SENATE BILL REPORT
SB 5048

As of February 13, 2019

Title: An act relating to establishing a reentry community safety program for state hospital patients.

Brief Description: Establishing a reentry community safety program for state hospital patients.

Sponsors: Senators O'Ban, Conway and Wagoner.

Brief History:
Committee Activity: Behavioral Health Subcommittee to Health & Long Term Care: 2/01/19.

Brief Summary of Bill

- Expands the Offender Reentry Community Safety Program (ORCSP) to include state hospital patients who have committed acts constituting a violent felony or who are not guilty by reason of insanity.
- Enables community custody supervision for patients released from a state hospital who have committed acts constituting a violent felony and requires provision of community mental health services to conditionally released patients who were committed as criminally insane.
- Expands ORCSP services to provide recidivism reduction interventions in every region of the state.

SENATE COMMITTEE ON BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE

Staff: Kevin Black (786-7747)

Background: Offender Reentry Community Safety Program. The Offender Reentry Community Safety Program (ORCSP) is a collaborative program between the Department of Corrections (DOC) and the Health Care Authority (HCA) to provide intensive services to DOC inmates who have a mental disorder, are reasonably believed to be dangerous to themselves or others, and are within six months of release from prison. ORCSP participants receive in-person engagement services before release and continue receiving services for up

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to five years following release, including intensive case management, specialized treatment services, housing assistance, and other basic community supports. HCA maintains contracts to provide community services to ORCSP participants in 25 counties. ORCSP was established in 1999 under the name Dangerous Mentally Ill Offender Program. Since 2000, the program has admitted 1,177 individuals, and there are 176 individuals currently being served by ORCSP.

ORCSP has been evaluated six times by the Washington State Institute for Public Policy (WSIPP) to determine its effectiveness in reducing recidivism. A 2009 study found ORCSP reduces new felony recidivism by 42 percent and new violent felony recidivism by 36 percent, causing WSIPP to identify ORCSP in 2017 as the most effective recidivism abatement program known in the State of Washington. In its current benefit-cost analysis, WSIPP estimates ORCSP produces $70,943 in community benefits per participant compared to a total cost of $37,369, for a ratio of $1.90 benefits for every $1 spent on the program. The benefits of ORCSP are split between taxpayers and crime victims.

Criminal Insanity Patients. Criminal insanity patients are state hospital patients who have been committed after a finding of not guilty by reason of insanity (NGRI). NGRI means, that due to a mental disease or defect, when a criminal offense was committed the person was unable to perceive the nature and quality of the acts charged or unable to tell right from wrong with reference to the acts charged. To be found NGRI, a person must be competent to stand trial. A person found NGRI may be committed to a state hospital if the court or jury finds they present a substantial danger to other persons or present a substantial likelihood of committing criminal acts jeopardizing public safety or security. A criminal insanity patient may apply for conditional release to the superior court of the committing county at least every six months, and must be released if they no longer present a substantial danger or likelihood of community criminal acts. When granting an application for conditional release, the court may require supervision by a community corrections officer.

1114 Patients. E2SHB 1114 (2013) established a special designation for state hospital patients who are civilly committed after committing acts constituting a violent felony and dismissal of charges based on incompetency to stand trial (1114 patients). These patients lose certain procedural rights at their civil commitment hearings. 1114 patients must be released when their condition is such that their needs can be safely met in a less restrictive alternative to inpatient hospitalization (LRA). The options of a court upon conditional release of an 1114 patient to an LRA do not include supervision by a community corrections officer. Services available on an LRA are specified in statute and must be made available to all civil patients, but are not mandated to be provided to criminal insanity patients.

Public Safety Review Panel. The Public Safety Review Panel (PSRP) was established in 2010. The purpose of the PSRP is to advise the Department of Social and Health Services (DSHS) and the courts relating to the release of 1114 patients and criminal insanity patients. The PSRP consists of seven members appointed by the Governor, including a:

- psychiatrist;
- psychologist;
- representative of DOC;
- prosecutor;
- representative of law enforcement;

- representative who advocates for consumers and families; and
- representative of criminal defense attorneys.

