk violence.

Table 2. Violent Recidivism Trends for High-Risk Designations

Assessment	Sample Size N=	High-Risk Classification	% Felony Recidivism	% Violent Recidivism	Source
RMI	56,547	RMA	44	18	Drake & Barnoski (2009)
RLC	56,547	HV	44	24	Drake & Barnoski (2009)
SRI	360,071	HV	57	23	Barnoski & Drake (2007)
SRA	15,149	High Highest-High	49.9 62.4	24.7 26.5	Burley & Drake (2015)*
SRA2	184,585	HV Male HV Female	not reported not reported	17 12	Hamilton et al. (2016)
STRONG-R	184,585	HV HVPD	not reported 43	18 17	Hamilton et al. (2016)

* All studies examined 3-year recidivism trends, except Burley and Drake (2015), which only calculated 2-year recidivism rates.

As part of a pilot study (Hamilton et al., 2016), surveys were given to 45 evaluators who

scored the STRONG-R for the sample population (n=200). Survey results support a perspective

that the WAONE has limitations assessing the following populations: "sex offenders, the

mentally ill and low functioning offenders, first time offenders, drug offenders including cases of

drug use, offenders identified as a security risk, and long-term prison offenders" (Hamilton et al.,

2016, p. 23). Researchers also conceded that "cases that exist in the extremes of the prediction

landscape will not be appropriate for broadband assessments and procedures should be included

to provide for overrides" (Hamilton & van Wormer, 2015, p. 6).

While STRONG-R development documentation outlines the statistical justification for

widespread use within the WADOC system, the credibility of this research is limited, as "the one

and only published study of the STRONG-R's utility was the one that the instrument developers

had completed and published themselves" (Jimenez, Delgado, Vardsveen, & Wiener, 2018, p. 4). In particular, Routh and Hamilton's (2016) Interrater Reliability (IRR) study deserves special attention. The most glaring issue here surrounds the statistical methods used to calculate Intraclass Correlation Coefficients (ICC). Based on what is presented, methods are insufficiently outlined, analysis appears oversimplified and potentially erroneous, and statistics are reported in an atypical fashion (see Koo & Li, 2016, for ICC reporting recommendations). Additionally, inter-item reliability was not calculated, despite this being an ideal step to conduct when developing an assessment measure. These issues, among others, raise concern that Washington State University (WSU; Routh & Hamilton, 2016) reliability analysis may be invalid.

ICCs reported were excellent (mean ICC=.89); however, Routh and Hamilton's (2016) model only coded four, videotaped sample interviews (1 male in prison, 1 male under community supervision, 1 female in prison, and 1 female under community supervision), with administration by 33 raters. It seems highly unlikely that the complexity of a classification system with six risk categories (twelve, with gender considerations; Appendix B.4) could be assessed with only four examples. This design also contrasts with recommendations to "obtain at least 30 heterogeneous samples and involve at least 3 raters" (Koo & Li, 2016, p.158).

Routh and Hamilton (2016) reported a mean ICC=0.61 when controlling for Criminal Conviction Record (CCR). This is because the CCR was auto-populated, and by unavoidable consequence, resulted in 100% agreement for observations; whereas the ONA required manual scoring. This suggests that although the combined mean ICC was strong (ICC=0.89), the portion of the assessment that actually required interrater coding possessed relatively weak ICC=0.61. By including the CCR agreements (no coding between raters), overall ICC results were inflated. Authors also cite Cicchetti (1994) for agreement guidelines (identical critical values are reported

by Fleiss, 1986). Contemporary standards (Koo & Li, 2016) recommend more stringent interpretation ranges (see Table 3), further weakening STRONG-R reliability claims.

Table 3. Recommendations for Intraclass Correlation Coefficients (ICC)

	Cicchetti (1994)	Koo & Li (2016)
Poor	< 0.40	< 0.50
Acceptable	0.40 – 0.59	0.50 – 0.75
Good	0.60 – 0.74	0.75 – 0.90
Excellent / Strong	0.75 – 1.00	0.90 – 1.00

At some point after its development stage, the STRONG-R was rebranded as the WAONE, due to a switch in software providers. The WAONE was launched in early 2018, and is currently undergoing its second year of a two-year norming period. With regard to the needs of the ORCSP, the WAONE may have some utility for identifying risk and developing risk management plans for reentry. For mental health assessment, the WAONE screens for relevant mental health symptoms, but should not replace more in-depth evaluation. Furthermore, its broadband approach has been recognized by WADOC evaluators and WSU researchers as an inconsistent and potentially invalid measure to assess dangerousness among PSMIs (Hamilton & van Wormer, 2015). As such, it is recommended that the ORCSP consider, but not rely on the WAONE to make risk determinations.

ORCSP Selection Efficiency

Even though it is likely that creating mechanisms to access mental health treatment, Substance Use Disorder (SUD) services, and community resources reduces serious recidivism, no investigation to this date has determined if PSMI-N screening processes adequately select apposite candidates based on the original intentions of SSB 5011. Further study may help

identify which types of individuals benefit most from ORCSP involvement; and conversely, which configuration of services provide the best outcome for participants and the community. From a societal standpoint, selection efficiency is vital, because "preventing people from reoffending has the potential to save millions of dollars" (Tripodi, 2014, p. 891). It is important to remember that the invention and design of the original DMIO decision tree, which has provided the scaffolding for the current program structure, relied heavily on data from PSMIs (rather than PSMI-Ns) discharged from prison during the years 1996 to 1997. According to current WADOC staff, early classification systems (RMI, RLC), historical clinical judgment procedures, the '*DMIO Algorithm*,' and the following assessments: SRI, SRA, SRA-2, STRONG, and WAONE, were used, but never evaluated for ORCSP selection efficacy.

Rationale for Inclusion of Violence Risk Assessment

Any evaluation of the current state of violence risk assessment must answer two important questions: Does violence risk assessment produce valid information? And is this information clinically useful? (Large & Nielssen, 2017, p. 25)

Despite the expansion of violence risk assessment (VRA) procedures and practice since the 1980s (Monahan, 1981; Singh, 2013), considerable ambiguity persists in relation to how these instruments ought to be utilized and in what context (Brown & Singh, 2014). According to Scurich (2016), "virtually all of the legal statutes that necessitate a risk assessment fail to specify the degree of risk that justifies a particular liberty intrusion" (p. 169). Hart's (1998) thoughtful critique of risk assessment theory and methodology highlights the complex psycho-legal issues involved in forecasting dangerousness and proposes that "there is no simple way to predict or define violence" (p. 127). Harris et al. (2015) further suggest that the overlap between mental health and criminal justice systems convolutes the problem by providing diverging

conceptualizations of how best to mitigate risk factors once identified. Such variance has stimulated some researchers to frame the ethical balance between public safety and the validity of evaluation tools as political and cultural phenomena (Fazel, Singh, Doll, & Grann, 2012). The desire to better understand and detect the underlying factors that contribute to criminal acts remains a salient topic within the field of forensic psychology (Jackson, 2008).

In the face of differing assessment approaches, actuarial methods and structured professional judgment (SPJ) are endorsed over unstructured clinical judgment (Andrews & Bonta, 2017; Douglas & Kropp, 2002; Hanson & Morton-Bourgon, 2004; Harris et. al, 2015; Skeem et. al, 2015). Both methods gather information through mixed methods (i.e., diagnostic interview, interview of collateral sources, review of relevant paperwork from multiple systems) and provide risk estimates. For the actuarial approach, assessments appraise "risk posed by an individual over a fixed period, compared to a reference group" (Kropp & Hart, 2004, p. 3). One of the most famous and widely used actuarial tools for PSMIs is the Violence Risk Appraisal Guide (VRAG; for sex offenses=SORAG), which has been designed for use with "violent adult male offenders in forensic psychiatric and criminal justice systems" (Harris et al., 2015, p. 167),

Despite fairly robust statistical evidence across multiple settings, some have argued that actuarial only approaches are atheoretical, and in some scenarios, may dismiss idiosyncratic risk factors (Andrews & Bonta, 2017). For example, Sreenivasan, Kirkish, Garrick, Weinberger, and Phenix (2000), discuss the outlandishly flawed low-risk designation that would be given to the infamous serial killer, Jeffrey Dahmer, using the RRASOR. In Dahmer's case, lacking previous convictions and older age at index offense are scored as protective factors, neglecting to account for undetected habitual violence and preoccupation with sexual deviancy. Similarly, and relevant to PSMI-N screening, delusional content with a clear nexus to dangerousness will not be

captured by the VRAG, because it does not probe for presence of delusional content and meeting the diagnostic criteria for schizophrenia is scored as a protective factor. Such rigid use of tools is discouraged and "limiting one's scope of inquiry to a single actuarial measure, would not be construed as a prudent or acceptable practice for the basis of a clinical-forensic opinion on violence" (Sreenivasan et al., 2000, p. 441). Litwack (2001) has conjectured that actuarial tools most often target clinical variables that require less human judgement compared to equally important, but somewhat more abstract ideas, like personality style, moral proclivity, ecology, or an individual's potential to change behavior.

A particular challenge that arises when using actuarial approaches with PSMIs is the variation between etiology of violence (i.e., predatory vs. non-predatory; dangerous actions impacted by mental health symptoms vs. mental health disorder with volitional control), crime type (i.e., person to person vs. domestic violence vs. sexual violence), and population (i.e., general population vs. PSMI vs. PSMI-N vs. SVP vs. high psychopathy). Although some have proposed that risk factors are relatively constant, regardless of these differences (Hamilton et al., 2017), others believe that "the factors that are most predictive of recidivism in a population of chronic offenders (e.g., young age and multiple imprisonments) may not be the factors that are most relevant to assessing dangerousness in psychotic murderers" (Litwack, 2001, p. 421).

Both actuarial and SPJ methods assume that risk probabilities increase as scores regress pointedly upward from a normed mean. Of the two, SPJ is less bound by cut-points and places subjective emphasis on a "minimum set of risk factors that should be considered in every case" (Kropp & Hart, 2004, p. 4). Professionals are asked to justify decisions in a unique constellation of assessed criminogenic and protective factors. In SPJ, scores are guided by coding directions that surrender ultimate discretion to the assessor, rather than the sum of static scores alone.

The VRAG (actuarial), for example, assesses age at index offense, a known correlate to increased aggression and recidivism for males under the age of 25. Although elevated statistical weight is technically warranted for younger age, such algorithmic warning does little practical good in understanding why some 21-year-olds commit crimes and others do not. The Historical Clinical Risk Management-20 (HCR-20, Douglas, Hart, Webster, & Belfrage, 2013), on the other hand, although equally apprehensive about instances of juvenile and early adulthood violence, might also uncover dynamic clinical and risk management factors, like certain mental health symptoms, substance use, negative peer influences, and/or poor response to treatment that may help elucidate conditions that increase risk for young adults. It is the goal of SPJ to mitigate proximate stressors and anticipate socio-ecological factors that might move someone closer to the contemplation, planning, or enactment of antisocial alternatives. A SPJ format encourages contextualization and the development of individualized mitigation plans, which are intended to be responsive to individual needs throughout risk management periods. This added complexity, although more nuanced, is also more susceptible to interrater reliability issues and bias.

As discussed in the book *Violent Offenders* (Harris et al., 2015), "offenders likely to exhibit high base rates of violent recidivism include those with lengthy histories of violent crime, psychopaths, and people repeatedly passed over for release when held under indeterminate conditions" (p. 45). Four of the top five risk factors for violent recidivism relayed by Bonta et al. (1998) were juvenile delinquency (d=.20), Antisocial Personality Disorder (ASPD; d=.18), adult criminal history (d=.14), and nonviolent criminal history (d=.13). Number one on their list was objective risk assessment (d=.30). Elsewhere, the inclusion of VRAs in predictive determinations is recommended (Harris et. al, 2015; Otto & Douglas, 2010), and by some legal experts considered "state of the art and should be required" (Morse, 2011, p. 944).

Interestingly, the variables, mentally disordered offender (d= -.10) and psychosis (d= -.04) yielded negative predictive values in previous research (Bonta et al., 1998). In a subsequent study, Bonta et al. (2014) reported similarly weak effect sizes for psychosis (d=.09), schizophrenia (d=.04) and mood disorders (d=.04), and claimed, "major mental illnesses are unreliable predictors of general and violent recidivism" (p. 285). Yet, between the years 2013-2015, 81% of those screened, but not enrolled, by the SRC received rule out (R/O) *Mental Disorder* designations (for clarification: these R/O cases almost always evidenced mental health symptomatology, despite not meeting *Mental Disorder* criteria). In the context of high-risk screening efficiency, findings are confounding. For if mental illness is not an effective or reliable predictor of future risk and no nexus to dangerousness is required for enrollment, why did screening efforts place focus on whether or not individuals met SMI criteria?

Additionally, risk for PSMIs is often compounded by co-occurring substance abuse disorders (Louden & Skeem, 2013; Swanson, 1994; Wolff, Morgan, & Shi, 2013). Bonta and colleagues (2014), for example, found that substance use (alcohol and drug use combined, d=.51) was the strongest predictor of general recidivism, but only a moderate predictor for violent recidivism (d=.20). This same research (Bonta et al., 2014) also highlighted a strong relationship between alcohol use and violent recidivism, with drug use more predictive than alcohol use for general recidivism. These findings suggest that dynamic state factors, such as type and intensity of use, can significantly increase risk. When present, extra contextualization should be given to SUD issues during the development and implementation of mitigation plans.

Of all clinical variables in the above-mentioned study (Bonta et al., 2014), only Antisocial Personality Disorder, Unspecified Personality Disorder, and psychopathy were moderately associated with violent recidivism. This makes sense, however, when considering

that individuals with persistent rule-breaking histories are more likely to receive these diagnoses, and those with psychopathic traits tend to exhibit higher rates of criminal activity and serious violence (Hare & McPherson, 1984; Harris et al., 2015). With regard to community performance after institutional discharge, research clearly links psychopathy to lower survival rates (Hart, Kropp, & Hare, 1988; Serin & Amos, 1995), and "psychopathy proved to be more predictive of violent recidivism than alcohol abuse or schizophrenia" (Harris et al., 2015, p. 87). It is recommended that ORCSP screenings include consideration of psychopathy.

For sexual offenses, Hanson and Morton-Bourgon (2004) have proposed a model where "sexual recidivism is associated with at least two broad factors: a) deviant sexual interests, and b) antisocial orientation/lifestyle instability" (p. 1). Findings from this expansive meta-analysis suggest that sexually specific risk assessments, such as the Sexual Violence Risk - 20 (SVR-20) and Sex Offender Risk Appraisal Guide (SORAG), among others, possess positive predictive ability for sexual recidivism and ought to be included when assessing risk for such crimes. Given WADOCs incorporation of the Static-99, Stable-2007, and Acute-2007 assessments, it is recommended that these instruments be chosen over the SVR-20 and SORAG in ORCSP screening. It is not clear how the ORCSP would access these assessments, but if possible, it may be worthwhile to explore possible Static-99/Stable-2007 thresholds for PSMI-N eligibility.

More recently, Seto (2019) has outlined a highly contextualized theory of sexual offending, in which motivation to commit sexual crimes is both contingent on and primary to entrenched personality traits, underlying sexual desire, dynamic state factors, and environmental interactions. From this perspective, sexual offending risk factors, such as high sex drive, intense mating effort, and paraphilia are controlled in situations where the individual adequately self-regulates deviant sexual urges. The ability to self-control antisocial behaviors, therefore, is not

just viewed as a static personality trait, as there may be compound state factors (such as substance use or mood) and situational factors (such as access to victims and opportunity) that collectively increase or decrease sexual motivation. This Motivational-Facilitation Model (MFM) may offer some insight into just how complex risk prediction can be, as one would need to not only consider individualized risk factors and personality, but be able to anticipate state fluctuations and ecological interaction.

Metaphorically, Fazel (2013) suggests that traditional prediction methods "are no better than a coin toss" (p. 2); and Harris et al. (2015) claim, "predicting violence is much like predicting winners in horse races" (p. 40). Despite the reported benefits of using more structured approaches, such skepticism warns against overly-confident appraisal of risk using assessment tools only (Singh, Grann, & Fazel, 2013). Ultimately, it is helpful to remember that both SPJ and actuarial tools are designed to approximate and guide, rather than forecast with any degree of certainty. Compared to unstructured methods, VRAs offer a more standardized and empirical approach. For Grove & Meehl (2016), "to use the less efficient of two prediction procedures in dealing with such matters is not only unscientific and irrational, it is unethical" (p. 320). Kropp and Hart (2004) further relay that "professionals must decide how to strike the balance between scientific rigor and respect for the uniqueness of cases. Meteorology provides a suitable analogy: no matter how well climate tables and computer models predict the weather, it is still a good idea to look outside before deciding what to wear" (p. 4).

Other researchers, question the validity of structured risk assessments in general, claiming that replication studies most often deviate from original study design, making findings less comparable and robust (Rossegger, Gerth, Seewald, Urbaniok, Singh, & Endrass, 2013). The reliance on correlational data especially, which does not establish causal relationships, impacts a

perceived strength, accuracy, and meaning of factors included in risk assessments. Evaluators should be aware of these limitations and careful not to overvalue the power of assessment results. It has been proposed that when VRAs are "used to inform treatment and management of risk, then these instruments perform(ed) moderately well in identifying those individuals at higher risk of violence and other forms of offending… their use as sole determinants of detention, sentencing, and release is not supported by the current evidence" (Fazel et al., 2012, p. 1).

Justification of risk decisions is also dependent upon the experience and qualifications of assessors, which inevitably creates some problems for both reliability and validity (Harris et al., 2015; Litwack & Schlesinger, 1999). Since the SRC is comprised of an alternating set of mental health and criminal justice professionals, each at various degrees of expertise in risk assessment, a degree of variance to be expected. Reliability of screening methods has not yet been examined in close detail, but it is recommended that the ORCSP test interrater coding to safeguard against possible inconsistencies and inaccuracies between committee members.

Although positive prediction has been the traditional focus of most VRA research, increased attention is being given to the examination of negative predictive power. Fazel et al. (2012), for instance, report a high number of false positive decisions when conducting retrospective analysis of recidivism outcomes. Although this evidences poor positive predictive performance, researchers observed high negative predictive abilities. Researchers hypothesized that "low positive predictive values may not be as important as the ability of these instruments to predict those that are not at risk" (Fazel et al., 2012, p. 4). If this presupposition is valid, VRAs may be equally or more effective at screening out low-risk designations.

One of the most skeptical critiques of unstructured clinical judgment (UCJ) is that "clinicians are unable to predict violence at rates above chance" (or 50%; Brown & Singh, 2014, p. 52). Early research by Monahan (1981) placed successful prediction rates at about 33%. Grove and Meehl (1996) characterize UCJ as highly impressionable and suggest that "people who do not put a high value on scientific thinking, are not themselves engaged in scientific research, and take it for granted that clinical experience is sufficient to prove whatever they want to believe" (p. 318). Although Brown and Singh (2014) note the flexibility and inexpensiveness of UCJ, they dissuade such informal practice, accentuating increased probability of bias and weak statistical corroboration. For these reasons, among others, the literature minimally supports the use of unstructured approaches and "at the very least, practitioners should only consider risk factors that have some support in the empirical or clinical literature" (Kropp and Hart, 2004, p. 35). Litwack (2001) advises clinicians who choose not to incorporate actuarial or SPJ assessments "be able to rationally articulate why they believe the VRAG was inapplicable to their case" (p. 438). Since empirically validated tools exist to assess violence risk for PSMIs, the choice to retain UCJ methods in ORCSP screening is questionable.

In 2015, WSIPP researchers, Burley and Drake, examined the predictive ability of the SRA, a risk assessment previously used in WADOC's risk classification process, for individuals who received involuntary mental health treatment through either RCW 71.05 (Civil) or RCW 10.77 (Forensic). This two-year follow-up study reported AUCs of .81 (Civil) and .75 (Forensic) for new violent offenses suggesting a rather strong ability to predict serious recidivism among PSMIs. When reviewing recidivism trends, however, researchers could not identify clear cut-points in the range of SRA scores (Burley & Drake, 2015). The ORCSP is rather unique in that it considers a homogenous sample with high-risk designations. This means that most, if not all,

individuals reviewed by the ORCSP receive an elevated WADOC risk classification through the

RLC system, prior to ORCSP screening. As such, using the criminally diverse (HVPD) or High-

Violent (HV) risk bins as an indication of future risk, although tapering the overall pool of

potential participants, still has low discriminatory ability at the highest spectrum of risk.

Proponents of the Violence Risk Appraisal Guide - Revised (VRAG-R; Otto & Douglas,

2010) claim, "optimal long term, pre-release violence risk assessment can currently be achieved

by relying on a comprehensive set of static risk predictors without adjustment based on clinical

judgment" (p. 105). The VRAG has a long history of use within WADOC and was included as

an optional assessment on early DMIO screening forms (*Risk Management Identification Form*,

Aos, 2002); however, it has not been examined for use in the ORCSP. Although WADOC has

incorporated the WAONE into their assessment regime, examination of narrowband cut-points

has not been explored on PSMIs. At current, the ORCSP is unable to access raw scores from the

WAONE to begin a closer review. Until screening processes have been sufficiently appraised, it

is recommended that only assessments "*based on research*" (RCW 72.09.370 [SSB 5011], 1999,

p. 2) be implemented.

Cost-Benefit Analysis

> The availability of treatment is a question of the allocation of resources and depends in
> particular on how the problem is conceived by the government and the civil society, this
> controlling the political, legal, and social framework that provides the financial support
> serving as the final tool to influence mental health reforms. (Kalapos, 2016, p. 3)

There exists a growing body of research (Aos & Drake 2013; Bitney et al., 2017;

Mayfield, 2009, see Appendix B.5) that suggests the ORCSP effects a significant reduction in

recidivism and cost to WADOC and taxpayers. Similar findings have been noted for other

forensic programs that attempt to meet psychiatric needs of PSMIs (Morgan et al., 2012). Yet, one must question whether these findings can be equated with budgetary efficiency. As Hunt et al. (2017) relay, "at no point should these estimated benefits be equated as savings to the taxpayer because government pecuniary often works on a paradigm of spend it or lose it, and may not reduce spending for a reduction in crime" (p. 237). A review of WSIPP cost-benefit analyses exposes additional incongruences between theory and practical application.

To compensate for errors in estimation methods, WSIPP researchers used Monte Carlo simulation to measure financial efficacy of the ORCSP. This statistical approach applies computer-based sampling to "approximate solutions by specifying inputs as probability distributions to explicitly and quantitatively take uncertainties into account" (Hunt, et al., 2017, p. 238). Although it may be straightforward to gauge factors such as average length of prison sentence, "number of convictions or arrests" (Aos, 2002, p. 39), crime type, entitlement disbursement, and program budget; the tracking of outcomes like court costs (Hunt et al., 2017) and treatment expenditures, among others, is much more challenging. It is likely that there are many costs and benefits to both the individual and society unaccounted for in the Monte Carlo simulations. Therefore, power of cost-benefit analyses should be interpreted conservatively.

Another issue arises around impediments to social inclusion, referred to as "invisible punishments" (Christian, Veysey, Herrschaft, & Tubman-Carbone, 2009, p. 12), a term meant to capture the stigma experienced by individuals with criminal backgrounds. Weinstein and Wimmer (2010) suggest that "one problem with using a system based only upon calculation of benefits and costs is that it is difficult to determine when more good than harm has been achieved" (p. 35). Background checks that reveal lawbreaking, for example, can interfere with an individual's ability to financially and socially contribute to their communities. More importantly,

denied access to basic human resources, activities, and services, like housing, education,

employment, and suitable treatment constrain protective factors (Lovell et al., 2002). As

Alexander (2012) points out, having a criminal record is a form of "legalized discrimination" (p.

7) that keeps many individuals "locked up and locked out of mainstream society" (p. 7). Without

accounting for the negative impacts of stigma endured by ORCSP participants (Lurigio, 2013),

WSIPP cost-benefit figures are estimations with limited scope.

An area that has received little attention in the WSIPP studies are litigation fees.

According to Martin (2005), Washington State paid out $445 million for negligent claims

between the years 1987 to 2005. Interestingly, although predating cost-benefit analyses, a $5.5

million wrongful-death settlement was granted in 2001 to the Stevenson family, which was the

largest settlement of its kind in US history at the time (Clarridge, 2005). It is uncertain how or if

similar liability deductions are accounted for in WSIPP cost-benefit models.

A final cost-benefit consideration surrounds expenses incurred by ORCSP participants

who reoffend, but are routed, in many cases correctly, into the forensic mental health system

(i.e., RCW 71.05 or RCW 10.77, and in some cases voluntary hospitalization), rather than back

into WADOC custody. In these instances, it is apparent that use of non-DOC services will save

WADOC money; whereas secondary mental health costs, such as hospitalization, emergency

services, and forensic evaluations, drain macro-system resources. According to the Washington

Mental Health System Assessment, the Washington State total mental health budget has almost

doubled since 2007, from $696,113,000 to $1,220,947,000 (Washington State Office of

Financial Management, 2016). Despite this growth, there are inadequate mechanisms in place

within the ORCSP to evaluate an individual's financial impact on society. It is presumed that

meticulous, longitudinal tracking of expenditures will lead to more accurate cost estimates.

Recidivism

According to Landan & Levin (2002), more than two-thirds of individuals released from prison will return within 3 years of their discharge date. Comparable findings have been relayed by Feder (1991a, 1991b), who estimate that 60% of non-PSMIs and 64% of PSMIs will be rearrested within an 18-month follow-up period. A Bureau of Justice Statistics (BJS; Durose, Cooper, & Snyder, 2014) examination of recidivism rates for 404, 638 incarcerated individuals, from 30 states between 2005-2010, found that 76.6% of this sample had been rearrested within 5 years, 67.8% within 3 years, and 43.4% within the first year after release. Of the BJS sample, 28.6% had been rearrested for a violent offense. Burley and Drake (2015) provide significantly lower estimates for more serious crimes, reporting that 24% of individuals under WADOC supervision recidivate with new felony convictions and 9% committing a new violent offense.

Variable definitions. Historically, WSIPP has conceptualized recidivism in a variety of ways. Early research by Barnoski (1997) defined recidivism as "any offense committed after release to the community that results in a Washington State conviction" (p. 2). Later investigations specify duration and opportunity: "…any felony offense committed by an offender *within three years* (duration) of being *at-risk in the community* (opportunity) that results in a Washington State conviction" (Drake, 2011, p. 1; Drake and Barnoski, 2009, p. 2; parenthesized material not in original; see also Miller, Drake, & Nafziger, 2013). Drake and Barnoski (2009) compartmentalize types of recidivism into any felony conviction and violent felony convictions, whereas other research includes non-serious convictions in their definitions of recidivism: "violent felony conviction, non-violent felony conviction, and any conviction (misdemeanor or felony)" (Burley & Drake, 2015, p. 4; Theurer & Lovell, 2008). Although WSIPP has conducted well-designed research, shifting definitions over time has made it difficult to compare studies.

The ORCSP defines recidivism for tracking purposes as return to WADOC custody within three years post release. Considering that individuals can be enrolled in the ORCSP for up to 8 years, if or how recidivism is tracked after the third year of program enrollment remains unclarified. It is recommended that WADOC, HCA, DSHS, Department of Behavioral and Health Research (DBHR), law enforcement, legal entities, and legislature delineate recidivism nomenclature and parameters. This step could ultimately lead to shared methods for tracking different types of recidivism over variable durations (i.e., one-year, three-year, ten-year, etc…).

Harris et al. (2015) define violent recidivism as "any violent offense discovered to have occurred after release, regardless of the offense(s) that brought the individual into the cohort" (p. 48). Otto and Douglas (2010) paraphrase this definition as "any new criminal charge for a violent offense" (p. 102). For James (2015), this includes: "rearrest, reconviction, or reincarceration" (p. 5). Harris and colleagues (2015) argue that dangerousness is a matter of perspective and warn that decisions not based on objective criteria are more susceptible to bias. They suggest the following crimes for inclusion in violent recidivism definitions: "murder, manslaughter, sexual assault, wounding, assault causing bodily harm, simple assault, kidnapping, armed robbery, pointing a firearm, and acts that could result in such charges" (Harris et al., pp. 200-201; see Appendix B.6 for RCW definitions of violence). Here, detected acts of violence are counted, even when they do not result in criminal charges. Elsewhere, the HCR-20 manual (Webster, Douglas, Eaves, & Hart, 1997) also includes "acts which are serious enough to result in criminal or civil sanctions, or for which the perpetrator could have been charged, should be considered violent, and those that are not serious as this should not be considered violent" (p. 24).

Captured under the *Community Safety* portion of the ORCSP acronym, mitigating risk for community members is one of the program's main objectives. As such, it is this researcher's

opinion that any infringement on community safety, including those in which the individual is not returned to WADOC custody, should be considered for inclusion in future recidivism definitions. Since there may be a range of situations in which an individual is returned to WADOC without committing a serious crime, it is unclear if the current ORCSP recidivism definition adequately follows the legislative intent of dangerousness mitigation outlined in RCW 72.09.370 (2018). Currently, non-serious parole violations for breaking conditions and low-risk crimes are counted as recidivism. In other cases, violent acts may be detected, but not counted as recidivism, because of competency issues, diminished capacity, civil commitment, dismissals, or NGRI rulings. Similarly, with regard to suicidal behaviors, the ORCSP definition does not account for participants who die by or attempt suicide, which are unmistakably hazardous.

Institutional violence, although an important risk factor to inform treatment and management, is an inappropriate outcome measure for studying the efficacy of reentry services. PSMI-Ns who are not *at-risk* to commit violent acts in the community, due to scenarios such as ongoing incarceration, death (Hart, 1998), or transfer to other institutions of care (i.e., RCW 71.09 or RCW 71.05), should be removed from datasets (Harris et al, 2015), as their opportunity to reoffend is limited by their exclusion from the community itself.

Psychiatric relapse and other outcome measures. While many definitions of recidivism focus on the recommitting of crimes, others have suggested that psychiatric relapse and treatment compliance are equally important outcome measures (Bonta et al., 2014; Wolff et al., 2013). Previous DMIO Program research by Phipps and Gagliardi (2003), tracked inpatient hospitalization, community mental health treatment, DOC violations, and community chemical dependency treatment, in addition to criminal convictions. More recently, WSIPP two-year recidivism data indicated relatively low rates of reconviction for those civilly committed under

RCW 71.05 (n=11,050, 5.3% for non-violent felony convictions; 2.8% for violent convictions) and individuals who received forensic evaluations under RCW 10.77 (n=4099, 9.2% for non-violent felony convictions; 4.8% for violent convictions) between the years 2009-2012 (Burley & Drake, 2015). Although hospitalization involving danger to self or others is not currently used in ORCSP recidivism statistics, it probably should be. This assertion assumes that civil and forensic clients experience comparable symptoms to PSMI-Ns and engage in equivalently dangerous behaviors, but instead of returning to WADOC, they are routed to DSHS or released. Until reviewed, underrepresentation of violence in WSIPP and WADOC research is presumed.

A known precursor to psychiatric relapse is restricted prosociality. From a positive psychological perspective, "markers of success should perhaps instead focus on meaningful employment, appropriate treatment, and finding ways to give back to others" (Christian et al., 2009, p. 27; see also Braddock et al., 2001). Currently, there are no protective factor assessments used in ORCSP enrollment screening, nor objective measures to evaluate criminal desistence. For more information on emerging positive methods, The Good Lives Model and a limited number of other strengths-based approaches are reviewed in Chapter IV of this dissertation.

Poor medication compliance has also been associated with an "increased risk of relapse, hospitalization and suicide, arrest, violence and victimization, and greater overall public costs" (Rezansoff, Moniruzzaman, Fazel, McCandless, Procyshyn, & Somers, 2017, p. 852). In a robust literature review (715 articles) that compared the effectiveness of eleven compliance measures, Hess, Raebel, Conner, and Malone (2006), identified the Medication Possession Ratio (MPR) as "the preferred measure of adherence using administrative data" (p. 1280). This simple equation is calculated by dividing the number of days that medications are supplied to the patient by the total days within a given follow-up period. The MPR is a continuous variable that represents the

days that medications are successfully refilled. Lower percentages indicate expected lapses in medication availability. Although an indirect way of measuring medication compliance, low MPR has been linked to psychiatric hospitalization and relapse (Hess et al., 2006). In more controlled community settings where medication administration records (MAR) exist, reviewing data directly from MARs may be more useful and precise in determining adherence rates.

Since the ORCSP specializes in reintegration, most participants who interface with crisis services do so at a community level. Burley and Drake (2015) claim that about half of all adult crisis encounters in Washington State involve individuals who were booked into jail or involved in previous crisis contact within a 3-year follow-up period. Estimated annual service costs to treat these individuals (approximately 40,000 clients) reached upwards of $68 million. In addition to better capturing dangerous behaviors that do not result in return to WADOC custody, tracking ORCSP participants' crisis contacts and community hospitalizations may lead to more accurate recidivism statistics and cost-benefit analyses.

In other cases, ORCSP participants are rearrested, but before or during prosecution are found incompetent under RCW 10.77. Competency restoration considerations aside, charges may be dismissed, resulting in release to the community, civil commitment, or referral to crisis services. Even if booking charges are violent, they would not be counted as recidivism by the ORCSP, which only computes return to WADOC custody. In fact, Dan Van Ho's murder of Capt. Stevenson, a catalyst for DMIO Program development, would not meet current recidivism standards. Legislative intent of SSB 5011 clearly asks the ORCSP to target a specific PSMI-N profile, for purposes of safety and efficiency. If operational definitions do not provide an accurate representation of PSMI-N system involvement as it pertains to both of these values, measurement of recidivism will underestimate actual serious and violent acts.

CHAPTER II

OVERVIEW OF ORCSP SCREENING PROCEDURES

The first step in implementing a DMIO Program is to identify the DMIOs, and the first

step in identifying the DMIOs is to find the MIOs. (Phipps and Gagliardi, 2002, p. 47)

Eligibility Criteria for Program Enrollment

The following chapter summarizes current ORCSP screening procedures to draw

awareness to areas of success and opportunities for growth. A flow chart to visually depict

methods is included as part of the process evaluation (Appendix B.7). Before delving into a

functional analysis, the technical procedures are prefaced with a discussion of what potential

participants are being screened for:

- Presence of Mental Disorder; and

- Dangerousness.

Presence of Mental Disorder

There are no physical tests, including brain scans, that can accurately diagnose mental

disorders. The undoubted success of some biological interventions to ameliorate the

behavioral signs and symptoms of mental disorder does not undermine this conclusion.

The ability to successfully treat a disorder at some level of intervention, such as the

biological, the psychological, or the sociological, does not mean that the problem was

caused at that level. (Morse, 2011, p. 889)

Forensic model of mental illness. The notion that mental illnesses are "biologically-

based brain diseases" (Deacon, 2013, p. 847), or more simply put, "diseases of the mind"

(Criminal Code of Canada, 1985, p. 9), is well entrenched within the conventional mindset. For

example, the American Psychiatric Association (APA) has outlined a definition of mental

disorder in the DSM-IV-TR that specifies, "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual" (APA, 2000, p. xxxi). Interestingly, a grammatical reworking of this statement reveals the possible interpretation: individual behavior that occurs. Indeed, within the continuum of wellness and pathology, any behavior, including breathing, sleeping, eating, or exercising, could be construed pathological if the severity, discomfort, or interruption in functioning rises to a level that reaches or surpasses the individual's resiliency or oversteps social tolerance. Although meant to capture the complexity of conceivable symptomatology, such broadness is of little use within forensic settings where determinations rest upon whether or not an *individual's behavior* will be dangerous.

