UW Medicine

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December 15, 2009

Susan N. Dreyfus
Secretary, Department of Social and Health Services
PO Box 45010
Olympia, WA 98504-5010

RE: State Psychiatric Hospital Safety Review Panel – Final Report

Dear Secretary Dreyfus,

Thank you for the opportunity to offer our appraisal and recommendations in response to the recent critical incident at Eastern State Hospital (ESH).

As outlined in your letter of October 2, 2009, our objective was to conduct a thoughtful appraisal of the incident, to assess the adequacy of the Critical Incident Review conducted at ESH, to recommend changes in policy and procedures at ESH and Western State Hospital (WSH) to bring operations related to risk management into alignment with best practices, and to consider broader interventions to improve the management of individuals with mental illness in this state.

We approached this task with an appreciation for the inherent tensions between balancing public safety while also promoting the opportunity for mentally-ill individuals to achieve recovery and community reintegration. We were mindful as well of our responsibility not to contribute to the public fears and expressions of stigma that were evident in the aftermath of this incident.

Herein, please find our summary assessment and recommendations, which we believe are constructive and forward-looking. We identified a series of procedural deficiencies at ESH that contributed to this incident. We offer interventions addressing these problems and propose several initiatives targeting how the state manages seriously mentally ill offenders.

We have been impressed by the professionalism exhibited by staff at the state hospitals in response to this incident and, particularly, by the briskness of their efforts to implement to our interim interventions and recommendations.

We trust that you will find our report helpful. The Panel unanimously expressed its willingness to be reconvened at a later date should you wish to call on us for further consultation.

Sincerely,

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Safety Review Panel Chair
Chair, Psychiatry and Behavioral Sciences
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Final Report
State Psychiatric Hospital Safety Review Panel
December 14, 2009

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Executive Summary

Background. On September 17, 2009, a long-term forensic patient at Eastern State Hospital (ESH) eloped from the Spokane County Interstate Fair during an accompanied outing with 30 other patients and 11 staff. Fortunately, he was recaptured 3 days later without incident.

In 1987, this individual was judged not guilty by reason of insanity (NGRI) after murdering an elderly neighbor while psychotic and was sent to ESH for treatment. In 1990, he eloped from ESH and seriously injured a law enforcement officer during his recapture the next day. Between 1990 and January, 2009, he was in and out of ESH on Conditional Release. Although he attended community college, pursued part-time employment, lived intermittently with his family in Sunnyside and in residential housing in Spokane during this time, he was invariably returned to ESH for infractions or because of deterioration in mental functioning. For these reasons, his recent elopement, understandably generated substantial community concern.

In response to this incident, Susan Dreyfus, Secretary of the Department of Social and Health Services, immediately suspended all off-ward activities for forensic patients at both ESH and Western State Hospital (WSH) and convened a State Hospital Psychiatric Hospital Safety Review Panel (Panel) to recommend changes to department policy, protocols, practices, and laws, as they relate to patients, staff, and community safety.

Panel Work Process. The Panel met at ESH on October 16, 2009, with the principal focus to analyze the Critical Incident Review of the event that was conducted by ESH staff. Subsequent meetings were held at WSH on November 2nd, November 20th, and November 30th to continue this analysis and to formulate recommendations. Throughout this interval, the Panel actively engaged DSHS Mental Health Systems leadership and also senior executives and forensic program staff at both hospitals to gather information and develop policies.

Findings. The Panel made three fundamental observations about the ESH Critical Incident Review report.

- Problems with Policies/Procedures. The Panel concurred with the internal ESH assessment that policies and procedures generally related to safety and security, emergency response protocols, and those governing such activities as authorized leave, hospital campus privileges, inter-mingling of patient populations, and community outings were not uniformly up-to-date, systematically disseminated, or reliably implemented. The Panel agreed with the interventions proposed to remedy this situation, which are summarized in this report.

- Non-adherence to Existing Policies. ESH staff were not performing and documenting risk assessments as required by existing policies. In addition, forensic unit practices had evolved such that they no longer aligned with existing policies or procedures in some cases. As one consequence, the emergency response to the elopement was highly disorganized and did not conform to established protocols.

- **Insufficient Attention to Security**. It appears that ESH Forensic unit staff had become too familiar with the patients, leading to insufficient attention to safety and security issues. This was compounded by inadequate emphasis and oversight of these issues at the executive level.

Recommendations related to policies and procedures at the two state psychiatric hospitals. The Panel concurred with the changes in policy and procedures that were proposed by the ESH Critical Incident Review and are summarized in this report. Briefly, the Panel directed immediate attention to safety and security policies at ESH and recommended further action in several key areas, described more fully in the report:

- At the conclusion of its meeting at ESH on October 16th, the Panel recommended an **immediate review of ESH policies and procedures** related to safety and security to ensure that no critical gaps in policy existed and advised immediate adherence to all existing policies – this was initiated by DSHS.

- A personnel performance review for senior executive level staff at ESH was recommended - this was initiated by DSHS.

- ESH was advised to develop alternative schedules to eliminate co-mingling of forensic and civil commitment patient populations – this was initiated.

- An **Interim Policy for Off-Ward Activities** was developed in collaboration with staff at ESH, WSH, and DSHS and was forwarded to Secretary Dreyfus for approval and implementation (see Appendix B).

- A formal review to assess the structural and operational capacity of both hospitals to serve high risk patients safely was recommended – a review of both facilities by DOC was initiated by DSHS.

- The Panel believes strongly that the two hospitals should be working collaboratively under the guidance of an **executive partnership team** to develop standardized, uniform hospital policies and practices and to ensure that both hospitals are employing contemporary best-practices. Risk assessment tools, competency evaluation/restoration practices, and privilege/level schemes should be reviewed and standardized. Mechanisms are proposed to assist the hospitals in this effort.

- Both hospitals should be employing an **Internal Risk Review Board** mechanism to oversee the risk management programs and decisions related to Conditional Release status.

Recommendations related to the management of forensic mental health patients in Washington. The Panel reviewed the Satterberg report and considered best-practice approaches adopted in other states for managing individuals identified as not guilty by reason of insanity (NGRI) or considered dangerous.

- Consider consolidating the treatment of all NGRI patients at WSH. Based on perceived structural limitations of the forensic wards at ESH to ensure adequate security for the most dangerous individuals, the Panel **recommends exploring the prospect of locating all NGRI patients in Washington at WSH**. This has the potential advantage of reducing the programmatic variability that accompanies duplicate programs and might yield financial benefits due to economies of scale. This approach would need to be weighed against the potential for an adverse impact on families. Local workforce impacts would also need to be considered. If these important factors outweigh the benefits of locating all NGRI patients at WSH, an alternative might be to consolidate NGRI patients who have committed the most serious offenses at WSH.

- Psychiatric Security Review Board. The Panel conducted an extensive review of Oregon's **Psychiatric Security Review Board** model, which was established in 1977, and has been extensively evaluated as a best-practice approach to the management of mentally-ill offenders. The potential benefits of this program are reviewed. **The Panel strongly recommends that a model that is substantially similar to the Oregon PSRB be considered for Washington.**

- Satterberg Report. We believe there is great value in pursuing further several of the key recommendations of the Satterberg report that emphasize the need for:
    - better coordination, information-sharing and communication among state agencies that intersect in the management and community monitoring of mentally-ill offenders.
    - reform of the Involuntary Treatment Act.

- NGRI vs. "guilty but mentally ill" (GBMI). A rationale for **not** endorsing the adoption of a GBMI alternative to NGRI is summarized in the Panel's report.

  For low-level, non-violent individuals designated NGRI, the present system appears to work adequately. The impetus for adopting a GBMI approach comes from a number of murder cases resolved as NGRI where the offender was transitioned quickly back into the community, including two cases from King County where NGRI "patients" who committed murder were back in the community on Conditional Release within a period of five years. The present system, it is argued, does not properly distinguish among forensic patients committed for violent and non-violent crimes. The emphasis on reintegration of all NGRI offenders back into the community, regardless of their underlying offenses, is a serious concern to prosecutors and law enforcement.

The Panel reached a full, unanimous consensus on the findings and recommendations highlighted above and described more fully in this report. The Panel also unanimously expressed its willingness to be reconvened at a later date or periodically should its expertise and familiarity with these issues prove useful to Secretary Dreyfus or Governor Gregoire.

State Psychiatric Hospital Safety Review Panel Members

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Final Report
State Psychiatric Hospital Safety Review Panel

I. Introduction

Background. On September 17, 2009, a long-term forensic patient at Eastern State Hospital (ESH) eloped from the Spokane County Interstate Fair during an accompanied outing with 30 other patients and 11 staff. Fortunately, he was recaptured 3 days later without incident. Because of his history, the elopement caused substantial public alarm and was accompanied by extensive reporting in the local, regional, and national media.