The Community Behavioral Health System. The Community Behavioral Health System is divided into ten regional service areas. Prior to 2016, Medicaid services for persons with acute mental illness were delivered by a provider network established by behavioral health organizations (BHOs). Starting in 2020, all Medicaid services will be delivered through managed care organizations (MCOs) and behavioral health administrative services organizations (BH-ASOs). Some regions have already made the transition from BHOs to MCOs and BH-ASOs.

Summary of Bill: ORCSP is renamed the Reentry Community Safety Program (RCSP).

The RCSP is expanded to include state hospital patients who are civilly committed after committing acts constituting a violent felony and state hospital patients who are committed as criminally insane. DOC must collaborate with HCA and DSHS to provide training, consultation, and support during the expansion. DOC must ensure community corrections officers who supervise persons under RCSP receive appropriate training relating to:

- monitoring and engaging with persons with behavioral health disorders;
- collaborating with state hospitals and community behavioral health providers to support recovery; and
- appropriate measures to protect the safety of persons under supervision and the public.

DSHS must identify state hospital patients eligible for RCSP who can potentially be ready within six months for conditional release or discharge to an appropriate community placement. DSHS must notify the PSRP of the identity of these patients and provide full information about proposed community placements for these patients to the PSRP when it is available. DSHS must collaborate with HCA to ensure contracts with community partners under the RCSP require the provider to share information with the PSRP and participate in court reviews of plans for community placement or discharge.

1114 patients released under the RCSP may be ordered to receive supervision by a community corrections officer under the terms of an LRA order or conditional release order if such supervision is recommended as part of the patient's release plan.

DSHS must model the expansion of RCSP to state hospitals of the successful elements of ORCSP in consultation with DOC and behavioral health care experts. Interagency training and consultation must occur to sustain the program and promote effective collaboration and information sharing among RCSP agencies and community partners.

BHOs, MCOs, and BH-ASOs must provide LRA services to criminal insanity patients who receive conditional release. These entities must ensure adequate provider capacity exists in each regional service area to support the operation of the RCSP. These entities may expand the services they provide to include reentry services.

Appropriations made to support 1114 patients must be used to support the RCSP expansion.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: This bill would expand a very successful reentry program implemented at DOC that has fantastic results compared other programs. We are taking the best program and applying it to 1114 patients and NGRIs, who have a history of violent conduct that led to actual felony charges. We should expand this program to those who are most likely to present a safety risk on their release. We need to do something proactive that will help the patients be successful and assuage legitimate concerns of the communities where they are released. The PSRP struggles to find release plans for NGRI patients because there are few services for them in the community.

CON: We are three workers from Western State Hospital who work with NGRI patients in the community program. We believe the community program is successful at managing NGRI patients because we have the ability to return patients to the state hospital without any bureaucratic hurdles. Community providers do not know what to do with NGRI patients, who are stable due to their very long stays at the state hospital. Giving them community mental health services would be taking them away from those who need them more. The community program covers them for their whole life, not just five years. NGRI patients have multiple diagnoses and need addiction recovery as well as mental health services. Our services for NGRI patients in the community come without additional funding. There is a low reoffense rate. A correctional philosophy is not effective for treating persons with mental illness. It is frightening to think of DOC officers supervising the mentally ill. ORCSP has a good record but there is no guarantee it would work for state hospital patients. NGRI patients and 1114 patients are very different. We do not see a need for additional supervision; our philosophy is that patients should be treated as patients not criminals. I became the director of the community program in 2011 and retired last July. The program was incredibly conservative and safety-focused, which was not helpful because NGRI patients are a low-risk population. The Groundswell Report in 2014 made findings that were damning to the community program; stating that it is easier for participants to leave the state hospital in a coffin than to leave with a discharge. Changes have been made since then propelled by the *Ross v. Inslee* lawsuit, which demanded that we move patients through the system faster. This is now beginning to happen; complying has been a period of growing pains at the state hospital. There is only a finite number of forensic beds. If we can not discharge the NGRI patients, we don't have as many competency restoration beds. The system we are using is too complicated, so we should avoid complicating it more.

Persons Testifying: PRO: Senator Steve O'Ban, Prime Sponsor.

CON: Kourtney Wytko, Washington Federation of State Employees; Jennifer Arsanto, Washington Federation of State Employees; Jack Cruzan, Washington Federation of State Employees; Roberta Kresse, citizen; David Lord, Disability Rights Washington.

Persons Signed In To Testify But Not Testifying: No one.