The legal definition of mental disorder traditionally and currently used by the ORCSP reads, "any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions" (RCW 71.05.020, 2018, p. 7). The term *'impairment'* implies an inherent deficit in individual performance, thought process, mood regulation, and/or action (Oliver, 1996). The RCW 71.05 definition in many ways mimics the DSM-IV-TR (APA, 2000): "manifestation of a behavioral, psychological, or biological dysfunction in the individual" (p. xxxi). Both in this nomenclature and the RCW 71.05 adjectives, *'organic, mental,* and *emotiona*l,*'* we see an unnecessary redundancy, since contemporary psychological thought has transcended the Cartesian split and rejects a "reductionistic anachronism of mind/body dualism" (DSM-IV-TR; APA, 2000, p. xxx). It is now widely accepted that mind, body, and spirit are inextricable (Stein, Phillips, Bolton, Fulford, Sadler, & Kendler, 2010), making all *'individual behavior'* a result of psychobiology. Morse (2011) further amplifies this point by stating, "an organic abnormality must only be assumed and need not be identified" (p. 889).

Social model of mental illness. The most compelling assumption about the causation of complex human behavior, including severe mental disorders, is that it will require a multifield, multilevel approach to explanation that avoids biological reductionism or any other form of univariate explanation. (Morse, 2011, p. 890)

Medical and social models of mental illness are reminiscent of the age-old nature vs. nurture debate, which positions genetic predisposition (diathesis) against ecological exposure and experience (stress). While not denying an individual's psychobiological resilience and limitations, the social model of mental illness understands disability as a function of "society's failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organization" (Oliver, 1996, p. 32). The social classism and negative stigma associated with mental illness frequently presents barriers for PSMIs in educational, occupational, relational, and housing arenas that are difficult to overcome (Evans, 2011). In many cases, these social confines precipitate incarceration (Frisman, Swanson, Marin, & Leavitt-Smith, 2010). For example, many PSMIs do not have income and/or rely on limited disability benefits to meet their basic needs (Whitaker, 2010). Living in poverty has not only been shown to negatively affect mental health, but is a known risk factor for future violence (Brown & Singh, 2014; Webster et al., 1997). Lovell et al. (2002) suggest that crimes committed by individuals with mental disorders are "more a reflection of a marginal urban existence" (p. 1296) than an intentional expression of civil disobedience.

Level of Dangerousness

In determining an offender's dangerousness, the secretary shall consider behavior known

to the department and factors, ***based on research***, that are linked to an increased risk for

dangerousness of MIOs and shall include consideration of an offender's chemical

dependency or abuse. (RCW 72.09.370, 2019, online publication, emphasis added)

Although the definition of Mental Disorder used by the ORCSP originates in Washington

civil commitment law that does, in fact, specify that dangerousness must occur "as a result of a

mental disorder or substance use disorder" (RCW 71.05.280), no nexus between mental health

symptomatology and dangerousness is required for ORCSP enrollment. It is recognized that the

motivations behind criminal acts are not always clear, and treating *Dangerousness* and *Mental*

Disorder assessments as parallel processes is a reasonable strategy. Since legislature mandates

the use of assessment tools that are supported by research, the ORCSP has recently incorporated

the WAONE to guide *Dangerousness* determinations. As discussed previously, this instrument

possesses questionable reliability and has not yet been validated on PSMI samples. Creators of

the WAONE have also specified that the tool was intended for broadband classification, not

narrowband filtering of highest-risk PSMIs (Hamilton et al., 2016). Unfortunately, this is the task

faced by the ORCSP. So, even though the WAONE appears to be an attractive solution to

objectively measuring risk for PSMIs, further research is needed to confirm this hypothesis.

<div align="center">

ORCSP Participant Selection Procedures

</div>

Individuals who enter or return into the WADOC prison system undergo evaluation at a

designated intake facility, known as the Shelton Receiving Center. After initial intake screening

and assessment, individuals are classified into one of six risk bins (L, M, HD, HV, HP, HVPD),

based on an aggregate tally of various static and dynamic test items. For individuals who have

been previously enrolled in the ORCSP, a referral is automatically generated and sent to ORCSP administrative staff. In other cases, WADOC staff refer directly by submitting a form to the ORCSP. Although it is true that index offense, demographics, criminal convictions record (CCR), prison behavior, custodial mental health treatment, supplemental risk assessment, and other procedures precede OCRSP referrals and participant screening, these pieces of data inform, rather than determine, the outcome of ORCSP selection processes. Additionally, it is not the responsibility of ORCSP staff to conduct these pre-screening assessments or ensure their quality; nor can they control the variance that exists between intake specialists at the interrater level (Phipps & Gagliardi, 2002). More importantly, risk classification cut-points are predetermined and are not able to be manipulated by ORCSP staff to conduct narrowband assessment, resulting in an overwhelmingly dense selection pool of PSMIs with high-risk classifications.

Screening Tools

ORCS Pre-screening Computer Algorithm. The *ORCS Prescreening Computer Algorithm* (ORCS-PCA) is a computer program designed by WADOC's statistical department for purposes of limiting the total number of candidates considered for enrollment by the ORCSP (it should be clarified that the ORCSP does not currently have a descriptive term for this procedure; the term ORCS-PCA was developed by this researcher). It is the earliest step in the ORCSP screening process that involves an ORCSP staff member. When run, the ORCS-PCA filters several databases and outputs individuals that are 12 months or less from their Earned Release Date (ERD), who have met specific electronic database conditions (Appendix B.8). For example, individuals with HV or HVPD designations and high utilization of mental health services will be included, while individuals with lower risk classifications (except if under age 25 with violent index offense) and low mental health needs will not. Each month, an ORCSP

program administrator reviews results of the ORCS-PCA and manages the selection of cases to be reviewed by the SRC. Automated filtering of larger databases may be beneficial to administrative task efficiency, but it also reduces the total number of cumulative risk and protective factors considered when determining if an individual should proceed to the next phase of screening. Although it is possible that the ORCS-PCA proficiently directs the attention to potential PSMI-Ns, it is unclear if the ORCSP administrator is able to accurately and consistently prioritize risk and needs based on information from the ORCS-PCA database. Further investigation should test the validity and reliability of this tool.

Analyzing a more expansive dataset was beyond the scope of this dissertation. However, if one were to conduct such study, it is recommended that WADOC analyze recidivism data for individuals previously filtered by the ORCS-PCA. This would allow comparison between recidivism rates for different groups (i.e., ORCS-PCA, entire WADOC population, ORCSP designated, and Non-ORCSP designated) at different follow-up durations. More notably, since the ORCSP continues to use ORCS-PCA as a guiding instrument, there is utility in better understanding which ORCS-PCA factors have or do not have efficacious properties.

Review packet summaries. For candidates believed to meet PSMI-N criteria (using initial screening procedures described above), mental health, criminal, legal, and other relevant records are requested from internal and collateral sources. The ORCSP administrator then reviews received records to determine fit for presentation to the SRC. This decision is guided by UCJ. Historical concerns about the quality of requested records are voiced below:

> The uneven quality of DOC and other mental illness documentation has caused
> difficulties in identifying MIOs in prison. It has also proven to be an obstacle for the
> SRC, which must make decisions based on existing documentation. In addition,

formalized methods for decision-making and documenting decisions are lacking. There

has not been a clear consensus on the definitions of mental disorder and dangerousness,

and there is little evidence to suggest that research-based risk assessment instruments are

used in decision-making processes. (Phipps & Gagliardi, 2002, p. 2)

A document titled, *Offender Reentry Community Safety Committee Review* (internal

WADOC document), is completed to overview the requested records. Packet summaries include:

a general introduction to the individual (name, DOB, DOC#, county of first felony conviction,

risk level, sex-offender level), index offense (date, crime, county, summary of crime from

records), sentencing parameters (ERD, max date, months of community supervision, current

facility), and information related to previous ORCS designation if applicable. A portion of the

form attempts to condense several known risk factors into dichotomous variables (yes/no:

substance abuse history, current medications, prior medications, psychiatric hospitalizations,

community mental health treatment, danger to self, DDA enrolled, use of weapon, felony serious

violent offense, felony violent offense, threats to persons, dangerous infractions, hate crime,

gang member), as a means to emphasize areas of concern. The items *risk level* and *sex-offender

level* are taken from the ORCS-PCA and are WADOC specific designations assigned using the

SRA2 (Burley & Drake, 2015) and Washington State Sexual Offender Risk Level Classification

(WSSORLC; Pedneault & Fisher, 2016; Washington Association of Sheriffs & Police Chiefs,

2016). A narrative portion of the summary form recapitulates historical diagnostic and legal

findings, including any infractions committed while in custody. These brief write-ups are used to

introduce cases to the SRC during the next stage of the screening process. It is unclear how or if

these summaries impact SRC decisions.

Statewide Review Committee. The SRC meets monthly (with some exceptions) to review documentation gathered in the previous screening stages and make final determinations regarding *Mental Disorder* and *Dangerousness*, as it pertains to RCW 72.09.370. Selection into the ORCSP is dependent on meeting both criteria separately. As clarified previously, this is a parallel process and SMI need not influence dangerous behaviors to be enrolled into services.

In addition to understanding how SRC members review, organize, and weigh records, an important question that remains is: "if the risk assessment task is to be shared between DOC and the SRC, who should assess which elements of risk at which stage of risk assessment?" (Phipps & Gagliardi, 2002, p. 50). UCJ determinations of *Dangerousness* were an integral component of SRC meetings until 2018. The motivation to add a more consistent and objective risk assessment to screening processes influenced the ORCSP to incorporate the WAONE. Currently, all individuals screened by the SRC meet *Dangerousness* criteria through the RLC system and ORCS-PCA before being reviewed for *Mental Disorder*. Although this limits instances where the SRC could make downward override decisions that contradict RLC classifications, it remains debatable whether the WAONE is a valid and reliable tool to assign risk for PSMI-Ns.

According to Phipps and Gagliardi (2003), the SRC originally included 12 representatives: "four from DOC (Community Protection Unit, Mental Health Services, Regional Corrections, and one unspecified); three from DSHS (MHD, DASA, and DDD); one from a RSN; one community mental health treatment provider; one county designated mental health professional; one county alcohol and drug coordinator; and one law enforcement representative" (p. 7). The actual number and ratio of committee members observed by this researcher during attended SRC meetings appeared relatively close to recommendations by Phipps and Gagliardi (2003). Since beginning work on this dissertation, however, the ORCSP has additionally

required that all SRC members possess Mental Health Professional (MHP) qualifications (WAC 388-865-0238; current SRC is comprised of 7 MHPs). This is recognized as an improvement in process, since prior to this change, *Mental Disorder* decisions were sometimes made by non-MHPs, outside the scope of their practice and/or competence.

Bias

In practical terms, people think they have more information than they actually have, are therefore willing to make more extreme judgments than warranted, and are much more confident than is justified. (Harris et al., 2015, p. 172)

When opinions are voiced during SRC meetings, how does such subjective input sway other voters? Although it might seem like a prudent choice to have multiple reviewers included in the selection process, open voting may influence an unintended level of suggestibility, where groupthink persuades distorted judgments (Asch, 1951; Milgram, 1974) and conformity is encouraged by "making dissent seem somehow improbable" (Surowiecki, 2005, p.76).

It is understood that there may be many forms of implicit and explicit biases that drive forensic decisions (Zappalla, Reed, Beltrani, Zapf, & Otto, 2018). Hindsight bias, for example, has been shown to influence overestimation of risk for low-risk PSMIs when there has been a publicly prominent case involving similar symptomatology within the greater community (Brown & Singh, 2014; Large, Ryan, Singh, Paton, & Nielssen, 2011). Fundamental attributional bias places emphasis on risk factors associated with the person, while minimizing contextual factors that may have been far more relevant to actual offense behaviors (Zapalla et al., 2018). Misunderstandings of base rates and subjective clinical perspectives, in particular, often lead to over-prediction of violence risk (Buchanan, Binder, Norko, & Swarts, 2012). Although there are many other examples, it is indisputable that the consequences of bias can be quite detrimental.

Errors in human decision making have also been associated with state-dependent factors, like attentional deficits and fatigue (Bianchi, Laurent, Schonfeld, Verkuilen, & Berna, 2018), time of day, affect, stress, decision streaks, or even what an assessor had for lunch (Laquer & Corpus, 2016). Historically, the SRC was tasked with reading hundreds of pages of electronic documents for each case reviewed during SRC meetings. This often resulted in instances where SRC members were pressured to review more records than feasible within an allotted time period. Even though the ORCSP now provides access to review packets prior to SRC sessions, it is unknown how SRC members evaluates collateral information before casting votes (i.e., Do they use comparable methods? Is there a difference in time spent by committee members sifting through documents? Do individual risk estimations align with group votes?). It is presumed that early distribution of records permits more time to review material; however, it does not guarantee consistency of screening techniques or quality of evaluations. The SRC may benefit from a study that explores the efficacy of historical and current SRC records-review processes.

Selection Trends

Between the years 2013 and 2015, the ORCSP held 31 SRC meetings and reviewed 295 cases. 53% (n=156) met the requirements for both *Mental Disorder* and *Dangerousness* criteria, and were designated into the ORCSP; while the remaining 47% (n=139) were not. Of those not designated as PSMI-N, 81% were assessed as not meeting criteria for *Mental Disorder* and 19% were ruled out (R/O) based on *Dangerousness* (see Table 4). Compared to earlier statistics (Phipps & Gagliardi, 2003), rates for R/O *Mental Disorder* decisions have increased (81% in 2015 vs. 61% in 2003), rates for R/O *Dangerousness* have decreased (19% in 2015 vs. 29% in 2003), and there is no longer an option to select R/O *Other* (10% in 2003).

Table 4. ORCSP Committee Review Decisions (2013-2015)

Date	Reviewed by SRC	R/O Mental Disorder	R/O Danger	R/O Total	Designated
01/28/13	**13**	9	0	9	4
02/25/13	**9**	5	0	5	4
03/25/13	**10**	3	1	4	6
04/15/13	**9**	4	2	6	3
05/20/13	**8**	2	0	2	6
06/17/13	**10**	3	0	3	7
07/15/13	**6**	1	1	2	4
08/19/13	**9**	0	3	3	6
09/16/13	**8**	4	0	4	4
11/18/13	**11**	1	1	2	9
12/16/13	**6**	2	0	2	4
01/27/14	**9**	3	2	5	4
02/24/14	**9**	3	2	5	4
03/17/14	**7**	1	0	1	6
04/21/14	**6**	5	1	6	0
05/19/14	**9**	2	1	3	6
06/16/14	**10**	5	0	5	5
07/21/14	**10**	4	1	5	5
09/22/14	**11**	6	0	6	5
10/20/14	**10**	6	1	7	3
11/17/14	**12**	5	1	6	6
01/26/15	**11**	5	1	6	5
02/23/15	**10**	6	1	7	3
03/16/15	**11**	3	1	4	7
04/20/15	**11**	3	1	4	7
05/18/15	**10**	2	2	4	6
06/15/15	**10**	4	2	6	4
08/17/15	**12**	5	1	6	6
09/21/15	**10**	1	0	1	9
10/19/15	**10**	3	0	3	7
11/16/15	**8**	7	0	7	1
Total	**(N=295)**	113	26	139	156
Percentage of all cases		**38.31%**	**8.81%**	**47.12%**	**52.88%**
Percentage of R/O cases		**81.29%**	**18.71%**		

Closer examination of selection trends raises some important questions. Perhaps most pertinent is, which rule out criteria (R/O *Mental Disorder* vs. R/O *Dangerousness*) should receive precedence? Given high rates of R/O *Mental Disorder* decisions, it is likely that a significant portion of the SRC's time was spent reviewing mental health records, some of which may have been insufficiently documented to establish presence of serious mental health history. In the seminal textbook, *Violent Offenders* (Harris et. al, 2015), it is noted that "many clinicians overlook gathering objective data about past criminal behavior among PSMIs and concentrate on the history of mental disorder and other invalid indicators of risk" (p. 85). Although criminal history records were available to and potentially reviewed by screeners during committee meetings, it appears that processes did not give equal consideration to *Dangerousness*. Because the SRC voted on *Mental Disorder* first, they may have inadvertently ruled out extremely dangerous individuals, and selected less-risky PSMIs to be program participants, based on severity of mental health symptoms and increased utilization of services while incarcerated.

It should be clarified that just because an individual was ruled out for *Mental Disorder*, does not mean that they were also ruled out for *Dangerousness*. As a function of historical ORCSP screening processes, reviewers first voted on *Mental Disorder* criteria. If ruled out for *Mental Disorder*, a vote for *Dangerousness* was not obligatory, as it would not have altered the ultimate non-ORCS designation. This likely explains why there were significantly more individuals ruled out for Mental Disorder (81%) vs. Dangerousness (19%). Such postulation, however, cannot be verified without a closer look at the data; which would be difficult to access, since in many cases R/O *Dangerousness* decisions were not made. To maximize public safety, it seems prudent to review *Dangerousness* regardless of R/O *Mental Disorder* decision, rather than

a default non-vote. This would serve as an additional pre-release risk screening, potentially incurring mitigation efforts through sanctions and/or referrals to other WADOC departments.

Future Direction of the ORCSP

Within the last few years, the ORCSP Steering Committee collaborated with a multi-disciplinary team intent on updating the language, format, and implementation of the PSMI-N decision tree to reflect current medications, DSM-5 diagnoses, and risk mitigation strategies, among other relevant issues. Although the inclusion of the VRAG-R and HCR-20, two widely accepted risk assessments for PSMIs, were recommended and considered, none were added to processes, nor researched. It is hoped that this dissertation presents a strong argument for including VRAs that have been normed on PSMIs moving forward. At the very least, this project has surfaced research questions for ongoing empirical investigation.

During the first annual ORCSP provider meeting of 2017 (meeting held: 1/24/17 at Washington State Correctional Industries headquarters in Tumwater, WA), a diverse showing of criminal justice and mental health representatives from across the state discussed strengths and weaknesses of ORCSP community-based programs and services. Despite some similarities, dialogues revealed that implementation of the ORCSP varied from provider to provider. Even with some mutual propositions between criminal justice and mental health disciplines, "without a shared, integrative model there is a very real risk that interventions will be implemented in an uncoordinated, unsystematic, or ad hoc manner" (Robertson, Barnoa, & Ward, 2011, p. 479). This is supported in part by a long history of unique intervention types, resource usages, program durations, and treatment compliance patterns for each jurisdiction. Notwithstanding program differences, those in attendance widely believed that treatment variables were indispensable to desistence. If true, needs assessments may help discriminate appropriate candidates for ORCSP

services by anticipating what a particular individual might need in place to successfully

reintegrate into the community (see Figure 1)? Similar hypothetical pre-enrollment, treatment

planning may be appropriate for Non-ORCSP designations as well. Developing ways to track

PSMI-Ns and Non-ORCSP (i.e., R/O decisions) service utilization would be quite relevant to the

program's overall goals of optimizing allocation of resources.

Figure 1. Hypothetical Treatment Needs Decision Tree

```
          ┌──────────────────────┐
          │  Criminogenic Needs &│
          │   Protective Factors │
          │                      │
          │   What conditions    │
          │   would need to be   │
          │    in place for      │
          │     desistence?      │
          └──────────┬───────────┘
                     │
                     ▼
          ┌──────────────────────┐
          │   Can the ORCSP      │
          │     create or        │
          │   enhance these      │
          │    conditions?       │
          └──────────────────────┘
         ┌────Yes────┴────No────┐
         │                      ▼
         │            ┌──────────────────┐
         │            │    Non-ORCSP     │
         │            └────────┬─────────┘
         │                     ▼
         │            ┌──────────────────┐
         │            │   Does the       │
         │            │ offender still   │
         │            │    require       │
         │            │   intensive      │
         │            │ intervention to  │
         │            │    desist?       │
         │            └──────────────────┘
         │           ┌──Yes──┴──No──┐
         ▼           ▼              ▼
    ┌─────────┐  ┌─────────┐  ┌─────────────┐
    │  ORCSP  │  │  Refer  │  │ No referral │
    └─────────┘  └─────────┘  └─────────────┘
```
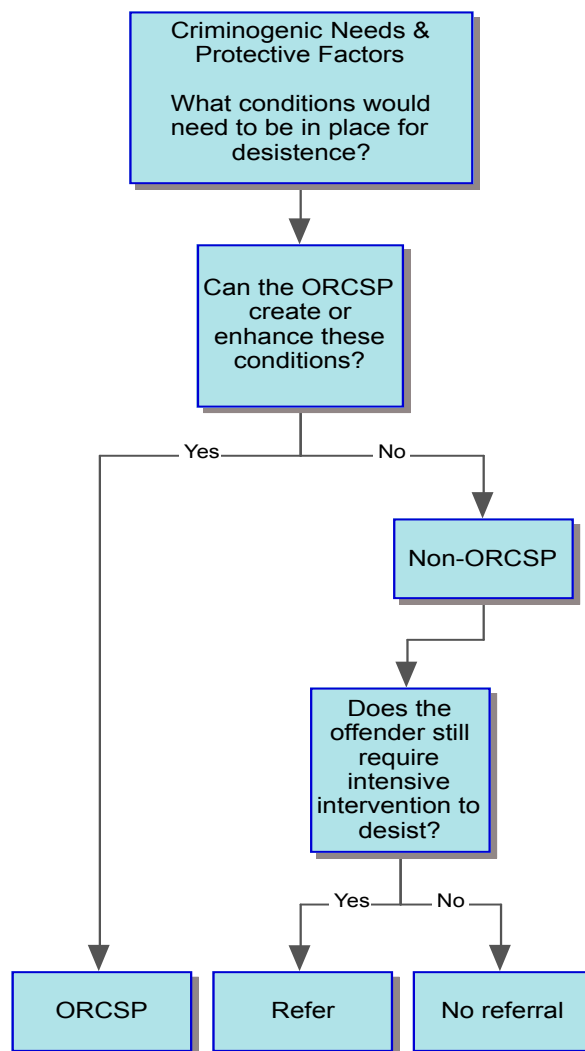
CHAPTER III

METHODS

Several outcome studies suggest that ORCSP services lower recidivism rates and improve cost efficiency (Aos & Drake 2013; Bitney et al., 2017; Mayfield, 2009); yet, no research to date has examined the efficacy of PSMI-N screening processes or the standards used to calculate recidivism rates. Nor do we know exactly how the ORCSP methods measure up against gold-standard risk assessments. Until tested, it should not be assumed that low reported recidivism rates, the use of complex computer algorithms, multi-staged screening, and cross-system collaboration, equates to safeguarding the public interest. The need to study these issues was voiced to the DMIO Program in the early 2000s (Phipps & Gagliardi, 2002 & 2003), without any notable follow-up research or reform of screening processes. Given this excessive delay, such investigation was not only long-overdue, but empirically and ethically merited.

Although a process analysis was ultimately chosen to explore these issues, a validation study was initially designed to investigate the utility of the ORCSP screening procedures using the VRAG-R. Specifically, recidivism data had been requested by this researcher for participants who were screened, but not selected into the ORCSP between the years 2013 to 2015, based on the assumption that to assess the feasibility of participant selection, one would need to code the total "number of potentially eligible participants and those subsequently enrolled" (Carroll et al., 2015, p. 274). Since the ORCSP already had recidivism data for those enrolled, all that was needed, was recidivism rates for Non-ORCSP designations (n=139). Regrettably, WADOC staff relayed that a backlog of resource demanding projects, infrastructure change, and staffing shortages limited the research department's ability to complete new data requests. Within a month of the initial data request, however, it was communicated informally by ORCSP

administrative staff, that the requested recidivism statistics had been calculated by the research department and distributed internally to the ORCSP, but could not be shared with this researcher. Because ORCSP screening processes are routinely implemented on individuals thought to be at the highest end of the risk spectrum and outcomes impact public safety, future research should explore these issues in greater depth. It was clear from a review of the literature that even if a validation study could not be completed as planned, the rationale for conducting such research should be detailed and communicated to relevant stakeholders and policy makers.

Process Evaluation

Process evaluations are "necessary because they identify the effective and less effective components" (Arends, Bode, Taal, & Van de Lear, 2016, p. 38) of a system function. Ideally, information gathered in these types of examinations guide stakeholder's future policy and practice. This is largely because findings often influence an appreciation of how processes are executed, why they exist, and whether or not they align with a particular theory or program objective (Johnson-Turbes, Schulueter, Moore, Buchanan, & Fairly, 2015). In the same vein as program evaluations, process evaluations can be viewed as "a driving force for planning effective public health strategies, improving existing programs, and demonstrating the results of resource investments" (Centers for Disease Control and Prevention [CDC], 1999, p. 34). Most importantly, they provide a distinct practical advantage over traditional research, in that results can be tailored to meet program or jurisdictional needs. Where a program is at in its lifecycle dictates which processes are to be evaluated at that time (Silverman, Mai, Bouler, & O'Leary, 2007). It is assumed that periodic reexamination of a specific process can influence more efficient operational procedures, calibrated service implementation, and improved outcomes.

Stakeholder Needs Assessment

A critical component of a successful process evaluation is gathering stakeholder input to make sure the evaluation conducted is relevant to program needs. The CDC (1999) and W.K. Kellogg Foundation (2004) program evaluation models encourage a consideration of possible stakeholders to diversify perspectives, as a way to show respect to those governing and those impacted by the program. In the current investigation, an assorted set of program needs were gathered through exposure to numerous aspects of the ORCSP. For example, the primary researcher was privileged to: attend several ORCSP selection meetings, ORSCP steering committee meetings, and individual meetings with ORCSP administrative staff; participate in in the first annual ORCSP provider meeting; complete multiple trainings that focused on violence risk assessment and high-risk management; consult with relevant forensic mental health professionals; and interface directly with a limited number of ORCSP clients through forensic, clinical work at an Evaluation and Treatment center on the grounds of Western State Hospital in Lakewood, WA (2016-2018, Telecare E&T, Pierce). It was only through these diverse interactions that a more in-depth understanding of the program's breath and complexity were appreciated.

It is recognized that capturing the perspectives of individuals, both screened in and out of the program, would be invaluable pieces of information for the ORCSP to analyze. Input from DSHS, HCA, legislation, legal systems, treatment providers, and other Washington State correctional programs would have also served as critical data points. Despite being relevant, such investigation digressed too far from the ORCSP's primary need to examine screening methods.

Secondary ORCSP Needs

Although the principal objective of this dissertation was to explore the history and efficacy of ORCSP selection processes, ORCSP stakeholders also identified related topics of interest, including: national standards in PSMI-N selection, general overview of risk assessment and management, EBPs for reentry, and contextual considerations.

National standards. To extrapolate risk classification and management standards on a national level, the Criminal Justice/Mental Health Consensus Project (CJMHC; Council of State Governments, 2002) was chosen to identify appropriate US programs for consultation. After reviewing and filtering program descriptions contained in Appendix B of the CJMHC (n=108), 29 programs were selected for inclusion in this study based on their relevance to assessment of PSMIs (see Appendix C.4 for more information on consultative sample selection procedures). The research design intended to survey PSMI screening and care standards across differing systems and contexts. The goal was to attempt contact with at least one member of each consultative program. Upon IRB approval, the researcher organized available program contacts, literature and/or web-based material, and then proceeded to call each of the identified CJMHC programs during the summer of 2018. Results of these consultative interviews are contained in Chapter V of this dissertation.

Overview of risk assessment and management. It is important to consider that many organizational practices do not overlap between systems and that individuals do not react in identical ways to comparable intervention. This variance is a significant barrier to generalizability and reentry programming. Despite these limitations, it is hypothesized that awareness of risk-management recommendations may offer potential solutions to address the absence of empirically supported tools in ORCSP processes.

In addition to an expansive literature review, the availability of high-quality, risk-assessment education and training, made this knowledge quite accessible. Several risk assessment and management strategies are reviewed in Chapter IV, which serve as a primer for PSMI assessment and triage, but do not represent a comprehensive summary of all options available for PSMI risk management. It is recommended that ORCSP staff participate in ongoing education on topics of mental health and violence risk to keep abreast of contemporary and evolving Evidence-Based Practices (EBP).

How assessments can be used in screening. Although a basic understanding of VRA construction, statistical estimation, and calibration lays a strong foundational argument for why empirically-supported assessments should be used, how they function at the program level is a much more intricate matter. Opportunities for future growth should be planned between the ORCSP and multiple systems as a means to increase transparency, clarify budgetary needs, design research to test developed methods, determine feasibility of proposed recommendations, and lessen the number of program changes made without legislative oversight. Since it is plausible that instances of violence have been and will be committed by Non-ORCSP designees (i.e., candidates identified by the ORCS-PCA and individuals reviewed, but not enrolled by the SRC), communications should also clarify liability limitations and responsibility.

Several prospective assessment options and VRA best-practice recommendations are outlined in Chapter IV. A hypothetical assessment strategy is also proposed based on recidivism typology and contextualization of risk and protective factors (see Figure 2). Even though PSMI-N screening needs were focal, it is believed that much of information shared in this dissertation has implications for a variety of forensic settings, clients, and stakeholders outside of WADOC.

CHAPTER IV

REENTRY BEST PRACTICE

How can the mental health and criminal justice systems respond effectively to the complicated needs of criminally involved persons with serious mental illness? (Lurigio & Harris, 2007, p. 149*)*

Beyond Punitive Measures

It is hard to imagine that criminologists once believed that treatment had little to no effect on recidivism rates (Oullette & Applegate, 2015), but that was in fact, a popular belief. Andrews and Bonta (2010) claim that a *'get tough'* on crime ideology overshadowed a rehabilitative model beginning in the 1970s, primarily fueled by the philosophies of Martinson (1974) and von Hirsch (1982). Meta-analysis research (Cullen, 2005; Cullen, 2012; Lipsey & Cullen, 2007), however, has presented compelling evidence that efficacious treatment not only exists, but "programs that are punishment-oriented are largely ineffective, if not criminogenic" (Ouellett & Applegate, 2015, p. 289). For Washington State in particular, punitive sanctions have been associated with iatrogenic effects (Aos, Miller, & Drake, 2006; Drake, Barnoski, & Aos, 2009).

Mainstream criminal theory locates the origin of crime within a web of sociopolitical, psychological, and ecological experiences (Andrews & Bonta, 2017). As such, how professionals choose to approach PSMI-N assessment and reentry, including service allocation, will be dependent on their conceptualization of the problem (Kalapos, 2016). For many systems, a narrowed scope may result in restricted programming, constrained discharge planning, and limited resource options. Although cohesion between mental health, criminal justice, and political systems may eventually impact uniformity of PSMI-N reentry practice, an historical lack of agreement on the subject, has influenced conflicting ideologies and treatment

inconsistencies. In 2016, an assessment of Washington mental health systems emphasized that "community based resources exist in a complex, disparate set of systems that do not effectively support complex patient needs" (Washington State Office of Financial Management, 2016, p. 6). So, even as best practices are recognized and decreed, legislative oversight may still be obligatory, "especially when government officials are unwilling to assume the financial implications of implementing such an order" (Council of State Governments, 2002, p. 131).

Barnoa and Ward's (2015) literature review examining forensic rehabilitation trends within the last 15 years, identifies three overarching theoretical trajectories: "(1) Treatments targeting metal illness and other psychological issues, (2) Interventions based on the principles of the Risk-Need-Responsivity (RNR) model that are focused on reducing recidivism, and (3) Strengths-based models that aim to enhance well-being of individuals, and in the process, reduce the risk to themselves and others" (p. 77). Although these are distinct approaches, it is not uncommon for interventions to involve eclectic, multilayered strategies.

Cullen, Myer, and Latessa (2009) underscore the peril of non-adherence to Evidence-Based Practice (EBP). Systems are encouraged to find and do 'what works;' yet, what constitutes EBP is not entirely agreed upon or easily studied. Heilbrun, DeMatteo, King, Thornewill, and Phillips (2016), for example, claim that the dearth of randomized controlled trials (RCTs) and insufficient recidivism statistics limit the strength and quantity of known EBPs. Notwithstanding these empirical drawbacks, Kerr and Lockshin (2010) believe that reintegration services for PSMIs "are essential to interrupt the repetitive pattern of reoffending and resultant harm to both individuals and their communities" (p. 3). It is suggested that reentry services include: "discharge planning, transitional case management by reentry specialists, housing with supportive services, and mental health care services" (Frisman et al., 2010, p. 9). The Council of

State Governments' (2002) report on EBPs for PSMIs adds the following: "appropriate use of all available psychotropic medications, Assertive Community Treatment, supported employment, family psychoeducation, illness self-management, and integrated treatment for co-occurring mental illness and substance abuse disorders" (p. 251). Of the above-mentioned interventions, the ORCSP incorporates all approaches to some degree and endorses ongoing interest in service diversity. Collaborative communication at a statewide level also creates an opportunity to compare and test practices across systems. Continued efforts should strive to enhance consistency of EBP implementation between contracted ORCSP service providers.

Evidence-Based Risk Assessment

Matching evaluation tools to context is crucial, but even properly selected assessments, despite improved validity, are susceptible to assessment protocol deviations and evaluator errors. This may be related to misinterpretation of coding manuals, theoretical misunderstandings, poor assessment calibration, bias, inadequate training, or a number of other reasons. In a recent WADOC survey (Pedneault & Fisher, 2016), 72.3% of evaluators reported using the Static-99 in risk decisions, which suggests that a relatively large portion of staff chose appropriate tools for the population being evaluated. However, in this same study, 36.2% of WADOC evaluators reported using the Static-99, an adult tool, on juveniles. Furthermore, even though research suggests that WSSORLC total assessment scores have weak predictive abilities (Barnoski, 2006a; AUC for felony recidivism: 0.614, violent felony recidivism: 0.616, felony sex recidivism: 0.557), it is still used as a classification model. These issues, among others, suggest significant variance between WADOC assessors and highlight discrepancies between applied assessments and available research. Although many SRC members have significant forensic experience, individual proficiency in risk assessment may vary across profession and between

professional. It is recommended that ongoing risk assessment educational opportunities be made available to ORCSP staff to shape a program culture highly engrossed in continual learning.

It was speculated in 2002 that "a system for better identification, treatment, and management of the risks that MIOs pose for violent recidivism cannot be built in a year or two; it is at least a decade-long enterprise" (Phipps & Gagliardi, 2002, p. 51). Estimates clearly did not anticipate postponed empirical study of methods or retention of an UCJ model. In many ways, the ORCSP is in a similar position to the one they were in 17 years ago. At minimum, the lack of empirical support for UCJ justifies a need for future investigation of screening methods. The absence of protective factor appraisal in SRC review also conflicts with recommendations to include strength-based considerations in assessment (American Psychological Association Presidential Task Force on EBP, 2006). When to assess, in what context, and what types of evidence-based assessments are appropriate and sufficient to establish risk for PSMI-Ns remains unclear, but may be a ripe area for future research.