In 1987, this individual was judged not guilty by reason of insanity (NGRI) after murdering an elderly neighbor while psychotic and was sent to ESH for treatment. In 1990, he eloped from ESH and seriously injured a law enforcement officer during his recapture the next day. He was charged with First Degree Escape and Second Degree Assault. Between 1990 and January, 2009, he was in and out of ESH on Conditional Release or Partial Conditional Release to attend community college and to pursue part-time employment in Spokane. He was granted a full Conditional Release by the courts in 2000 and was released to live with his family in Sunnyside, WA. After 6 months in the community, he was returned to ESH after he expressed an interest in researching the life of the woman he had killed and a therapist observed increasing paranoia. After a period of stabilization, he was granted Conditional Release and resumed community college. He lived in the Carlyle Congregate Care Facility in Spokane beginning in 2005, but his Conditional Release was revoked on several occasions for minor rule violations and non-adherence to treatment. He was returned to ESH in January, 2009, after verbally threatening a store clerk. Revocation of his Conditional Release status was pending at the time of his elopement from the Fair.

In response to this event, Susan Dreyfus, Secretary of the Department of Social and Health Services, immediately suspended all off-ward activities for forensic patients at both ESH and Western State Hospital (WSH) and convened a State Hospital Psychiatric Hospital Safety Review Panel (Panel) to recommend changes to department policy, protocols, practices, and laws, as they relate to patients, staff, and community safety (Appendix A).

The Panel met at ESH on October 16, 2009 with the principal focus to analyze the Critical Incident Review of the event and the associated Root Cause Analysis (RCA). Subsequent meetings were held at WSH on November 2nd, November 20th, and November 30th to continue this analysis and to formulate recommendations. Throughout this interval, the Panel actively engaged Mental Health Systems leadership and senior executives and forensic program staff at both hospitals to gather information and develop policies.

This report addresses the two main topics the Panel was charged to pursue and summarizes our key recommendations. It is important to emphasize that the Panel was

not asked to conduct an in-depth investigation of the circumstances leading to this incident, to perform a hospital personnel performance assessment, or to appraise the security systems at ESH or WSH. As required by executive order, an administrative investigation of personnel performance at ESH is being conducted by the Washington State Patrol. Also, the Department of Corrections (DOC) is conducting a formal security survey at both state hospitals. Findings from these investigations have not been available to the Panel. Thus, our recommendations below might require reappraisal depending upon the outcome of these investigations.

II. Charge 1 - Recommend Changes in DSHS Policy, Protocol, Practice and Law Related to Review of the Critical Incident at ESH on September 17, 2009.

The Panel met in Spokane on October 16, 2009 to analyze and discuss the Critical Incident Review and RCA performed by ESH staff in response to this incident.

A. Conclusions regarding the thoroughness and completeness of the critical incident review and actions taken by ESH. The critical incident review and RCA **correctly identified a number of deficiencies** related to the incident. The Panel found that the following factors contributed to the incident:

1. Formal violence and escape risk assessments had not been routinely performed as required by existing ESH policy.

2. The FSU Security Committee was charged in hospital policy to establish, review and make recommendations for changes in unit security policies and procedures and to oversee security training of employees. *This committee was apparently terminated several years ago. Its functions have not been replaced and this change in operations was not reflected in existing policy (emphasis added).*

3. Policies and procedures related to off-campus outings had not been followed.

4. Staff training on policies governing off-campus passes was inadequate.

5. Unit rules about patient eligibility for off-campus passes apparently changed several years ago but this was not documented in updated policy nor effectively communicated to staff through training.

6. Concern expressed by some staff about the appropriateness of certain patients selected for participation in the outing was apparently not registered by unit leaders nor addressed.

7. The possibility of elopement occurring on the outing was not anticipated, nor was there any planning for such emergencies.

8. There was a lack of clarity about notifying Fair security and local law

enforcement; staff on the outing did not call 911 as required by policy.

9. There was no designated leader among the staff who accompanied patients to the Fair, nor was a clear line of authority established to the executive and supervisory leaders at ESH.

10. The ESH Emergency Management Plan provides for the establishment of a Command Center in emergency situations, but this mechanism was not activated, resulting in poor communication among staff members at the Fair and between staff members and both the hospital leadership and local law enforcement.

11. Contradictory instructions were given to staff members who contacted ESH leadership requesting guidance following the elopement.

12. No policy exists on inspecting backpacks, bags, or containers used by patients prior to or returning from outings.

B. Issues not adequately addressed in the critical incident review and root cause analysis that require further attention:

1. **Non-adherence to Existing Policies**. Hospital staff were not performing and documenting risk assessments as required by existing policies or as would be expected in contemporary practice at hospitals serving high risk populations. This appears to have reflected a **cultural shift** that values therapeutic interventions and community reintegration more highly than security, safety, and quality assurance.

2. **Insufficient Attention to Security.** It appears that Forensic Unit staff had become **too familiar with the patients**, leading to insufficient attention to safety and security issues. This was compounded by inadequate emphasis and oversight of these issues at the executive level.

C. Policies and procedures that must be changed. The Panel proposes a series of interventions at ESH and WSH that are intended to emphasize security and safety; expand staff education and training; update policies and procedures; promote evidence-based best practices; and encourage increased communication and operational symmetry at the two state adult psychiatric hospitals. These include:

1. Adherence to Existing Policies. At the conclusion of its meeting at ESH on October 16, 2009, the Panel recommended for ESH an immediate emphasis on adherence to existing polices; a systematic review of all policies to ensure that they were up-to-date and to assure that no critical gaps in policy or procedures exist; and re-training of clinical staff on policies and procedures relevant to their functional roles.

2. Revise Off-Ward Policy. Immediately following the Panel's initial meeting, an intense effort was undertaken by the Panel, with support of the executive leaders and forensic staff at both hospitals, to develop an **Interim Policy for Off-Ward Activities** (Appendix B). This proposed policy reflects the strong sentiment of the Panel that a greater emphasis on security is required in considering when to allow egress of individuals designated NGRI from the secure forensic facilities. As written, only individuals with court-designated Conditional Release or Partial Conditional Release will be afforded this privilege, with the exception of medical emergencies. Operations governing such activities as periodic risk assessments, eligibility for off-ward activities, notification of applicable law enforcement, and emergency communication procedures are specifically clarified.

   Additional work is needed to define by policy the **therapeutic rationale** for increased freedom of movement and such activities as escorted outings and furloughs by NGRI patients along the continuum toward community reintegration. This overriding policy should reflect the required balance between providing effective treatment and safeguarding the public and must conform to Department of Justice directives.

3. Assess Effectiveness of Executive Leadership. A comprehensive appraisal of the performance and effectiveness of the senior executive, medical, nursing and quality program staff at ESH should be undertaken to ensure that the institution maintains contemporary standards of operation and clinical care. The Panel believes strongly that the two hospitals should be working collaboratively under the guidance of an **executive partnership team** that is focused on mutual support and the adoption of uniform practices.

4. Staff Training. Extensive staff orientation and re-training on policies and procedures related to safety, security, and risk management need to be implemented.

5. Risk Management and Assessment Tools. The risk management programs and risk assessment tools being used at both hospitals appear to be **outdated and not-evidenced based**. They should be re-evaluated in the context of contemporary, evidence-based practice. We recommend that the Washington Institute for Public Policy (WSIPP) be enlisted to identify national best practices related to risk management of NGRI patients in the mental health system. WSIPP recently conducted a similar review of risk management programs for the DOC, which would offer an opportunity to enhance symmetry across programs and agencies.

6. Assessment for Competency and Restoration. The policies and procedures for assessing patients for competency to stand trial and for restoration of competency need to be standardized at the two hospitals. They should also be reviewed and updated to assure that effective, contemporary, bench-marked, and evidence-based procedures are being employed at both facilities.

7. Internal Risk Review Board. WSH employs a Risk Review Board to oversee eligibility for assignment of patients to privilege levels that allow increased freedom of movement and to determine preparedness to request Conditional Release and Partial Conditional Release from the courts. ESH does not use this mechanism, although this appears to be a common best-practice in other states, based on our limited review. Senior leaders at ESH and WSH should be charged to work collectively to establish a hospital-based Risk Review Board or an equivalent committee under the authority of the CEOs or their designees.

8. Privileging Systems. The two hospitals use entirely different patient privileging, 'level' classifications for forensic program patients. Both systems appear to be more complex and idiosyncratic than necessary and as compared to privilege/level schemes employed by comparable hospitals in the several states whose policies we surveyed. A simplified, uniform privilege/level system should be developed at both hospitals that is linked to formal risk appraisals using evidence based measures and protocols. Changes in privileges/levels that result in increased freedom from supervision for NGRI or other patients deemed potentially dangerous should be reviewed and approved by a Risk Review Board or an equivalent committee.

9. Outdated Policies. The hospitals should be instructed to conduct a comprehensive survey of current policies and procedures related to patient care, safety, and emergencies. Policies need to be simplified with clear titles and similar formats and should conform to contemporary best practice. This should be accomplished jointly, with an expectation that the desired outcome is uniformity of policies and procedures on both campuses, unless structural or programmatic differences prevent this.

   Along these lines, a joint, multidisciplinary group of union and management staff from both hospitals conducted a systematic review of Forensic policies in early November, 2009. Polices were scrutinized for strengths, weaknesses and opportunities for improvement and were classified in a priority listing for revision.

   The Panel commends this interdisciplinary approach and recommends that the executive leadership of both hospitals develop a work-plan that especially identifies critical policies needing urgent revision. A specific time-line for completion of this project should be established. The Washington Institute for Mental Health Research and Training and the UW Department of Psychiatry and Behavioral Sciences through the UW Center for Evidence-Based Treatment might be enlisted to assist in this effort by identifying national best practices and by providing oversight accountability for this effort.

10. Backpack Policy. A policy and procedure for searching backpacks or other containers used by patients should be established at both hospitals.

11. Technology Tools. Consideration should be given to assessing how available technology might be employed to reduce future risks. For example, current digitized photographs for all patients should be maintained for use in emergencies, as is proposed in the proposed Interim Off-Ward Policy.

III. **Charge 2 - Recommendations on how to assure patient, staff, and community safety while providing appropriate therapeutic interventions and community reintegration support for forensic mental health patients in Washington.**

A. Consider consolidating the treatment of all NGRI patients at WSH.

1. A **security review** has been initiated at ESH and WSH by DOC professionals to assess the structural and operational capacity of both hospitals to serve high risk patients safely and effectively. Until recently, Forensic Program patients at ESH had been sharing dining facilities with patients in the civil commitment program. We consider this a high risk situation. This arrangement has been remedied temporarily by scheduling changes. At WSH, forensic program patients are housed and access psychosocial program facilities within a secure building, but forensic patients at ESH must be escorted to a separate facility to access psychosocial treatment program resources. This represents a security risk.

2. Presently, there is a total of 365 beds at ESH (n=95) and WSH (n=270) designated for forensic program patients. The average daily census of NGRI patients in Washington is 194 patients, with an average of 67 patients at ESH and 126 patients at WSH. Approximately 22 new NGRI patients enter the system annually, averaging 8 patients per year at ESH and 14 at WSH. The remaining 171 forensic beds at the two hospitals are occupied by patients undergoing assessment for competency or restoration of competency, with the exception of a few civilly committed patients who are considered high risk and in need of a secure treatment setting.

   Based on the structural limitations of the forensic wards at ESH and the probable high expense of remedying this situation, the Panel **recommends exploring the prospect of locating all NGRI patients in Washington at WSH**. This has the potential advantage of reducing the programmatic variability that accompanies duplicate programs and might yield financial benefits due to economies of scale. This approach would need to be weighed against the potential for an adverse impact on families. Local workforce impacts would also need to be considered. If these important factors outweigh the benefits of locating all NGRI patients at WSH, an alternative might be to consolidate NGRI patients who have committed the most serious offenses at WSH.

B. Establish a Psychiatric Security Review Board in Washington.

1. Challenges to Safeguarding Public Safety. It is important to emphasize that only a small minority of individuals living with serious mental illness are dangerous. Nevertheless, the management of dangerous mentally-ill offenders represents a national challenge to the public, mental health professions, courts, and law enforcement. In most states, including Washington, individuals deemed NGRI fall under the oversight of the state mental hospitals and state mental health divisions rather than departments of correction. This presents several problems. First, states often use procedures for NGRI acquittees similar to those used for seriously ill patients with mental illness who are civilly committed, which can translate into short hospital stays and uncertain community monitoring for individuals ultimately released from the hospital. Secondly, existing laws for NGRI patients place the jurisdiction of such individuals on the criminal courts, which are often unprepared in terms of timeliness, resources, clinical information, or expertise to make accurate judgments about an individual's potential danger to others. Moreover, contemporary psychiatric treatment for serious mental illness has advanced such that individuals who commit serious offenses while psychotic can be rapidly stabilized. In the hospital setting, this customarily leads to efforts to reintegrate patients back into the community, often far earlier than prosecutors, victims' families or the general public feels is appropriate for individuals whose offenses involve serious personal injury or death to others.

   The majority of NGRI patients have psychotic illnesses, such as schizophrenia, which are often chronic, remitting conditions that can worsen if treatment is not maintained. Thus, an individual might legitimately be assessed to be safe in the community, only to suffer a recurrence that renders him/her dangerous at a later date if treatment is not mandated or if a change in mental health status is not detected through ongoing community supervision. Finally, all of these concerns need to be balanced with the societal value of providing effective treatment, reintegrating individuals living with mental illness back into the community, and safeguarding civil liberties.

2. The Oregon Psychiatric Security Review Board model. In response to these challenges, a few states have adopted an alternative approach. The most mature program, which is also considered the most effective, is Oregon's Psychiatric Security Review Board (PSRB)[12]. Mary Claire Buckley, PSRB Executive Director, graciously provided extensive background information on the history of the program and shared recent effectiveness data. The Panel also had an opportunity to interview Joseph Bloom, MD, former Chair of Psychiatry and Emeritus Dean of Oregon Health and Sciences University, on a

[1] Hospital and Community Psychiatry. 1994;45:1127-31
[2] http://www.leg.state.or.us/ors/161.html

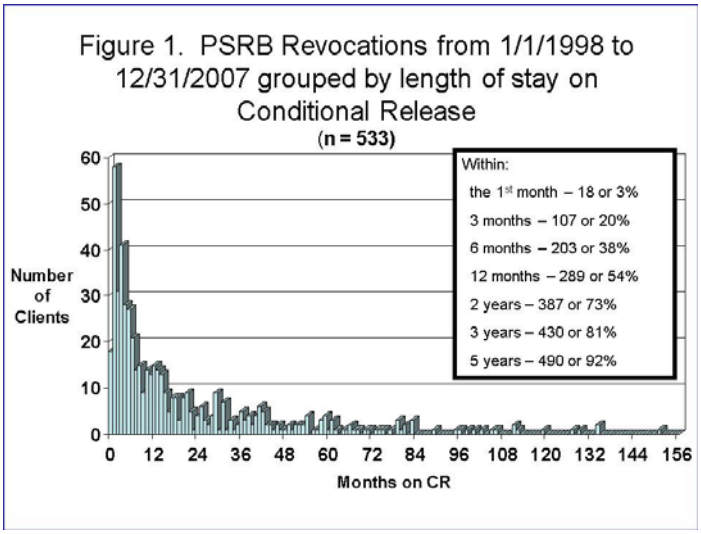
conference call during the November 20th meeting. He has been involved with the PSRB program since its inception and has studied and written extensively about its impact and outcomes.

Protection of the Public. Established in 1977, **the primary purpose of the PSRB is to protect public safety** through the management and treatment of insanity acquittees (Appendix C). This five-member board, appointed as volunteers by the governor to four-year terms, includes a psychiatrist and a psychologist experienced in the criminal justice system, a probation/parole officer, an experienced criminal trial attorney, and a member of the general public. The PSRB is staffed by an executive director who is presently an attorney. The board assumes sole authority for determining whether individuals assigned by the courts to PSRB jurisdiction should be committed to the state hospital, granted conditional release, have conditional release revoked, or be discharged from PSRB authority if it is determined the individual is no longer affected by mental illness or, if affected, no longer presents a substantial danger to others.

Governance Structure. The PSRB is authorized by state law to function independently of the Oregon Mental Health and Developmental Disability Services Division and the courts, although it closely coordinates its activities with the mental health and criminal justice systems. Dr. Bloom noted that the independent authority ascribed to the PSRB has been instrumental in allowing it to be more successful than similar review boards that have been established in a few other states. This governance design promotes a more consistent application of rules and resources than when decisions are made by the diversity of trial court judges in the state. This model also allows for more accountability.