Communicating Risk and Calibration of Tools

When reporting risk for decision making, Hanson et al. (2017) propose using absolute recidivism rates, percentile ranks, and risk ratios. *Absolute recidivism rates* compare risk scores of a particular person to sample scores and classify them into risk bins based on similarity to norms. Predetermined cut-points are calculated from sample recidivism rates and used to delineate risk category parameters (i.e., Low, Moderate, High). Risk assessment manuals typically include reference tables that synopsize recidivism trends in a variety of ways, but "it would be best to create local experience tables using samples from the same population to which an instrument would be applied, followed for the relevant duration, and using the relevant operationalization of recidivism" (Harris et al., 2015, p. 167). The next form of measurement

identified by Hanson and colleagues (2017), *percentile rank*, relays how an individual's risk score relates, in percentage, to the entire sample. Percentile rank does not predict "a person's actual probability of reoffending, or how it compares with others in the reference group" (Hanson et al., 2017, p. 6). Being in the 75th percentile, for example, means that 25% of the sample population scored higher than this person, not that they have a 75% chance of reoffending. Being aware of program goals and setting cutoffs for percentile rank is ideal for allocation of limited resources (i.e., only those who reach 90% threshold receive services). Finally, *risk ratios* help provide a ratio comparison, either higher or lower to average scores, which can help clarify how risk scores differ from recidivism base rates.

Utility ratios are described as a "means by which to formally compare the likelihood estimate to the policy preference" (Scurich, 2016, p. 173) and can be developed to numerically define risk decision-making thresholds. How to calculate utility functions is a subjective process that obliges policy makers to set probability values that tolerate a predetermined ratio of false positive and false negative decisions. It is recommended that the WADOC explore WAONE percentile ranks and risk ratios for those screened by the ORCS-PCA and the SRC. Doing so may permit narrowband assessment of risk.

Negative prediction. In a meta-analysis involving 73 samples (n=24,827), it was found that 59% of those forecasted to violently reoffend, did not, prompting Fazel et al. (2012) to claim that risk assessment tools often identify a large number of false positives. These researchers hypothesize that "negative predictive values were high, and suggest that these tools can effectively screen out individuals at low risk of future offending" (Fazel et al., 2012, p. 4), and may be less accurate for moderate- and high-risk groups. According to the five-level system proposed by Hanson and colleagues (2017), calibration of risk scores within one's own

jurisdiction can lead to Level-V designations, which contain less than 15% false positive

decisions and possess recidivism estimates of 85% or greater. WADOC currently implements a

dual four structure (IV-A and IV-B) when using the Static-99R and Stable-2007. They chose not

to demarcate a fifth level, because so few scores met Level-V criteria during testing.

Interpreting risk decisions. With regard to risk decisions themselves, false positives

may receive unneeded services, while false negatives recidivate with violent acts. Both situations

are undesirable, but it has been argued that cost is a matter of perspective. For the system, it will

undoubtable be cheaper (in the short-term) to release individuals without services; whereas

Monahan (1977) reasons that the seriousness of false negatives, in the context of violent crime,

outweighs any economic benefit. Given the variance between individual functioning, risk/need

variables, and treatment constellations, the distinction between which combination of factors are

most influential to PSMI-N recidivism prediction and prevention is imprecise at best;

particularly, because the relationship between rendered ORCSP services and participant response

to intervention is not yet understood.

When ORCSP participants recidivate, it is assumed that a proper selection was made, but

risk mitigation strategies were unsuccessful in preventing the individual from returning to

WADOC custody. On the contrary, when ORCSP participants do not recidivate, this could be

interpreted as a sign of effective treatment and selection, or it might represent a false positive

decision in which designees received services that were inappropriate for their actual level of risk

and/or functioning. It seems extremely difficult to tease out whether individuals who are not

designated into the ORCSP recidivate (false negative) due to insufficient support and services,

struggles with treatment engagement, or improper selection. The following contingency table

(Table 5) offers attributional connotations of possible SRC decisions and recidivism outcomes.

Table 5. ORCSP Contingency Table

Designation	Recidivate	Does Not Recidivate
PSMI-N **Meets both Mental Disorder and Dangerousness criteria** **ORCSP enrollment**	**True +** Predictive w/ inadequate risk mitigation Routed correctly ORCSP ineffective vs. Treatment resistant/non-compliance	**False +** Predictive w/ adequate risk mitigation Misrouted ORCSP effective vs. Unnecessary treatment vs. Participant engaged/compliant
R/O Mental Disorder **Routed to community or RCW71.05** **Non-ORCSP**	**False –** Prediction not made for dangerousness Misrouted: Does not meet mental disorder criteria, but does meet dangerousness criteria, thus more likely to re-offend Non-ORCS services ineffective or inadequate vs. Treatment resistant/non-compliance	**True –** Prediction not made for dangerousness Routed correctly Non-ORCSP services effective vs. Mental disorder criteria invalid vs. Individual engaged/compliant
R/O Dangerousness meets Mental Disorder criteria **Routed to community or RCW71.05** **Non-ORCSP**	**False –** Missed prediction Misrouted Non-ORCS services ineffective or inadequate vs. Treatment resistant/non-compliance	**True –** Predictive Routed Correctly Non-ORCSP services effective vs. Individual engaged/compliant

Since most of what is known about the ORCSP has been extrapolated from participants already selected into the program, there is very little known about Non-ORCSP recidivism, service utilization, cost/benefit estimates, and response to ORCSP intervention. Although the ORCSP has acknowledged the shortage of post-discharge, resource-allocation data and taken recent steps to enhance documentation of intervention plans for program participants, the same cannot be said for candidates not enrolled. It is recommended that empirical study investigate the efficacy of practice for both populations (i.e., all individuals reviewed by ORCS-PCA and SRC, whether selected or not), with equitable tracking strategies for comparison purposes. Detailed queries would necessitate coordination among multiple criminal justice, legislative, and mental health systems throughout the State of Washington. At this time, such mechanisms are not in place and are beyond the scope of this project.

Sample Risk Assessment Strategy for ORCSP Consideration.

Although much has already been said about the importance of risk assessment in correctional management, there has been little attention given to the application of such assessments in ORCSP processes. Choosing appropriately fit VRAs ought to be based on the psycholegal context and type of recidivism being evaluated (Otto & Douglas, 2014). For example, the Static-99 was normed on individuals with sex-offence histories (Hanson et al., 2003) and would not be advised for use with individuals without sex-offence histories. Likewise, the VRAG-R and HCR-20 are recommended for PSMIs in forensic settings (Fazel et al., 2012), making them ideal tools for ORCSP screening and risk management. From this researcher's perspective, one of the most organized and practical implementation guides is outlined by Hart (2016; Appendix B.9), who groups empirically supported risk assessments based on typology. In Figure 2, please find a simplified adaptation of Hart's model, tailored for ORCSP discretion.

Figure 2. Sample WADOC Risk Assessment Strategy Based on Typology
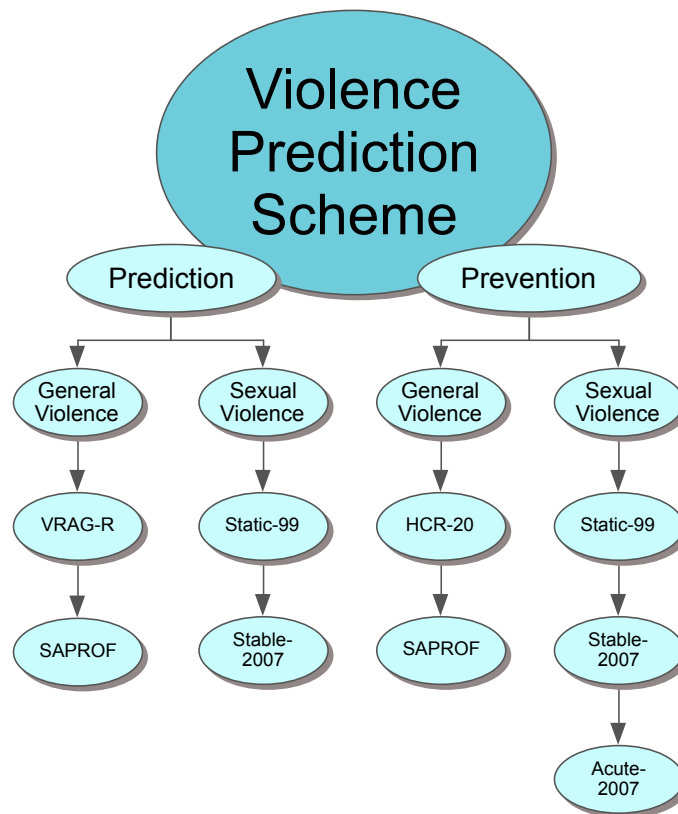
Theories of Risk Management

Actuarial risk assessment is best applied in the execution of forensic policies that apportion interventions and their intensity or duration (e.g., treatment, supervision, custody) in accordance with relative risk. (Harris et al., 2015, p. 167)

Risk-Needs-Responsivity

Many professionals (Andrews & Bonta, 2017; Heilbrun et al., 2016; Hildebrand, Bosker, & Hol, 2013) encourage the Risk-Needs-Responsivity (RNR) model when working with forensic populations., and is recognized by some researchers as "the premier treatment model" (Ward, Mesler, and Yates, 2007, p. 209). Its use is supported by an extensive evidence base (Morgan et al., 2012), widespread use in treatment and evaluation (Ward et. al, 2007), integration into

WADOC policy (WADOC policy no. 320.400, 2017) and Washington State budget, and legal decree from the State of Washington (Third Engrossed Substitute Senate Bill 5034, 2014, p. 111). In 2013, the general fund allocated $3,753,000 "solely to implement an evidence-based RNR model for community supervision" (Proposed Senate 2013-2015 operating budget, Sec. 1217. 2012 2nd sp.s. c 7 s 220). WSIPP research suggests a 16% decrease in crime when using RNR, compared to intensive supervision with (10% decrease) and without treatment (0.16% increase; Miller et al. 2013).

The *Risk* component of the RNR model is by far the most critical, because it defines the context and nature of risk that forensic work attempts to mitigate. As such, it is of great importance that risk assessments be comprehensive and accurate. Although needs and strengths invariably contribute to and alter a cumulative picture of risk, these are paltry without an association to pathological cognitions and unsafe behaviors. The RNR model recommends that high-risk cases be matched with increased levels of intervention, while less restrictive plans be paired with lower-risk clients (Andrews & Bonta, 2010). Although this is an attempt to address higher costs associated with serious recidivism, ethical arguments have been raised regarding the "denial of care to those assessed to be lower risk" (Large & Neilssen, 2017, p. 25).

Risk assessments typically involve the gathering and review of relevant, collateral information, and ideally include an interview with the test subject (Harris, et al., 2015). The use of actuarial and SPJ assessments to classify risk is recommended over UCJ by a number of forensic specialists (Andrews & Bonta, 2017; Bonta et al., 2014; Cullen, 2012; Douglas, 2014; Grove & Meehl, 1996; Harris et al., 2015; Looman & Abracen, 2013; Otto & Douglas, 2010; Scurich, 2016). It is hypothesized that using empirically valid structure limits the amount of non-relevant information considered in decision making.

When assessing risk for PSMIs, the Council of State Governments (2002) recommends that "a screening instrument should use an objective scoring system" (p. 130). Although assessment measures may differ in design, they "must address the following: suicidality; depression; use of narcotic drugs and alcohol; anxiety; history of hospitalization for psychiatric problems; trauma history; and the use of any medications prescribed for a mental illness" (p. 130). In addition, evaluators often consider general history, criminal background, age, culture, access to resources, mental status, medical issues, attitude, dangerousness to others, and client strengths, among many other unique factors. Initial assessments may establish a baseline; however, ongoing assessment is expected to improve longitudinal risk estimation, tracking of progress, and overall service implementation.

Creators of the RNR model, Andrews and Bonta (2010; see also Bonta et al., 2014), organize risk-factors into a set of domains, known as the Central Eight, which consists of the Big Four: criminal history, pro-criminal companions, antisocial personality pattern, and pro-criminal attitudes and cognitions; and the Moderate Four: family/marital, education/employment, substance abuse, and leisure. Although all eight risk domains are empirically validated, "the primary status of the Big Four may be more important to the prediction of violent recidivism compared to the prediction of general recidivism" (Bonta et al., 2014, p. 285).

Gornik (2004) emphasizes a requisite for evaluators to understand the nuances of individual risk factors. For example, a pro-criminal attitude is not synonymous with advocacy for antisocial acts or viewing criminal activity in a favorable light. Although this is plausible, there are often less palpable, antisocial value systems and attitudinal networks at play, which justify antisocial acts and disregard of social norms. It is hypothesized that since many individuals have been victims of injustice themselves and feel unfairly treated, it is not uncommon for them to

evidence behaviors such as defiance, hostility, and thinking patterns that rationalize criminal acts (Gornik, 2004). When interpreted from this perspective, crime is a maladaptive coping strategy. Elsewhere, Yu and colleagues (2017) have outlined an etiologic model in which victimization serves as a mediating factor between mental health symptomatology and violence. It is expected that professional sensitivity to trauma, ongoing risk assessment training, and regular practice will decrease concrete and/or improper interpretations of RNR domains by evaluators.

The *Need* component of the RNR model advocates for interventions that target individualized, criminogenic factors (Hildebrand et al., 2013). For example, a referral to an employment specialist or completing a SSDI application might be advantageous for a client who lacks economic stability. Comparably, an individual with dysfunctional relationships within family and support structures may benefit considerably from an assortment of interpersonal interventions that attempt to address these matters from a family systems perspective; perhaps by incorporating family members into treatment or referring couples experiencing relational strain to counseling.

Harris et al. (2015), identify several common problems evidenced by PSMIs: "management problems and criminal propensity, aggression, anger, substance abuse, life skills deficits, active psychotic symptoms, social withdrawal, and family problems" (pp. 235-240). Each of the listed areas require customization based on need, but as a set, may serve as a prototypical framework for ORCSP reentry management. The HCR-20's clinical and risk management scales also appear helpful when developing mitigation plan and systematically tracking progress over time (HCR-20 v3; Douglas et al., 2013). RNR interventions should target risk and need factors for that particular individual, rather than blanket programming or one-size-fits-all approaches based on risk classification. When trying to properly match risk level and

allocation of resources for individuals with elevated risk, Burnett and Roberts (2004) recommend

"high service level focused on need assessment and risk management plan" (p. 59). Although

ORCSP service providers can and sometimes do assess dynamic criminogenic factors, it does not

appear that needs assessments are consistently applied.

      For individuals with chemical dependency backgrounds, management strategies ought to

include substance use prevention components. According to Harris et al. (2015), chemical

dependency treatment "has the greatest likelihood of reducing subsequent violence" (p. 89). This

contention is supported by data relaying higher base rates of violent recidivism for

schizophrenics with alcohol abuse issues (26%) vs. schizophrenics without alcohol abuse issues

(7%; Harris et al. 2015); and higher reports of violence by individuals with mental health

disorders and comorbid substance abuse (Corrigan & Watson, 2005). Interventions could involve

any and/or all of the following: inpatient rehabilitation, SUD assessment, outpatient therapy,

drug court hearings, self-help group attendance (AA/NA), random urine analysis, and/or a focus

on recovery during intervention planning and implementation. Because SUD treatment in

Washington is voluntary (except under Ricki's Law, which petitions the court for involuntary

treatment if substance use is related to dangerousness or grave disability, RCW 71.05), it is

important to deliver motivational interviewing techniques aimed at increasing participation. In

cases, where treatment or supervision requirements are not fulfilled, sanctions should be

prudently considered.

      The final RNR stage, *Responsivity*, concerns the principle that treatment must be

malleable to adapt to context. Drake (2014) adds that interventions work best when "aligned with

the offender's abilities and motivation" (p. 2) and are perceived to be "shared treatment goals"

(Heilbrun et al., 2016, p. 273). As elements of the individual's world change, modifications to

treatment and risk management plans may become necessary. Given that professionals often manage large caseloads, such amending is not always easily achieved. It is recommended that community providers update plans on a regular basis with ORCSP oversight to enhance sensitivity to changes in participant circumstances, motivation, and mental health functioning.

Positive Psychology, Good Lives, and Identity

Conservatives deny the humanity of offenders whereas liberals deny the pathology of offenders. (Cullen, 2012, p. 102)

The concept of desistence, or the stopping of crime, has become a cornerstone of positive, forensic psychology (Maruna, 2001; Veysey, Martinez, & Christian, 2009). Instead of a binary model of recidivism (e.g., recidivate vs. does not recidivate), desistence is conceptualized as a change process that may require multiple incarcerations (Christian et al., 2009). Maruna (2001) reasons that transformation is the creation of new identities that are incongruent with long standing, pro-criminal value systems. Desistence, therefore, becomes an amorphous phenomenon that is both cognitive and rooted in prosocial opportunity (Giordano, Cernkovich, & Rudolph, 2002). While RNR interventions typically target maladaptive cognitive processes, criminogenic core beliefs, and risk-related behaviors, positive models place emphasis on individual strengths, client-identified hopes and goals, and self-transformation. It is assumed that increasing exposure to healthy environmental factors will stimulate prosocial identity formation. Veysey et al. (2009), for example, have discussed identity shifts optimized under "conditions in which change is most likely to occur" (p. 5). Overpopulated institutional atmospheres, which often have a high density of antisocial peers and institutionalized value structures, likely present barriers to change, rather than encourage or inspire it.

What constitutes optimal conditions during the reentry process differs based on the uniqueness of the individual and their situation. The Good Lives Model (GLM; Ward, 2002), in contrast to RNR, attempts to frame conversion through a positivistic, recovery/client-centered, strengths-based lens. According to Presser and Kurth (2009), in order to maximize reintegration, "we must begin with *their* preferred identity, not those we prefer for them" (p. 85; italics in original). Similarly, Barnoa & Ward (2015) have criticized a "reductionist, fragmented and mechanical approach to forensic rehabilitation whereby individuals are delivered a series of interventions that are 'matched' to specific problems, with little regard to the core issues underpinning them, or indeed the person themselves" (p. 83).

Even though the GLM adds depth to assessment and treatment, there remains hesitancy within the field to fully integrate positive approaches into mainstream correctional practice. One of the main arguments against adopting an excessively positive model is that the semantic intersections between deficit-based and strength-based approaches are not yet defined in ways that isolate meaning. What the GLM coins strength, for example, RNR interprets as a protective factor. In some circumstances, risk factors are understood by the GLM as the absence of strengths or protective factors (e.g., lack of self-control). In general, rousing prosocial values that lead to meaning and purpose is the primary focus of the GLM (Carich, Wilson, Carich, & Calder, 2010), just as much as buttressing protective factors to counteract risk in the RNR model. Rather than viewing the GLM as a mere reframing of the RNR model, Ward and colleagues (2012) argue that "the GLM is an *enhancement* to current existing practices, including the RNR, cognitive-behavioral intervention, MI approaches, and so on" (p. 107).

Another critique of the GLM is that it has not yet accumulated enough pragmatic evidence compared to extensively researched RNR approaches. According to Cullen (2012), many of the GLM studies to date include trivial effect sizes, small samples, and derisory conclusions. Whether such research is still meaningful remains contentious, but even "a relatively small reduction in offending behavior by a large number of offenders will represent a large number of crimes prevented, and fewer crimes means fewer tangible and intangible costs" (Ferguson & Wormith, 2013, p. 1092). Despite current statistical limitations, contemporary research appears to be pushing forward to validate the GLM ideals. It is anticipated that future investigation will augment the global discussion of forensic rehabilitation.

Carich and colleagues (2010) have maintained that self-transformation is an important aspect of the change process. Since self-structures are thought to be multiple and contextual (Cushman, 1995; Hermans, 2007; James, 1890), how to transform the self is a rather abstract concept. Forensic sociologists, Presser and Kurth (2009), suggest that identities are "running stories of the self" (p. 74), and for Hermans (2007), the self is a highly compartmentalized whole, with each self-division holding socially constructed truths and filtered worldviews. In her relational writings, Orbach (2014) encourages therapists to hold perspectives that "do not seek a truth, but many truths; truths that contradict one another, that change in time, and are always perspectival and partial" (p. 25). This is particularly relevant for those individuals with persistent criminal and mental health histories, whose 'dangerous' and 'mentally disordered' self-states have superseded more 'safe' and 'mentally healthy' ways of being.

In correctional settings, individuals are frequently defined by their deficits, not their strengths. Take for example the terms, 'offender' and 'inmate.' For Orbach (2014), these are only partial truths; labels that likely have very stigmatizing effects in the context of assessment

and rehabilitation. Correctional pursuits to classify individuals often overshadow existing or desired wellness, and overlook non-criminal self-states. Currently, the ORCS-PCA database does not assess, and SRC meetings rarely consider protective factors. It is unknown if the addition of protective factor assessment would benefit PSMI-N selection, but it seems intuitive that individuals with few protective factors and higher density of needs are riskier than those with multiple strengths and fewer needs, regardless of PSMI-N eligibility or risk classification.

Through a positive psychology lens, classification and static risk factors are less imperative to change behaviors than transformational opportunities and support. If small scale identity shifts, do in fact, lead to longer periods of desistence, there is utility in developing strength-based approaches for ORCSP use. The quality and quantity of prosocial identity narration by PSMIs has received little empirical attention, but may be central to long-term change potential. For example, when analyzing autobiographical statements, Christian and colleagues (2009) discovered that pre- and post-change identities often differ descriptively. It is hypothesized that the way an individual languages the self can provide insight into how to support conversion from an "offender" to an "advocate/employee in the field, person in recovery, survivor, well/healthy, and various citizen roles" (Christian et al., 2009, p. 20).

Contextualization

The RNR and GLM models represent a much-needed step toward understanding individual complexity within dynamic correctional and community settings. When contextualization is applied, assessments and interventions are conducted on a case-by-case basis, and except where bound by specific sanction or legal decree, should be customized to match unique conditions (Andrews & Bonta, 2010). As highlighted by Christian et al. (2009), "there is no single pathway through the role transformation process" (p. 27).

Providing individualized care is often complicated by limited and/or manualized treatment options. Marshall (2004), for example, writes that "child molesters are not a homogeneous group, so forcing them to address in detail all aspects of a uniform program would be unwise" (p. 98). Seto (2019) also makes a distinction between persistent and onset offending, claiming that experiencing sexual abuse as a child is associated with onset of sexual offense, but is not a reliable risk factor for sexual recidivism. These findings suggest that risk factors for first-time sexual offense may be significantly different than those for individuals who have previously offended. Such variance justifies increased compartmentalization of offense typology (i.e., first-time vs. recidivistic risk; sex offense with violence vs. without; domestic violence vs. murder). It is presupposed that the implementation of customized risk/needs assessments and individualized mitigation plans that consider these idiosyncratic issues, among others, will improve violence triage and change outcomes.

Gender considerations. Research suggests that higher frequencies of trauma, depression, and drug use are experienced by justice-involved females (Frisman, et al., 2010; Golder et al., 2005; Lovell et al., 2002), whereas males are more likely to be diagnosed with a psychotic disorder (NICE, 2014). Similarly, Garcia-Mansilla, Rosenfeld, and Nicholls (2009) reported elevated scores on previous violence, substance use problems, psychopathy, and negative attitudes for males; and for females it appeared that relationship instability, employment problems, major mental illness, and early maladjustment were more pertinent to the prediction of risk (see Figure 3). Given these differences, VanVoorhis and Salisbury (2014) believe needs assessments possess more predictive power for females than static risk factors. Other research has noted that SPJ tools that incorporate strengths-based assessment enhance gender responsivity for both sexes, with some evidence of superior predictive abilities for males (Viljoen et al.,

2016). Strub, Douglas, and Nicholls (2016) also highlight that many actuarial risk tools provide

"particularly erroneous" (p. 83) indicators of risk for females. Hamilton and van Wormer (2015)

discuss modifying assessment scores either manually or based on factor weighting to create more

gender-responsive measures. They suggest that the Women's Risk Needs Assessment (WRNA),

which considers trauma and parental stress for women, is one example of how to customize

assessment scales for female populations (Hamilton & van Wormer, 2015). Construction of

gender-specific, rather than gender-neutral, case formulations likely enhances identification of

females in need of intensive services.

Figure 3. Gender-Specific Risk Factors (Garcia-Mansilla et al., 2009)
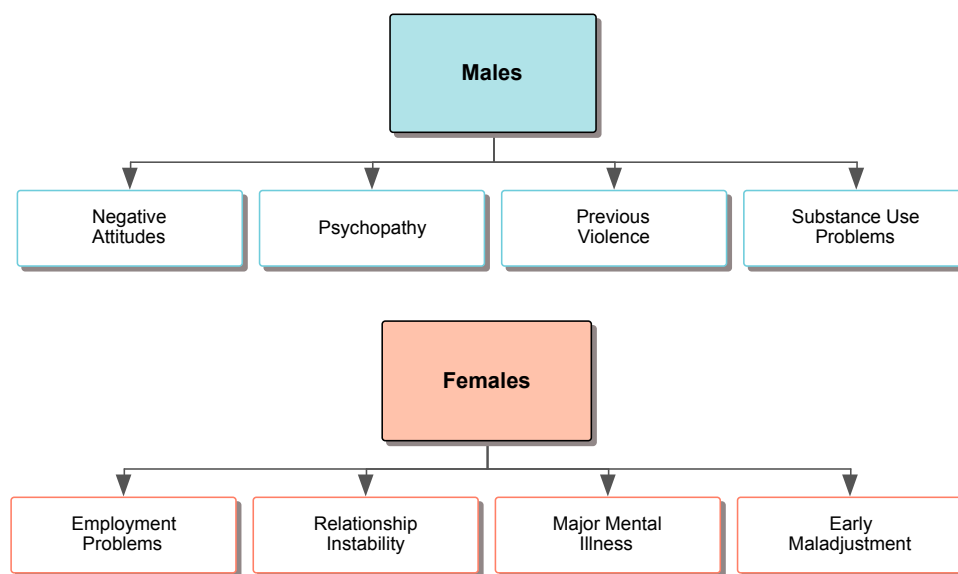
In addition to gender, PSMIs may also carry unique designations, such as *Level 3 Sex*

Offender, geriatric, and/or developmentally/intellectually disabled. All of these subdivisions

require distinct programming needs (NICE, 2014). As such, professionals should consider the

interaction of needs, strengths, protective factors, and risk factors when tailoring treatment and

harm-reduction strategies for special populations. For example, Miller et al. (2013) provide EBP

recommendations specific to domestic violence. Elsewhere, dynamic factors unique to sexual

offenses are outlined, such as internet usage (Kloess, Hamilton-Giachritsis, & Beech, 2019) and

co-offender status (Williams, Gillespie, Elliot, & Eldridge, 2019). Finally, with regard to

appropriateness for treatment, Lowenkamp, Latessa, and Hostlinger (2006) suggest that the RNR

model is best suited for high-risk classifications. It has been hypothesized that individuals with

lower-risk may not benefit from intensive services and are more likely to experience suboptimal

outcomes from overly-involved professional intervention. This has led to suggestions for low-

risk groups to receive punishment or diversion only, with resources and interventions allotted

only to individuals with higher-risk designations (Maguire & Raynor, 2010). It is unclear how

low-risk PSMIs would respond to ORCSP reentry services.

Specific Interventions

  Medication management. As part of discharge, reentry teams should attempt to verify

active insurance status, confirm that prescriptions can be refilled, and ensure all medication

orders are sent to receiving pharmacies. In certain circumstances, unique programs, like the

Clozaril Risk Evaluation and Mitigation Strategy (REMS) program, may exist that necessitate

enrollment before a pharmacy is legally permitted to dispense medications. Institutional

prescriptions should also be assessed for suitable community use, as there may be unique dosing

strategies while incarcerated (as in the case of *defensive medicine*; Reutter, 2016; see also

Citizens Commission on Human Rights, 2015) that increase risk if continued after release. Even

in cases where correctional prescriptions adequately alleviate symptoms, equilibrium gained

through medicine may be negated by even slight changes made by community providers. For this

reason, it is recommended that collaborative information sharing and communication occur

between ORCSP transitional staff and community providers as a means to augment treatment

consistency. For more in-depth information on specific forensic prescription strategies, please consult the 'National Formulary,' published by the Federal Bureaus of Prisons (2016).

The germaneness of continuity of care is endorsed by many national mental health organizations, including the APA, American Medical Association (AMA), American Public Health Association (APHA), and Joint Commission on Accreditation of Healthcare Organizations (JCAHO), among others (Kerr & Lockshin, 2010). Transitional teams should strive to work closely with outpatient providers to relay medication history, patient response to institutional regime, and longer-term medication goals. For individuals with low medication needs, continuity of care might simply consist of faxing relevant documentation to post-release prescribers. Others have recommended that correctional staff attend the first outpatient appointment; a practice sometimes referred to as a "warm hand-off" (Kerr & Lockshin, 2010, p. 20). Individuals with more elaborate polypharmacy and/or poor medication compliance histories may require ancillary monitoring, regular reminders and encouragement to take prescriptions, and detailed planning with intensive outpatient services throughout their pre-discharge period. Clients should be released with enough medication to last them until their first outpatient prescriber appointment (Kerr & Lockshin, 2010). Discharging into medication gaps is unwise and medication evaluations are advised prior to and shortly after discharge. The intensity of monitoring medication adherence should be decided on a case-by-case basis. Independence may be appropriate for clients who evidence responsibility and stability. In circumstances where minimally monitored participants become symptomatic or experience a disruption in their medication regime, reentry staff should adjust management strategies to match the situation.

The seriousness of some declined behaviors makes medication management services for PSMI-Ns a foundational treatment target for the ORCSP. Regrettably, medication practices while in correctional settings differ drastically from outpatient services in many ways. For one, while incarcerated, PSMIs do not typically self-manage medications. Accordingly, institutional dependence can limit an individual's capacity to learn important skills like organizing medications (i.e., filling medisets, bubble-packing, and/or developing methods/accommodations that improve adherence and decrease misuse), setting appointments, memorizing medication schedules, receiving blood draws, and/or making sure to reorder medications when running low. Transitional support can circumnavigate some these issues through psychoeducation, encouragement, modeling, and practice; teaching some PSMI-Ns to become more independent. For others, the goal of reentry will be the bridging of care, whereby transitional workers connect individuals with appropriate community-based psychiatric management resources, advocate for medication needs, and maintain adequate communication with prescribers, pharmacies, insurance companies, and other pertinent healthcare organizations. For PSMI-Ns who struggle with medication management skills, reentry staff should consider making accommodations, perhaps by offering injectable medications, intensifying contact, or referring participants to ACT programs that deliver and/or administer medications to clients.

        Psychological interventions. There is little evidence to suggest that treatments for

        PSMIs that focus on clinical variables reduce recidivism. (Bonta et al., 2014, p. 286)

        One of the more commonly implemented psychological interventions supported by Washington State Legislature (3ESSB 5034, 2014), Cognitive Behavioral Therapy (CBT), appears connected to positive outcomes for justice-involved adults (Golder et al., 2015) and individuals with sex offenses (Hanson et al. 2004). CBT is posited by Golder and colleagues

(2005) as "the most effective type of psychosocial intervention for reducing recidivism" (p. 109), with Landenberger and Lipsey (2005) suggesting that CBT decreases recidivism rates by about 25% to 50% when properly implemented. For those in restricted housing settings, "specific cognitive-behavioral interventions and other programming/idleness-reducing activities" (WADOC, 2016, p. 2) are an integral part of WADOC policy.

Part of CBT's success may lie in its effectiveness to address value systems and behavioral patterns. It is hypothesized that many individuals are exposed, at an early age, to role models that evidence antisocial acts and valuations. In turn, they learn, integrate, and/or act on antisocial cognitions. CBT attempts to help individuals become more aware of and less aligned with negative thoughts and behaviors, while simultaneously relearning more adaptive configurations of being.

CBT has a long history of support as a gold-standard approach in multiple contexts (David, Cristea, & Hofmann, 2018), including correctional settings (Andrews & Bonta, 2017; Aos et al., 2006; Landenberger & Lipsey 2005), crisis intervention teams (CIT; Washington State Office of Financial Management, 2016), incarcerated veteran services (Blonigen et al., 2018), and mental health and drug courts (SAMHSA, 2018). Manualized CBT approaches, like Thinking-4-a-Change (T4C; Bush, Glick, Taymans, & Guevara, 2011) and Moral Reconation Therapy (MRT; Little & Robinson, 1988) endeavor to reprogram criminogenic thinking and moral reasoning, respectively, and have been linked to reduced recidivism rates (Lipsey & Cullen, 2007). In addition to addressing core values and beliefs, many CBT approaches inspire self-control and prosocial problem-solving techniques through structured exercises, groups, and homework assignments (Blonigen et al., 2018).

Despite well-established empirical backing, research has provided marginal insight into how CBT interventions are best implemented for PSMI-Ns transitioning back into the greater community, with limited studies conducted on justice-involved PSMIs (Ferguson & Wormith, 2013). Barnoa and Ward (2015) suggest using a manualized CBT intervention program, called *Reasoning and Rehabilitation 2 for Mentally Disordered Offenders* (R&R2M; Young & Ross, 2007). The original R&R program (Ross, Fabiano, & Ross, 1986), revealed poor completion rates for PSMIs. In response, a modified model was created based on PSMI needs (i.e., fewer sessions and less focus on neurocognitive skill development; similar simplification has been suggested for MRT; Blonigen et al., 2018). Reported completion rates for R&R2M were 65% to 80% (Barnoa & Ward, 2015), with observed decreases in violent attitudes and increases in coping and problem-solving abilities. Another modified EBP, Computer-Based Training for Cognitive Behavioral Therapy (CBT4CBT), implements weekly, virtual CBT modules geared toward the needs of individuals with co-occurring substance use disorders (SAMHSA's NREPP, 2018). Because of its electronic format, the reach of SUD programming can be expanded without considerably increases in cost.

In their landmark meta-analysis, Leichsenring and Rabung (2008) claimed that psychotherapy approaches were superior to CBT for long-term treatment of complex mental and personality disorders. Authors operationalized 'long-term' as 50 or more sessions, but also recognized that for long-term psychoanalytic psychotherapy (LTPP), "there is no generally accepted duration'' (p. 1552). Even though Beck and Bahr (2009) critique Leichsenring and Rabung's (2008) methodological issues, such as indecorous meta-analytic inclusion criteria and overgeneralized conclusions, it is likely that when properly implemented, LTPP can be quite

effective for some individuals. Why or how disorder-specific symptoms respond to certain treatments or combinations of treatments, however, it is not fully understood.

In 2011, Roseborough offered the perspective that instead of comparing Leichsenring and Rabung's (2008) optimistic findings for LTPP to CBT, interventions are perhaps better conceptualized as "disorder-specific treatment" (p. 359), rather than modality dependent. For instance, it would be improper to implement LTPP, CBT, or any intervention for Antisocial Personality Disorder (ASPD) in the same way that you would for individuals with depression. Each disorder and associated symptoms exist within a set of unique etiologies and individual treatment responsivities. Therefore, treatment may necessitate floating between psychoanalytical, CBT, solution-focused, and other suitable approaches during a session, as long as interventions address presenting risk management issues, are sensitive to PSMI needs, and adjust to the session content. Similar disorder-specific contextualization is already widely accepted for Borderline Personality Disorder, which predominantly implements Dialectical Behavioral Therapy (DBT; Linehan, 1993); and for PTSD, which often includes integrated, trauma-informed approaches like Seeking Safety (Najavits, 2009), Trauma-Focused CBT (TF-CBT), and Eye Movement Desensitization and Reprocessing (EMDR; Watts et al., 2013). In this sense, Washington State's legislative adoption of CBT as its flagship EBP, misses the opportunity to cross-frame therapeutic interventions.