PSRB Functions. The PSRB generally manages approximately 750 individuals and receives approximately 100 new referrals annually. The majority of PSRB clients are male (>80%) with an average age in the mid-40s. The primary diagnoses are schizophrenia and bipolar disorder, commonly associated with a secondary diagnosis of substance abuse. In 2009, 99% of the individuals under PSRB jurisdiction had initially committed felony offenses.

Unless discharged, the insanity acquittee remains under the authority of the board for the **maximum sentence that would have been applied if the individual had been convicted.** Approximately 50% of clients under PSRB jurisdiction are on Conditional Release in the community. Importantly, individuals are required by law to undergo a thorough evaluation for suitability for Conditional Release prior to being granted this status. State law stipulates that this evaluation include plans for adequate supervision and treatment, living arrangements, and case management or clinical supervision.



Community Monitoring. Monitoring of individuals granted Conditional Release in Washington is highly variable and not closely tracked by any central authority. Conditional Release requirements are established by the court that grants Conditional Release status. In Washington, this introduces tremendous variability into this decision-making process, because the courts making such judgments often have limited experience with such cases and might not have full access to information about how the individual is functioning. In contrast, in Oregon eligibility for Conditional Release is judged and approved by the PSRB. Ongoing supervision of individuals on Conditional Release is also centralized by the PSRB and takes the form of calls and correspondence from case managers, providers and others; monthly progress reports from case managers or community treatment providers; and monitoring of the state Law Enforcement Data System. In addition, the **PSRB has independent authority to revoke Conditional Release status** if the individual violates release conditions, which might include mandated treatment, or if deterioration in mental health status is observed. A revocation order has the same legal effect as an **arrest warrant** except that the individual is taken to the state psychiatric hospital instead of jail, unless the revocation order is in response to a new crime having been committed.

Outcomes. The effectiveness of the PSRB program was extensively characterized in 1993.[3] More recent data from the period of 1998-2007 provided by Mary Claire Buckley reflect the continuing effectiveness of the program. Figure 1 illustrates that supervision mechanisms are highly effective. More than 90 percent of individuals on conditional release followed during the period of 1998-2007 received a revocation order, mostly for relatively minor infractions and non-compliance with provisions of the Conditional Release. Importantly, over the 10 year period ending in 2007, only 12 of 1058 individuals committed new felony offenses while on conditional release (see Figure 2).

Figure 2. 12 Felony Offenses Among 1,058 PSRB Clients on Conditional Release 1998-2007

1. Possession of a Controlled Substance; Distribution
2. Possession of a Controlled Substance
3. Stalking
4. Possession of a Controlled Substance
5. Rape III
6. Arson I
7. Burglary I
8. Unlawful Use of a Motor Vehicle
9. Sex Abuse I
10. Arson; Assault; Attempted Murder
11. Reckless Driving; Attempt to Elude
12. Possession of a Controlled Substance

[3] Bloom JD, Williams MH: *Management and Treatment of Insanity Acquittees--A model for the 1990s*. American Psychiatric Press, Inc, Washington, D.C., 1993

Strengths of the PSRB Model. The Panel was impressed that the Oregon PSRB model has functioned well for 30 years and its outcomes have been carefully studied. Several major strengths were noted. The PSRB model:

- Is defined by law to **protect public safety as its number one priority**.
- Imposes **consistency of application** of judgments that are critical to patient wellbeing and public safety.
- Provides for '**insanity sentences'** that are equivalent in duration to the maximum sentence applied to individuals convicted of the same offense.
- Allows more **informed judgments** about determining whether potentially dangerous patients qualify for conditional release
- **Reduces the delays** inherent in relying upon criminal courts to grant or revoke conditional releases.
- Relies upon a well-established **monitoring system** for patients under PSRB jurisdiction.
- Is armed with **revocation mechanisms** that can be executed promptly and with the authority of an arrest warrant.
- **Redirects patients back into the mental health system**, not the jails, if conditional release is revoked.
- **Allows for continuing supervision when individuals achieve a state of remission** because state law recognizes that some individuals have mental illnesses that might, with reasonable medical probability, occasionally become active and, when active, render the person a danger to others[4].

These attributes differ substantially from the decentralized system of management of seriously mentally-ill NGRI offenders employed in Washington. For these reasons, **the Panel strongly recommends that a model that is substantially similar to the Oregon PSRB be considered for Washington**. If this model were to be implemented, Panel members entertained the idea that a hybrid review board structure that integrates representatives from the law enforcement and corrections community might be considered to provide joint community oversight of individuals designated NGRI and individuals leaving the corrections system who are considered dangerously mentally ill offenders (DMIO).

C. *Tools in the Toolbox: A Review of Community Supervision of Dangerous Mentally Ill Offenders*. Last year, King County Prosecuting Attorney, Daniel T. Satterberg, and Department of Corrections Secretary, Eldon Vail, convened a multidisciplinary team to consider regional improvements in the management of dangerous mentally-ill offenders with serious mental illness and risk of violence (Satterberg report). Their report

[4] http://www.leg.state.or.us/ors/161.html; 161.327.B.(3)

highlights the tremendous challenges of providing for public safety while attempting to pursue effective treatment with a hope of community reintegration for mentally-ill offenders.

1. Potential Reforms. The Satterberg Report produced an inventory of 76 concepts for potential reform. The Panel felt the scope of these reforms extended far beyond the Panel's charge but many of the topics bear directly on how NGRI patients are managed in Washington. Several key themes are evident in reviewing the Satterberg report inventory. They include:
    - Cross-system communication and cooperation
    - Changes to the Involuntary Treatment Act (ITA) system – inpatient and outpatient
    - Changes to the criminal justice system
        i. Enhance criminal mental health courts
        ii. Improve competency statutes
        iii. Alter existing NGRI statutes
        iv. Create a "Guilty but Mentally Ill" finding
        v. Increase post-supervision sanctions
    - Hybrid options - civil commitment/criminal justice
        i. Pre-charging - create Jail Diversion Programs
        ii. Create separate civil commitment systems for those with violent convictions
        iii. Create a system to classify the risk of danger for offenders with mental illness who have been dangerous in the past
    - DMIO program concepts for reform

    Several of these topics deserve special comment in the context of the Panel's recommendations.

2. Cross-system communication and cooperation. The recent ESH elopement illustrated with unambiguous clarity the **value of strengthening communication and interactions among agencies and systems** involved in the management of mentally-ill offenders. The proposed Interim Policy for Off-Ward Activities (Appendix B) addresses this issue by delineating specific security measures to be implemented, e.g., digital photographs; by specifying routine notification requirements when patients are granted conditional release, furloughs or participate in off-campus outings; and by indentifying emergency notification protocols in the case of unauthorized leave.

    The Panel concurs with the Satterberg Report and recommends implementing a **focused review of interagency and system communication and data-sharing** about NGRI and other potentially dangerous mentally-ill offenders. Some improvements are neither complex nor expensive, e.g., developing **joint policies and protocols**. Others might require investment in emerging **data repository**

platforms that are designed to promote information-sharing among divergent data systems. Legislation might also be required to allow **sharing of some forms of personal health information** while safeguarding personal privacy.

3. Changes to the ITA system – inpatient and outpatient. It is important to emphasize that the Panel's work was focused rather narrowly on Forensic Program patients at ESH and WSH. NGRI patients and other forensic patients undergoing competency evaluation/restoration represent only a small segment of the much larger population of individuals engaged in the civil commitment system. As noted in the Satterberg Report, there is tremendous complexity and variability in how local communities manage these individuals. Although incidents such as the elopement that precipitated this review understandably generate substantial alarm and interest, it is important not to overlook the tremendous **opportunities to improve how Washington manages patients in the much larger ITA system**.

4. NGRI vs. "Guilty but Mentally Ill." The Hinckley shooting of President Reagan in 1981 sparked a national outcry for reform of NGRI statutes. The fact that some individuals clearly do not have decisional capacity when committing serious offenses has been reflected in common law for centuries. Nevertheless, this remains a controversial and often confusing interface between the mental illness treatment and criminal justice systems. Largely spawned by the Hinckley shooting, a number of states enacted laws creating one or another version of a "guilty but mentally ill" verdict (GBMI). Oregon employs a "guilty except for insanity" judgment as the precursor to individuals being assigned to PSRB jurisdiction. Situations where individuals who have caused serious personal injury or death and have been declared NGRI but are subsequently released from confined treatment in a relatively short time, as was the case for the individual who eloped from the Spokane Fair, tend to amplify calls for changes in NGRI laws.

   The Panel considered whether or not to advocate for instituting a GBMI alternative to NGRI. GBMI gives substantial weight to the crime committed by individuals with mental illness and emphasizes public safety. This topic was discussed at several meetings and scholarly reports about this topic in the criminal justice and mental health academic literature were reviewed. **The consensus of the Panel was <u>not</u> to promote a GBMI initiative**. Several perspectives were offered in defense of maintaining the NGRI judgment. Although the Panel did not engage in an exhaustive exploration of this topic, the literature indicates that the GBMI judgment is compromised by the following:
   - **Juries have difficulty understanding the "guilty but mentally-ill'** judgment, which has led to marginal support for this option in the academic literature.[5]
   - While Washington has the benefit of a **Special Offenders Unit** at the Monroe Reformatory that is dedicated to providing mental health care to

[5] CA Palmer, M Hazelrig. J Am Acad Psychiatry Law. 2000;28:47-54

inmates living with serious mental illness, such resources are not often available in other states.

- Individuals who are labeled GBMI, incur the **stigma** of being considered both mentally-ill and a criminal[6].
- Individuals who receive this judgment often **spend more time incarcerated** than if convicted of the offense.
- Some individuals truly are not guilty due to mental incapacity and should be offered **treatment with the hope of reintegration into the community rather than punishment**.

For low-level, non-violent individuals designated NGRI, the present system appears to work adequately.

The impetus for adopting a GBMI approach comes from a number of murder cases resolved as NGRI where the offender was transitioned quickly back into the community, including two cases from King County where NGRI "patients" who committed murder were back in the community on Conditional Release within a period of five years.

The present system, it is argued, does not properly **distinguish among forensic patients committed for violent and non-violent crimes**. The emphasis on reintegration of all NGRI offenders back into the community, regardless of their underlying offenses, is a serious concern to prosecutors and law enforcement.

The recent resolution in Skagit County of the Zamora case, where the defendant had been charged with aggravated murder for the slaying of a police officer and five other people demonstrated a resolution that was akin to a GBMI model. A plea deal was struck whereby the defendant will be confined to WSH as a NGRI forensic patient for treatment. But the defendant also pled guilty to murder charges in criminal court and thus, if he were to meet the prerequisites for Conditional Release, he would be transferred to the jurisdiction of the Department of Corrections instead of being released to the community. This outcome will undoubtedly be the subject of more discussion by policy-makers, the legal community, and others.

In the 13 states that have a GBMI model, the option of NGRI still remains, as do the concerns about premature release of violent offenders doing well in institutional treatment settings. For that reason and the reasons stated above, it is the Panel's view that the adoption of the Oregon PSRB model with an emphasis on public safety in re-integration decisions is a more fruitful policy reform to pursue than adoption of a GBMI model.

[6] JD Melville, D Nimark. J Am Acad Psychiatry Law. 2002;30:553-55

Appendix A – Secretary Dreyfus Charge Letter, pg. 1

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
P.O. Box 45010, Olympia, Washington 98504-5010

October 2, 2009

Richard Veith, M.D., Chair
Psychiatry and Behavioral Sciences
University of Washington
1959 Pacific Avenue, NE
Box 356560
Seattle, Washington 98195-6560

Dear Dr. Veith:

SUBJECT: Appointment to the State Psychiatric Hospital Safety Review Panel

Due to recent events at Eastern State Hospital, I am convening a State Psychiatric Hospital Safety Review Panel (Safety Review Panel) to provide me with recommended changes to department policy, protocols, practices, and laws, as they relate to patient, staff, and community safety. Your leadership in this policy discussion will be of great value. I am sending this letter as confirmation of your appointment as Chair of the Safety Review Panel.

We have notified the panel participants that you will be contacting them in the near future. The panel participants have been specifically selected for this team because of their background, experience, and subject matter expertise.

I am asking that the team address the following topics:

1. Recommend changes in DSHS policy, protocol, practice and law related to review of the items listed below:
   - Review and make recommendations concerning the critical incident review at Eastern State Hospital.
   - Request any additional information necessary so that, along with the critical incident review, you may reach conclusions regarding the thoroughness and completeness of the critical incident review and the actions taken by the hospital.
   - Identify policy and procedures related to this incident that must be changed for both state psychiatric hospitals.

2. Because the number of forensic patients in state psychiatric hospitals is growing and the cases are becoming more complex, I would also like the review panel to:

   - Provide recommendations on how to assure patient, staff, and community safety while providing appropriate therapeutic interventions and community reintegration support for the growing numbers of forensic mental health patients in this state. In doing so, consider the recommendations from last year's report prepared by King County Prosecutor Dan Satterberg, as well as best practices in other states.

   - *Provide a final written report by December 1, 2009.*

Thank you for contributing your knowledge and time to identify opportunities to improve our mental health hospital delivery system for the safety of our forensic patients, staff, and communities.

Sincerely,

Susan N. Dreyfus
Secretary

By email and regular mail

cc: Cindy Zender, Chief of Staff, Governor's Office
Robin Arnold-Williams, Executive Policy Director, Governor's Office
Kari Burrell, Executive Policy Advisor, Governor's Office
Tracy Guerin, Chief of Staff, DSHS
Doug Porter, Assistant Secretary, HRSA

Appendix B – Interim Policy for Off-Ward Activities: Eastern and Western State Hospitals Forensic Units

INTERIM POLICY FOR OFF-WARD ACTIVITIES
EASTERN AND WESTERN STATE HOSPITALS FORENSIC UNITS
DECEMBER 10, 2009

A. Conditional Release/Partial Conditional Release

1. All patients must have a Court authorized full (CR) or partial conditional release (PCR), treatment team approval, required patient category/level (see C.1., and D.3., below), and a current risk assessment to be considered for Authorized Leave (AL) or other off campus activities with or without staff escort. The only exception would be trips to the community for mandatory appointments, such as needed individual medical services, appointments with patient's CCO, or court hearings.
2. The treatment team will review all patients who reside on campus with CR or PCR on a weekly basis and document in the medical record any changes in risk of unauthorized leave (UL), violence, or other risk factors as identified in the patient's most recent risk assessment.
3. Formal risk assessments must be completed in accordance with hospital policies and must be current with signature/date of the person completing the assessment prior to requesting a CR/PCR.
4. The risk assessment must be documented in the treatment plan or other medical record section as identified by hospital policy.
5. The attending psychiatrist must document in the patient record concurrence with the risk assessment, review of potential for UL or violence, and specific authorization for the off ward or off campus activities.
6. When the CR or PCR is approved by the Court, staff will take a digital photo of the patient and ensure it is on file or on the hospital information system. A new photo will be taken and filed whenever the patient's appearance changes, e.g. weight gain or loss, new haircut, changes in facial hair, or when leaving the campus on AL. Assigned staff at the hospital (ESH: Nursing Staff; WSH: Security Staff) will be responsible for taking the pictures, and they will be maintained in patient record.
7. When the CR or PCR is approved by the Court, the hospital will:
   (a) Notify any patient required under RCW 9A.44.130 to register as a sex offender of that obligation. The patient must register within twenty-four hours from the time of release with the county sheriff for the county of the patient's new residence. Additionally, if the patient being conditionally released has been found not guilty by reason of insanity of a sex, violent, or felony harassment offense, the hospital must comply with RCW 10.77.205 by sending written notice of the conditional release at the earliest possible date, but no later than thirty days before the patient's release, to the following:
      (i) The chief of police of the city, if any, in which the person will reside; and
      (ii) The sheriff of the county in which the person will reside.

(b) The same notice required by RCW 10.77.205 above shall be sent to the following, if such notice has been requested in writing by the following:

(i) The victim of the crime for which the person was committed or the victim's next of kin if the crime was a homicide;

(ii) Any witnesses who testified against the person in any court proceedings; and

(iii) Any person specified in writing by the prosecuting attorney.

Documentation will be completed by the social worker/forensic therapist and placed in the patient record.