For a more detailed overview of specialized interventions for PSMIs, please consult Heilbrun et al. (2016). Of relevance to the current discussion, these authors recommend the use of a Modified Therapeutic Communities (MTC) and Forensic Assertive Community Treatment services (FACT; detailed below). Similar to R&R2M, MTC programs are simplified and composed of fewer program requirements. Although altered to meet the complex needs of PSMIs

with co-occurring substance use issues, MTCs preserve peer support and self-help structures from traditional Therapeutic Community (TC) approaches. MTCs also incorporate interventions aimed at medication management, a component that should be considered for all PSMI-Ns that have psychotropic prescription needs.

One issue does arise here regarding the efficacy of MTCs for PSMIs with psychopathic tendencies. As discussed in Harris et al. (2015), research found that individuals who had high levels of psychopathy were more likely to recidivate when receiving treatment vs. no treatment; whereas the non-psychopathic group had an inverse relationship. It was hypothesized that psychopaths assimilate additional interpersonal skills, learned in MTCs, that may help them more successfully manipulate others and/or situations. Although it would be unwise to conclude that no treatment is best in these situations, research urges professionals to carefully weigh therapeutic progress. Additional development and evaluation of MTC models may benefit programming and treatment outcomes for individuals with elevated psychopathy.

Swift and Certain. The use of Swift and Certain (SAC) has been touted as an EBP that maximizes community corrections' violations through punishment consistency and appropriately matched severity (Drake, 2012; Hamilton et al., 2015); however, it is also believed that incarceration alternatives, such as probation or conditional release, expand the criminalization of many non-dangerous behaviors, such as missing appointments or substance use, through restrictive consequences (Wagner & Rabuy, 2017). SAC quickly moves some individuals between community and institution, without addressing core treatment issues and ecological factors, like "anger management, domestic violence counseling, employment assistance, dealing with trauma, and parenting classes" (Hamilton et al., 2105, p. 33), which may have a better chance of impacting long-term stability. Furthermore, many CCOs have voiced the opinion that

SAC is not appropriate for clients with mental health disorders, because their individualized needs necessitate increased contextualization (Hamilton, et al., 2015). There is no doubt that in some cases incarceration is the best option to impede risky behavior before escalation to re-offense. In others though, PSMIs may be punished for minor infractions or sanctioned to programs that have little or iatrogenic impact.

It has been reported that 86% of individuals with sexual offense histories recidivate for non-sex crimes, and of those, 51% are rearrested for the criminal sanction of Failure to Register as a Sex Offender (RCW 9A.44.132, 2015; WADOC SOTP Fact Sheet, 2015). Although non-registration has some empirical associations to increased risk of sexual recidivism and violence in Washington State (Barnoski, 2006), many of those violated also experience bias, poverty, and other social factors, such as not being able to secure stable housing, transportation, or employment. In these instances, punitive policy results in the incarceration of individuals who are, more likely than not, in need of practical, social intervention and support, rather than a return to institutional setting.

Researchers have described WADOC's incorporation of SAC as a "naturalized experiment" (Hamilton et al., 2015, pp. 16 & 52), explaining that the SAC model was applied department wide in 2012 before final testing of the model had been completed in 2015. This choice appears partially informed by optimistic findings from a pilot study of the HOPE program in Hawaii, which showed some efficacy for SAC when implemented on individuals with substance use issues. Even though the 2015 study did provide additional support for the SAC model, it raises concern about the ordering of programming, where implementation precedes thorough investigation and outcomes confirm non-comparative practice. The creation of the original DMIO Program, and more recently, the implementation of the WAONE assessment

system are other examples of this in-vivo experimentation. It is this researcher's opinion that research should take place through multiple, abbreviated trials, and incorporate a variety of comparative samples, before significant resources are allocated to widespread development and implementation of a specific tool. The feasibility of conducting longer pre-implementation investigation by internal, affiliated, and nonpartisan research groups should be explored as well. It is hypothesized that ongoing 'naturalized experimentation' will be costlier, less effective (unless by chance), and increases the need for frequent recalibration.

Assertive Community Treatment. The ORCSP frequently contracts with Assertive Community Treatment (ACT) programs throughout Washington State. In principle, ACT strives to provide fluid and customized outpatient care without the limitations of clinic-only amenities. ACT teams utilize a multidisciplinary approach and usually have smaller caseloads compared to traditional outpatient clinics. The ACT model integrates case and care management, medication support, psychosocial and legal system navigation, compassionate professional contact, and community monitoring. According to Wolff (2005), individuals at the highest level of need should receive six months of pre-planning, eighty-five hours of case management, and ongoing ACT services after discharge.

Researchers have noted increased medication adherence and treatment engagement, reduced hospital admissions, greater consumer satisfaction, and improved residential constancy for individuals with schizophrenia and bipolar disorders enrolled in ACT programs (Schöttle et al., 2014). Additional findings support pairing Housing First models with ACT as a tactic to decrease environmental impediments to prescription access, boost overall medication adherence, and provide consistency of psychiatric services (Manuel, Covell, Jackson, & Essock, 2011).

Poor medication compliance rates have been reported for homeless individuals (Rezansoff et al., 2017). This may be partially explained by the qualities and environmental support needed to successfully manage medications over time: having a place to store and organize medications, ability to track appointments and medication administration times, access to drinking water, ability to decipher prescription instructions and medication names (including generic), knowing how to advocate for medication changes, communicating with prescribers via phone or face-to-face contact, making appointments with aid of reliable transportation, and paying for medications. With regard to the last of these barriers, medical insurance and other benefits are directly affected by homelessness. For example, having a mailing address may be the difference between receiving a Medicaid review letter vs. being unaware that one's access to services are being terminated. To address these complex and multifaceted issues, ACT teams employ members who are highly trained housing specialists, treatment providers, case managers, social workers, and clinicians skilled in behavioral modification techniques and motivational interviewing. In Forensic ACT (FACT) teams, inclusion of correctional, legal, and law enforcement professionals is essential.

In every ACT intervention, the balance between intrusion and autonomy should be a negotiated process between the treatment team and the client. It is suggested that intensive services be administered during the initial stages of reentry, with incremental decay of service after the participant has evidenced successful time 'at risk' within the program. Higher levels of service are reserved for acute crisis and more serious community correctional violations. For those who are sanctioned or recidivate, the ACT team may act as a liaison between legal and correctional systems, while simultaneously advocating for proper mental health treatment and salvaging intact supportive resources. In such cases, a representative of the ACT team should

attempt to coordinate transfer of care, either temporarily or permanently, with the receiving facility (i.e., hospital, jail, or E&T), including communicating whether the client will be welcomed back into the ACT program after discharge.

Critical Time Intervention. Critical Time Intervention (CTI) is an EBP recommended for individuals with recurrent homelessness histories and severe mental health symptomatology (SAMHSA's NREPP, 2018), women in domestic violence situations (Lako, de Vet, Beijersbergen, Herman, van Hemert, & Wolf, 2013), PSMIs (Morandi, Silva, Golay, & Bosnak, 2017), and individuals transitioning from prison (Draine & Herman, 2010). Even though CTI has not yet been tested on an ORCSP sample, the CTI theoretical model and incorporation of strength-based assessment offers a strategy to gradate services based on need. Additionally, the CTI model places emphasis on building autonomy and tracks program progress throughout enrollment, which are both goals of ORCSP service.

The CTI implementation stages (Draine and Herman, 2010, p. 8), *Transition, Try-Out,* and *Transfer of Care* are intended to last for approximately 9 months, with the ultimate goal of transferring clients to other systems of care by program completion. Because ORCSP enrollment periods are typically longer in duration (up to 60 months within an 8-year period), it is unclear if CTI is an appropriately fit tool for PSMI-Ns. Stakeholders are encouraged to explore the pros and cons of interpreting ORCSP risk mitigation through a CTI lens. It is hypothesized that conducting such investigation may expose variance between contracted providers' service utilization trends and reentry philosophies; thus, creating opportunity to standardize nomenclature and practice.

Resource development. Housing is a primary concern for most individuals returning to the greater community from an institutional setting and for professionals tasked with risk management. Research supports the complex and multidirectional relationship between homelessness, mental illness, substance abuse, victimization, and criminal justice involvement (Fazel, Khosla, Doll, & Geddes, 2008; Fox, Mulvey, Katz, & Shafer, 2016). In addition to adhering to societal norms and easing access to basic needs (Taxman, Young, & Bryne, 2002), housing affects many indirect, positive mental health outcomes. In Canada, for example, Rezansoff and colleagues (2017) found that Housing First interventions influenced greater medication adherence rates for clients with schizophrenia. More locally, research from Washington State (Miller & Ngugi, 2009) provides some evidence that housing individuals with mental illness leads to decreases in recidivism, hospitalization, and periods of homelessness.

The ORCSP deserves special recognition for their ongoing efforts to expand housing resources for PSMI-Ns throughout Washington State. This has been accomplished through partnerships with a multitude of mental health, criminal justice, and community housing partners; as well as advocacy work aimed at decreasing stigma. During the first annual ORCSP provider meeting, those in attendance repeatedly expressed a concern that despite their best efforts, viable housing was often scarce and overpriced. Evolving housing crises plague the State and constrain ideal service implementation (Dlugacz, 2010). In the face of these challenges, the ORCSP continues to cultivate sustainable residential solutions for program participants.

In addition to housing, PSMI-Ns may be eligible for entitlements through the Social Security Administration (SSA), DSHS, and/or a variety of other sources. Reentry workers will want to familiarize themselves with application processes within their jurisdiction. In many cases, establishing or reactivating benefits prior to discharge will provide the best outcomes. One

strategy proposed by McCormick and Perret (2010) is for professionals to become certified to complete Supplemental Security Income/Social Security Disability (SSI/SSDI) Outreach Access and Recovery (SOAR) applications for SSI and SSDI entitlements. In this process, the reentry specialist, not only helps prepare and submit completed paperwork, but gathers and summarizes relevant clinical documentation to corroborate reason for eligibility. SOAR applications have a "71 percent approval rate within an average of eighty-nine days on initial claims, much improved from the usual 10-15 percent approval rate for applicants who are homeless over a period that can last up to one to two years in appeal" (McCormick & Perret, 2010, p. 9).

There are many other areas of practical support that can have positive impact on an individual's stability, treatment engagement, and life trajectory. For example, helping a client acquire a phone can increase therapeutic contact and provide additional means of tracking. Purchasing clothing or relaying information about clothing banks, can build self-esteem and strengthen healthy identity concepts. Encouraging the client to pursue vocational interests can lessen economic hardships, while simultaneously fostering a sense of purpose and meaning. Repairing a vehicle or purchasing a bus pass can inspire client independence and increase access to appointments or other prosocial activities. Advocating with debtors, like utility companies, Department of Child Support (Alternative Solutions Program is such a program in Washington State), or credit card companies, may stop negative financial actions and/or decrease monthly expenditures. Helping a client enroll in educational programs or institutes of higher learning can influence profound changes in cognition by providing structure and prosocial modeling that may lead to an adoption of a student identity. Evans (2011), in particular, has provided compelling evidence to support the expansion of educational programs within WADOC facilities (Table 6).

Table 6. WADOC One-Year Employment and Recidivism Outcomes

		% One-Year Post-Release	
		Employment	Recidivism
Educational Program	**Completed (n=102)**	25.50%	19.60%
	Did Not Participate (n=40)	15.70%	36.00%

Informal discussion with ORCSP staff, community providers that worked directly with ORCSP clients, and ORCSP clients, revealed several other, non-traditional, outside-of-the-box intervention strategies. For example, one ORCSP committee member discussed purchasing a guitar for a client, which facilitated engagement in a prosocial art form and occupied a great deal of the participant's time. Another staff relayed purchasing mechanical tools, so that an individual could work. One ORCSP client said that he was given aid to fix his computer that he used for gaming, which helped him deal with stress more effectively.

Although expanding resources is an important aspect of reentry work, there are situations where an overreliance on staff support could lead to negative outcomes. Take for instance, someone who has relied on ORCSP service providers to pay rent and act as housing advocates during their entire enrollment period. Without mindful discharge planning or providing opportunities to practice independent living skills, once discharged from the ORCSP, the client may be unable to successfully navigate their world without supportive services. It is recommended that an independent living assessment be created and conducted throughout ORCSP enrollment periods, with additional emphasis on skill verification during the final year of program services. In cases, where it is suspected that an individual will be unable to manage their obligations, ORCSP staff should attempt to establish an appropriate mitigation plan that involves assistance from family, friends, payees, guardians, other agencies, professionals, and/or supports in their care network.

Opportunities to Enhance Practice

As with any process or system, there are areas of strength and opportunities to enhance practice. For the ORCSP, cross-systems communication and thoughtful reentry planning have led to significant advancements in PSMI-N treatment and management options in Washington State. It is worth noting that the ORCSP budget has remained relatively fixed over the last 20 years. Taking inflation into account and the ever-rising cost of living throughout the Pacific Northwest, USA, one can extrapolate that current participants are receiving less provision than those served in the early 2000s (see Appendix B.10). How to balance the pecuniary needs of program, community, and participant should be a topic for further discussion between WADOC and legislature. It is recommended that funding be increased for the ORCSP, so they can not only pay for rent, but develop affordable, low-barrier housing programs specifically designed for PSMI-Ns. Such a strategy may lead to further enhancements and diversity of risk mitigation services available for both ORCSP and Non-ORCSP participants.

The ORCSP seems to generally follow the RNR model and, in many circumstances, excels when it comes to implementation of need and responsivity principles. Without adequate tracking of services, however, utility and cost effectiveness cannot be calculated. Provider autonomy to develop jurisdiction-specific management plans has both pros (cross-system communication; individualized plans) and cons (variable service implementation; poor tracking protocol). The risk principle, in particular, is confounded by homogeneity in WADOC's high-risk classification system, unknown efficacy of WAONE and ORCS-PCA, and reliance on UCJ during ORCSP screening procedures. Without validation and fine-tuning of current assessment processes, objective cutoff scores cannot be properly established. According to Bechtel and Pierce (2011), risk thresholds should "guide practitioner decision-making" (p. 3).

CHAPTER V

CONSULTATIVE INTERVIEWS

We must help them while they are in and embrace them while they are out. They can't do

it on their own. (Consultant 1)

Unique Perspectives

The Criminal Justice/Mental Health Consensus (CJMHC; Council of State Governments,

2002) represents one of the most expansive bipartisan criminal justice efforts completed to date

and is comprised of 46 policy statements spanning the continuum of forensic mental health.

After its publication in 2002, it became an exemplar for working with justice-involved PSMIs.

Contributors to the CJMHC included delegates from law enforcement, legal entities, legislature,

correctional staff (jails, prisons, and community based), mental health organizations and

advocates. 108 program examples in total were summarized in the CJMHC. This information

was amassed from multiple agencies from 32 states (98 examples), 7 national organizations, 2

from the Canadian parole board, and 1 informational entry outlining the Assertive Community

Treatment (ACT) model. Of the 4 Washington State programs discussed in the report, the

ORCSP (DMIO Program in 2002) was the only mental health reentry program cited for the state.

Although the CJMHC provides a snapshot of criminal justice, legal, and community-

based programs aimed at cultivating rigorous services for PSMIs, it is by no means a

comprehensive list of national agencies that employ violence triage techniques. Even in the

instance that a registry for violence triage programs were accessible, it is unlikely that many

other programs have risk management procedures, staffing, operational definitions, treatment

options, outcome measures, and/or funding streams analogous with the ORCSP. Discerning

which organizational processes are or are not working better than others at a macro-level is confounded by these functional and systemic differences.

For a more granular distinction, let us consider that some programs exclude PTSD and other mental health disorders from qualifying diagnostic lists. If these programs then implement practices that appear efficacious, it may be tempting to generalize findings to other jurisdictions that do enroll individuals with PTSD without specifying the conditions in which supporting research was conducted. Outcome studies must be mindful to distinguish uniqueness of population, setting, and research design to encourage better contextualization of care and risk management. In the example above, individuals with PTSD may respond quite differently to treatment that was tested on individuals with other SMIs. For this reason, among others, it is this researcher's opinion that the development of EBPs must begin with a grounded theoretical framework and shared nomenclature. As Silverman and De Leo (2016) have discussed in the context of suicide risk, parsimony between professionals and research groups "make particularly desirable the aggregation of data" (p. 83). The unavailability of shared processes used to identify, manage, and track outcomes for PSMI-Ns continues to hinder multisite, empirical study.

Even though the RNR and GLM models overshadow contemporary correctional philosophy, how risk management unfolds in real life, deserves further attention. The field may benefit from more collaborative research, similar to the CJMHC, as a step toward the standardization of criteria for *Dangerousness*, *Mental Disorder*, recidivism, budgetary tracking, among other areas of relevance. The ORCSP is in a unique position to contribute to this effort, as they already have perspectives on many of these issues, including evolving operational definitions and procedural instructions. Most pertinent to future research, they have done an excellent job retaining electronic data, pre-screening forms, and decisions made by the SRC.

Consultation Methods

Consultative Sample

By means of CJMHC program summaries, risk and mental health assessment practices within forensic settings were examined for relevance to PSMI-N screening procedures. It is expected that many violence triage programs and tactics were not captured by CJMHC investigators, which this researcher recognizes as a significant limitation. However, since exploration of national standards was a subsidiary stakeholder need, the choice to use previously organized data seemed more prudent than initiating an independent, comprehensive search for national triage services. Moreover, each CJMHC program summary provided contact information, which presented a practical way of communicating with the selected sample. In addition to convenience, it was assumed that those organizations included in the consensus were of exceptional quality, given the multidisciplinary review and professional oversight that guided the project. Finally, the fact that the ORCSP (DMIO in 2002) was one of the listed CJMHC programs suggested applicability to the current investigation.

Appendix B of the CJMHC (2002) contains an annotated list of the 108 programs included in the study. When delineating a consultative sample, the researcher first reviewed all 108 program descriptions (Appendix C.1) to determine if any overlapped with ORCSP agenda. Program examples were then coded and grouped based on service descriptions and whether or not a screening procedure was referenced. Specifically, this researcher attempted to identify summaries that contained statements regarding assessment methods for participant selection and/or the rendering of reentry services. Of the 108 CJMHC programs, 28 were deemed to meet selection criteria. Although technically meeting sample selection criteria, the ORCSP was not included, since it is already covered in great detail throughout this document. Texas's Program

for Aggressive Mentally Ill Offenders (PAMIO), despite not being listed in the CJMHC, was discovered during data collection and added to the contact list based on the likely relevance to the dissertation topic. Please see Appendix C.2 and C.3 for a more detailed explanation of sampling methods and Appendix C.1 for a complete list of coding decisions. Appendix C.4 provides a list of programs that met sample selection criteria (n=29).

Potential benefits of including a consultative sample. During meetings with the ORCSP in 2017, stakeholders voiced curiosity about national program standards, with particular interest in learning how PSMIs are assessed by other violence triage programs. By polling an assortment of qualified specialists, this researcher hoped to capture an array of viewpoints, which could then be analyzed to apprise PSMI-N risk management in Washington State. In addition to offering the ORCSP conferment with outer-agencies, these consultations were an opportunity to compare and contrast program functions, across settings. Without an investigation into how other programs operate, efficacious and innovative ideas may remain insular within a particular system; or worse, ineffective strategies may thrive unnecessarily.

The benefits of including an anonymous, consultative sample far outweighed the potential risks to participants. This assumption was fueled by the idea that misapplication of violence risk and/or mental health assessment can lead to infringement of individual liberties, mismanagement of taxpayer funds, and risk to the public. It was also believed that practices implemented within county, state, and federal facilities should be transparent and subject to recurring internal and external review to ensure quality assurance. Because forensic populations are vulnerable to exploitation and prejudice without proper oversight, deliberate withholding of information to legitimate research projects raises ethical concern. Whether, and in what circumstances, a professional is able to or qualified to share information with external

investigators was not assessed by this project. It is likely that some consultants were limited by organizational policy, such as IRB approval or non-disclosure rules. Even though all 29 CJMHC's were contacted, only five professionals participated in consultative interviews.

Data Collection

It was presumed that many of the CJMHC programs worked extensively with PSMIs and employed violence triage experts who possessed a base knowledge of risk and mental health assessment practices. It was precisely this specialized proficiency that the ORCSP was interested in gleaning. Because this dissertation centers on screening practices for PSMIs, prompts were designed to illicit information about processes, rather than criminal theory or moral value. Appendix C.5 outlines the intended flow of unstructured interviews.

<div align="center">

Results

</div>

The remainder of this chapter summarizes consultative participant responses to phone-interview prompts (see Appendix C.6). Results are organized by the aforementioned semi-structured interview guideline (Appendix C.5). It is recognized that there may have been alternative ways to present findings, but for the sake of simplicity and continuity, interview content was analyzed between consultants, rather than in combination or sequence.

Vocational Role

Of the five consultants interviewed for this study, all were in middle to upper management roles within their organizations. Three were reentry program managers (DOC=2; community organization=1), one was a manager in operations for a State Department of Mental Health (SDMH), and the remaining consultant supervised clinicians in a larger county jail. All endorsed overseeing other professionals in a managerial or supervisory capacity, with only Consultant 5 (supervisor at county jail) reporting direct administration of risk assessments.

Populations Served

All consultants claimed to work with PSMIs in general (including PSMI-Ns), in contrast to the ORCSP's PSMI-N specificity (PSMI-N only). For consultative programs, estimation of dangerousness may be considered during screening, but is not obligatory for enrollment. Dissimilarity in populations served, highlights the uniqueness of the ORCSP. There may be few programs in the United States of its kind.

Mental Health Assessment, Eligibility Criteria, and Referral

Mental illness has been broadly expressed as "the conjunction of a DSM mental disorder and serious role impairment" (SAMHSA, 1999, p. 33891). For the ORCSP and other triage programs, however, mental health symptoms must be narrowly defined in order to focus limited resources. As such, mental health assessment in a forensic context should not only evaluate for diagnostic criteria, but determine how mental health symptoms relate to risky criminal behaviors. This position was echoed by two consultants, who discussed UCJ screening processes that considered the contextual relationship between symptoms and risk on a case-by-case basis. In contrast, the remaining consultants (n=3) endorsed fairly stringent diagnostic lists for SMI and claimed that standard operating procedures were in place to guide enrollment decisions. Consultant 4, for example, who worked in a community-based setting, claimed that mental health eligibility determinations were made by SDMH staff prior to referral.

Whether UCJ deliberations outperform diagnostic lists in identifying PSMIs is unclear; however, it does seem that these are distinct approaches to mental health eligibility. On the one hand, discretionary enrollment may be able to "pick and choose who they think should get services" (Consultant 2) and enroll high-risk designees with low to moderate mental health symptoms. Inversely, they may also cast a diagnostic net that is too expansive, requiring

significant time and resources to conduct thorough assessment of all potential candidates.

Diagnostic eligibility decisions, on the other hand, are easy to use administratively and may

influence less subjective and/or biased clinical decisions, but may also fail to detect risk for

PSMIs with non-eligible diagnoses.

Consultants who reported use of UCJ referenced consideration of diagnostic history,

symptoms, medication usage, functional limitation, risk, and clarified that they did not require

dangerousness as a mandatory requirement for service eligibility. In some cases, participants can

volunteer to receive services, and in others, professionals identify and refer. Interestingly, no

consultant reported using a computer program comparable to ORCS-PCA to select participants.

Similarly, although it is likely that teams of criminal justice and mental health professionals are

involved in enrollment decisions, no consultant discussed a formal, statewide, multidisciplinary

committee. It is likely that incorporating computer programs and diverse professional

perspectives adds richness to mental health evaluations and release planning; however, when it

comes to SMI assessment, we do not know how the ORCS-PCA and SRC perform compared to

evaluations conducted by trained mental health clinicians who have direct contact with patients.

Moreover, it is not clear how the ORCSP limits qualifying diagnoses to those whose

symptoms are severe and persistent. Up until last year, they relied upon the ORCS-PCA, a

diagnostic list (see Table 7), and SRC vote to make *Mental Disorder* determinations. In 2019,

diagnostic criteria were removed and more emphasis is now placed on ORCS-PCA mental health

markers (i.e., medication history, Residential Treatment Unit placement, service utilization) and

documentation of SMI. How to account for risk influenced by mental illness is not outlined in

current ORCSP procedural guidelines.

Table 7. Comparison of SMI Diagnostic Eligibility Criteria

Federal Recommendations (US Department of Justice, 2014)		

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Major Depressive Disorder
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma and Stressor-Related Disorders
- Intellectual Disabilities and Autism Spectrum Disorders
- Major Neurocognitive Disorders
- Personality Disorders

CJMHC Program (2018)	'DMIO Algorithm'	ORCSP-draft (2017)

Schizophrenia
Schizophreniform
Other Psychotic Disorder
Delusional Disorder
Psychotic Disorder NOS
Bipolar I Disorder
Major Depressive Disorder
Schizotypal and Borderline
    Personality Disorder
	Schizophrenia
	Schizophreniform
	Schizoaffective
	Brief Psychotic Disorder
	Psychosis NOS
	Bipolar I Disorder
	Major Depressive Disorder
	Mood Disorder, NOS
	Organic Brain Syndromes
	Dementia
	Borderline Personality
	    Disorder
	
	SRC checklist also considered:
	
	Developmental Disabilities (DDA)
	OCD
	Delusional Disorder
	Paranoia Disorder
	Anxiety Disorders
	Borderline Personality Disorder
	Paranoid Personality Disorder
	Schizoid Personality Disorder
		Schizophrenia Spectrum
		   and Other Psychotic
		   Disorders
		Schizotypal Disorder
		Delusional Disorder
		Schizophreniform Disorder
		Schizophrenia
		Schizoaffective Disorder
		Other Specified/Unspecified
		    Schizophrenia Spectrum
		    Disorder
		Bipolar I Disorder
		Major Depressive Disorder
		Dissociative Identity
		    Disorder
		Posttraumatic Stress
		    Disorder
		Intellectual Disabilities (DDA)
		
		May be considered in conjunction with full diagnostic profile:
		
		Neurocognitive Disorders
		Intellectual Disabilities
		Autism Spectrum Disorder
		Substance Use Disorders
		Antisocial Personality Disorder
		Other Personality Disorder

ORCSP (2019)		

Prescreening Computer Algorithm (ORCS-PCA)
UCJ = Administrator Clinical Discretion + Committee Vote
No longer specifies diagnostic criteria

Risk Assessment

All consultants reported the use of risk assessments to some degree, but only provided information about which assessments where known by them, rather than detailing comprehensive implementation strategies. It is quite possible that supplementary assessments and/or techniques are used within these consultative systems. To what degree and how each program, or individual assessor for that matter, uses risk assessments in classification and management processes remains unclarified. Consultative responses suggest variable organizational practices within and between systems.

Risk assessments identified by consultants included: LSI-R, HCR-20, Fire Setting Evaluation, Sex Offender Battery (not specified), Columbia, CAMS, Suicide Prevention Screening Guidelines Tool (SPSG), and Basis-32. Given the limited number of assessments identified here and trivial consultative sample size, it is expected that throughout the county, many other assessments are conducted. Even within the current sample, consultants stated general knowledge of assessments used by external referral sources, such as state mental health administrations or DOC. How risk assessments assimilate into systems and become standard practice is unknown, but may be a byproduct of attempted process improvement, mandated policy, and/or evolution through arbitrary or purposeful organizational/program choices. It is hypothesized that understanding the origins, history, intentions, and complexity of assessment tools within a given system can help situate and ascribe meaning to any explicit process.

With regard to the timing of assessments, consultants frequently referenced processes contingent on proximity to release date. Although screening and risk tools administered at intake certainly steer classification and programming, reentry programs may only begin to assess cases for program eligibility when institutional discharge is imminent. A range of 90- to 180-days prior

to release, was disclosed by consultants, suggesting that many reentry programs do not follow participants throughout their prison terms. The ORCSP is no exception, with ORCS-PCA priority given to individuals who are approaching their ERD. According to ORCSP staff, it is most helpful when potential candidates become known to the program around 18-months prior to release. Such awareness allows administrators to better manage overall enrollment decisions and offer earlier pre-release planning. Despite this goal, it was also relayed that there are instances where participants are enrolled with less than 30-days left on their sentence, affording a limited timeframe to assess needs, (re)establish collateral support, and cultivate robust reentry plans. Given that reintegration programs are designed to aid individuals as they leave institutional setting, it makes some sense to wait until nearing release. However, beginning reentry assessment and engagement during or shortly after a system's main intake process may permits longitudinal tracking of risk. Although resource intensive, such a strategy could influence more sophisticated discharge planning, with highly customized post-release services. Researchers may wish to explore different models to develop optimal pre-release assessment scheduling.

Although consultants claimed that structured risk assessments were often considered, they were not endorsed as compulsory enrollment tools. This is perhaps due to the fact that consulting programs do not work with PSMI-Ns exclusively. Since the ORCSP must rule-in Dangerousness (WAONE classification) for program eligibility, in addition to mental illness, its functions are somewhat unique compared to consultative programs.

Protective Factors

In line with the opinion, "protective factors are not routinely assessed in forensic mental health" (Haines et al., 2018, p. 3966), no formal processes for evaluating protective factors were identified by consultants. This is not to say they were not evaluated by these or other programs,

but suggests that many systems have not yet assimilated strength-based protocol and remain "risk-askew" (Haines et al. 2018, p. 3966). Of the two respondents who did endorse attention to protective factors, one claimed (Consultant 5), "we ask," but did not explicate a specific tool or structured method. The second consultant (Consultant 1) discussed looking for protective factors on DOC documents, such as psychosocial assessments, but again did not identify how protective factors were defined, gathered, or interpreted by reentry staff in any systematic way. Although speculative, it is conceivable that many criminal justice systems are concerned foremost with static deficit-based variables (de Vries Robbé, 2014), and often give more weight to propensity or likelihood that risky behaviors will reoccur, than to change potential, as is proposed in the Good Lives Model.

In defense of the ORCSP and consulting programs, reentry clients may be exposed to some positive interventions while in prison, and may be bridged to services that engage and prompt client-centered goals after release. In this way, clinical attention to strengths is made, or at least attempted, prior to and after incarceration periods. Protective factors, however, may be minimized during participant selection. Take for example the ORCSP selection process: presence of Mental Disorder and Dangerousness. Although these are meaningful determinations, what an individual hopes to do with their life after prison and/or whether their plans are feasible may be equally important to public safety.

How then can protective factor assessments compliment risk and needs assessments? According to de Vries Robbé and de Vogel (2013), there are limited alternatives. One option, the *Inventory of Offender Risk, Needs, and Strengths* (IORNS; Miller, 2006b) a self-report measure, can be used in conjunction with other non-self-report methods, but should not be used alone, since the veracity of self-report does not always provide objective, consistent, or in many cases,

valid results. The *Short-Term Assessment of Risk and Treatability* (START; Webster, Martin, Brink, Nicholls, & Desmarais, 2009), a more robust tool that can be used alone, asks professionals to balance 20 dynamic strengths and vulnerabilities to assess short-term risk (defined as up to eight weeks). For individuals with more significant SMI, the *Structured Assessment of Protective Factors for violence risk* (SAPROF; de Vogel, de Rulter, Bouman, & de Vries Robbé, 2012) "was developed to assess 17 protective factors for medium-term (defined as up to one year) violence risk in adult (forensic) psychiatric patients" (de Vries Robbé & de Vogel, 2013, p. 297). When administered in tandem with other risk assessments, like the HCR-20 or VRAG-R, the assessor is able to adjust risk level based on compensatory SAPROF protective factors. When considering the population served by the ORCSP, of the three approaches described by de Vries Robbé and de Vogel (2013), the SAPROF appears to be most appropriate for use with PSMI-Ns.

Despite these suggestions, the utility of including protective factors in PSMI-N risk assessment is not fully understood. If we generalize from other research, protective factor assessments have evidenced some validity in predicting rule violations in halfway houses (Miller, 2006a), aggression among psychiatric patients (Braithwaite, Charrette, Crocker, & Reyes, 2010; Viljoen et al., 2016), and are believed "vital for an accurate appraisal of the risk of relapse into violence" (de Vries Robbé & de Vogel, 2013, p. 293). Thornton, Kelley, and Nelligan (2017) have harshly criticized the exclusion of strength-based assessment, claiming the following about deficit-based techniques:

> Commonly used risk assessment methodologies focus on internal risk rather than on how risk might be exacerbated or mitigated by factors in the environment. This leads to a unidimensional understanding of the client's risk and a tendency to see such clients as

chronic and unchangeable due to their major mental illness. Rather, well-targeted

interventions that build internal protective factors and openness to professional-provided

protective factors allow the later to be provided on a voluntary basis. ***This depends on the***

establishment of effective community resources that match the needs of clients and

which are delivered in a way designed to sustain motivation for treatment, prosocial,

and risk management behaviors. (Thornton et al., 2017, p. 35, emphasis added)

Gender Differences

According to Moga (2018), culture plays a significant role in developing one's

perspectives and value systems, with some researchers purporting that gender is non-binary

(Hoskin, 2017) and best portrayed by a spectrum with more than 50 unique and fluid gender

positions (Scholnick & Miller, 2018). If we are to accept that identities are socially constructed

and dynamic, how then can gender-specific considerations be studied and implemented without

clear gender lines? Furthermore, how should professionals juxtapose the perspectival needs of

cultural multiplicity against objective assessment methods recommended by the APA (APA

forensic guidelines, 2013).

A potential answer to these questions may be found in cultural humility theory, where the

intricacies of identity and multiculturalism are not predefined. Only through self-reflection,

continual learning, and openness to the other is it thought that one can arrive at a place of

cultural understanding. In this sense, culture is co-constructed: a contextual target in constant

flux, led by the other's point of view, and filtered through self-values and biases (Tervalon &

Murray-Garcia, 1998). Although eloquently conceptualized, such nuance obfuscates empirical

study. As Berkamp and Agassiz (2018, online publication) point out, "there is a dearth of

research informing the forensic practitioner about incorporation of culturally competent practice

in a way that is transparent, articulated, and defensible." While there are not yet sophisticated methods for weighing risk based on gender in Washington, further cultural humility research in forensic settings may help uncover more client-centered approaches and disinter more gender-responsive management practices.

At present, individuals who enter the criminal justice system are most often categorized based on biological sex, male or female. This dichotomous approach was endorsed by consultants who discussed routing males and females into different correctional facilities and/or programs. When asked about gender-divergent assessment practices, no gender-specific methods for assessing mental health or risk for PSMIs were reported. In all consultant responses, assessments were processed in a homogenous fashion for both males and females. Even though there are lower base rates of violence for females (Lovell et. al, 2002), "mental health services that are offered are often based on the needs of men, including the criteria used in screening and psychiatric evaluations, the use of psychotropic medications, and specialized housing" (Veysey, 1998, p. 373). The efficacy of such uniformity remains unclear, but emerging research suggests that applying different standards and processes based on gender may improve predictive accuracy (Viljoen et al., 2016; Hamilton et al., 2016). Despite some developments, the field as a whole has struggled to develop gender-sensitive practice standards.

Program Duration

Given the differences in interventions implemented, small sample size, and divergent funding streams, a direct comparison between programs cannot be made. It is, nonetheless, worth noting that the ORCSP's enrollment period of *up to 60 months* was longer than average length of service reported by all other consultative programs (see Appendix C.6). This extended service duration may be justified by the increased risk associated with PSMI-Ns.

Several consultants endorsed using discretion when discharging participants from services. Making case-by-case decisions regarding duration of enrollment offers programs leeway in individualizing plans. Such discretion may also speed up service completion for well-bridged and stabilized clients. The downside to such professional prudence is determining how much intervention is sufficient to mitigate risk? Previous research has found that rates of recidivism become less likely after 3.5 years after release (Litwack, 2001). According to the Alaska Department of Corrections (AKDOC, 2015), for example, approximately 90% of individuals who return to custody do so within the first year after their release, with 62% returning within the first three months (see Figure 4). In Washington State, an evaluation of the CTS survival rates found that "a relatively steep drop begins to level at approximately 12 months from release and becomes nearly flat at approximately 24 to 30 months. Few new crimes are committed after this time period" (Braddock et al., 2002, p. 13).

Figure 4. Alaska Recidivism Timeline for Individuals on Probation/Parole, 2014

AKDOC (Probation/Parole) Recidivism Timeline, 2014
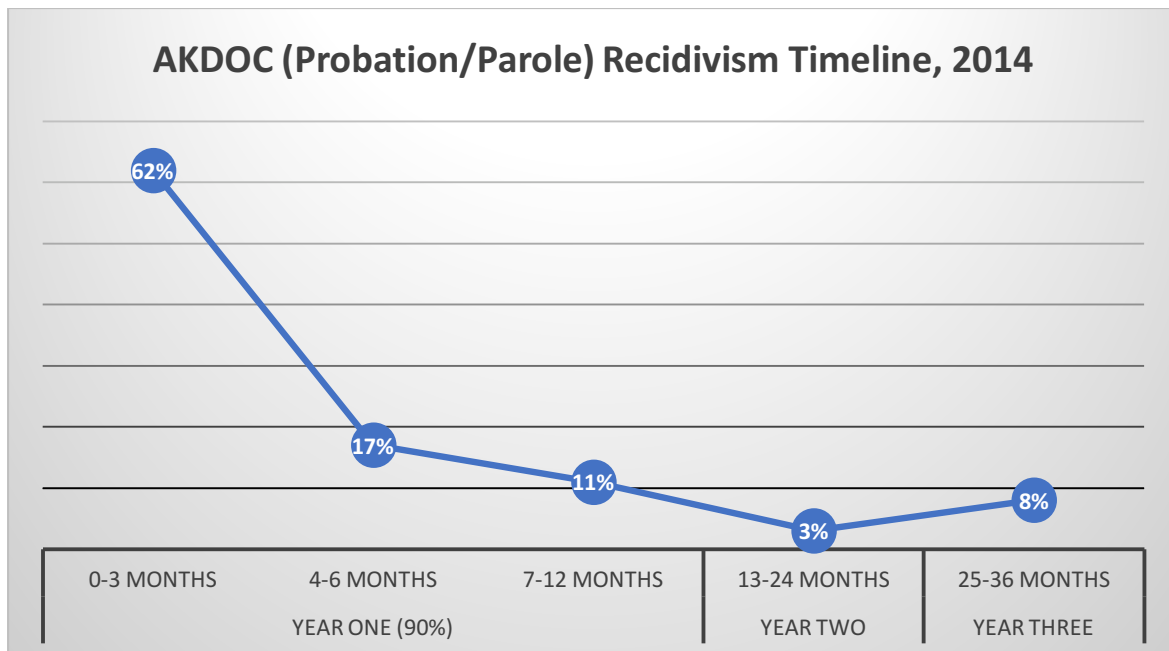
Fascinatingly, ORCSP participants do not appear to follow this downward pattern, with average reported recidivism rates per year as follows: 2% (first year), 8% (second year), and 8% (third year). This data suggests that the majority of ORCSP participants are not being returned to WADOC custody during their first year after release, and three-year recidivism rates are similar to previous high-risk samples at 17% (see Table 2). It is unclear if this is a product of higher instances of false-positive decisions or limited operational definitions of recidivism. It has been hypothesized by ORCSP staff that participants may begin to drift into criminal behavior after their community supervision ends (typically, participants have one to two years of supervision). It is recommended that the ORCSP attempt to refine their understanding of these issues through empirical study and comparison to recidivism data from other correctional systems.

Measurable Outcomes

ORCSP recidivism is currently defined as a return to WADOC custody within three years, post-release. This definition is restrictive and excludes NGRI rulings, unadjudicated crimes, death by suicide, or pled-down violence. Although all consultants indicated a method for tracking outcomes, there did not appear to be a consistent response pattern to support or establish a consensus. Similar to the ORCSP, many count return to DOC custody. Other outcomes identified included: rearrest, length of time out of prison, parole violations, incidents that are reported (not prosecuted), psychiatric hospitalization, and "how many people we are able to divert" (Consultant 5).

Consultant Recommendations

Consultant 1: Get family involved immediately. For this consultant, securing prosocial family support was discussed as a meaningful step in the reentry process. Incarceration, by design, isolates individuals from pre-established, social connections. If positive influences can

provide emotional and instrumental support that help shape noncriminal identities (Taylor,

2016), it then makes sense to maximize the amount of this contact while in custody.

Recognizably, determining who should be involved is contingent on relationship quality. Gideon

(2007), for example, found that social supports that did not value treatment influenced increased

relapse behaviors in recovering addicts. This may be especially true for relatives, partners,

friends, or affiliations who have sustained their substance use during incarceration periods.

Research also suggests that significant strain is placed on relationships during the community

reintegration process, which can impact depression and interpersonal instability (Comfort et al.,

2018). Although safety concerns justify needed barriers for deleterious influences, how

correctional systems can increase emotionally supportive relationships is equally important.

Taylor (2016) provides recommendations for implementing successful family interventions:

> (a) "Assess the level and quality of emotional support that family members are capable of
> providing" (p. 348).

> (b) Increase contact by lengthening visitation hours, create affordable and user friendly
> telephonic and videoconferencing systems, encourage and/or facilitate support contact,
> provide travel compensation for long-distance visits, and make the visitation experience
> more welcoming for visitors.

> (c) Enhance the quality of social relationships through arranging family meetings,
> conducting counseling sessions to address family discord, and coordinating prosocial
> gatherings, such as recreational events or communal meals.

Consultant 2: Abbreviated program duration. Calibrating post-release services to

match risk seems sensible; however, to this writer's knowledge, no best-practice standards for

reentry program length, nor optimal gradation schedules, have been outlined in the literature for

PSMI-Ns. As a consequence, programs often develop operational guidelines that support administrative goals within a particular jurisdiction or system.

Consultant 2, a transitional program manager, endorsed an average length of service of three months, with a primary goal of bridging participants from institutional to community-based, mental health services. According to this consultant, many release plans "fall apart within the first few weeks" and "sometimes three months is more than enough." It was also relayed that enrollment lasting the full three-month period was sometimes provided to clients who needed minimal support. It was thought that keeping low-need participants actively enrolled created little extra work for staff, while still providing a safety net to quickly deliver targeted risk management, if needed. Differences between program populations, funding, and risk make this recommendation non-generalizable to the ORCSP; however, studying program duration and intervention scheduling may uncover additional insights into best practices for resource allocation and PSMI-N service gradation.

Consultant 3: Recruit and involve interns. Recent incorporation of graduate level interns, to conduct assessments and develop pre-release plans, has been well received by this organization's reentry team and clients. According to Consultant 3, "this has helped tremendously." Of all recommendations, this one seems most straightforward and practical, and echoes findings by Heilbrun, Kelley, Koller, Giallella, and Peterson (2013), who claim that university-based forensic services "have the potential to contribute significantly to assessment, treatment, and consultation services provided in forensic and correctional contexts" (p. 199). In order to maintain quality assurance, researchers recommend incoming students shadow current interns and professionals until proficiency is achieved (Heilbrun et. al, 2013). Forensic training sites may also afford opportunities for students to engage in research and share emerging

practices. Interestingly, although forensic internships are common among many graduate schools, performance-appraisal guidelines within the relevant literature are scarce. Given best-practice standards that call for in-person risk and mental health assessment (Harris et al., 2015), creating internship opportunities may be a feasible option to supplement ORCSP screening procedures, which do not currently require interface with potential candidates.

Consultant 4: Upward override decisions. When discussing program strengths, Consultant 4 identified a way in which evaluators sometimes resolve incongruence between clinical judgment and risk assessment tools. Based on relevant LSI-R risk estimates, Consultant 4 discussed using discretion to enroll participants thought to be dangerous, "even if they are not classified as high risk." How exactly these determinations are accomplished was not summarized by this consultant, but leaves one to wonder how often do assessors override risk tools.

Conservative findings range from 3% (Girard & Wormith, 2004) to 6.5% (Guay & Parent, 2018); with higher estimations noted around 15% (general population) to 35% (individuals with sex offense histories; Wormith, Hogg, & Guzzo, 2012). Such upward overrides are undoubtedly necessary, as there have been historical instances of very dangerous individuals, whose risk went undetected during screening. For example, before the Cleveland Strangler, Anthony Sowell, was arrested for the sexual serial killing of 11 women, he was deemed low-risk on the Static-99 (Paglin, 2016). Relatedly and oddly, if given the Static-99 today, Gary Ridgway, the Green River Killer, would also be deemed low-risk, based on the way in which this tool consolidates offenses prior to detection by law enforcement. This type of false negative error has led some to purport that society "can never do enough to protect their citizens from all conceivable danger" (Franklin, 2010, online publication). Although true, such skepticism minimizes the impracticality of detecting risk without the use of structured risk assessments.

More importantly though, what factors or criteria should drive exceptions to the rule? To this writer's knowledge, these issues have been minimally clarified in the literature, and highlight two major tenants within the risk assessment field: (1) low-base-rate behaviors, such as serious violence and sexual violence, are difficult to detect with and without risk assessment tools, and (2) discretionary overrides are not recommended for most cases, since actuarial and SPJ tools routinely outperform UCJ.

In a study that examined override decisions among 3,646 individuals screened with the Level of Service/Case Management Inventory (LS/CMI), Guay and Parent (2018) found that "evaluators were not able to correctly identify exceptions… upward overrides are less damaging to the quality of the instrument than downward overrides" (p. 95). Their ultimate recommendation was to reserve downward overrides for "broken-leg" situations, a term coined by Meehl (1954) to describe rare circumstances, such as a broken-leg, that would significantly limit the chances of reoffense. It is interesting to consider that most R/O Dangerousness decisions made by the ORCSP between January 2013 to April 2016 were downward overrides, at a rate of approximately 8.6% (29 of 336 cases were ruled-out for Dangerousness).

Consultant 5: Moral Reconation Therapy. Grounded in Kohlberg's (1976; later revised by Gibbs, Basinger, Grime, & Snarey, 2007) theory of moral development, "MRT seeks to move offenders from a lower, hedonistic level of moral reasoning (pleasure vs. pain) to a higher level where social rules and others become important" (Ferguson, & Wormith, 2013, p. 1078). MRT treatment is manualized, typically involves 12 to 16 small-group sessions, and is thought to be slightly more efficacious when implemented while incarcerated vs. in the community. MRT has a long history of use within correctional settings, and as a RNR intervention is intended for use with individuals classified as medium to high risk. Evidence

suggests that individuals who receive properly implemented MRT intervention are two-thirds less likely to recidivate compared to untreated persons (Ferguson, & Wormith, 2013). Additional benefits of MRT include better overall correctional spending (Little, Robinson, Burnette, & Swan, 2010) and favorable substance use outcomes (Little & Robinson, 1989).

Despite these promising findings, the etiology of criminal morality remains debatable. For some, moral judgement is thought to be socially constructed (Shapland & Bottoms, 2011), with individual values born out of external influence and the power of social pressures. For others, distinct neurological differences, especially within limbic-system structures, such as the amygdala and ventromedial pre-frontal cortex, lay the "neural foundations of sociomoral reasoning and antisocial behavior" (Amador, 2016, p. 235). Since many forensic assessments do not include neuropsychological evidence, it is challenging to base risk management decisions on microbiological conceptualizations.

When considering how morality might be impacted by gender, it has been speculated by proponents of MRT that moral development is quite similar for males and females (Colby, Gibbs, Liebermann, & Kohlberg, 1983). Although sanguine, from a cultural-relativistic perspective, Kohlberg's conceptualization of morality is overly male-centric and highly individualistic, prompting caution for use with females and individuals from collectivistic cultures (Shweder, Mahapatra, & Miller, 1987). Recommendations have been made to focus on female-specific responsivity factors, like trauma, drug use, interpersonal relationships, and financial hardship (Schlarb, 2009). According to Schlarb (2009), providing culturally sensitive programming may decrease the replication of victimization and protect against gender bias exuded by practices that assess women based on male needs.

References

Alaska Department of Corrections. (2015). *Community Supervision Subgroup: Agenda 9/15/15*. Retrieved from http://www.ajc.state.ak.us/sites/default/files/meeting-summaries/workgroup/justice-reinvestment-initiative/community-supervision/communitysupervision9-15-2015.pdf

Alexander, M. (2012). *The new Jim Crow: Mass incarceration in the age of colorblindness.* New York, NY: The New York Press.

Amador, B. (2016). Victimization, limbic system irritability and sociomoral reasoning in male sex offenders. *Journal of Sexual Aggression, 22*(2), 233–245. doi:10.1080/13552600.2015.1090025

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association. (2013). Specialty guidelines for forensic psychology. *American Psychologist, 68*(1), 7-19. doi:10.1037/a0029889.

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist 6*(4), 271–285. doi:10.1037/0003-066X.61.4.271

Andrews, D. A., & Bonta, J. L. (1995). *Level of Service Inventory - Revised (LSI-R)*. North Tonawanda, NY: Multi-Health Systems.

Andrews, D. A., & Bonta, J. L. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law, 16*(1), 39-55. doi:10.1037/a0018362

Andrews, D. A., & Bonta, J. L. (2017). *The psychology of criminal conduct* (6th ed.). New Providence, NJ: LexisNexis Matthew Bender.

Aos, S. (2002). *Washington's Offender Accountability Act: An evaluation of the Department of Corrections' Risk Management Identification system* (Document no. 02-01-1201). Olympia, WA: Washington State Institute for Public Policy.

Aos, S., & Drake, E. K. (2013). *Prison, police, and programs: Evidence-based options that reduce crime and save money* (Document no. 13-11-1901). Olympia, WA: Washington State Institute for Public Policy.

Aos, S., Miller, M., & Drake, E. K. (2006). *Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates* (Document no. 06-10-1201). Olympia, WA: Washington State Institute for Public Policy.

Applegate, L. I. (2018). Deviancy, dependency, and disability: The forgotten history of eugenics and mass incarceration. *Duke Law Journal, 68*(3), 417-478. Retrieved from https://scholarship.law.duke.edu/dlj/vol68/iss3/1

Arends, R. Y., Bode, C., Taal, E., & Van de Laar, M. A. (2016). A mixed-methods process evaluation of a goal management intervention for patients with polyarthritis. *Psychology and Health, 32*(1), 38-60. doi:10.1080/08870446.2016.1240173

Arnold-Williams, R., Clarke, H., & MacLean, J. (2005). Mentally Ill Offender Program Community Transitions Program: Annual report to the Legislature. Retrieved from https://www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/ MIOCT P1205.pdf

Arnold-Williams, R., Clarke, H., & MacLean, J. (2006). Mentally Ill Offender Program Community Transitions Program: Annual report to the Legislature. Retrieved from https://www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/ MentallyIllOffender.pdf

Arnold-Williams, R., Clarke, H., & MacLean, J. (2007). Mentally Ill Offender Program Community Transitions Program: Annual report to the Legislature. Retrieved from https://www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/ MentallyIllOffender2007.pdf

Arnold-Williams, R., Vail, E., & MacLean, J. (2008). Mentally Ill Offender Program Community Transitions Program: Fourth annual report to the Legislature. Retrieved from https://www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/ MentallyIllOffender1208.pdf

Asch, S. E. (1951). Effects of group pressure on the modification and distortion of judgments. In H. Guetzkow (Ed.), *Groups, leadership, and men* (pp. 177–190). Pittsburgh, PA: Carnegie Press.

Assessments.com. (2008). *The STRONG-Static Risk and Offender Needs Guide fact sheet*. Spokane, WA: Washington State University. Retrieved from https://www.assessments.com/assessments_documentation/STRONG%20 Fact%20Sheet.pdf.

Bales, W. D., & Mears, D. P. (2008). Inmate social ties and the transition to society. *Journal of Research in Crime and Delinquency, 45*, 287-321. doi:10.1177/00 22427808317574

Barnoa, M., & Ward, T. (2015). Sailing uncharted seas without a compass: A review of interventions in forensic mental health. *Aggression and Violent Behavior, 22*, 77-86. doi:10.1016/j.avb.2015.04.009

Barnoski, R. (1997). Standards for improving research effectiveness in adult and juvenile justice (Document no. 97-12-1201). Olympia, WA: Washington State Institute for Public Policy.

Barnoski, R. (2006). *Sex offender sentencing in Washington State: Failure to register as a sex offender-revised* (Document no. 06-01-1203A). Olympia, WA: Washington State Institute for Public Policy.

Barnoski, R., & Drake, E. K. (2007). *Washington's Offender Accountability Act: Department of Corrections' Static Risk Assessment* (Document no. 07-03-1201). Olympia, WA: Washington State Institute for Public Policy.

Baseball Almanac. (2018). 1997 Seattle Mariners Schedule: New York Yankees vs Seattle Mariners (8/24/1997). Retrieved from http://www.baseball-almanac.com/teamstats/schedule.php?y=1997&t=SEA

Berkamp, J., & Agassiz, K. (2018). Cultural competency in forensic practice: Bridging the divide. *American Psychology Law Society Newsletter*. Retrieved from http://apls.wildapricot.org/resources/EmailTemplates/2018_09%20September%20AP-LS%20Newsletter/ExpertOpinion9_18.pdf

Bechtel, K., & Pierce, B. A. (2011). An overview of what works in correctional interventions. Retrieved from https://b.3cdn.net/crjustice/aac3cda45ab8784552_ogm6bn2pd.pdf

Beck, A. T., & Bahr, S. (2009). Letters: Analyzing the effectiveness of psychodynamic psychotherapy. *Journal of the American Medical Association, 301*(9), 931. doi:10.1001/jama.2009.179

Bianchi, R., Laurent, E., Schonfeld, I. S., Verkuilen, J., & Berna, C. (2018). Interpretation bias toward ambiguous information in burnout and depression. *Personality and Individual Differences, 135*, 216–221. doi:10.1016/j.paid.2018.07.028

Bitney, K., Drake, E. K., Grice, J., Hirsch, M., & Lee, S. (2017). *The effectiveness of reentry programs for incarcerated persons: Findings for the Washington Statewide Reentry Council* (Document No. 17-05-1901). Olympia, WA: Washington State Institute for Public Policy.

Blackstone, C., & Westinghouse, R. (2016). Investigative report: Department of Corrections – Early release of offenders (Vol. 1). Retrieved from http://www.governor.wa.gov/sites/default/files/documents/2016-02-25_DOC_Report.pdf

Blonigen, D. M., Rodriguez, A. L., Manfredi, L., Nevedal, A., Rosenthal, J., McGuire, J. F., … Timko, C. (2018). Cognitive–behavioral treatments for criminogenic thinking: Barriers and facilitators to implementation within the Veterans Health Administration. *Psychological Services, 15*(1), 87-97. doi:10.1037/ser0000128

Bonta, J. (1996). Risk-needs assessment and treatment. In A. Harland (Ed.), *Choosing correctional options that work* (pp. 18- 32). Thousand Oaks, CA: Sage.

Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin, 124,* 123-142. doi:10.1037/0033-2909.123.2.123

Bonta, J., Blais, J., & Wilson, H. (2014). A theoretically informed meta-analysis of the risk for general and violent recidivism for mentally disordered offenders. *Aggression and Violent Behavior, 19,* 278-287. doi:10.1016/j.avb.2014.04.014

Braddock, D., Lehman, J. D., & Gliene, B. J. (2001). Mentally Ill Offender Community Transitions Program: Fourth annual report to the legislature. Retrieved from https://www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/MIOCT.pdf

Braddock, D., Lehman, J. D., & MacLean, J. (2002). Mentally Ill Offender Community Transitions Program: Annual report to the Legislature. Retrieved from https://www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/MIOCTP.pdf

Braddock, D., Lehman, J. D., & MacLean, J. (2003). Mentally Ill Offender Community Transitions Program: Annual report to the Legislature. Retrieved from https://www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/MIOCTPO.pdf

Braithwaite, J. (1982). Challenging just deserts: Punishing white-collar criminals. *Journal of Criminal Law & Criminology, 73*(2), 723-763. doi:10.2307/1143113

Braithwaite, E., Charrette, Y., Crocker, A. G., & Reyes, A. (2010). The predictive validity of clinical ratings of the Short-Term Assessment of Risk and Treatability (START). *International Journal of Forensic Mental Health, 9,* 271-281. doi:10.1080/14999013.2010.534378

Brown, J., & Singh, J. P. (2014). Forensic risk assessment: A beginner's guide. *Archives of Forensic Psychology, 1*(1), 49-59. Retrieved from https://www.academia.edu/25597163/Forensic_Risk_Assessment_A_Beginners_Guide

Buchanan, A., Binder, R., Norko, M., & Swarts, M. (2012). Resource document on psychiatric violence risk assessment (APA resource document). *American Journal of Psychiatry, 169*(3), 1-10. doi:10.1176/appi.focus.130402

Burley, M., & Drake, E. K. (2015). *Assessing the risk of criminal offense for Washington's involuntary treatment and forensic commitment populations* (Document no. 15-10-1901). Olympia, WA: Washington State Institute for Public Policy.

Burnett, R., & Roberts, C. (2004). *What works in probation and youth justice.* Portland, OR: Willan Publishing.

Bush, J., Glick, B., Taymans, J., & Guevara, M. (2011). *Thinking for a change: Integrated cognitive behavior change program* (version 3.1). Washington, DC: U.S. Department of Justice, National Institute of Corrections.

Carich, M. S., Wilson, C., Carich, P. A., & Calder, M. C. (2010). Contemporary sex offender treatment: Incorporating circles of support and the good lives model. In J. Brayford, F. Cowe, & J. Deering (Eds.), *What else works? Creative work with offenders* (pp. 188-210). Portland, OR: Willan Publishing.

Carroll, J., Winters, P., Fiscella, K., Williams, G., Bauch, J., Clark, L., & Bennett, N. (2015). Process evaluation of practice-based diabetes prevention programs: What are the implementation challenges? *The Diabetes Educator, 41*(3), 271-279. doi:10.1177/0145721715572444

Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. *Morbidity and Mortality Weekly Report, 48*(No. RR-11), 1-40. Retrieved from https://www.cdc.gov/mmwr/PDF/rr/rr4811.pdf

Christian, J., Veysey, B. M., Herrschaft, B., & Tubman-Carbone, H. (2009). Moments of transformation: Formerly incarcerated individuals' narratives of change. In B. M. Veysey, J. Christian, & D. J. Martinez (Eds.), *How offenders transform their lives* (pp. 12-29). NY/London: Routledge.

Citizens Commission on Human Rights. (2015). Psychiatric drugs: Creating crime and profit in prisons. Retrieved from http://www.cchrflorida.org/psychiatric-drugs-creating-crime-and-profit-in-prisons/

Clarridge, C. (2005, July 20). Two Utah women shot by parolee sue state. *The Seattle Times*. Retrieved from https://www.seattletimes.com/seattle-news/two-utah-women-shot-by-parolee-sue-state/

Colby, A., Gibbs, J., Lieberman, M., & Kohlberg, L. (1983). *A longitudinal study of moral judgment: A monograph for the Society of Research in Child Development*. Chicago, IL: The University of Chicago Press.

Comfort, M., Krieger, K. E., Landwehr, J., McKay, T., Lindquist, C. H., Feinberg, R., Kennedy, E. K., & Bir, A. (2018). Partnership after prison: Couple relationships during reentry. *Journal of Offender Rehabilitation, 57*(2), 188–205. doi:10.1080/10509674.2018.1441208

Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project*. New York: US Department of Justice. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf

Corrigan, P. W., & Watson, A. C. (2005). Findings from the National Comorbidity Survey on the frequency of violent behavior in individuals with psychiatric disorders. *Psychiatry Research, 136*(2-3), 153-162. doi:10.1016/j.psychres.2005.06.005

Criminal Code of Canada. (1985). Criminal Code (R.S.C. c. C-46*)*. Retrieved from https://www.canlii.org/en/ca/laws/stat/rsc-1985-c-c-46/latest/rsc-1985-c-c-46.html

Cullen, F. T. (2012). Taking rehabilitation seriously: Creativity, science, and the challenge of offender change. *Punishment and Society, 14*, 94-114. doi:10.1177/1462474510385973

Cullen, F. T., & Jonson, C. L. (2012). *Correctional theory: Context and consequences.* US: Sage Publications.

Cullen, F. T., Myer, A. J., & Latessa, E. J. (2009). Eight lessons from Moneyball: The high cost of ignoring evidenced-based corrections. *Victims and Offenders, 4*, 197-213. doi:10.1080/15564880802612631

Cushman, P. (1995). *Constructing the self, constructing America: A cultural history of psychotherapy*. New York: Da Capo.

David, D., Cristea, I., & Hofmann, S. G. (2018). Why Cognitive Behavioral Therapy is the current gold standard of psychotherapy. *Frontiers in psychiatry, 9*(4), 1-3. doi:10.3389/fpsyt.2018.00004

de Vogel, V., de Ruiter, C., Bouman, Y., & de Vries Robbé, M. (2012). *SAPROF. Guidelines for the assessment of protective factors for violence risk* (2nd ed.). Utrecht, The Netherlands: Van der Hoeven Stichting.

de Vries Robbé, M. (2014). *Protective factors: Validation of the structured assessment of protective factors for violence risk in forensic psychiatry*. Nijmegen: Radboud University.

de Vries Robbé, M., & de Vogel, V. (2013). Protective factors for violence risk: Bringing balance to risk assessment. In C. Logan & L. Johnstone (Eds.), *Managing Clinical Risk: A guide to effective practice* (pp. 293-310). London: Routledge.

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review, 33*, 846-861. doi:10.1016/j.cpr.2012.09.007

Douglas, K. S. (2014). Version 3 of the Historical-Clinical-Risk Management 20 (HCR-20V3): Relevance to violence risk assessment and management in forensic conditional release contexts. *Behavioral Sciences & The Law, 32*(5), 557-576. doi:10.1002/bsl.2134

Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). *HCR-20V3: Assessing risk of violence – User guide*. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.

Douglas, K. S., & Kropp, P. R. (2002). A prevention-based paradigm for violence risk assessment: Clinical and research applications. *Criminal Justice and Behavior, 2*, 617-658. doi:10.1177/009385402236735

Drake, E. K. (2011). *Washington State recidivism trends: Adult offenders released from Prison, 1990-2006* (Document no. 11-01-1201). Olympia, WA: Washington State Institute for Public Policy.

Drake, E. K. (2012). *Chemical dependency treatment for offenders: A review of the evidence and benefit-cost findings* (Document no. 12-12-1201). Olympia, WA: Washington State Institute for Public Policy.

Drake, E. K. (2014). *Predicting criminal recidivism: A systematic review of offender risk assessments in Washington State* (Document no. 14-02-1901). Olympia, WA: Washington State Institute for Public Policy.

Drake, E. K., Aos, S., & Miller, M. G. (2009). Evidence-based policy options to reduce crime and criminal justice costs: Implications in Washington State. *Victims and Offenders*, *4*, 170-196. doi:10.1080/15564880802612615

Drake, E. K. & Barnoski, R. (2009). *New risk instrument for offenders improves classification decisions* (Document no. 09-03-1201). Olympia, WA: Washington State Institute for Public Policy.

Drake, E. K., Barnoski, R., & Aos, S. (2009). *Increased earned release from prison: Impacts of a 2003 law on recidivism and crime costs, revised* (Document no. 09-04-1201). Olympia, WA: Washington State Institute for Public Policy.

Draine, J. W., & Herman, D. (2010). Critical Time Interventions. In H. A. Dlugacz (Ed.), *Reentry planning for offenders with mental disorders: Policy and practice* (pp. 1-15). Kingston, NJ: Civic Research Institute.

Durose, M. R., Cooper, A. D., & Snyder, H. N. (2014). *Recidivism of prisoners released in 30 states in 2005: Patterns from 2005 to 2010*. US Department of Justice: Office of Justice Programs. Retrieved from https://www.bjs.gov/content/pub/pdf/rprts05p0510.pdf

Engrossed Second Substitute House Bill 1114 (E2SHB1114). (2013). Addressing criminal incompetency and civil commitment. Retrieved from http://lawfilesext.leg.wa.gov/ biennium/2013-14/Pdf/Bills/House%20Passed%20Legislature/1114-S2.PL.pdf

Evans, M. (2011). *Tracking Washington State offenders pilot study: Do education programs affect employment outcomes*. WA, US: Washington State Department of Corrections. Retrieved from http://www.doc.wa.gov/docs/publications/reports/200-SR005.pdf

Fazel, S. (2013). Coin flip judgement of psychopathic prisoners' risk. *New Scientist*. Retrieved from https://www.newscientist.com/article/mg22029464-800-coin-flip-judgement-of- psychopathic-prisoners-risk/

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys. *The Lancet, 359*(9306), 545-550. doi:10.1016/S0140-6736(02)07740-1

Fazel, S., & Grann, M. (2006). The population impact of severe mental illness on violent crime. *American Journal of Psychiatry, 163*(8), 1397-1403. doi:10.1176/ appi.ajp.163.8.1397

Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008). The prevalence of mental disorders among the homeless in western countries: Systematic review and metaregression analysis. *PLoS Medicine, 5*, 1670-1681. doi:10.1371/journal.pmed.0050225

Fazel, S., Singh, J. P., Doll, H., & Grann, M. (2012). Use of risk assessment instruments to predict violence and antisocial behavior in 73 samples involving 24,827 people: Systematic review and meta-analysis. *British Medical Journal, 345*(7868), 1-12. doi:10.1136/bmj.e4692

Feder, L. (1991a). A comparison of the community adjustment of mentally ill offenders with those from general population: An 18-month follow-up. *Law and Human Behavior, 15*, 477-493. doi:10.1007/BF01650290

Feder, L. (1991b). A profile of mentally ill offenders and their adjustment in the community. *Journal of Psychiatry and the Law, 19*, 79-98.

Federal Bureaus of Prisons. (2016). Federal Bureaus of Prisons Health Services: National formulary (Part 1). Retrieved from https://www.bop.gov/resources/pdfs/formulary.pdf

Ferguson, L. M., & Wormith, J. S. (2013). A meta-analysis of moral reconation therapy. *International Journal of Offender Therapy and Comparative Criminology, 57*(9), 1076-1106. doi:10.1177/0306624X12447771

Fleiss, J. L. (1986). *Reliability of measurement. The design and analysis of clinical experiments*. New York, NY: John Wiley & Sons.

Fox, A. M., Mulvey, P., Katz, C. M., & Shafer, M. S. (2016). Untangling the relationship between mental health and homelessness among a sample of arrestees. *Crime and Delinquency, 62*(5), 592-613. doi:10.1177/0011128713511571

Franklin, K. (2010, October 27). Delusional campaign for a world without risk: Sometimes bad stuff just happens. *Psychology Today*. Retrieved from https://www.psychologytoday.com /us/blog/witness/201010/delusional-campaign-world-without-risk

Frisman, L. K., Swanson, J. W., Marin, M. C., & Leavitt-Smith, E. (2010). Estimating costs of reentry programs for prisoners with severe mental illness. In H. A. Dlugacz (Ed.), *Reentry planning for offenders with mental disorders: Policy and practice* (pp. 1-9). Kingston, NJ: Civic Research Institute.

Garcia-Mansilla, A., Rosenfield, B., & Nicholls, T. L. (2009). Risk assessment: Are current methods applicable to women? *The International Journal of Forensic Mental Health, 8*, 50-61. doi:10.1080/14999010903014747

Gibbs, J. C., Basinger, K. S., Grime, R. L., & Snarey, J. R. (2007). Moral judgment development across cultures: Revisiting Kohlberg's universality claims. *Developmental Review, 27*, 443-500. doi:10.1016/j.dr.2007.04.001

Gideon, L. (2007). Family role in the reintegration process of recovering drug addicts. *International Journal of Offender Therapy and Comparative Criminology, 51*, 212-226. doi:10.1177/0306624X06287104

Giordano, P. C., Cernkovich, S. A., & Rudolph, J. L. (2002). Gender, crime, and desistence: Toward a theory of cognitive transformation. *American Journal of Sociology, 107*(4), 990-1064. doi:10.1086/343191

Girard, L., & Wormith, J. S. (2004). The predictive validity of the Level of Service Inventory–Ontario Revision on general and violent recidivism among various offender groups. *Criminal Justice and Behavior, 31*, 150-181. doi:10.1177/0093854803261335

Golder, S., Ivanoff, I., Cloud, R. N., Besel, K. L., McKiernan, P., Bratt, E., & Bledsoe, L. K. (2005). Evidenced-based practices with adults in jails and prisons: Strategies, practices, and future directions. *Best Practices in Mental Health, 1*(2), 100-132. Retrieved from https://search-ebscohost-com.antioch.idm.oclc.org/login.aspx? direct=true&db=psyh&AN=2015-28900-008&site=ehost-live&scope=site

Gornik, M. (2004). Moving from correctional program to correctional strategy: Using proven practices to change criminal behavior. In K. Knight & D. Farabee (Eds.), *Treating addicted offenders: A continuum of effective practices* (pp. 1-12). Kingston, NJ: Civic Research Institute, Inc.

Gould, M. S., Cross, W., Pisani, A. R., Munfakh, J. L, & Kleinman, M. (2013). Impact of applied suicide intervention skills training on the National Suicide Prevention Lifeline. *Suicide and Life-Threatening Behavior, 43*(6), 676-691. doi:10.1111/sltb.12115

Grob, G. N. (1991). *From asylum to community: Mental health policy in modern America.* Princeton, New Jersey: Princeton University Press.

Grove, W. M., & Meehl, P. E. (1996). Comparative efficiency of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: The clinical–statistical controversy. *Psychology, Public Policy, and Law, 2*(2), 293-323. doi:10.1037/1076-8971.2.2.293

Guay, J. P., & Parent, G. (2018). Broken legs, clinical overrides, and recidivism risk: An analysis of decisions to adjust risk levels with the LS/CMI. *Criminal Justice and Behavior, 45*(1), 82–100. doi:10.1177/0093854817719482

Haines, A., Brown, A., Javaid, S. F., Khan, F., Noblett, S., Omodunbi, O., Sadiq, K., Zaman, W., & Whittington, R. (2018). Assessing Protective Factors for Violence Risk in U.K. General Mental Health Services Using the Structured Assessment of Protective Factors. *International Journal of Offender Therapy and Comparative Criminology, 62*(12), 3965–3983. doi:10.1177/0306624X17749449

Hamilton, Z. K., Kigerl, A., & Routh, D. (2016). *The STRONG-R pilot assessment study.* Spokane, WA: Washington State Institute for Criminal Justice. Retrieved from https://wsicj.wsu.edu/wp-content/uploads/sites/436/2016/03/THE-STRONG-R-PILOT-ASSESSMENT_Technical-Report_2016-06-01.pdf

Hamilton, Z. K., Campagna, M., Tollefsbol, E., van Womer, J., & Barnoski, R. (2017). A more consistent application of the RNR model: The STRONG-R needs assessment. *Criminal Justice and Behavior,* 44(2), 261-292. doi:10.1177/0093854816678032

Hamilton, Z. K., & van Wormer, J. (2015). *Customizing offender assessment.* Spokane, WA: Washington State Institute for Criminal Justice. Retrieved from https://s3.wp.wsu.edu/uploads/sites/436/2014/11/Hamilton-White-Paper_color.pdf

Hamilton, Z. K., van Wormer, J., Kigerl, A. Campbell, C, & Posey, B. (2015). *Evaluation of Washington State Department of Corrections (WADOC) Swift and Certain (SAC) policy, process, outcome, and cost-benefit evaluation.* Spokane, WA: Washington State Institute for Criminal Justice. Retrieved from https://s3.wp.wsu.edu/uploads/sites/436/2015/11/SAC-Final-Report_2015-08-31.pdf

Hanson, R. K., Bourgon, G., McGrath, R. J., Kroner, D., D'Amora, D. A., Thomas, S. S., & Tavarez, L. P. (2017). *A five-level risk and needs system: Maximizing assessment results in corrections through the development of a common language.* New York, NY: The Council of State Governments Justice Center.