B. Authorized Leave for Eligible Patients with CR/PCR

1. Before a person with CR/PCR is permitted to leave ESH or WSH for any period of time for any/all authorized leave without constant accompaniment by facility staff, the case manager/social worker/forensic therapist shall in writing notify by fax the prosecuting attorney of any county to which the person is released and the prosecuting attorney of the county in which the criminal charges against the committed person were dismissed, of the decision conditionally to release the person. The notice shall be provided at least forty-five days before the anticipated release and shall describe the conditions under which the release is to occur and notification will be documented in the medical record.
2. In addition to the notice required in B. 1., the case manager/social worker/forensic therapist shall notify community law enforcement, including local police where the patient will be located, relevant Sheriff's office, and the Washington State Patrol. Notification shall be made at least thirty days before the AL, and shall include the name of the person, the place to which the person has permission to go, the dates and times during which the person will be on AL. Notification will be completed by the case manager/social worker/forensic therapist and documented in the patient record.
3. Patients who are planning to live near family or where they have lived in the past will be considered for overnight AL to establish a support system. These ALs will be without a staff escort. There will be an order by the physician in the chart for each overnight stay. The patient will have a Court ordered CR or PCR that allows overnight visits.
4. If clinically indicated and the patient has a CR or PCR that allows overnight visits, the patient may be allowed to visit their family for Thanksgiving and/or Christmas. Proposed arrangements will be communicated to the family by the assigned case manager/social worker/forensic therapist. The treatment team will review each request, verify that the risk assessment has been reviewed and indicates that the AL is appropriate, and the attending psychiatrist will sign an order in the chart.
5. Prior to any/every overnight AL, the treatment team will document in the patient record that a review of risk factors was completed and that no changes were identified. The attending psychiatrist must document in the progress notes his/her review of the risk assessment and confirm that the AL is appropriate.
6. Prior to any/every AL, the planned AL will be documented in the patient's medical record with specificity and dates.
7. Any patient elopement from off-ward activities or AL will be reported immediately to 911 and to relevant local and state law enforcement, including the chief of police of the city and the sheriff of the county in which the person resided immediately before the person's arrest,

as soon as an elopement is recognized. If previously requested, notification will be provided to the witnesses and the victim, if any, of the crime for which the person was committed or the victim's next of kin if the crime was a homicide, pursuant to RCW 10.77.165. Reporting is the responsibility of the escort in the field, the patient's ward leadership, and Forensics, Psychiatry, and Nursing Program leadership in that order.

8. Patients who meet all conditions of the interim policy for community privileges and leave campus to participate in outings are limited to groups of no more than four patients with the required staff escort.

C. ESH: Levels/Off Ward Privileges

1. At ESH, the patient category/level system has five levels ranging from E (most restrictive) through A (least restrictive). Patients with Level A and with a CR/PCR may be allowed off-ward activity without staff escort as described in #4 below.
2. When the hospital is asking for revocation of a CR or PCR, the patient is not allowed to gain access to level B or A.
3. If clinically indicated, all patients may go off the ward (on campus) with staff escort without a PCR/CR for attendance at specific psychosocial rehabilitation programming or treatment mall activities.
4. ESH Patients with a CR or PCR and Level A may be allowed to go off the ward without staff escort as long as all criteria in Section A., 1-6 above are met. The times patients are allowed off the ward will be determined by the treatment team and documented in the treatment plan.
    - Patients will be allowed to go to the following on campus locations only:
        - Go to the ESH Campus Café and ESH Campus Club when open
        - Walk the campus within the identified campus limits
        - Participate in treatment mall programming off the ward during treatment mall hours (9 a.m. to 2 p.m.)
        - Participate in AA/NA meetings off the ward as scheduled.
5. Any patient elopement from off-ward activities will be reported as described in B.7., above.

D. WSH: Levels/Off Ward Privileges

1. At WSH, the Center for Forensic Services has a patient level system with 8 steps ranging from level 1 (most restrictive) to Level 7 (eligible for activities outside of secure building as approved by Risk Review Board) to Level 8, moving to the Community Program Ward.
2. Movement to the Community Program Ward follows the issuance of a CR by the court which issued the NGRI order. The Community Program Ward has a patient level system with 5 steps ranging from Level 1 (most restrictive, all new transfers into the program) to Level 5 (least restrictive, eligible for WSU staff-endorsed CR to live in a residence located in western Washington).
3. When the hospital is asking for revocation of a partial or full conditional release, the patient is not allowed to gain access to Levels that permit off-ward access without staff escort.
4. Patients in the Community Program Ward with Levels 4 and 5 would be permitted off ward activity without staff escort as described below:
    - Eligible patients may be allowed to go off the grounds but may only go to the 2 gas stations on Far West Drive and the 2 shopping malls, Chambers Creek and Oakbrook on Steilacoom Blvd.

- As per their treatment plan, patients may be allowed to attend Rose House, TACID, AA/NA meetings, and acquire Washington State ID and Social Security cards. They may also attend other off-campus treatment related activities as approved by the MD. A CFS staff member will escort patients off campus in groups no larger than 4 when the destination is to areas other than those in the first sub point.

5 Any patient elopement from off-ward activities will be reported as described in B.7., above.

6. Consistent with procedures in Sec B.2., there shall be notification to law enforcement (sheriff and municipal PDs and the WSP), prosecutor of record, and county prosecutor if travel is to a different county than conviction 45 days ahead of the furlough. For travel to Lakewood, authorized passes will be faxed to LWPD a second time 72 hours before the leave begins. A current picture is available on the ward and a copy of departure clothing description is documented.

Reviewed and Approved
State Hospital Safety Review Panel
November 20, 2009
Modified: November 30, 2009; December 10, 2009

Appendix C – Oregon Psychiatric Security Review Board

Gold Award

A Model for Management and Treatment of Insanity Acquittees

Psychiatric Security Review Board, State of Oregon

In the mid 1970s, both the public and the mental health professions in Oregon were concerned about the threat to the public presented by persons found not guilty of crimes due to insanity who were released from psychiatric hospitals. In addition, the forensic unit of the state mental hospital was overcrowded with insanity acquittees, but there were few community programs to supervise or treat dangerous mentally ill offenders who might be released.

At the same time, increased attention to the rights of mentally ill patients in the 1960s and 1970s had led to due-process reforms that made it difficult to legally detain mentally ill persons. The state often used procedures for insanity acquittees similar to those used for civilly committed persons—short hospital stays with little or no community monitoring. Existing laws placed authority for disposition of insanity acquittees on the criminal courts, which often lacked the time, resources, or expertise to make informed judgments about an individual's clinical condition or dangerousness to others.

To address these problems, the state of Oregon in 1978 established the Psychiatric Security Review Board, an independent, interdisciplinary program for monitoring persons who are found guilty except for insanity and who are considered to present a substantial danger to others. In recognition of its commitment to improved integration of mental health services within the criminal justice system and its responsibility to community and societal values, the State of Oregon's Psychiatric Security Review Board was selected to receive the 1994 Gold Achievement Award from the Hospital and Community Psychiatry Service of the American Psychiatric Association. The award is presented each year to recognize outstanding programs for mentally ill and developmentally disabled persons. It includes a $10,000 prize made possible by a grant from Roerig, a division of Pfizer Pharmaceuticals. The award was presented October 1 at the opening session of the 46th Institute on Hospital and Community Psychiatry in San Diego.

The primary purpose of the Psychiatric Security Review Board, which is the first program of its kind in the United States, is to protect society through the postadjudication management and treatment of insanity acquittees, almost all of whom are chronically mentally ill. The board assumes sole authority for determining whether persons assigned by the courts to its jurisdiction should be committed to the state hospital, granted conditional release or have conditional release revoked, or be discharged from the board's authority if they are no longer mentally ill and dangerous to others. Unless discharged early, an insanity acquittee remains under the board's jurisdiction for the maximum sentence that could have been received if the person had been convicted. The program's conditional release component provides a mechanism for reducing the number and length of costly inpatient stays.

The Psychiatric Security Review Board successfully bridges the mental health and criminal justice systems, while acting independently of both systems. Persons come under the jurisdiction of the board through the courts and are treated and supervised by staff from the mental health system. About 65 new persons are placed under the board's jurisdiction each year. Currently the board is responsible for about 500 people, 180 of whom are on conditional release. In a study of criminal recidivism among 366 subjects who were conditionally released between 1978 and 1986, only 15 percent were rearrested while on conditional release.

Oregon's Psychiatric Security Review Board has received highly favorable attention from national organizations, including the endorsements of the American Psychiatric Association and the National Alliance for the Mentally Ill. Two other states—Connecticut and Utah—have established review boards that substantially replicate the Oregon program. The board's continued vitality during a period of budget constraints, legal assaults on mental health systems, and public opinion favoring abolishment of the insanity defense attests to the confidence it has inspired among defense and prosecuting attorneys, judges, mental health professionals, and the citizens of Oregon.

Organization of the board

Oregon's Psychiatric Security Review Board functions independently of the court system and the Oregon Mental Health and Developmental Disability Services Division, although it closely coordinates its activities with the mental health division, which provides treatment to insanity acquittees.

The board effectively integrates the disciplines of law, psychiatry, psychology, and social work. By law, two of its five part-time members must be a psychiatrist and a psychologist experienced in the criminal justice system, one an experienced parole and probation officer, one an attorney experienced in criminal trial practice, and one a member of the general public. The psychiatrist and the psychologist cannot be employees of the state mental health division. The attorney cannot be a district attorney or public defender. The board members receive per diem expenses for their meetings.

Board members are appointed by the governor and confirmed by the state senate for four-year terms. The current members are George Saslow, M.D., Stephen Scherr, Ph.D., Kim Drake (parole and probation officer), Hilda Galaviz-Stoller, J.D., and Vern Faatz (public member).

The board has four staff positions—an executive director, two administrative assistants, and a secretary. Mary Claire Buckley, J.D., an attorney with mental health law experience in both civil and criminal commitments, serves as executive director. Staff duties include working with the staff of Oregon State Hospital in Salem, which provides inpatient services for persons under the board's jurisdiction; with members of the bar; with staff of community mental health agencies; and with victims and families of insanity acquittees.

The board operates on a biennial budget, with funds appropriated by the Oregon state legislature. Current funding, approved through mid-1995, for administrative costs associated with operation of the board is about $630,000 for the two-year period. The Oregon Mental Health and Developmental Disability Services Division provides the funds for community care of insanity acquittees on conditional release. The division contracts with public and private agencies to provide a range of mental health services.

The basic cost for community supervision of an insanity acquittee is about $5,000 per year. The cost for acquittees who need enhanced outpatient services is about $9,000 per year and for the few who need extensive residential placement services, about $33,000 per year. These totals compare with an annual cost of $60,130 for inpatient care.

The 1994 H&CP Achievement Award Winners

The American Psychiatric Association honored five outstanding mental health programs in an awards presentation on October 1 at the opening session of the 46th Institute on Hospital and Community Psychiatry in San Diego. The Psychiatric Security Review Board of the State of Oregon received the Gold Award and a $10,000 prize made possible by a grant from Roerig, a division of Pfizer Pharmaceuticals.

Four programs received certificates of significant achievement. They are the Alternative Family Program of Gulf Coast Community Care in Clearwater, Florida, the Emory Autism Resource Center in Atlanta, Evolving Consumer Households of the Massachusetts Mental Health Center in Boston, and Independence Center in St. Louis.

The winning programs were chosen from among 52 applicants by the 1994 H&CP Achievement Awards board, which was chaired by Don R. Lipsett, M.D., of Cambridge, Massachusetts. The awards have been presented annually since 1949. Descriptions of this year's winning programs are included in this issue, beginning on page 1127.

Population served

Since the 1970s, the clinical characteristics of insanity acquittees have become increasingly homogeneous due to adoption of more restrictive definitions of the insanity defense. For example, in 1983 Oregon eliminated the insanity defense for people with a sole diagnosis of personality disorder. Most persons involved in a successful insanity defense have a diagnosis of a chronic mental illness, primarily schizophrenia or other psychosis, and have extensive past experience with both the mental health and the criminal justice systems. The persons for whom the board is responsible are often the sickest patients in the population of chronic mentally ill persons.

In a sample of 758 persons assigned to the jurisdiction of the Psychiatric Security Review Board between 1978 and 1986, almost 90 percent were men, and half were between the ages of 20 and 30. Most were white, in keeping with the ethnic distribution of Oregon's population. They were generally unemployed or underemployed and either lived alone, with family, or in protected settings.

More than three-quarters of the group had a previous state hospital stay. The group as a whole had a mean of 3.1 prior psychiatric hospitalizations, 59 percent of them involuntary. Psychosis accounted for 72 percent of diagnoses—60 percent of the group had a diagnosis of schizophrenia, and 7 percent had bipolar disorder. Eleven percent had a personality disorder, 8 percent had mental retardation, and 5 percent had organic mental disorders. Substance abuse disorders accounted for only 3 percent of primary diagnoses, but 27 percent of the group had substance abuse problems.

The group had extensive involvement with the criminal justice system—a mean of 5.5 police contacts per person—before being assigned to the board's jurisdiction. Seventy-seven percent of the sample had previously been charged with criminal offenses. Seventy-three percent were assigned to the board's jurisdiction after charges involving felonies, and 27 percent after misdemeanors. The most frequently occurring felonies were assaults, burglaries, and unauthorized use of motor vehicles. Harassment was the most frequently occurring misdemeanor. Cases resulting in death of another—murder or manslaughter—accounted for 4 percent of the crimes.

How the board operates

Board powers. The Psychiatric Security Review Board was created by 1977 legislation—Oregon Revised

Statutes, Sections 161.319 –161.351, 161.385–161.395 (1977)—which transferred legal responsibility for insanity acquittees from the trial courts to the board as of January 1, 1978. The statute specifies that the primary concern of the board is protection of the public and gives the board sole authority for determining the placement of persons assigned to its jurisdiction.

To counterbalance these stipulations, the law provided substantial legal safeguards to persons under the board's jurisdiction, including rights to periodic hearings, legal representation at all hearings, cross-examination, subpoena power, independent professional evaluation before hearings, and appeal of the board's decisions to the Oregon appellate courts.

A key innovation is development of a well-supervised conditional release for insanity acquittees that covers both the individual's readiness for release and the availability of supervision and treatment in the community. The system allows for protection of the civil liberty interests of insanity acquittees by developing treatment in the least restrictive setting that is appropriate for each acquittee. The board may promptly revoke conditional release if it receives reports that the individual has violated the release conditions or that the individual's mental status has deteriorated. However, once a person is discharged from the board's jurisdiction, neither the trial court nor the board has any continuing authority over that person.

The board is a state agency administratively located within the Department of Administrative Services. Because authority over insanity acquittees is centralized in the board, which has specialized knowledge of the patient population and the care available for them, the state's interest in consistent application of rules and resources can be more easily accommodated than when decisions are made by a diverse group of trial court judges.

Commitment to the board's jurisdiction. Insanity defense cases in Oregon use a standard to define insanity that is based on the American Law Institute test. In 1983 the state changed the name of the plea used for insanity defense cases from "not responsible due to mental disease or defect" to "guilty except for insanity." A successful insanity defense initiates the Psychiatric Security Review Board's procedures for managing insanity acquittees.

After a finding of guilty except for insanity, the trial judge decides if the evidence shows that the defendant continues to be affected by a mental disease or defect and if the person presents a substantial danger to others. If the answer to either question is no, the state's jurisdiction terminates and the defendant is discharged; however, this outcome is relatively rare. The vast majority are not set free but are subject to management by the Psychiatric Security Review Board, which includes the probability of confinement and close supervision for an extended period of time.

> Most persons involved in a successful insanity defense have a diagnosis of a chronic mental illness and extensive past experience with both the mental health and the criminal justice systems.

The trial court judge determines the maximum length of this period based on the sentence the individual would have received if found criminally responsible for the offense. This time period is known in Oregon as the "insanity sentence," which ranges from year for a misdemeanor to a lifetime for murder. The court may assign individuals with multiple charges to the board's jurisdiction for longer periods reflecting consecutive sentencing.

The trial judge also determines whether there is a victim of the defendant's crime and whether the victim wishes to be notified if the board decides that the insanity acquittee will be conditionally released or discharged or if the acquittee escapes from supervision. If so, the board must make reasonable efforts to notify the victim of these events. Finally, the trial court judge determines whether the insanity acquittee will be initially placed in the forensic unit of the state hospital or in the community on conditional release.

Hearings. Insanity acquittees serve their "insanity sentence" within the mental health system either in the state hospital or in the community in a monitored conditional release program. The Oregon statutes require the Psychiatric Security Review Board to conduct periodic hearings for each individual it supervises. Each person is eligible for a hearing every six months. Insanity acquittees, hospital staff, and staff of community monitoring agencies may also request hearings. The board conducts about 300 full hearings each year.

Hearings are held once a week at Oregon State Hospital. Relaxed rules of evidence provide a less stringent burden of proof than in civil commitment hearings and allow board members to consider proceedings of the acquittee's trial, information submitted by interested parties, and the acquittee's entire psychiatric and criminal history.

During the days before the hearings, the board's staff compiles and provides to board members documents about the case, which may consists of several hundred pages. Over the last five years, the board has become more efficient in conducting hearings by employing a case summary coordinator to computerize records and then to index them for board members.

At least three board members must be present for a hearing. The state is represented by an assistant attorney general or local district attorney. The insanity acquittee has a right to legal counsel, and indigent persons are provided counsel without cost. Psychiatrists, social workers, and psychologists from the state hospital staff testify regarding the acquittee's mental health status and progress. The acquittee is present and can subpoena and cross-examine witnesses. All hearings are recorded,

and the transcript constitutes the record if the person decides to appeal the board's decision to the appellate court.