Hanson, R., & Morton-Bourgon, K. (2004). *Predictors of sexual recidivism: An updated meta-analysis* (User report 2004-02). Ottawa, Canada: Public Works and Government Services Canada.

Hanson, A., Phenix, A., Hanson, R. K., & Thornton, D. (2003). *Static-99 coding rules: Revised 2003.* Ottawa; Department of the Solicitor General of Canada.

Hanson, R. K., Sheahan, C. L., & VanZuylen, H. (2013). Static-99 and RRASOR predict recidivism among developmentally delayed sexual offenders: A cumulative meta-analysis. *Sexual Offender Treatment, 8,* 1-14. Retrieved from http://www.sexual-offender-treatment.org/119.html

Hare, R. D., & McPherson, L. M. (1984). Violent and aggressive behavior by criminal psychopaths. *International Journal of Law and Psychiatry, 7*, 35-50. doi:10.1016/0160-2527(84)90005-0

Harris, G. T., Rice, M. E., Quinsey, V. L., & Cormier, C. A. (2015). *Violent offenders: Appraising and managing risk* (3rd ed.). Washington, DC, US: American Psychological Association.

Hart, S. D. (1998). The role of psychopathy in assessing risk for violence: Conceptual and methodological issues. *Legal and Criminological Psychology, 3*(1), 121-137. doi:10.1111/j.2044-8333.1998.tb00354.x

Hart, S. D., Kropp, P. R., & Hare, R. D. (1988). Performance of male psychopaths following conditional release from prison. *Journal of Consulting and Clinical Psychology, 56*(2), 227-232. doi:10.1037/0022-006X.56.2.227

Hartvig, P., & Kjelsberg, E. (2009). Penrose's Law revisited: The relationship between mental institution beds, prison population and crime rate. *Nordic Journal of Psychiatry, 63*(1), 51-56. doi:10.1080/08039480802298697

Heilbrun, K., DeMatteo, D., King, C., Thornewill, A., & Phillips, S. (2016). Risk-reducing interventions for justice-involved individuals: A critical review. In B. H. Bornstein, M. K. Miller, B. H. Bornstein, M. K. Miller (Eds.). *Advances in psychology and law* (pp. 271-304). Cham, Switzerland: Springer International Publishing.

Heilbrun, K., Kelley, S. M., Koller, J. P., Giallella, C., & Peterson, L. (2013). The role of university-based forensic clinics. *International Journal of Law and Psychiatry, 36*(3-4), 195–200. doi:10.1016/j.ijlp.2013.04.019

Hermans, H. (2007). How to perform research on the basis of dialogical self theory? Introduction to the special issue. *Journal of Constructivist Psychology, 21*, 185-199. doi:10.1080/10720530802070684

Hess, L. M., Raebel, M. A., Conner, D. A., & Malone, D. C. (2006). Measurement of adherence in pharmacy administrative databases: A proposal for standard definitions and preferred measures. *Annals of Pharmacotherapy, 40*, 1280–1288. doi:10.1345/aph.1H018

Hildebrand, M., Hol, A., & Bosker, J. (2013). Predicting probation supervision violations. *Psychology, Public Policy, and Law, 19*(1), 114-125. doi:10.1037/a0028179

Hoskin, R. A. (2017). Femme theory: Refocusing the intersectional lens. *Culture and Social Justice, 38*(1), 95-109. Retrieved from http://journals.msvu.ca/index.php/atlantis/article/view/4771/95-109%20PDF

Hsieh, M. L. & Hamilton, Z. K. (2014). *Research in brief: The Static Risk and Offender Needs Guide-Revised for Sex Offenders (STRONG-S)*. Spokane, WA: Washington State Institute for Criminal Justice. Retrieved from https://s3.wp.wsu.edu/uploads/sites/436/2014/11/2014-03-27_STRONG-S.pdf.

Human Rights Watch. (2003). World report: United States. Retrieved from https://www.hrw.org/legacy/wr2k3/us.html#conditions

Hunt, P., Anderson, J., & Saunders, J. (2017). The price of justice: New national and state-level estimates of the judicial and legal costs of crime to taxpayers. *American Journal of Criminal Justice, 42*(2), 231-254. doi:10.1007/s12103-016-9362-6.

In re King, 146 Wn. 2d 658 (2002).

Jackson, R. (2008). *Learning forensic assessment*. New York, NY: Routledge/Taylor & Francis Group.

James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates*. US Department of Justice: Office of Justice Programs. Retrieved from https://www.bjs.gov/content/pub/pdf/mhppji.pdf

James, N. (2015). Offender reentry: Correctional statistics, reintegration into the community, and recidivism. *Congressional Research Service*. Retrieved from https://fas.org/sgp/crs/misc/RL34287.pdf

James, W. (1890). *The principles of psychology* (Vol. 1). London: Macmillan.

Jimenez, A. C. Delgado, R. H., Vardsveen, T. C., & Wiener, R. L. (2018). Validation and application of the LS/CMI in Nebraska probation. *Criminal Justice and Behavior,* 20(10), 1-22. doi: 10.1177/0093854818763231

Johnson-Turbes, A., Schulueter, D. Moore, A. R., Buchanan, N. D., & Fairly, T. L. (2015). Evaluation of a web-based program for African American young breast cancer survivors. *American Journal of Preventative Medicine, 49*(65), 543-549. doi:10.1016/j.amepre.2015.09.003

Joplin, L., Sihler, A., Enslow, B., Chambers, B., & Griffith, N. (2016). *Jail diversion for people with mental illness in Washington State*. Washington, US: State of Washington Office of Financial Management. Retrieved from https://www.ofm.wa.gov/sites/default/files/public/legacy/reports/Jail%20Diversion%20for%20People%20with%20Mental%20Illness%20in%20Washington%20State%20Study.pdf

Kalapos, M. P. (2016). Penrose's law: Methodological challenges and call for data. *International Journal of Law and Psychiatry, 49*(A), 1-9. doi:10.1016/j.ijlp.2016.04.006

Keene, L. (1997, August 21). Tragedy in Seattle. *The Seattle Times*. Retrieved from http://www.schizophrenia.com/newsletter/997/997seattle.htm

Kerr, S., & Lockshin, A. (2010). Legal standards for securing reentry services. In H. A. Dlugacz, *Reentry planning for offenders with mental disorders: Policy and practice* (pp. 1-25). Kingston, NJ, US: Civic Research Institute.

Kloess, J. A., Hamilton-Giachritsis, C. E., & Beech, A. R. (2019). Offense processes of online sexual grooming and abuse of children via internet communication platforms. *Sexual Abuse, 31*(1), 71-96. doi: 10.1177/1079063217720927

Kohlberg, L. (1976). Moral stages and moralization: The cognitive-developmental approach. In T. Lickona (Ed.), *Moral development and behavior* (pp. 31-55), New York, NY: Holt, Rinehart & Winston.

Koo, T. K., & Li, M. Y. (2016). A guideline of selecting and reporting intraclass correlation coefficients for reliability research. *Journal of Chiropractic Medicine, 15*(2), 155–163. doi:10.1016/j.jcm.2016.02.012

Kropp, P. R., & Hart, S. D. (2004). *The development of the Brief Spousal Assault Form for the Evaluation of Risks (B-SAFER): A tool for criminal justice professionals.* Canada: Research and Statistics Division, Department of Justice Canada.

Lako, D. A. M., de Vet, R., Beijersbergen, M. D., Herman, D. B., van Hemert, A. M., & Wolf, J. R. L. M. (2013). The effectiveness of Critical Time Intervention for abused women and homeless people leaving Dutch shelters: Study protocol of two randomized controlled trials. *Journal of Public Health, 13*(1), 555. doi:10.1186/1471-2458-13-555

Lamb, H. R., & Weinberger, L. E. (2017). Understanding and treating offenders with serious mental illness in public sector mental health. *Behavioral Sciences and the Law, 35*(4), 303-318. doi:10.1002/bsl.2292

Landan, P. A., & Levin, D. J. (2002). *Recidivism of prisoners released in 1994* (NCJ 193427). US Department of Justice: Office of Justice Programs. Retrieved from https://www.bjs.gov/content/pub/pdf/rpr94.pdf

Landenberger, N., & Lipsey, M. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology, 1*(4), 451-476. doi:10.1007/s11292-005-3541-7

Laquer, H., & Corpus, R. (2016). Machines learning justice: A new approach to the problems of inconsistency and bias in adjudication. Retrieved from https://www.law.berkeley.edu/php-programs/jsp/fileDL.php?fID=5106

Large, M., & Neilssen, O. (2017). The limitations and future of violence risk assessment. *World Psychiatry, 16*(1), 25. doi:10.1002/wps.20394

Large, M. M., Ryan, C. J., Singh, S. P., Paton, M. B., & Nielssen, O. B. (2011). The predictive value of risk categorization in schizophrenia. *Harvard Law Review*, *19*, 25-33. doi:10.3109/10673229.2011.549770

Lee, S. C., & Hanson, R. K. (2016). Recidivism risk factors are correlated with history of psychiatric hospitalization among sex offenders. *Psychological Services, 13,* 261-271. doi:10.1037/ser0000081

Leichsenring, F., & Rabung, S. (2008). The effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *JAMA: Journal of the American Medical Association, 300*(13), 1551-1565. doi:10.1001/jama.300.13.1551

Linehan M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York, NY: Guilford Press.

Lipsey, M. W., & Cullen, F. T. (2007). The effectiveness of correctional rehabilitation: A review of systematic reviews. *Annual Review of Law and Social Science, 3*, 297-320. doi.org/10.1146/annurev.lawsocsci.3.081806.112833

Little, G. L., & Robinson, K. D. (1988). Moral Reconation Therapy: A systematic step-by-step treatment system for treatment resistant clients. *Psychological Reports, 62*, 135-151. doi:10.2466/pr0.1988.62.1.135

Little, G. L., & Robinson, K. D. (1989). Effects of Moral Reconation Therapy upon moral reasoning, life purpose, and recidivism among drug and alcohol offenders. *Psychological Reports, 64(*1), 83-90. doi:10.2466/pr0.1989.64.1.83

Little, G. L., Robinson, K. D., Burnette, M. S., & Swan, E. S. (2010). Twenty-year recidivism results for MRT-treated offenders: A preliminary analysis. *Journal of Community Corrections, 14*(3-4), 15-34. Retrieved from https://www.moral-reconation-therapy.com/Resources/2010-Journal_of_Community_Corrections.pdf

Litwack, T. R. (2001). Actuarial versus clinical assessments of dangerousness. *Psychology, Public Policy, and Law, 7*(2), 409-443. doi:10.1037/1076-8971.7.2.409

Litwack, T. R., & Schlesinger, L. B. (1999). Dangerousness risk assessments: Research, legal, and clinical considerations. In A. K. Hess & I. B. Weiner (Eds.), *The handbook of forensic psychology* (2nd ed., pp. 171–217). Hoboken, NJ: John Wiley & Sons Inc.

Looman, J., & Abracen, J. (2013). The risk need responsivity model of offender rehabilitation: Is there really a need for a paradigm shift? *International Journal of Behavioral Consultation and Therapy, 8*(3-4), 30-36. doi:10.1037/h0100980

Louden, J. E., & Skeem, J. L. (2013). How do probation officers assess and manage recidivism and violence for probationers with mental disorder? An experimental investigation. *Law and Human Behavior, 25*, 22-34. doi:10.1037/h0093991

Lovell, D., Gagliardi, G., & Peterson, P. (2002). Recidivism and use of services among mentally ill offenders released from prison. *Psychiatric Services, 53*(10), 1290-1296. doi:10.1176/appi.ps.53.10.1290

Lowenkamp, C., Latessa, E., & Hoslinger, A. (2006). The risk principle in action: What have we learned from 13,676 offenders and 97 correctional programs? *Crime and Delinquency, 52*(1), 77-93. doi:10.1177/0011128705281747

Lurigio, A. J. (2013). Criminalization of the mentally ill: Exploring Causes and current evidence in the United States. *The Criminologist, 38*(6), 3-8. Retrieved from https://pdfs.semanticscholar.org/0675/1116a9b30349d6a98601992c52435c3d65b6.pdf

Lurigio, A. J., & Harris, A. (2007). The mentally ill in the criminal justice system: An overview of historical causes and suggested remedies. *Professional Issues in Criminal Justice, 2*(2), 145-169. Retrieved from https://campus.purdueglobal.edu/documentstore/docs09/pdf/picj/vol2/issue2/PICJv2n2.pdf

Maguire, M., & Raynor, P. (2010). Putting the OM in NOMS: Problems and possibilities for offender management. In J. Brayford, F. Cowe, & J. Deering (Eds.), *What else works? Creative work with Offenders* (pp. 236-253). Portland, OR: Willan Publishing.

Manuel, J. I., Covell, N. H., Jackson, C. T., & Essock, S. M. (2011). Does Assertive Community Treatment increase medication adherence for people with co-occurring psychotic and substance use disorders? *Journal of American Psychiatric Nurses Association, 17*, 51–56. doi:10.1177/1078390310395586

Marshall, W. L. (2004). Cognitive-behavioral treatment of child molestors. In R. K. Hanson, F. Pfafflin, & M. Lutz (Eds.), *Sexual abuse in the Catholic Church: Scientific and legal perspectives: Proceedings of the conference "Abuse of children and young people by Catholic Priests and Religious"*. Vatican City: Libreria Editrice Vaticana, Pontificia Academia Pro Vita.

Martin, J. (2005, September, 16). Court rules state can be held liable if supervised felons commit crimes. *The Seattle Times*. Retrieved from https://www.seattletimes.com/seattle-news/court-rules-state-can-be-held-liable-if-supervised-felons-commit-crimes/

Martinson, R. (1974). What works? – Questions and answers about prison reform. *Public Interest, 35*, 22-54.

Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives*. Washington, DC: American Psychological Association.

Mayfield, J. (2009). *The Dangerous Mentally Ill Offender Program four-year felony recidivism and cost effectiveness* (Document No. 09-02-1901). Olympia, WA: Washington State Institute for Public Policy.

McCormick, C. T., & Perret, Y. M. (2010). Accessing public benefits: More advocacy than entitlement. In H. A. Dlugacz (Ed.), *Reentry planning for offenders with mental disorders: Policy and practice* (pp. 1-9). Kingston, NJ, US: Civic Research Institute.

Meehl, P. E. (1954). *Clinical versus statistical prediction: A theoretical analysis and a review of the evidence*. Minneapolis, MN: University of Minnesota Press.

Mei, X. & Hamilton, Z. K. (2016). *Internal Structure of the STRONG-R*. Spokane, WA: Washington State Institute for Criminal Justice. Retrieved from https://s3.wp.wsu.edu/uploads/sites/436/2016/10/Research-Brief-Formatted-Internal-Structure-Final.pdf

Mei, X., Routh, D., & Hamilton, Z. K. (2016a). *Content Validity of the Static Risk Individual Need Guide for Recidivism (STRONG-R)*. Spokane, WA: Washington State Institute for Criminal Justice. Retrieved from https://s3.wp.wsu.edu/uploads/sites/436/2016/11/Research-Brief-Formatted-Content-Validity.pdf

Mei, X., Routh, D., & Hamilton, Z. K. (2016b). *Convergent and Discriminant Validity of the STRONG-R*. Spokane, WA: Washington State Institute for Criminal Justice. Retrieved from https://s3.wp.wsu.edu/uploads/sites/436/2016/10/Research-Brief-Formatted-Convergent-Discriminate-Validity-Final.pdf

Milgram, S. (1974). *Obedience to Authority*. New York, NY: HarperCollins Publishers.

Miller, H. A. (2006a). A dynamic assessment of offender risk, needs, and strengths in a sample of pre-release general offenders. *Behavioral Sciences and the Law, 24*(6), 767-782. doi:10.1002/bsl.728

Miller, H. A. (2006b). *Inventory of Offender Risk, Needs, and Strengths (IORNS). Professional manual.* Lutz, Florida: Psychological Assessment Resources Inc.

Miller, M., Drake, E. K., & Nafziger, M. (2013). *What works to reduce recidivism by domestic violence offenders?* (Document no. 13-01-1201). Olympia, WA: Washington State Institute for Public Policy.

Miller, M., & Ngugi, I. (2009). *Impacts of housing supports: Persons with mental illness and ex-offenders* (Document No. 09-11-1901). Olympia, WA: Washington State Institute for Public Policy.

Moga, D. E. (2018). So what is gender anyway? And who's having sex with whom? *Journal of the American Psychoanalytic Association, 66*(3), 527-543. doi:10.1177/0003065118783518

Monahan, J. (1977). Strategies for an empirical analysis of the prediction of violence in emergency civil commitment. *Law and Human Behavior, 1*(4), 363-371. doi:10.1007/BF01048595

Monahan, J. (1981). *The prediction of violent behavior: A theoretical analysis and a review of the evidence*. Minneapolis: University of Minnesota Press.

Monahan, J., Steadman, H., Silver, E., Appelbaum, P., Robbins, P., Mulvey, E., Roth, L., Grisso, T., & Banks, S. (2001). *Rethinking risk assessment: The MacArthur study of mental disorder and violence*. New York: Oxford University Press.

Morandi, S., Silva, B., Golay, P., & Bonsack, C. (2017). Intensive case management for addiction to promote engagement with care of people with severe mental and substance use disorders: An observational study. *Substance Abuse Treatment, Prevention, and Policy. 12*(26), 1-10. doi:10.1186/s13011-017-0111-8

Morgan, R., Flora, D., Kroner, D., Mills, J., Varghese, F., & Steffan, J. (2012). Treating offenders with mental illness: A research synthesis. *Law and Human Behavior, 36*(1), 37-50. doi:10.1037/h0093964

Morse, S. (2011) Mental disorder and criminal law. *Journal of Criminal Law and Criminology, 101*(3), 884-986. Retrieved from https://scholarlycommons. law.northwestern.edu/cgi/viewcontent.cgi?article=7406&context=jclc

Najavits, L. M. (2009). Seeking Safety: An implementation guide. In A. Rubin & D. W. Springer (Eds.), *The Clinician's Guide to Evidence-Based Practice*. Hoboken, NJ: John Wiley

National Institute on Drug Abuse. (2010). *Comorbidity: Addiction and Other Mental Illnesses* (Publication no. 10-5771). US Department of Health and Human Services: National Institutes of Health. Retrieved from https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf

National Institute for Health and Care Excellence. (2014). *Psychosis and Schizophrenia in Adults: Prevention and Management*. Retrieved from https://www.nice.org.uk/guidance/cg178.

National Sheriffs' Association. (2014). The treatment of persons with mental illness in prisons and jails: A state survey. Retrieved from http://tacreports.org/storage/documents/ treatment-behind-bars/treatment-behond-bars.pdf

Neal, T. M. S., & Grisso, T. (2014). The cognitive underpinnings of bias in forensic mental health evaluations. *Psychology, Public Policy, and Law*, 20(2), 200–211. doi:10.1037/law0000022

Noonan, M., & Mumola, C. (2004). *Veterans in state and federal prison, 2004: Veterans in prison or jail* (Bureau of Justice Special Report No. NCJ 217199). U.S. Department of Justice: Office of Justice Programs. Retrieved from https://www.bjs.gov/content/pub/ascii/vsfp04.txt.

O'Connor v. Donaldson, 422 U.S. 563, 575, 45 L. Ed. 2d 396, 95 S. Ct. 2486 (1975).

Offender Accountability Act, E2SSB 5421, Chapter 196 (1999).

ORCSP program guidelines. (2018). Retrieved from https://www.google.com/search?client=safari&rls=en&ei=mQl6XNXgB4rl-gSfu7SwDQ&q=offender+reentry+community+safety+program+guidelines&oq=offender+reentry+community+safety+program+guidelines&gs_l=psy-ab.3...10643.16828..17896...0.0..0.166.2825.36j2......0....1..gws-wiz.......0i71j0i8i7i30j0i7i5i30j0i7i30j0i67j0i8i30j33i10.AqByb2NTNhA

Oliver, M. (1996). *Understanding Disability from Theory to Practice*. London: MacMillan Press.

Orbach, S. (2014). Democratizing psychoanalysis. In D. Loewenthal & A. Samuels, *Relational psychotherapy, psychoanalysis and counseling: Appraisals and reappraisal* (pp. 12-26). NY/London: Routledge.

Otto, R.K., & Douglas, K.S. (2010). *Handbook of violence risk assessment*. New York, NY: Routledge.

Ouellette, H. M., & Applegate, B. K. (2015). The professional ideology of criminologists. *The Prison Journal, 95*(3), 287-308. doi:10.1177/0032885515587459

Paglin, L. (Producer & Director). (2016). *Unseen* [Motion Picture]. United States: Creative Filmmakers Association.

Pedneault, A., & Fisher, L. R. (2016). *Risk assessment of sex and kindnapping offenders: A review of practices and training needs in Washington State.* State of Washington Office of Financial Management: Sex Offender Policy Board. Retrieved from https://sgc.wa.gov/sites/default/files/public/sopb/documents/SOPB_risk_assessment.pdf

Phipps, P., & Gagliardi, G. (2002). *Implementation of Washington's Dangerous Mentally Ill Offender law* (Document no. 02-03-1901). Olympia, WA: Washington State Institute for Public Policy.

Phipps, P., & Gagliardi, G. (2003). *Washington State's Dangerous Mentally Ill Offender law: Program selection and services interim report* (Document no. 05-03-1901). Olympia, WA: Washington State Institute for Public Policy.

Presser, L., & Kurth, S. (2009). 'I got a quick tongue': Negotiating ex-convict identity in mixed company. In B. M. Veysey, J. Christian, & D. J. Martinez (Eds.), *How Offenders Transform Their Lives* (pp. 72-86). NY/London: Routledge.

Pulkkinen, L. (2009, March 2). King County's mental health court marks milestone: Program inspired by slaying called success at age 10. *Seattle P-I Reporter*. Retrieved from http://seattle pi.com/local/article/King-County-s-mental-health-court-marks-milestone-1301445.php.

Reutter, D. (2016, March 7). California overmedicates prisoners with psychotropic drugs. *Prison Legal News.* Retrieved from https://www.prisonlegalnews.org/news/2016/mar/7/california-overmedicates-prisoners-psychotropic-drugs/

RCW 4.24.550 (Community Protection Act), c 3 § 117 (1990)

RCW 9A.44.132, c 261 § 5 (2015)

RCW 71.05.020, c 305 § 1 (2018)

RCW 72.09.370, (SSB 5011), c 214 § 2 (1999)

RCW 72.09.370, c 201 § 9012 (2018)

RCW 71.24.450, (2SSB 6002), c 342 § 1 (1997)

RCW 71.24.470 (SHB 1201), c 319 § 1 (2009)

Rezansoff, S. N., Moniruzzaman, A., Fazel, S., McCandless, L., Procyshyn, R., & Somers, J. M. (2017). Housing first improves adherence to antipsychotic medication among formerly homeless adults with schizophrenia: Results of a randomized controlled trial. *Schizophrenia Bulletin, 43*(4), 852-861. doi:10.1093/schbul/sbw136

Robertson, P., Barnoa, M., & Ward, T. (2011). Rehabilitation frameworks in forensic mental health. *Aggression and Violent Behavior, 16*(6), 472-484. doi:10.1016/j.avb.2011.03.003

Roseborough, D. (2011). There are some things I don't want to know: Leichsenring and Rabung's long road to the 2008 JAMA report. *Clinical Social Work Journal, 39*(4), 355-361. doi:10.1007/s10615-010-0302-5

Rossegger, A., Gerth, J., Seewald, K., Urbaniok, F., Singh, J. P., & Endrass, J. (2013). Current obstacles in replicating risk assessment findings: A systematic review of commonly used actuarial instruments. *Behavioral Sciences and The Law, 31*(1), 154-164. doi:10.1002/bsl.2044

Ross, R. R., Fabiano, E. A., & Ross, R. (1986). *Reasoning and rehabilitation: A handbook for teaching cognitive skills*. Ottawa, Canada: T3 Associates.

Routh, D., & Hamilton, Z. K. (2016). *Research in brief: Inter-rater Reliability (IRR) of the Static Risk Offender Need Guide for Recidivism (STRONG-R)*. Spokane, WA: Washington State Institute for Criminal Justice. Retrieved from https://s3.wp.wsu.edu/uploads/sites/436/2016/03/DRR-Research-Brief-STRONG-R-IRR.pdf

Schlarb, A. M. (2009). A comparison of the effects of a cognitive behavioral program between male and female parolees. *ProQuest Information & Learning, Dissertation Abstracts International: Section B: The Sciences and Engineering*. Retrieved from http://antioch.idm.oclc.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2009-99200-481&site=ehost-live&scope=site.

Scholnick, E. K., & Miller, P. H. (2018). Categories, gender, and development: A feminist perspective. In N.K. Dess, J. Marecek & L.C. Bell (Eds.), *Gender, sex, and sexualities: Psychological perspectives* (pp. 319–341). New York, NY: Oxford University Press.

Schöttle, D., Schimmelmann, B. G., Karow, A., Ruppelt, F., Sauerbier, A. L., Bussopulos, A., … Lambert, M. (2014). Effectiveness of integrated care including therapeutic assertive community treatment in severe Schizophrenia Spectrum Disorder and Bipolar I Disorders: The 24-month follow-up ACCESS II study. *Journal of Clinical Psychiatry, 75*(12), 1371-1379. doi:10.4088/JCP.13m08817

Scurich, N. (2016). Structured risk assessment and legal decision-making. In M. K. Miller, B. H. Bornstein, M. K. Miller, B. H. Bornstein (Eds.), *Advances in psychology and law* (pp. 159-183). Cham, Switzerland: Springer International Publishing.

Serin, R. C., & Amos, N. L. (1995). The role of psychopathy in the assessment of dangerousness. *International Journal of Law and Psychiatry, 18*(2), 231-238. doi:10.1016/0160-2527(95)00008-6

Seto, M. C. (2019). The Motivation-Facilitation Model of sexual offending. *Sexual Abuse, 31*(1), 3-24. doi:10.1177/1079063217720919

Shapland, J., & Bottoms, A. (2011). Reflections on social values, offending and desistance among young adult recidivists. *Punishment and Society, 13*, 256-282. doi:10.1177/1462474511404334

Shweder, R. A., Mahapatra, M., & Miller, J. G. (1987). *Culture and moral development. The emergence of morality in young children.* Chicago, IL: University of Chicago Press.

Silverman, B., Mai, C., Boulet, S., & O'Leary, L. (2007). Logic models for planning and evaluation: A resource guide for the CDC State Birth Defects. *Centers for Disease Control and Prevention.* Retrieved from https://stacks.cdc.gov/view/cdc/11569.

Silverman, M. M., & De Leo, D. (2016). Why there is a need for an international nomenclature and classification system for suicide. *Crisis, 37*(2), 83-87. doi:10.1027/0227-5910/a000419

Singh, J. P. (2013). Predictive validity performance indicators in violence risk assessment: A methodological primer. *Behavioral Sciences & the Law, 31*, 8-22. doi:10.1002/bsl.2052

Singh, J. P., Grann, M., & Fazel, S. (2013). Authorship bias in violence risk assessment? A systematic review and meta-analysis. *PloS ONE, 8*(9). Retrieved from https://search-ebscohost-com.antioch.idm.oclc.org/login.aspx?direct=true&db=psyh&AN=2013-38636-001&site=ehost-live&scope=site

Skeem, J. L., Steadman, H. J., & Manchak, S. M. (2015). Applicability of the risk-need-responsivity model to persons with mental illness involved in the criminal justice system. *Psychiatric Services, 66*(9), 916-922. doi:10.1176/appi.ps.201400448

Spohn, C. (2015). Race, crime, and punishment in the twentieth and twenty-first centuries. *Crime and Justice, 44*(1), 49-97. doi:10.1086/681550

Sreenivasan, S., Kirkish, P., Garrick, T., Weinberger, L. E., & Phenix, A. (2000). Actuarial risk assessment models: A review of critical issues related to violence and sex-offender recidivism assessments. *Journal of the American Academy of Psychiatry and the Law, 28*(4), 438-448. Retrieved from https://search-ebscohost-com.antioch.idm.oclc.org/login.aspx?direct=true&db=psyh&AN=2001-14181-007&site=ehost-live&scope=site

Stein, D. J., Phillips, K. A., Bolton, D., Fulford, K. M., Sadler, J. Z., & Kendler, K. S. (2010). What is a mental/psychiatric disorder? From DSM-IV to DSM-V. *Psychological Medicine, 40*(11), 1759-1765. doi:10.1017/S0033291709992261

Strub, D. S., Douglas, K. S., & Nicholls, T. L. (2016). Violence risk assessment of civil psychiatric patients with the HCR-20: Does gender matter? *The International Journal of Forensic Mental Health, 15*(1), 81-96. doi:10.1080/14999013.2016.1141438

Substance Abuse and Mental Health Services Administration. (1999). Estimation methodology for adults with serious mental illness. *SAMHSA Federal Register, 64*(121), 33890-33897. Retrieved from https://www.gpo.gov/fdsys/pkg/FR-1999-06-24/html/99-15377.htm

Substance Abuse and Mental Health Services Administration. (2017). *State and substate estimates of serious mental illness from the 2012-2014 national surveys on drug use and health*. Retrieved from https://www.samhsa.gov/data/sites/default/files/report_3190/ShortReport-3190.html.

Substance Abuse and Mental Health Services Administration. (2018). *National Registry of Evidenced-based Programs and Practices (NREPP).* Retrieved from https://nrepp.samhsa.gov/landing.aspx

Surowiecki, J. (2005). *The wisdom of crowds.* New York: Anchor Books.

Swanson, J. W. (1994). Mental disorder, substance abuse, and community violence: An epidemiological approach. In J. Monahan & H. Steadman (Eds.), *Violence and mental disorder: Developments in risk assessment* (pp. 101-136). Chicago, IL: University of Chicago Press.

Swartz, M. S., & Bhattacharya, S. (2017). Victimization of persons with severe mental illness: a pressing global health problem. *World Psychiatry, 16*(1), 26. doi:10.1002/wps.20393

Talbott, J. A. (1975). Current clichés and platitudes in vogue in psychiatric vocabularies. *Hospital and Community Psychiatry, 26*, 530.

Taxman, F. S., Young, D., & Bryne, J. (2002). Offender's views of reentry: Implications for processes, programs and services (Document no. 196490). *National Criminal Justice Reference Service.* Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/196490.pdf

Taylor, C. J. (2016). The family's role in the reintegration of formerly incarcerated individuals: The direct effects of emotional support. *The Prison Journal, 96*(3), 331-354. doi:10.1177/0032885516635085

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*, 117-125. doi:10.1353/hpu.2010.0233

The Associated Press. (1997, August 28). Man charged with murder in stabbing of retired firefighter. *Kitsap Sun.* Retrieved from https://products.kitsapsun.com/archive/1997/0828/0010_man_charged_with_murder_in_stabbi.html

The Associated Press. (1998, April 4). Legislation: Bill tightly controls mentally ill offenders. *Kitsap Sun.* Retrieved from http://web.kitsapsun.com/archive/1998/04-03/0008_legislation__bill_tightly_control.html

Theurer, G., & Lovell, D. (2008). Recidivism of offenders with mental illness released from prison to an intensive community treatment program. *Journal of Offender Rehabilitation, 47*(4), 385-406. doi:10.1080/10509670801995023

Thornton, D., Kelley, S. M., & Nelligan, K. E. (2017). Protective factors and mental illness in men with a history of sexual offending. *Aggression and Violent Behavior, 32*, 29–36. doi:10.1016/j.avb.2016.12.003

Third Engrossed Substitute Senate Bill 5034 § 220 (3ESSB 5034). (2013). *2013-2015 Operating budget.* Retrieved from http://lawfilesext.leg.wa.gov/biennium/ 201314/Pdf/Bills/Senate%20Passed%20Legislature/5034-S.PL.pdf

Tripodi, S. (2014). Emphasis on rehabilitation: From inmates to employees. *International Journal of Offender Therapy and Comparative Criminology, 58*(8), 891-893. doi:10.1177/0306624X14541656

US Department of Justice. (2014). *Treatment and care of inmates with mental illness* (OPI: RSD/PSB, No. 5310.16). Retrieved from https://www.bop.gov/policy/ progstat/5310_16.pdf

VanVoorhis, P., & Salsibury, E. (2014). *Correctional counseling and rehabilitation.* Waltman, MA: Anderson Publishing.

Veysey, B. M. (1998). The specific needs of women diagnosed with mental illnesses in U.S. jails. In B. L. Levin, A. K. Blanch, & A. Jennings (Eds.), *Women's mental health service: A public health perspective* (pp. 368-389). Thousand Oaks, CA: Sage Publications.

Veysey, B. M., Martinez, D. J., & Christian, J. (2009). Identity transformation and offender change. In B. M. Veysey, J. Christian, & D.J. Martinez (Eds.), *How offenders transform their lives* (pp. 1-11). NY/London: Routledge.