The burden of proof on all issues is by a preponderance of the evidence. The state bears the burden of persuasion in all hearings except those held to consider an acquittee's application for change of status, in which the person must prove his or her suitability for release or discharge.

All three board members must vote unanimously for a decision to be made at the hearing. If a consensus decision cannot be reached, the case file and transcript of the hearing are referred to the two board members who were not present and three of the five members must concur. At the conclusion of the hearing, the board's chair or acting chair gives the insanity acquittee and the attorney written notification advising of the right to appeal an adverse decision within 60 days from the date an order is signed. The board must provide a written order within 15 days of the hearing.

The board also conducts administrative hearings in which an insanity acquittee's conditional release or treatment plan is reviewed or modified. The acquittee does not have to be present for such hearings.

Hospitalization, conditional release, and discharge. Hospital care for insanity acquittees is provided at the Oregon State Hospital forensic unit in Salem. Almost 325 of the 700 beds at the state hospital are devoted to patients under the board's jurisdiction. The patient's treatment plan is developed by hospital staff, but major alterations in the plan, such as off-campus passes, must be approved by the Psychiatric Security Review Board.

Some patients who are assigned to the board's jurisdiction cannot be released into the community under any foreseeable conditions. But for others, conditional release is a reasonable prospect, provided they are closely monitored and supervised by mental health programs in the community. Community programs for insanity acquittees have been influenced by many of the major reforms that took place in community mental health in general in the late 1970s and early 1980s, particularly a refocusing on the needs of chronic mentally ill patients who were being discharged from state mental hospitals. In 1981 Oregon legislation recognized chronic mentally ill people as the population with the highest priority for public mental health services and reorganized community mental health programs to emphasize support services for them. Within this reorganization, a separate component for community services for released insanity acquittees was created.

The patient, the patient's attorney, or hospital staff members may file a request for conditional release. A patient may request a hearing for the board to consider conditional release every six months. The board then has 60 days within which to set that hearing. Hospital staff may submit a request for conditional release of a patient at any time. Those hearings are set as soon as possible.

At the board's request, a community program conducts a thorough evaluation of each insanity acquittee being considered for release. State law prohibits conditional release until the community program, in cooperation with the board, develops a plan to provide adequate supervision and treatment. The conditional release plan constitutes an agreement among the board, the Mental Health and Developmental Disability Services Division, the community program, and the insanity acquittee. The plan includes provisions for living arrangements, mental health aftercare, and case management.

The plan may specify that the acquittee reside in a specific group home and not change residence without approval of the case manager. He or she may be required to take medication under observation of group home staff, to attend a day treatment program, and to submit to drug screening and medical monitoring. The plan may also stipulate additional conditions; for example, the person may be prohibited from driving, using alcohol or other drugs, or contacting certain persons.

The board designates a particular person, usually the case manager, to monitor the insanity acquittee's progress and make reports to the board monthly or at any time the conditions of the release are violated or the acquittee's mental status changes. In addition, any police contact with the conditionally released person, even if he or she is a victim of a crime, is immediately reported to the board via the law enforcement data system computer. The community program usually reports to the board by telephone if a problem arises requiring prompt board action. On receipt of such a report, the board or its chairperson may immediately issue a written order revoking conditional release. This order constitutes a sufficient warrant for the police to take the person into custody. The person may not be jailed, but must be transported to the state hospital.

The entire process from report to rehospitalization may be accomplished within a few hours. The board must then hold a hearing within 20 days to decide if the person should remain committed to the hospital, return to conditional release, or be discharged. Data on persons under the board's jurisdiction before 1986 showed that although more than half of those on conditional release had their release revoked within a year, only a few revocations were due to new criminal charges. Most occurred because of violations of conditions of release such as a requirement to take medication or refrain from using alcohol or because of deteriorating mental health.

Persons may be discharged from the board's jurisdiction while in the hospital or on conditional release. At any hearing, the board must discharge a person found to be no longer affected by mental disorder or no longer presenting a substantial danger to others. Thus both criteria—mental disease or defect and dangerousness—must be met for the board to retain jurisdiction. A person is automatically discharged after having been under the board's jurisdiction for the duration of the "insanity sentence." At the end of the insanity sentence, the state has the option of instituting civil commitment procedures to retain custody of a person believed to meet criteria for civil commitment.

Research on outcomes

The Psychiatric Security Review Board monitors its own performance as well as that of the insanity acquittees it supervises. Quality improvement mechanisms include a full financial audit done by the Secretary of State's audit division every four years and an internal quarterly review using a productivity matrix developed by the board's staff. Performance measures (and their averages since 1992) include percentage of hearings held within statutory time limits (85.7 percent), percentage of conditional releases maintained per month (95.7 percent), and percentage of revocations based on new felonies (1.7 percent).

The board's centralized record keeping system has provided opportunities for extensive research on the characteristics of the forensic population and on service outcomes. Joseph Bloom, M.D., professor and chairman of the department of psychiatry at Oregon Health Sciences University, and his colleagues Douglas A. Bigelow, Ph.D., Bentson H. McFarland, M.D., Ph.D., Jeffrey Rogers, J.D., and Mary H. Williams, M.S., J.D., have studied various aspects of the Psychiatric Security Review Board's operation since its inception. A study funded by the National Institute of Mental Health developed in-depth information about a cohort of 758 persons assigned to the board's jurisdiction between 1978 and 1986, including data on their management while under the board's jurisdiction and on their involvement with the mental health and criminal justice systems after discharge.

The results showed that the system tended to use conditional release conservatively, in keeping with its mandate to protect the public; 68 percent of the study sample spent their entire insanity sentence or the entire study period in the hospital. Women were more likely than men to be conditionally released, as were subjects with fewer past contacts with the mental health and criminal justice systems and less serious crimes leading to board jurisdiction. Subjects whose conditional release was revoked tended to be younger, to have more extensive histories of substance abuse and of contact with the mental health and criminal justice systems, and to have spent more time in the hospital before conditional release. Follow-up an average of 53 months after subjects were discharged from the board's jurisdiction showed a significant decrease in the number of criminal justice contacts per year compared with the period before subjects became the board's responsibility. Among subjects who were arrested after discharge from the board's jurisdiction, there was an overall decrease in the number of felonies and an increase in the number of misdemeanors, compared with the period before board jurisdiction.

Plans for the future

The Psychiatric Security Review Board intends to continue to seek ways to increase its efficiency without jeopardizing its effectiveness. Current plans include training in administrative law procedure for board members and advanced training in computer technology for staff.

Staff of the Psychiatric Security Review Board also plan to increase efforts to fight state budget cuts that may threaten the board's existence. Adequate funding for the program beyond 1995 is not assured, as the final phase of a state initiative limiting the use of property tax revenue for government operations will go into effect that year. Staff plan to work with community organizations such as the Friends of Forensic, consisting of people with relatives and friends under supervision of the board, and the National Alliance for the Mentally Ill to mobilize support for continuing the board's mission of protecting public safety while promoting cost-effective supervision and treatment of mentally ill persons who commit crimes.

For more information, contact Mary Claire Buckley, J.D., Executive Director, Psychiatric Security Review Board, 620 Southwest Fifth, Number 907, Portland, Oregon 97204; telephone, 503-229-5596.

Applications for 1995 Achievement Awards

The Hospital and Community Psychiatry Service of the American Psychiatric Association is now accepting applications for the 1995 Achievement Awards. The awards will be presented at the Institute on Psychiatric Services (the new name for the Institute on Hospital and Community Psychiatry), to be held October 6–10, 1995, in Boston. The deadline for receipt of applications is January 6, 1995.

The American Psychiatric Association presents the awards each year to recognize programs that have made an outstanding contribution to the mental health field, that provide a model for other programs, and that have met challenges presented by limited financial or staff resources or other significant obstacles.

The winner of the first prize, the Gold Award, receives a $10,000 grant from Roerig, a division of Pfizer Pharmaceuticals. If more than one program is chosen as a Gold Award winner, the programs share the grant. The winner of the Gold Award also receives a plaque, and the winners of Significant Achievement Awards receive certificates.

Applicants should submit six copies (including the original) of a completed application form and a program description. Each program that applies will be visited by a representative of the local district branch of the American Psychiatric Association. The site visitor's evaluation will assist the Achievement Awards board in selecting the winning programs.

Ricardo P. Mendoza, M.D., of Torrance, California, is chair of the 1995 Achievement Awards board. To receive an application form or additional information, write Achievement Awards, APA, 1400 K Street, N.W., Washington, D.C. 20005, or telephone 202-682-6174.