Viljoen, S., Nicholls, T. L., Roesch, R., Gagnon, N., Douglas, K.S., & Brink, J. (2016). Exploring gender differences in the utility of strength-based risk assessment measures. *The International Journal of Forensic Mental Health, 15*(2), 149-163. doi:10.1080/14999013.2016.1170739

von Hirsch, A. (1982). Desert and white-collar criminality: A response to Dr. Braithwaite. *Journal of Criminal Law and Criminology, 73*(3), 1164-1175. doi:10.2307/1143189

W.K. Kellogg Foundation. (2004). *Evaluation handbook.* Retrieved from https://cyc.brandeis.edu/pdfs/reports/EvaluationHandbook.pdf

Wagner, P., & Rabuy, B. (2017, March 14). Mass incarceration: The whole pie 2017. *Prison Policy Initiative.* Retrieved from https://www.prisonpolicy.org/reports/pie2017.html

Wainberg, M. L., Cournos, F., Wall, M. M., Pala, A. N., Mann, C. G., Pinto, D., Pinho, V., & McKinnon, K. (2016). Mental illness sexual stigma: Implications for health and recovery. *Psychiatric Rehabilitation Journal, 39*(2), 90-96. doi:10.1037/prj0000168

Ward, T. (2002). Good lives and the rehabilitation of offenders: Promises and problems. *Aggression and Violent Behavior, 7*(5), 513-528. doi:10.1016/S1359-1789(01)00076-3

Ward, T., Mesler, J., & Yates, P. (2007). Reconstructing the Risk-Needs-Responsivity model: A theoretical elaboration and evaluation. *Aggression and Violent Behavior, 12*, 208-228. doi:10.1016/j.avb.2006.07.001

Ward, T. Yates, P., & Willis, G. M. (2012). The Good Lives model and the Risk Need Responsivity model: A critical response to Andrews, Bonta, and Womith (2011). *Criminal Justice and Behavior, 39*(1), 94-110. doi:10.1177/0093854811426085

Washington Administrative Code. (2019). *Behavioral health organizations – definitions* (WAC 388-865-0238). Retrieved from https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Rules%20%26%20Notices/Former-chapter-388-865_red-italics.pdf

Washington Association of Sheriffs & Police Chiefs. (2016). *Guide to the Washington State Sex Offender Risk Classification tool* (version2/2016). https://www.waspc.org/assets/SexOffenders/wssorlc%20instructions%202-16-2016.pdf

Washington State Department of Corrections. (2016). *Restrictive Housing* (DOC Policy No. 320.255). Retrieved from https://www.doc.wa.gov/information/policies/files/320255.pdf

Washington State Department of Corrections. (2017). *Risk and Needs Assessment Process*. (DOC Policy No. 320.400). Retrieved from http://www.doc.wa.gov/information/policies/files/320400.pdf

Washington State Department of Social and Health Services. (2016). *Fact Sheet: Offender Reentry Community Safety Program (ORCSP)*. Retrieved from https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Fact%20Sheets/ORCSP.p

Washington State Institute for Public Policy. (2017). *Benefit-Cost Technical documentation*. Olympia, WA: Washington State Institute for Public Policy. Retrieved from http://www.wsipp.wa.gov/TechnicalDocumentation/WsippBenefitCostTechnicalDocumentation.pdf

Washington State Office of Financial Management. (2016). *Washington mental health system assessment*: *Initial findings report*. Retrieved from http://kitsapgov.com/hs/sbho/documents/Reports/2017/WA_Initial_Findings_Report_November_2016_Final.pdf

Watts, B. V., Schnurr, P. P., Mayo, L., Young-Xu, Y., Weeks, W. B., & Friedman, M. J. (2013). Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *The Journal of Clinical Psychiatry, 74*(6), e551–e557. doi:10.4088/JCP.12r08225

Webster, C., Douglas, K. S., Eaves, D, & Hart, S. D. (1997). *HCR-20: Assessing risk for violence (version 2)*. Vancouver, Canada: Simon Fraser University.

Webster, C. D., Martin, M. L., Brink, J., Nicholls, T. L., & Desmarais, S. L. (2009). *Short-Term Assessment of Risk and Treatability (START)* (Version 1.1). Coquitlam, BC, Canada: British Columbia Mental Health and Addiction Services.

Weinstein, J. B. & Wimmer, C. (2010). Sentencing in the United States. In H. A. Dlugacz (Ed.), *Reentry planning for offenders with mental disorders: Policy and practice* (pp. 1-45). Kingston, NJ, US: Civic Research Institute.

Whitaker, R. (2010). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Crown Publishers.

Wolf, T. (2013, September, 15). Suspect in professor's fatal stabbing may have criminal record in California. *The Seattle Times*. Retrieved from http://www.seattletimes.com/seattle-news/suspect-in-professorrsquos-fatal-stabbing-may-have-criminal-record-in-california/

Wolff, N. (2005). Community reintegration of prisoners with mental illness: A social investment perspective. *International Journal of Law and Psychiatry, 28*(1), 43-58. doi:10.1016/j.ijlp.2004.12.003

Wolff, N., Morgan, R., & Shi, J. (2013). Comparative analysis of attitudes and emotions among inmates: Does mental illness matter? *Criminal Justice and Behavior, 40*(10), 1092-1108. doi:10.1177/0093854813488760

World Health Organization. (1992). *International classification of diseases and related health problems* (10th rev., ICD-10). Geneva, Switzerland: Author.

Young, S., & Ross, R. R. (2007). *Reasoning & Rehabilitation 2 for youths & adults with mental health problems: A prosocial competence program*. Ottawa, Canada: Cognitive Centre of Canada. Retrieved from http://www.cognitivecentre.ca.

Yu, R., Branje, S., Meeus, W., Koot, H. M., van Lier, P., & Fazel, S. (2017). Victimization mediates the longitudinal association between depressive symptoms and violent behaviors in adolescence. *Journal of Abnormal Child Psychology, 46*(4), 839-848. doi:10.1007/s10802-017-0325-2

Zappala, M., Reed, A. L., Beltrani, A., Zapf, P. A., & Otto, R. K. (2018). Anything you can do, I can do better: Bias awareness in forensic evaluators. *Journal of Forensic Psychology Research and Practice, 18*(1), 45–56. doi:10.1080/24732850.2017.1413532

APPENDIX A

Recommendations

A.1. Introduction to Appendix A

In 2002, Phipps and Gagliardi's first report on the DMIO Program, titled *Implementation of Washington's Dangerous Mentally Ill Offender Law: Preliminary Findings,* included a table of recommendations (pp. 71-81) that were meant to improve processes and program effectiveness. Although there is no question about the complexity of identifying PSMI-Ns, there does not appear to be documentation that explains how Phipps and Gagliardi's (2002) recommendations were addressed. The following sections (Appendix A.2 through A.8) are structured similar to Phipps and Gagliardi's (2002) original format to provide consistency and opportunity for comparison. Recommendations prefaced with an asterisk are critical areas, as they were also made in 2002, without noticeable response or resolution.

A.2. Electronic Records

Recommendations   Comments

Electronic Records	
1a-Assess the validity and reliability of the ORCS Pre-screening Computer Algorithm (ORCS-PCA).	Without empirical substantiation, continued use of this tool in screening procedures is ill-advised and raises ethical concerns surrounding non-adherence to evidence-based assessment recommendations outlined in the literature and decreed by RCW 72.09.370.
1b-Consider adding specifiers to electronic databases that would allow the ORCS-PCA filtering system to capture WADOC assessors' opinions about PSMI-N eligibility.	Because the WAONE utilizes a broadband classification system with limited consideration of mental health needs, it would likely be helpful if WADOC assessors were able to use correctional databases to flag individuals suspected of meeting PSMI-N criteria before running the ORCS-PCA.
1c-Adapt electronic records to address Washington's evolving integrated managed care model.	It is unclear how systems throughout Washington State will be affected by ongoing conversion to integrated health models. It would be prudent to discuss ORCSP electronic record needs with BH-ASOs & MCOs to enhance collaborative information sharing between multiple jurisdictions.
1d-Develop a more nuanced and consistent expenditure tracking process, including creating a database of monthly service disbursement for each contracted agency and for each client.	As a first step in fine-tuning resource allocation, the ORCSP should improve tracking for each participant's service utilization and resource expenditures. Without doing so, contractors will continue to be paid without itemized accounting. From a bookkeeping standpoint, such loose tracking is non-transparent and mismanages public-sector dollars. Universal, electronic tracking forms may also permit a level of comparison between providers and implemented services that was not possible previously.
1e-If the ORCSP continues to bypass conducting their own actuarial and/or SPJ risk assessments, WADOC should create mechanisms to allow access to raw scores on risk assessments administered throughout individuals' custodial stay.	Review of risk assessment raw scores could foster improved narrowband discrimination within HV and HVPD groups through the creation and calibration of ORCSP enrollment thresholds. As part of this process, it is recommended that ORCSP staff be trained to administer and interpret relevant VRAs.

A.3. PSMI Identification and Selection

Recommendations   Comments

PSMI Identification and Selection	
*2a-"WADOC, HCA (DSHS in 2002), the communities, and the SRC need to come to an agreement about which objective criteria (diagnosis, functional impairment) will qualify a candidate as mentally ill for purposes of the ORCSP (DMIO program in 2002)." (Phipps & Gagliardi, 2002, p. 72)**	The ORCSP continues to define major mental disorder using RCW 71.05.020, but no longer follows specific diagnostic eligibility guidelines for program enrollment. Although this change expands the number of qualifying diagnoses, without clear diagnostic or symptom-level criteria, screening processes may primarily identify individuals with high utilization of prison mental health services, potentially overlooking a portion of PSMIs who are dangerous, but do not require or receive significant intervention while in a controlled setting.
*2b-Test current processes used to select individuals identified by the ORCS-PCA.**	Even though the ORCSP has restructured operating procedures for the ORCS-PCA, these guidelines should be tested for efficiency. This could, in part, be accomplished by analyzing historical datasets (i.e., how do current methods perform when run on previous datasets) and using other methods (i.e., how do those selected compare to those not selected; do current methods identify similar participants as gold-standard risk assessments).
*2c-Consider augmenting screening for PSMIs classified as HV or HVPD by requiring supplemental psychological and risk assessments. Where appropriate, allow WADOC staff to make *Mental Disorder* designations prior to SRC review.**	Full SRC review may still be helpful in making ultimate decision regarding program enrollment.
2d-Consider integrating doctoral or master's level interns, who are adequately trained in VRA and SMI diagnosis.	Use of interns in forensic settings is supported in the literature and was recommended by one of the participating consultants in this study. It is recognized that the feasibility of this recommendation is largely dependent on WADOC policy and available resources.

A.4. Statewide Review Committee Procedures

Recommendations   Comments

Statewide Review Committee Procedures	
*3a-For candidates being considered for SRC review, a formal, structured clinical interview and mental status exam should be conducted in-person, by a qualified mental health professional to assess current SMI symptomatology, pre-release mental status, treatment response, mental health history, therapeutic goals, strengths, protective factors, and substance use issues.	Although all SRC members must now possess MHP qualifications, *Mental Disorder* determinations continue to be made without clinical interview. It has been posited previously that the SRC "doubtlessly could arrive at a meaningful diagnosis without having personally conducted a clinical assessment of the offender under consideration" (Phipps and Gagliardi, 2002, p. 73). At the very least, SRC methods should evidence consistent and accurate assessment outcomes between raters.
3b-Consider removing candidate photographs from SRC review packets as a means to minimize bias.	Multicultural research suggests that judgement is frequently impacted by cultural factors, even in situations where impartiality is attempted or intended. Across multiple contexts (employment, housing, sentencing, arrest, etc…) evaluator awareness of ethnic identity has been shown to influence preferential/biased outcomes. How best to minimize cultural noise within a racially disparate and prejudiced criminal justice system remains a salient social justice issue.
3c-Conduct an investigation to learn how committee members review files prior to SRC meetings.	As a means to further reduce bias related to fatigue and/or being swayed by other SRC members, the ORCSP has recently allowed SRC members to review files prior to SRC meetings. Since some cases necessitate the review of hundreds of pages of mental health and criminal history documentation, it is not yet clear if there is consistency between SRC members' review methods.
3d-Examine if there are differences in selection trends for open vs. closed voting.	It is possible that making committee votes anonymous would create a more neutral approach to the enrollment process.

A.5. Dangerousness Screening

Recommendations   Comments

Dangerousness Screening	
4a-Incorporate protective factor assessments into risk screening processes.	Protective factor assessments, such as the SAPROF, may offer additional points of data to inform risk decisions and mitigation planning. Additionally, it is believed that motivation to desist can be enhanced by aligning treatment objectives with client goals and strengths, expanding positive social relationships, and nurturing already established prosocial aspects of self.
4b-Explore potential risk thresholds by evaluating the relationship between the WAONE and other risk assessment raw scores, ORCSP screening procedures, and recidivism.	At this point in time, the ORCSP is unable to access raw scores to manipulate WAONE or other risk assessment cut-points in screening, despite a need for narrowband thresholds. As a consequence, screening processes have low discriminatory abilities between high-risk and highest-risk groups. Legislature has specifically tasked the ORCSP to make such narrowband determinations.
4c-In cases in which an individual is ruled out for *Mental Disorder*, the SRC should still conduct an assessment of *Dangerousness* and refer to non-ORCSP mitigation services, where appropriate.	In some cases, individuals who do not meet *Mental Disorder* criteria may still be equally or more risky than enrolled PSMI-Ns. WADOC should develop a mitigation process or program to address reentry needs of those deemed *Dangerous*, but not *Mentally Disordered*. Currently, this is sometimes done through Community Corrections if the person has post-release supervision; however, standardizing procedures may offer additional safeguards to protect the public.
4d-Using archival data, conduct a retrospective study to examine the validity and reliability of the WAONE and other gold-standard VRAs, like the VRAG-R and HCR-20.	The ORCSP has done an excellent job storing and organizing previous ORCS-PCA data, SRC packets, and SRC decision sheets. Gold-standard VRAs should be coded (via records) and tested for individuals screened, including those ruled out as non-PSMI-N, to clarify false negative rates, risk ratios, AUCs, IRR, and other relevant statistical analyses.

A.6. Documentation

Recommendations   Comments

Documentation	
*5a-"Identify documentation considered critical for review decisions" (Phipps & Gagliardi, 2002).	Although SRC review packets have been used for many years now and SRC members are familiar with their structure, they have not undergone testing to verify that the items included are relevant and correlated to SMI diagnosis and/or serious recidivism.
*5b-For all individuals reviewed by the SRC, a detailed written justification of inclusion/rule-out should be included with submitted decision sheets and uploaded electronically.	Until the SRC screening methods undergo validity and reliability testing, robust and relevant summaries should be completed for each individual reviewed by the SRC that detail SRC rationale for *Mental Disorder* and *Dangerousness* decisions. Quality assurance of current methods is confounded by non-standardization of packet review processes. It is recommended that summaries be structured similar to EBP recommendations for risk assessment justification (Harris et al., 2015; Otto & Douglas, 2010).

A.7. Oversight

Recommendations   Comments

Oversight	
6a-Continue periodic review of processes by both internal and external researchers as a means of ensuring adherence to contemporary EBPs and assessment methods.	The ORCSP has endorsed an interest in ongoing empirical investigation of processes. In addition to conducting their own investigations, they have partnered previously with WSIPP and were extremely helpful and receptive during the course of this dissertation. Expanding the ORCSP research network may lead to more expansive projects and create opportunities for cross-system, comparative designs. The WAONE, in particular, should be examined more closely by non-WSU research groups.
6b-All ORCSP staff should be trained and qualified to administer and interpret risk assessments.	This may include a vetting process by which ORCSP staff are required to pass proficiency tests. At a minimum, SRC members should be objectively approved by a qualified trainer. Staff should also be able to evidence mastery of risk formulation and mental health diagnosis before allowed to participate in SRC meetings. MHP qualification alone does not ensure expertise in VRA.
6c-Explore the utility of incorporating gatekeeper trainings.	Gatekeeper trainings are often employed in the context of suicide risk assessment training and generally refer to programs that seek to develop individuals' "…knowledge, attitudes and skills to identify those at risk, determine levels of risk, and make referrals when necessary" (Gould et al., 2003). The Gatekeeper model encourages 'train the trainer' education and is considered an EBP.

A.8. Labels

Recommendations   Comments

Labels	
***7a-Consider changing the program name, as including the acronym 'ORCS,' and the terms 'Offender' and 'Community Safety,' in current label may lead to unintended discrimination for participants, especially as it relates to employment, education, housing, and other social opportunities.**	When interpreted through a popular-cultural lens, the acronym 'ORCS' describes a group of mythical beasts known for their blood-thirsty violence, warring, and disloyalty. It is possible that some people, including program participants, will assume using the term in this way is derogatory. The label 'Offender' seems unnecessary, since 'Reentry' implies an individual is releasing from institutional to community setting. The term 'Community Safety,' although an accurate program goal, implies that an individual is unsafe and may inadvertently increase bias towards participants in a variety of contexts.
7b-Consider changing the process name 'Dangerousness' to 'RLC Classification.'	Using the term 'RLC Classification,' may be a more precise description of current *Dangerousness* screening, as eligibility is now guided by risk classification, rather than empirically supported estimations of risk for PSMIs. 'RLC Classification' is also less stigmatizing than describing an individual as dangerous.
7c-Reinforce person-centered language and positive framing of terminology for ORCSP participants.	Throughout this dissertation, the label 'Person with Serious Mental Illness and supported Needs' (PSMI-N) was used in place of 'Dangerous Mentally Ill Offender' (DMIO). Although the ORCSP has also abandoned the DMIO acronym and often utilizes the term 'participant,' it was noted that the terms 'inmate' and 'offender' linger in some WADOC documentation and relevant legislation. It is recommended that nomenclature be reviewed and updated, where appropriate.

APPENDIX B

Supporting Material

B.1. Risk Management Identification (RMI) - Risk Management Levels

Risk Management Levels (Aos, 2002)			
RMD	**RMC**	**RMB**	**RMA**
LSI-R of 0 to 23 and not classified as RMA, RMB, or RMC	LSI-R of 24 to 40 and not classified as an RMA or RMB	LSI-R of 41 to 54 and conviction for a non-violent crime, or LSI-R of 32 to 40 and conviction for a violent crime	LSI-R of 41 to 54 and conviction for a violent crime
	Level I sex offender	Level II sex offender	Level III sex offender
			Other indicators of violent history
			DMIO (designated by the CPU)
Low-risk >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> High-risk			
Level of Risk			

Source: Aos, S. (2002). *Washington's Offender Accountability Act: An evaluation of the Department of Corrections' Risk Management Identification System* (Document no. 02-01-1201). Olympia, WA: Washington State Institute for Public Policy.

B.2. Static Risk Assessment (SRA): Weighting Rules

Felony Score	Property & Violent Score	Violent Score	Static Risk Factor
20	15	10	Risk Score Constant or Intercept
3	6	10	Felony Domestic Violence Assault or Violation of a Domestic Violence Related Protection Order, Restraining Order, or No-Contact Order
2	2	5	Prior Juvenile Non-Sex Violent Felony Convictions
6	5	5	Felony Violent Property Conviction for a Felony Robbery/Kidnapping/ Extortion/Unlawful Imprisonment/Custodial Interference Offense
3	2	5	Felony Weapon Offense
5	4	4	Gender
1	2	4	Felony Assault Offense - Not Domestic Violence Related
6	4	4	Misdemeanor Weapon Offense
2	2	3	Misdemeanor Assault Offense - Not Domestic Violence Related
2	3	3	Misdemeanor Domestic Violence Assault or Violation of a Domestic Violence Protection Order, Protection Order, or No-Contact Order
5	3	3	Total Sentence/Supervision Violations (three or more)
5	4	2	Age at Time of Sentence for Current Offense
4	4	2	Prior Juvenile Felony Convictions
4	3	2	Prior Commitments to a Juvenile Institution
-4	-2	2	Felony Sex Offense
4	3	2	Misdemeanor Escapes
2	1	1	Current Commitment to the Department of Corrections
-5	-3	1	Felony Homicide Offense
5	3	1	Felony Escape
-3	-1	1	Misdemeanor Other Domestic Violence
4	4	1	Misdemeanor Property Offense
-1	-1	1	Misdemeanor Alcohol Offense
5	3	1	Total Sentence/Supervision Violations (three or more scored as 3 for violent score)
4	5	0	Felony Property Offense
6	-2	0	Felony Drug Offense
3	-1	0	Misdemeanor Sex Offense
3	1	0	Misdemeanor Drug Offense
-3	-2	-1	Prior Juvenile Felony Sex Convictions

* Sorted by violence weighted score

Source: Barnoski, R., & Drake, E. K. (2007). *Washington's Offender Accountability Act: Department of Corrections' Static Risk Assessment* (Document no. 07-03-1201). Olympia, WA: Washington State Institute for Public Policy.

B.3. Static Risk Assessment (SRA): 5-level Classification System

Risk Level Classification System				
Low	**Moderate**	**High Drug**	**High Property**	**High Violent**
Not High Risk and not Moderate Risk Felony Score is less than 64	Not High Risk and Property/Violent Felony Score is greater than or equal to 38	Not High Violent Risk and not High Property Risk and Felony Score is greater than or equal to 64	Not High Violent Risk and Property/Violent Score is greater than or equal to 50	Violent Score is greater than or equal to 38
Low-risk >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> >>> High-risk				
Level of Risk				

Source: Barnoski, R., & Drake, E.K. (2007). *Washington's Offender Accountability Act: Department of Corrections' Static Risk Assessment* (Document no. 07-03-1201). Olympia, WA: Washington State Institute for Public Policy.

B.4. Possible WAONE Risk Classifications, with Gender Considerations (n=12)

Possible WAONE Risk Classifications		
	Male	**Female**
Risk Categories	Low	Low
	Moderate	Moderate
	High Drug	High Drug
	High Property	High Property
	High Violent	High Violent
	Diverse (HVPD)	Diverse (HVPD)

B.5. WSIPP ORCSP Cost/Benefit Estimates

WSIPP ORCSP Cost/Benefit Estimates										
Study	**Program**	**Findings**	**Total benefits**	**Taxpayer benefits**	**Non-taxpayer benefits**	**Costs**	**Benefits minus cost**	**Benefit to cost ratio**	**Chance benefits will exceed costs**
Bitney et al. (2017)	ORCSP	#1 Cost #1 Benefits to taxpayers, benefits to non-taxpayers #1 Overall cost/benefit ratio	$69,950.00	$23,873.00	$46,077.00	$36,726.00	$33,224.00	$1.90	96%
Aos & Drake (2013)	ORCSP	#1 Cost #1 Benefits to taxpayers, benefits to non-taxpayers #1 Overall cost/benefit ratio	$57,765.00	$19,087.00	$38,677.00	$32,924.00	$24,840.00	$1.75	93%
Drake et al. (2009)	DMIO	#1 Cost #1 Benefits to crime victims, benefits to taxpayers #3 Overall cost/benefit ratio	$30,732.00	$15,720.00	$15,012.00	$27,617.00	$18,836.00	$1.11	Not reported

Sources: Aos, S., & Drake, E. K. (2013). *Prison, police, and programs: Evidence-based options that reduce crime and save money* (Document no. 13-11-1901). Olympia, WA: Washington State Institute for Public Policy.

Bitney, K., Drake, E. K., Grice, J., Hirsch, M., & Lee, S. (2017). *The effectiveness of reentry programs for incarcerated persons: Findings for the Washington Statewide Reentry Council* (Document No. 17-05-1901). Olympia, WA: Washington State Institute for Public Policy.

Drake, E. K., Aos, S., & Miller, M. G. (2009). Evidence-based policy options to reduce crime and criminal justice costs: Implications in Washington State. *Victims and Offenders*, *4*, 170-196. doi:10.1080/15564880802612615

B.6. RCW Definitions: Violent Offense, Serious Violent Offense, and Risk Assessment

(55) "Violent offense" means:
(a) Any of the following felonies:

(i) Any felony or an attempt to commit a felony defined under any law as a class A felony;
(ii) Criminal solicitation of or criminal conspiracy to commit a class A felony;
(iii) Manslaughter in the first degree;
(iv) Manslaughter in the second degree;
(v) Indecent liberties if committed by forcible compulsion;
(vi) Kidnapping in the second degree;
(vii) Arson in the second degree;
(viii) Assault in the second degree;
(ix) Assault of a child in the second degree;
(x) Extortion in the first degree;
(xi) Robbery in the second degree;
(xii) Drive-by shooting;
(xiii) Vehicular assault, when caused by the operation or driving of a vehicle by a person while under the influence of intoxicating liquor or any drug or by the operation or driving of a vehicle in a reckless manner; and
(xiv) Vehicular homicide, when proximately caused by the driving of any vehicle by any person while under the influence of intoxicating liquor or any drug as defined by RCW 46.61.502, or by the operation of any vehicle in a reckless manner;

(b) Any conviction for a felony offense in effect at any time prior to July 1, 1976, that is comparable to a felony classified as a violent offense in (a) of this subsection; and
(c) Any federal or out-of-state conviction for an offense that under the laws of this state would be a felony classified as a violent offense under (a) or (b) of this subsection.

(46) "Serious violent offense" is a subcategory of violent offense and means:
(a) Any of the following crimes:

(i) Murder in the first degree;
(ii) Homicide by abuse;
(iii) Murder in the second degree;
(iv) Manslaughter in the first degree;
(v) Assault in the first degree;
(vi) Kidnapping in the first degree;
(vii) Rape in the first degree;
(viii) Assault of a child in the first degree; or
(ix) An attempt, criminal solicitation or conspiracy to commit one of these felonies; or

(b) Any federal or out-of-state conviction for an offense that under the laws of this state would be a felony classified as a serious violent offense under (a) of this subsection.

(44) "Risk assessment" means the application of the risk instrument recommended to the department by the Washington state institute for public policy as having the highest degree of predictive accuracy for assessing an offender's risk of reoffense.

Source: RCW 9A.44.132, c 261 § 5 (2015)

B.7. ORCSP Program Flow Chart (2019)

Offender Reentry Community Safety Program — Program Flow Chart
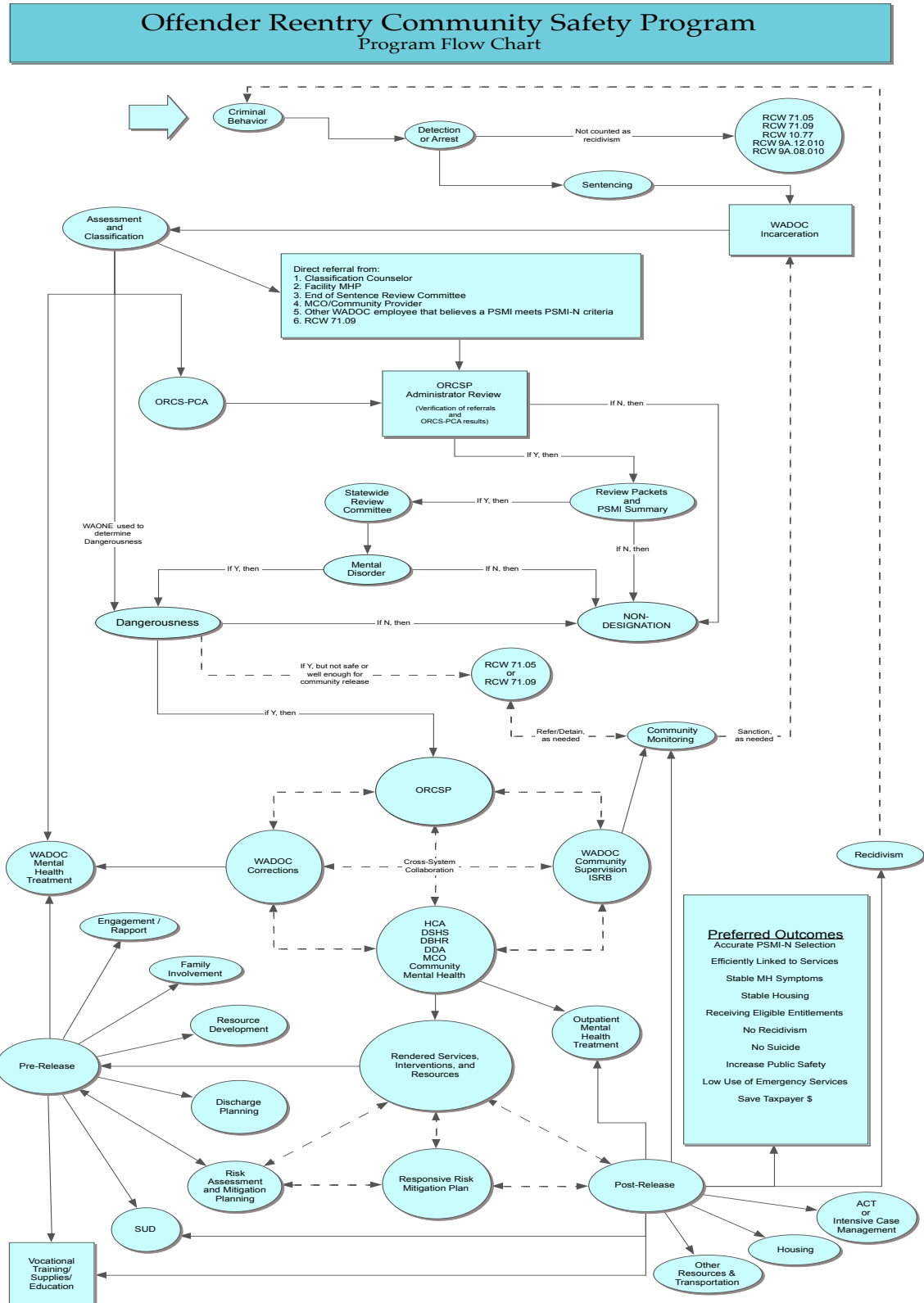
B.8. ORCS-PCA Variables (2017)

ORCS-PCA Variables
Name
Earned Release Date
Max Date
Notes
DOC#
Status
Risk Level
Date of Birth
Most Recent Admission Date
First Admission
SMI Confirmed Flag
Intellectually Disabled Flag
H-Code
S-Code
Historical Medications
Current Medications
History of Diagnosis
History of Serious Violent Crimes
History of Crimes Against People
Housing
Current Facility
County of First Felony Conviction

B.9. Violence Prediction Scheme (Hart, 2016)
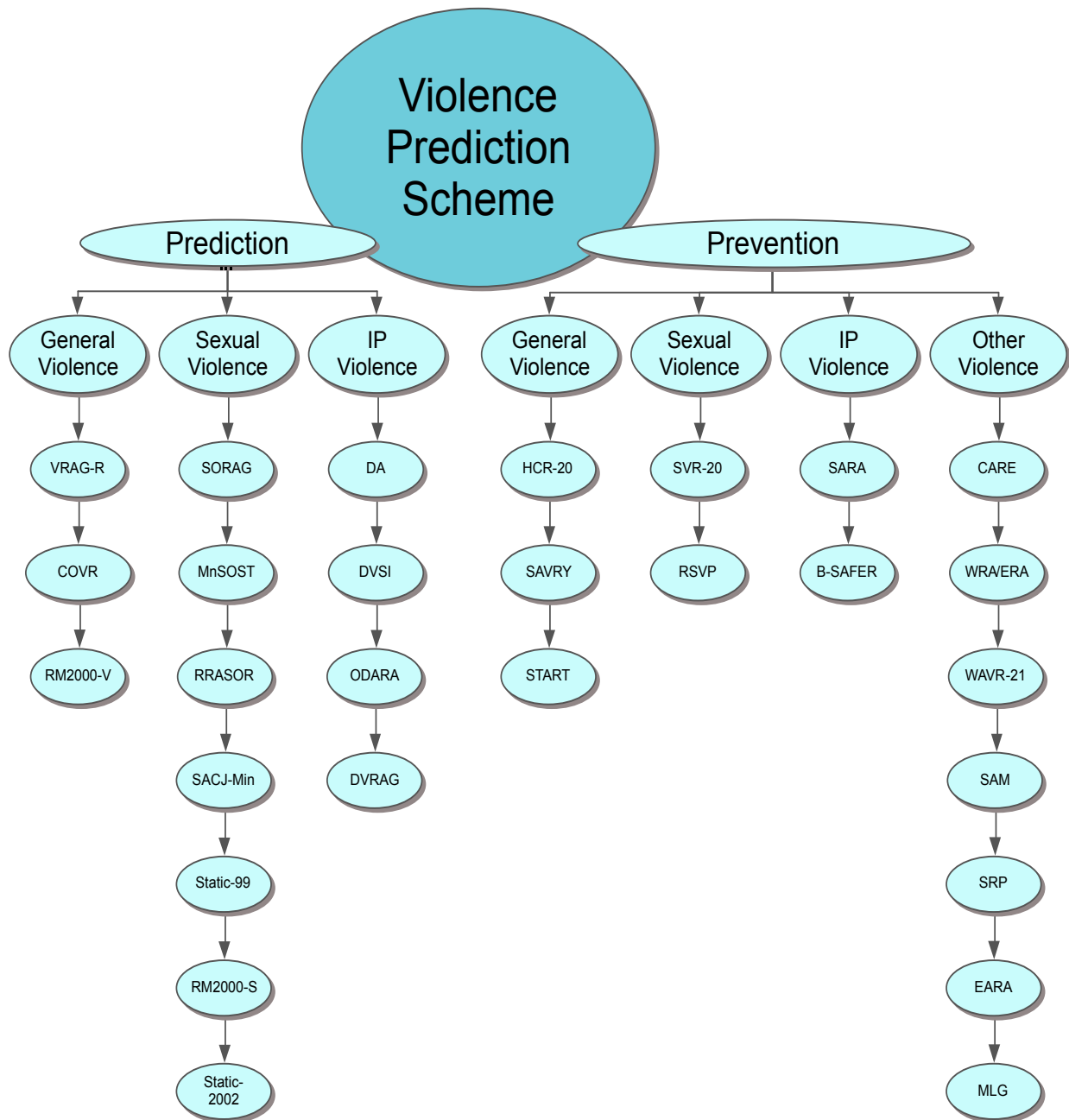
Source: Hart, S. (2016). Slide taken and adapted from training offerred through Concept Professional Learning: *Two methods for Assessing and Managing Risk* (6/9/2016). Reprinted with permission.

B.10. ORCSP Budget (1 of 2)

ORCSP Budget

Legend:
- •••• 1999 Budget
- ▬▬ Budget (2014-2018)
- ▬▬ Total Expenditures (2014-2018)
- ➤ Inflation (based on 1999 budget) *

*Inflation statistics calculated using https://www.usinflationcalculator.com.
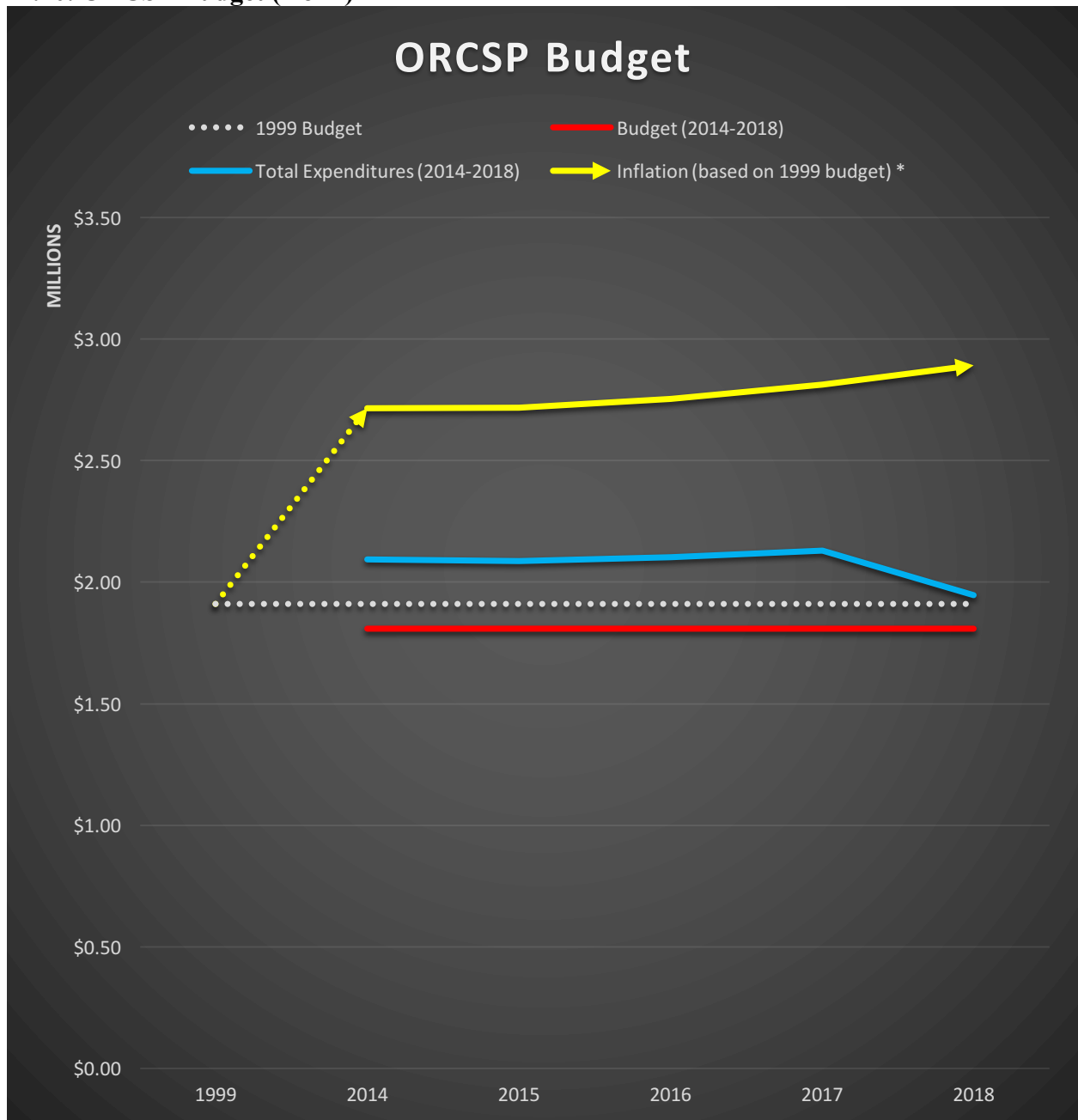
B.10. ORCSP Budget (2 of 2)

	1999	2014	2015	2016	2017	2018
Proposed Budget	$1,911,000	$1,810,000	$1,810,000	$1,810,000	$1,810,000	$1,810,000
Total Expenditures	Not reported	2,093,470	2,087,400	2,103,028	2,130,943	1,947,187
Amount Over Budget	Not reported	-283,470	-277,400	-293,028	-320,943	-137,187
Inflation (From 1999)	$1,911,000	$2,715,501	$2,718,724	$2,753,021	$2,811,671	$2,891,024
Percent Inflation (From 1999)	0%	42.1%	42.3%	44.1%	47.1%	51.3%
Difference (From 1999)	$0	-$622,031	-$631,324	-$649,993	-$680,728	-$943,837

*Inflation statistics calculated using https://www.usinflationcalculator.com.

Source: Budget data provided courtesy of the ORCSP. Reprinted with permission.

Spending Guidelines for ORCSP Clients - 2016
-Pre-release engagement (up to 6 months prior to release from DOC): $800/month
-Extended pre-release engagement: $600/month
-Ongoing service for Medicaid enrolled participants: $1,000/month
-Ongoing services for Non-Medicaid enrolled participants: $1,200/month

Source: Washington State Department of Social and Health Services. (2016). *Fact Sheet: Offender Reentry Community Safety Program (ORCSP)*. Retrieved from https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Fact%20Sheets/ORCSP.p

APPENDIX C

Consultation Study Methods

C.1. CJMHC Programs (N=108), p. 1 of 4

State	Agency Organization	Type	Program Title	Year Est	Pg	CODE
Alabama	Birmingham Police Department	PD	Community Service Officer Unit	1976	316	CRISIS
	Florence Police Department	PD	Community Mental Health Officer	1997	317	CRISIS
Alaska	Alaska DOC	DOC	Mental Health Management System	N/A	318	S
Arizona	Maricopa Adult Probation Department	PRO	Conditional Community Release Program	2000	318	S
	Maricopa County Sheriff's Office	PD	Data Link Project	1999	319	QI
	Pima County Pretrial Services	LEG	Mental Health Diversion Program	1997	320	LEG
California	Board of Corrections	DOC	Mentally Ill Offender Crime Reduction Grant (MIOCRG)	1998	320	POL
	Department of Mental Health	MH	California State Task Force	2000	321	POL
	Long Beach Police Department	PD	Mental Evaluation Team	1996	322	CRISIS
	Pacific Clinics: LA, Orange, Riverside, and San Bernardino Counties	MH	Pacific Clinics	1987	323	E/POL
	Orange County Probation Department	PRO	Project IMPACT	1999	323	RE
	Pasadena Police Department	PD	Mental Illness Law Enforcement System	2001	324	CRISIS
	PERT, Inc.	PD	Psychiatric Emergency Response Term	1996	324	CRISIS
	San Bernardino County	DOC	San Bernardino Partner Aftercare Network	1998	325	RE
	San Diego County Public Defender's Office	LEG	San Diego Homeless Court	1999	326	LEG
	Village Integrated Service Agency, Long Beach	MH	Village Integrated Service Agency	1987	326	OP
Connecticut	Department of Mental Health and Addition Services	MH	Jail Diversion Program	1994	327	LEG
Florida	Broward County District Court	LEG	Broward County Mental Health Court	1997	328	LEG
	Florida Bar	LEG	Florida Bar Continuing Legal Education	2001	329	E/LEG
	Seminole County Sheriff's Office	PD	CIT / Medical Bracelet Program	1999	330	CRISIS
	Pinellas County Sheriff's Office	PD	Crisis Intervention Training Program	2001	331	CRISIS
Georgia	Athens-Clarke County Police Department	PD	Crisis Intervention Program	1997	332	CRISIS
	Georgia Indigent Defense Counsel	LEG	Mental Health Advocacy Program	1992	333	LEG
Hawaii	Honolulu	DOC	Honolulu Jail Diversion Project	1988	333	LEG
Illinois	Cook County Adult Probation Department	PRO	Mental Health Unit	1988	334	PRO
	Cook County DOC, Illinois Office of Mental Health	DOC	Jail Electronic Access to Information	2001	334	QI
	Thresholds Psychiatric Rehabilitation Centers	DOC	Thresholds Jail Program	1997	335	S
Iowa	Community Corrections Improvement Association (of Iowa)	ADV	Commission on the State of Mental Health of Iowa's Corrections Population	2001	336	E/POL
Kentucky	Louisville-Jefferson County Crime Commission	MH	Mental Health Diversion Program	1992	337	S2
Maryland	Anne Arndel County Police Department	PD	Mobile Crisis Team	1999	338	CRISIS
	Baltimore Crisis Response, Inc. (BCRI)	MH	Mental Health Crisis Beds	1992	339	CRISIS
	Department of Health and Mental Hygiene	MH	Mental Hygiene Administration, Core Services Agencies (CSA's)	2002	339	OP
	Montgomery County Department of Correction and Rehabilitation	DOC	Information-Sharing with MH Providers	2002	340	QI
	Montgomery County Department of Correction and Rehabilitation	DOC	Suicide Screening Initiative	N/A	340	S
	Montgomery County Police Department	PD	Crisis Intervention Training	N/A	341	E
	Mental Hygiene Administration, Division of Special Populations	MH	Maryland Community Criminal Justice Treatment Program	1994	342	S
	Maryland Mental Hygiene Administration Division of Special Populations; Calvert, Dorchester, and Frederick Counties	MH	The TAMAR Project	1998	343	RE

C.1. CJMHC Programs (N=108), p. 2 of 4

State	Agency Organization	Type	Program Title	Year Est	Pg	CODE
Massachusetts	Committee for Public Counsel Services, Mental Health Litigation Unit	LEG	Certification Training Program	1991	343	LEG
	Department of Mental Health, Forensic Division	MH	Forensic Transition Team (FTT) Program	1998	344	RE
	Department of MH, DOC, and the Massachusetts Parole Board	CS	Cross Training	1998	345	E
	Harbor Inn Residential Facility (Boston)	MH	Peer Education	N/A	346	PEER
	Hampshire County Jail and House of Correction	DOC	Case Management	1970s	346	S2
Missouri	Lee's Summit Police Department	PD	Crisis Intervention Team (CIT)	2000	347	CRISIS
Nebraska	Lincoln Police Department	PD	Emergency Protective Custody Patrol	2000	348	CRISIS
Nevada	The National Judicial College	LEG	Courses on Co-Occurring Disorders	N/A	349	LEG
New Jersey	Division of Mental Health Services	MH	Peer-Counseling	2002	349	PEER
New Mexico	Albuquerque Police Department	PD	Crisis Intervention Team (CIT)	1997	350	CRISIS
	Bernalillo County Pretrial Services	LEG	Jail Diversion Through Pretrial Services	1994	351	LEG
	Forensic Intervention Consortium (Bernalillo County)	CS	Forensic Intervention Consortium (FIC)	1994	352	E/POL
New York	Center for Alternative Sentencing and Employment (CASES, NYC)	CS	The Nathaniel Project	1999	353	S
	Commission of Correction and Office of Mental Health	MH	Suicide Prevention Screening Guidelines Tool	1984	354	S
	Center for Alternative Sentencing and Employment (CASES, NYC)	CS	Parole Restoration Project (PRP)	2001	354	S2
	Common Ground (NYC)	HO	Common Ground	1991	356	HO
	Division of Parole (Buffalo / NYC)	PRO	Dedicated Mental Health Caseloads	1994	356	PRO
	Division of Parole, Office of Mental Health	CS	Memorandum of Understanding (MOU) between NY State Office of Mental Health and NY State Division of Parole	1994 (1985)	357	POL
	Division of Parole, Office of Mental Health	CS	Project Renewal, Parole Support and Treatment Program (PSTP)	2002	357	RE
	Foundation House (NYC)	MH	Fountain House	1940s	358	PEER
	Horizon Health Services (Erie County)	MH	Alternatives to Incarceration	N/A	359	LEG
	Office of Mental Health	MH	Conference on Evidence-based Practices	2001	360	E/POL
	Office of Mental Health	MH HO	Pathways to Housing (NYC, Westchester County)	1992	361	HO
	Office of Mental Health	MH	Transitions Training	2002	362	E
	University of Rochester, Department of Psychiatry	MH	Project Link	1996	362	LEG
	Urban Justice Center	MH	When a person with mental illness is arrested - How to Help: A NYC handbook for family, friends, peer advocates, and community mental health workers	2001	363	LEG
North Carolina	Chapel Hill Police Department	PD	Mobile Crisis Unit	1974	364	CRISIS
	Department of Corrections	DOC	Sexual Offender Accountability and Responsibility (SOAR) Program	1991	365	S2
Ohio	Department of Mental Health	MH	Coordinating Centers of Excellence	2002	366	E/QI
	Hamilton County Early Intervention Services	LEG	Hamilton County Early Intervention Services	N/A	367	S
	Summit County Jail	DOC	Screening Procedure, Alcohol, Drug Abuse and Psychotherapy Team (ADAPT)	1992	368	S

State	Agency Organization	Type	Program Title	Year Est	Pg	CODE
Oklahoma	Broken Arrow Police Department	PD	Mobile Outreach Crisis Intervention Services	2001	369	CRISIS
	Tulsa County Division of Court Services	LEG	Jail Diversion of Mentally Ill	1999	370	LEG
Oregon	Lane County Public Safety Coordinating Council	LEG	Lane County Diversion Program	1997	370	LEG
	Lane County Sheriff's Office	PD	Interim Incarceration Disenrollment Policy	2001	371	QI
Pennsylvania	Consumer Satisfaction Team, Inc. (Philadelphia)	MH	Consumer Satisfaction Team (CST)	1990	371	QI
	Department of Corrections	DOC	Forensic Community Re-Entry and Rehabilitation for Female Prison Inmates with Mental Illness, Mental Retardation, and Co-Occurring Disorders	2002	372	RE
Rhode Island	Department of Corrections	DOC	Women's Discovery Program and Safe Release Program	1999	373	RE
	Fellowship Health Resources	SOC	Fellowship Comity Reintegration Services	2002	374	RE
Tennessee	Memphis Police Department	PD	Crisis Intervention Team	1987	374	CRISIS
Texas	Department of Criminal Justice	DOC	Mentally Retarded Offender Program	1984	375	S
	Department of Criminal Justice, Texas Tech University Health Sciences Center for Telemedicine	MH	Telepsychiatry	1994	376	QI
	Department of Criminal Justice, University of Texas Medical Branch	CS	Non-Formulary Drugs	1995	377	MED
	Department of Mental Health and Mental Retardation	MH	The Texas Medication Algorithm Project (TMAP)	1996	377	MED
	Houston Police Department	PD	Crisis Intervention Team	1997	378	CRISIS
	Parole Board, Texas Council on Offenders with Mental Impairments	PRO	Medically Recommended Intensive Supervision Program (MRIS)	1989	379	S
	Texas Council on Offenders with Mental Impairments	MH	Post-Release Aftercare System	1987	380	S
Utah	Department of Corrections	DOC	The Adaptive Services for Environmental Needs Development (ASEND) Program	1997	381	S
	Multiple Criminal Justice and Mental Health Partners	CS	Forensic Mental Health Coordinating Council	2002	382	POL
Virginia	Department of Corrections (Brunswick Correctional Center)	DOC	Sex Offender Residential Treatment Program	2001	382	S
	Department of Corrections	DOC	Mental Health Services Training Program	1997	383	S
	Roanoke County Police Department	PD	Crisis Intervention Team	2000	384	CRISIS
Virginia	Fairfax County Sheriff's Department	PD	Offender Aid and Restoration	1981	384	S
	University of Virginia	LEG	Institute of Law, Psychiatry, and Public Policy	1980	385	E
Washington	Department of Corrections	DOC	Dangerous Mentally Ill Offender (DMIO) Program	2000	386	RE
	Dependency Health Services and Central Washington Comprehensive Mental Health	MH	Integrated Mental Health Crisis and Detoxification Programs	1990s	387	CRISIS
	King County District Court	LEG	Mental Health Court	1999	388	LEG
	Seattle Police Department	PD	Crisis Intervention Team	2001	389	CRISIS
Wisconsin	National Alliance for the Mentally Ill (NAMI) Wisconsin	MH	Mental Health Services for Mentally Ill Persons in Jail: A Manual for Families and Professionals Including Jail Diversion Strategies	1998	390	E
	Wisconsin Correctional Services	DOC	Community Support Program (Milwaukee)	1978	390	LEG
West Virginia	Division of Corrections, Mt. Olive Correctional Complex	DOC	Behavioral Modification Treatment Level System	N/A	391	S2

C.1. CJMHC Programs (N=108), p. 4 of 4

State	Agency Organization	Type	Program Title	Year Est	Pg	CODE
N/A	Federal Bureau of Prisons	DOC	Pharmacy and Therapeutic Committee	N/A	392	E
	Federal Judicial Center	PRO	Handbook for Working with Mentally Disordered Defendants and Offenders	N/A	393	E
	International Center for Clubhouse Development	POL	Clubhouse Certification	2001	393	PEER
	NAMI (National Alliance for the Mentally Ill)	MH	Training Courses	1990s	394	E
	Mental Health Statistics Improvement Program	MH	Consumer Surveys	1996	394	QI
	National Association of State Mental Health Program Directors (NASMHPD) Research Institute	MH	Center for Evidence Based Practices	2001	395	QI
	National Council for Community Behavioral Health care (NCCBH)	MH/POL	Governing Principals	1970	396	POL
	National Parole Board of Canada	PRO	New Board Member Training	1994	397	E
	National Parole Board of Canada	PRO	Risk Assessment for Pre-Release Decisions/Post-Treatment Report	1995	397	S
	N/A	N/A	Assertive Community Treatment	1970s	398	OP

C.2. Further Explanation of Coding Rules for Determining Consultative Sample

CJMHC programs whose descriptions discussed risk classification, screening procedures, and/or program eligibility requirements, received a screening designation, "S" (n=17). All 17 of these programs were included in the consultative sample, except the Parole Board of Canada since it was outside the scope of a *national* standards' data set. For cases in which screening procedures were discussed, but services were not comparable to the ORCSP, the researcher erred on the side of inclusion. The "S2" code was given in two cases where referrals from psychologists or correctional staff guided the participant enrollment process; however, because they did not reference a screening process, they were not included in the consultative sample. The remaining "S2" codes (n=3) were included for interpretation purposes.

Programs that discussed transition and reentry services were of special interest to the research team, and given a reentry designation, "RE" (n=9). Of those reentry programs identified, all were included in the consultative sample, except for one. New York's Project Renewal (CJMHC, 2002, p. 357) offers robust reentry services for MIOs with substance abuse issues, but eligible participants volunteer and are not selected. Although it is possible that parole staff encourage eligible participants to apply, this type of enrollment process was quite divergent from ORCSP appraisal. Additionally, this program was described as a non-profit, community-based program and appeared to focus on parole enhancement for co-occurring disorders, rather than violence triage services.

The ORCSP was ruled-out of the consultation sample, although it technically met criteria for programs that offer violence triage service and include risk screening practices.

Of the probation/parole programs coded (n=2), both agency summaries specified providing services for special needs populations. The Cook County Adult Probation Department discussed working with individuals with any mental diagnosis, whereas Buffalo's Division of Parole further specified severe and persistent mental illness. The researcher hypothesized that these programs had objective diagnostic lists comparable to previous and current ORCSP Mental Disorder operational definitions, and included both programs in the consultative sample.

It is likely that many other CJMHC programs had relevancy for PSMI management and would be of interest to the ORCSP. However, since this dissertation's focus is on assessment procedures, it was necessary to apply careful percipience. For programs that focused on medication management, crisis services, peer support, outpatient mental health, and housing, the choice to exclude from the consultative sample was rather straightforward based on service implementation. For example, police departments that assess individuals in the community have distinctive, behavioral assessment processes compared to the ORCSP. Similarly, peer support, outpatient mental health, and housing programs seemed more aligned with intervention than program enrollment. Although some organizational descriptions and missions relayed information regarding assessment, most programs were ruled out of the consultative sample, because they differed in context. For example, there were some legal programs that clearly outlined assessment processes for jail diversion; however, their concentration was on diverting special needs populations from the legal system, rather than risk management for individuals transitioning from correctional settings into the greater community. Likewise, educational programs, although they may provide exemplary teaching models for risk assessment and diagnostic work, do not provide insight into the actual practice of such efforts. One could just as easily rely on literature to capture these best practices. Unfortunately, it remains unclear if programs are following or implementing such strategies in a sound and reliable way, highlighting the need to clarify the relationship between education, policy, and practice

C.3. Coding Rules for Selecting Consultative Sample

Code	Type of Program	Description	CJMHC	STUDY
S	Screening	Programs that included statements about classification, identification, screening procedures, and/or program eligibility requirements.	17	17
S2	Screening/ referral for other services	Programs that included statements that could be coded as (s) screening, but whose services were not comparable to ORCSP services.	5	3
RE	Screening/ Re-entry	Programs that included statements that could be coded as (s) screening, but also discuss reentry services.	9	8
PRO	Probation	Probation programs whose primary purpose was related to management of MIOs.	2	2
MED	Medication focused	Programs whose primary purpose related to psychopharmacological issues.	2	0
QI	Quality Improvement (including access to benefits and services)	Programs whose primary purpose related to quality improvement.	8	0
CRISIS	Crisis services	Programs whose primary purpose related to community crisis services.	20	0
POL	Policy	Programs whose primary purpose was related to policy change.	5	0
LEG	Legal	Programs whose primary purpose was related to jail diversion or legal initiatives aimed at MIOs.	16	0
PEER	Peer support	Programs whose primary purpose was related to peer support services.	4	0
OP	Outpatient	Programs whose primary purpose was related to outpatient mental health services.	3	0
HO	Housing	Programs whose primary purpose was related to housing.	2	0
E	Education/training	Programs whose primary purpose was related to education and training.	9	0
E/LEG	Education/training	Programs whose primary purpose was related to education in a legal context.	1	0
E/POL	Education/training	Programs whose primary purpose was related to education in a policy context.	4	0
E/QI	Education/training	Programs whose primary purpose was related to education in a quality improvement context.	1	0
		Total:	108	29

C.4. Consultative Sample Pool (n=29), p. 1 of 4

State	Agency Organization	Program Title	Summary	Risk Assessment
Alaska	Alaska DOC	Mental Health Management System	Screening tool that can be administered by trained, non-medical staff-using a Palm Pilot that links data to a database. Mental health management system.	Structured psychiatric interview>>> diagnosis and tx planning
Arizona	Maricopa Adult Probation Department	Conditional Community Release Program	Community based supervision. Multidisciplinary team makes referral. Diverse community services.	Not disclosed in CJMHC
California	Orange County Probation Department	Project IMPACT	Jail Transition Services for MIO	Not disclosed in CJMHC
	San Bernardino County	San Bernardino Partner Aftercare Network	Prison transition services, including bridging services at a detention center.	Not disclosed in CJMHC
Illinois	Cook County Adult Probation Department	Mental Health Unit	Community supervision (probation) for special needs (excludes pedophiles and those found not competent).	Must have a diagnosis of mental illness and/or mental retardation.
	Thresholds Psychiatric Rehabilitation Centers	Thresholds Jail Program	Bridge Model/ACT, "provides services for as long as the offender needs them."	Hx of inpatient hospitalization and incarceration-? Not sure if this is how they screen participants
Kentucky	Louisville-Jefferson County Crime Commission	Mental Health Diversion Program	"Identifies nonviolent felony and misdemeanor defendants with SMI">jail diversion, 7-member committee (psychiatrist, psychologist, registered nurse, clinical social worker, attorney, veteran member of probation/parole or other law enforcement, mental health advocate	Not disclosed in CJMHC
Maryland	Montgomery County Department of Correction and Rehabilitation	Suicide Screening Initiative	Suicide screening	Seven question suicide assessment
	Mental Hygiene Administration, Division of Special Populations	Maryland Community Criminal Justice Treatment Program	"Program participants are identified through a classification process at the local detention center, or through parole/probation. They are then referred to the local program director for assessment and eligibility.">Psychiatrist and services.	Not disclosed in CJMHC
Massachusetts	Department of Mental Health, Forensic Division	Forensic Transition Team (FTT) Program	3-month post release transition services for SMI. "From April 1998-September 2001, 63 percent of releases had remained engaged in mental health services at the end of the three-month transition period. Only 4 percent had been reincarcerated and the same percentage had required acute hospitalization."	"To be eligible for work with FTT, inmates must fit certain clinical criteria (e.g.-diagnosis, functional impairment, and duration of illness), need DMH services, and be without other means to access those services."

C. 4. Consultative Sample Pool (n=29), p. 2 of 4

State	Agency Organization	Program Title	Summary	Risk Assessment
New York	Center for Alternative Sentencing and Employment (CASES)(NYC)	The Nathaniel Project	"Referral can be made by anyone, but typically come from court personnel. Candidates must undergo a multi-step screening and risk-assessment process to access their current situation, psychiatric and criminal history, and potential for success in the program. The Nathaniel Project will consider any prison-bound defendant who has been indicted on a felony charge, has a SMI, and requires on-going psychiatric treatment and supportive services to function in the community."	Not disclosed in CJMHC
	Commission of Correction and Office of Mental Health	Suicide Prevention Screening Guidelines Tool (SPSG)	Done at intake-most correctional institutes in NYS. Suicide Screening: Suicide Prevention Screening Guidelines Tool (SPSG). "Validated by numerous studies." Hi-risk identification.	Suicide Screening: Suicide Prevention Screening Guidelines Tool (SPSG).
	Center for Alternative Sentencing and Employment (CASES)(NYC)	Parole Restoration Project (PRP)	Detained parole violators with mental illness. Assessment of treatment needs. Wraparound care with CD tx, crisis services, "After identifying eligible violators, project staff assess their treatment needs, links them with community-based service providers, advocate for support of the treatment plan from parole field staff, and when appropriate, recommend the restitution of parole."	Not disclosed in CJMHC
	Division of Parole, Office of Mental Health	Project Renewal, Parole Support and Treatment Program (PSTP)	Identified by pre-release coordinators>housing and support services. Minimum of 6-month parole term.	Not disclosed in CJMHC
Ohio	Hamilton County Early Intervention Services	Hamilton County Early Intervention Services	Pretrial services interviews detainees>7 questions>identifies probable MIO>mental health staff administer self-report problem behavior symptom identification tool=BASIS-32>swift intervention to services	1. Have you ever been in special education classes? 2. Have you ever been in a psychiatric/mental hospital? 3. Have you ever seen a psychiatrist, psychologist, or case manager? 4. Have you ever taken medications for psychiatric reasons for your nerves? 5. Have you ever been in psychiatric outpatient treatment? 6. Have you ever heard voices? 7. Have you ever thought about or attempted suicide? >>> if screened yes>>>BASIS-32
	Summit County Jail	Screening Procedure, Alcohol, Drug Abuse and Psychotherapy Team (ADAPT)	Three-tiered method: Initial screening from booking officer>mental health worker>psychologist. Some go to MHUs.	Not disclosed in CJMHC

State	Agency Organization	Program Title	Summary	Risk Assessment
Pennsylvania	Department of Corrections	Forensic Community Re-Entry and Rehabilitation for Female Prison Inmates with Mental Illness, Mental Retardation, and Co-Occurring Disorders	Pilot program out of Muncy for females. Re-entry. DOC mental health staff will refer individuals with SMI, mental retardation, or substance abuse problems approximately 12 months before release>transition planning services/needs assessment>release/coordinated wraparound	Not disclosed in CJMHC
Rhode Island	Department of Corrections	Women's Discovery Program and Safe Release Program	Pilot program: DC planning and case management up to 1 year post release. "The use of community-based mental health providers as discharge planners ensures continuity of care after the inmate is released."	Not disclosed in CJMHC
	Fellowship Health Resources	Fellowship Community Reintegration Services	Reentry services similar to ORCSP. One year follow up. Use of "home confinement with provisions made for service delivery," in some cases.	Not disclosed in CJMHC
Texas	Department of Criminal Justice	Mentally Retarded Offender Program	Services in prison. Development of individualized habilitation plans. Mentally Retarded Offender Program (MROP): Interdisciplinary Team (IDT) will complete a comprehensive evaluation to determine the presence or scope of mental retardation within 30 days of arrival to the MROP facility.	IQ Group IQ test: if score < 70, Culture Fair Test: if score < 70, Wechsler: if score < 74, MROP enrollment
Texas	Department of Criminal Justice	Program for Aggressive Mentally Ill Offenders (PAMIO)	This program was discovered during preliminary research of contacts. It was added due to obvious relevance.	Not disclosed or included in CJMHC
	Parole Board, Texas Council on Offenders with Mental Impairments	Medically Recommended Intensive Supervision Program (MRIS)	Correctional Managed Health Care "identifies inmates who might be eligible for this program">three member MRIS parole board panel. TCOMI provides background information for this hearing, including tx history while incarcerated.	Not disclosed in CJMHC
	Texas Council on Offenders with Mental Impairments	Post-Release Aftercare System	ID individuals with special needs. Council consists of 9 members with outside agency consultants (SUD/MH advocates). Reduction in arrests as an outcome measure.	Not disclosed in CJMHC

C. 4. Consultative Sample Pool (n=29), p. 4 of 4

State	Agency Organization	Program Title	Summary	Risk Assessment
Utah	Department of Corrections	The Adaptive Services for Environmental Needs Development (ASEND) Program	Classification as special needs>services, including preparation for community release. Utah DOC program designed to address special needs - IQ < 70. Division of Institutional Operations (DIO) has an existing screening and referral process. Referrals can also come from DIO psychologists, social service workers, correctional habilitative specialists, housing unit administrative staff, school staff assigned to work at DIO, and self-referrals. criteria= IQ<80, cognitive or IQ deficits identified on testing instruments, documented history of being victimized by others as a result of deficits.	IQ testing - tests not specified
Virginia	Department of Corrections (Brunswick Correctional Center)	Sex Offender Residential Treatment Program (SORT)	"comprehensive assessment and tx services for inmates who have been identified as being at risk for committing a sex offense upon their release."	Not disclosed in CJMHC
	Department of Corrections	Mental Health Services Training Program	Training program to help identify and treat MIOs in special housing units	MMPI-II, PAI, "criminal thinking and psychopathology… risk assessment"
	Fairfax County Sheriff's Department	Offender Aid and Restoration	Discharge planning and post release services for MIOs. 8 professional staff (minimum-BA level training).	Not disclosed in CJMHC
Washington	Department of Corrections	Dangerous Mentally Ill Offender (DMIO) Program	ORCSP	Not disclosed in CJMHC

C.5. Semi-Structured Interview Question Guideline

Topic	Main Inquiry	Possible Follow-up Questions
Vocational Role	What is your professional role?	Do you conduct evaluations on PSMI-Ns?
Population Served	What is your target population?	Does your program serve PSMI-Ns?
Referral	How are clients referred to your program?	Process oriented questions to help clarify referral stages/criteria.
Risk Assessment	Does your program use risk assessments in screening/selection processes?	If yes, which ones? If no, ask participant to explain screening/selection processes?
Protective Factors	Does your program assess protective factors?	If yes, how does the program account for protective factors? If no, ask participant to explain decision not to include?
Duration	How long does your program serve clients?	Are there any special exceptions to the disclosed duration of service?
Measurable Outcomes	How does your program track outcomes?	How does your program define recidivism? Recidivism rates? How do you know when a client is ready to be discharged from the program?
Funding	How is your program funded?	Ask questions that relate to program budget.
Recommendations	Do you have any recommendations for the ORCSP?	Attempt to clarify any recommendations that are vague or necessitate further explanation.

C.6. Summary of Consultant Responses, p. 1 of 5

Consultant	Vocational Role	Program Focus	Funding
Consultant 1	Program Manager State Department of Corrections	Reentry for MIOs. Wraparound care & benefit help. "Community is not too keen on helping people… double standard…. We must help while they are in and embrace them while out. They can't do it on their own." (they need more help). Private agencies = unsung heroes. Hotel = mini state hospital.	Assessment Planning Identification Coordination (APIC)
Consultant 2	Operations Manager: Forensic Services State Department of Mental Health	Wide-ranging, includes most areas of forensic mental health. 23,000 estimated forensic enrollments out of total 100,000 PSMI. "3/4 of those who are referred to us are denied…That means that they are releasing folks not to a SDMH service or monitoring." = "Standard fare."	No response
Consultant 3	Director of Reentry Services Non-profit Organization	Reentry for individuals on parole. "We started out as a variation of the ACT team model, but realized after a couple years, if we are trying to get them reacclimated to the community, we need to let them go out into the community." In 2006, switched to targeted case management - ICM model.	No response
Consultant 4	Coordinator of Transitional Services State Department of Corrections	Reentry, continuity of care.	SAMHSA grant
Consultant 5	Supervisor of Jail Behavioral Health County Sheriff's Department	Discharge planning, continuity of care. "Goal to link to outpatient services." Communication with community MH providers. Some advocacy with courts. Goal is to maintain safety of the individual.	Community Services Board - through the county

Consultant	Population Served	Who/When Assess	Length of Service
Consultant 1	PSMI, some PSMI-N Many are Individuals with Sex Offenses	2 Clinicians 80 client caseload (40 per) <u>Release planning</u> -sentenced: 3-12 months -not-sentenced: continuous "As early as possible." "60% of Petition to Revoke Probation violations occur within first 3 months."	"Two years on average, but can be longer or shorter."
Consultant 2	General Mental Health, includes Forensic Mental Health Services, some PSMI-N	Individual can apply for SDMH services when they are getting close to release > if found eligible > service package SDMH conducts risk assessments	PSMI reentry program = 3 months Other State Department of Mental Health clients = "It depends, sometimes for life."
Consultant 3	"Single point of access. People in State prisons returning to the community." Not a program for PSMI-N, but serves PSMI. Individuals on parole, includes PSMI & PSMI-N	SDMH Staff	Case-by-case basis Minimum amount of parole time=15 months Ideally-18-24 months
Consultant 4	PSMI, some PSMI-N	1 manager 15 DC planners "Typically start the process 180-days prior to release."	90-day post-release Discharge clients once linked to community services
Consultant 5	PSMI, some PSMI-N, but index offense most likely not serious	Risk Assessments started at engagement process	"While they are in jail."

Consultant	Mental Health Assessment	Risk Assessment
Consultant 1	Structured psychiatric interview > diagnosis and tx planning <u>Can include:</u> Any psychosis Co-occurring FAS Lo Cog TBI "Not fixed delusional disorder" "Sometimes ASPD"	LSI-R They keep a "high challenge list" kept for everyone in DOC for last 5 years.
Consultant 2	"To be eligible for work with transitional programs, inmates must fit certain clinical criteria (e.g., diagnosis, functional impairment, and duration of illness), need SDMH services, and be without other means to access those services." Clinical judgement and interview with client Discretionary: "Pick and choose who they think should get services from us." Competency Decompensation after sentencing Tiered referral process (i.e., screen > assessment > psychologist/psychiatrist)	HCR-20 Fire Setting Evaluation Sexual Offender Battery Dangerous = "in need of strict security." Certain list of charges > independent forensic review > consultation with treatment team > privileges/discharge planning.
Consultant 3	"SDMH staff determine SMI using their own tools while in prison." Not based on list>Based on SMI and clinical discretion	"Often come with a risk assessment from SDMH in the referral."
Consultant 4	"We have standard operating procedures for what criteria meet our caseload." "May pick a case up based on consultations."	LSI-R, through DOC. "Use discretion if we have concerns... even if the they don't deem high risk on the LSI-R."
Consultant 5	Intake Assessment Brief Jail MH Screening (score over 2) Referral: Case-by-case basis Mental health needs Tiered referral process	Columbia CAMS Assessment of Charges Intake assessment Brief jail MH screening

Consultant	Protective Factors	Gender	Strengths
Consultant 1	"Nothing formal, but we look for protective factors on DOC documents" (i.e., PSA).	Same	Having people in the field who are dedicated and knowledgeable about the community. Staff must care = more robust release planning. Good motivational interviewing skills. Give choices > client's must be invested in goals. Weakness = psychiatric community beds.
Consultant 2	"Can't really speak to that."	Same Men>Secure psychiatric facility Female>State run MH facility	"Stepdown" process from "strict security" to SDMH facility (transition length is case-by-case) "One thing that we have gotten good at is not losing track of very, very serious offenses that happened sometimes decades ago that people have forgotten." Forensic side can be quick - "admissions within one day."
Consultant 3	No response	Same	Intensity of services: minimum of 1x per week F2F contact Staffing -Part-time psychiatric services -Part-time nurse -Dedicated MH staff and case managers. -Occupational Therapy Students through University – help conduct assessment of service needs.
Consultant 4	Consultant 4 was new on the job.	Same	No response
Consultant 5	"We ask."	Same	Team approach - "It takes a village." Coordination of care.

C.6. Summary of Consultant Responses, p. 5 of 5

Consultant	Trackable Outcomes	Recommendations
Consultant 1	Length of time out of prison Petition to Revoke Probation = violations/conditions Treatment (completion)	"Get family involved immediately."
Consultant 2	DOC Recidivism Return to Psychiatric Facility Individual cases = rearrest, incidents that are reported to SDMH	"Sometimes 3 months is more than enough." 3 months is often used for low need persons.
Consultant 3	No response	Internship Program
Consultant 4	No response	No response
Consultant 5	Brief jail MH screening Recidivism "How many people we are able to divert."	Moral Recognition Therapy "Staff work with MIOs closely, get them on medications, and try to link them up with services."

APPENDIX D

Permissions

D.1. Verbal Permission to Publish

'Violence Prediction Scheme'

Verbal permission was given by Dr. Stephan Hart on Friday, March 16, 2019 at the American Psychology Law Society (APA Division 41) Annual Conference to reprint a version of his 'Violence Prediction Scheme' in the current dissertation manuscript (see Appendix B.9).