

Arizona Psychiatric Security Review Board

Board should ensure it receives needed information to inform its decision making, improve its issuance of hearing notices and orders, and develop rules, policies, and procedures to help meet key responsibilities

Performance Audit and
Sunset Review

December 2018
Report 18-107

A Report to the Arizona Legislature

Lindsey A. Perry
Auditor General





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December 19, 2018

Members of the Arizona Legislature

The Honorable Doug Ducey, Governor

James P. Clark, M.D., Chairman
Arizona Psychiatric Security Review Board

Transmitted herewith is a report of the Auditor General, *A Performance Audit and Sunset Review of the Arizona Psychiatric Security Review Board*. This report is in response to a September 14, 2016, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting within this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

As outlined in its response, the Arizona Psychiatric Security Review Board agrees with all of the findings and plans to implement all of the recommendations directed to it.

My staff and I will be pleased to discuss or clarify items in the report.

Sincerely,

Lindsey Perry, CPA, CFE
Auditor General

cc: Arizona Psychiatric Security Review Board members



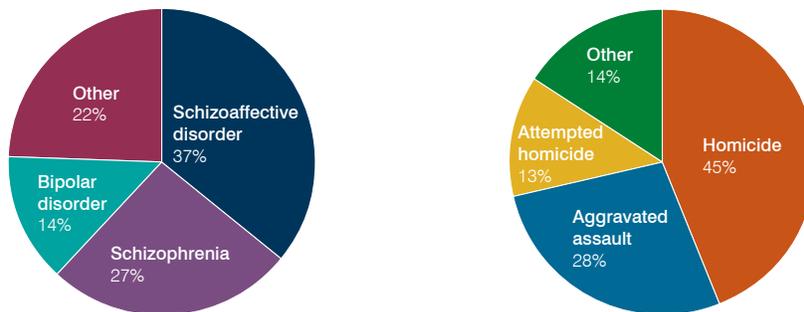
Arizona Psychiatric Security Review Board

CONCLUSION: The Arizona Psychiatric Security Review Board (Board) maintains jurisdiction over persons the Superior Court of Arizona has found guilty except insane (GEI) who have caused or threatened to cause death or serious physical injury to another individual. We found that the Board should take steps to help ensure it receives necessary information to inform its decisions regarding GEI persons. Additionally, the Board should ensure it issues hearing notices and board decision orders as statutorily required, and develop and implement internal controls, such as rules and policies and procedures, to help efficiently and consistently meet its key responsibilities. Finally, the Legislature should consider revising statute to establish authority and responsibility for providing the Board's administrative support.

Board oversees GEI persons who have committed serious crimes

GEI persons under the Board's jurisdiction are committed to the Arizona State Hospital (ASH) when sentenced. The Board conducts hearings for the GEI persons under its jurisdiction, including hearings to determine if GEI persons are eligible for release from ASH to the community based on several criteria, including whether the GEI person still suffers or is in stable remission from a mental disease or defect, is still dangerous, and has a propensity to reoffend. In fiscal year 2018, the Board conducted 23 release hearings and denied release for 21 GEI persons and granted conditional release for 2 GEI persons, which involves establishing conditions the GEI person must comply with while residing in the community. The Board is also responsible for monitoring GEI persons who have been released to the community. The Board may revoke release under certain circumstances, such as if a GEI person deteriorates mentally. As of June 30, 2018, the Board had 120 GEI persons under its jurisdiction, including 19 residing in the community.

Primary diagnoses and offenses of 120 GEI persons



Board should take steps to ensure it receives needed information to inform its decisions regarding GEI persons

To help inform the Board's decisions, ASH or the applicable community behavioral health provider is statutorily required to provide the Board with a report on the GEI person's mental health (mental health report) at least 15 days prior to a GEI person's hearing. Statute does not specify the required content of mental health reports, but the Board has developed hearing notification letters that outline the information that should be included in the mental health reports.

However, the Board does not consistently receive sufficient detail in these mental health reports. For example, some reports we reviewed included detailed information and support for conclusions being made, some reports included a mix of detailed and general information to support conclusions, and other reports provided only general conclusion statements with little or no support. The lack of sufficient information jeopardizes the Board's ability to make timely and consistent decisions regarding GEI persons.

The Board's hearing notification letters do not clearly explain the Board's expectations about the level of detail or type of support it expects to be included in the mental health reports. Similar boards in other states more clearly communicate expectations for needed information to help inform their decisions.

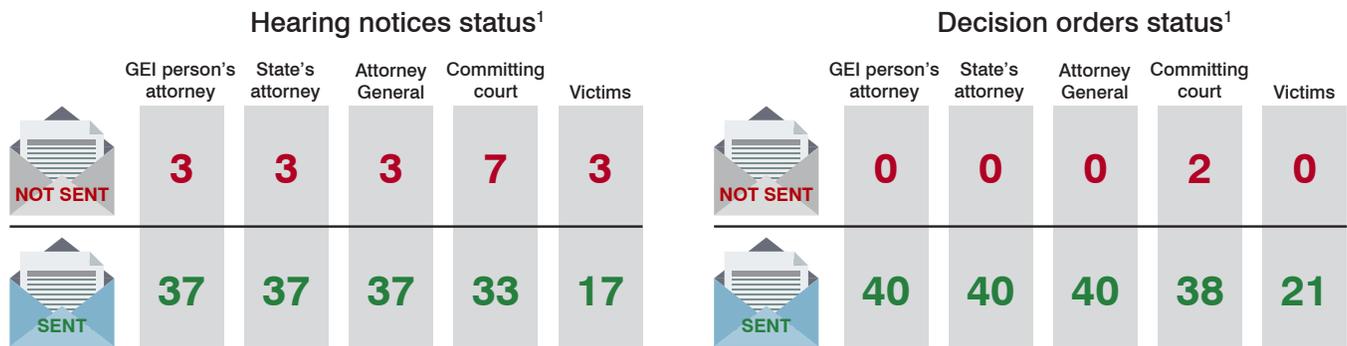
Recommendation

The Board should revise its hearing notification letters and develop written guidance to clarify its expectations for the information that mental health reports should provide.

Other board actions needed

As reported in the report's Sunset Factors section, we reviewed a random sample of 10 of the 120 GEI persons under the Board's jurisdiction as of June 2018 and found that the Board conducted release hearings for these persons as statutorily required. However, we identified the following areas for improvement:

Board should improve its process for issuing hearing notices and decision orders—We reviewed the Board's compliance with issuing hearing notices and board decision orders to persons statutorily required to receive them for 40 cases the Board heard between November 2017 and May 2018 and found that some hearing notices and board decision orders were not sent as required due to staff error.



¹ Hearing notices and board decision orders are required to be sent only to victims of GEI persons who request to receive them. According to board records, the victims associated with 20 of the 40 hearings requested to receive hearing notices, and the victims associated with 21 of the 40 hearings requested to receive board decision orders.

Recommendation

The Board should take steps to reduce errors in its process for sending hearing notices and board decision orders, such as requesting assistance for board staff and/or providing supervisory review of the process or requesting technological assistance to automate the process.

Board should develop and implement internal controls—The Board has not developed any rules and has minimal policies and procedures. Rules and policies and procedures are important for clarifying, operationalizing, and ensuring the consistent implementation of its statutory responsibilities.

Recommendation

The Board should establish rules to clarify its statutory responsibilities and develop and implement policies, procedures, and other written guidance for its key responsibilities.

Legislature should consider establishing authority and responsibility for Board's administrative support—Although the Arizona Department of Health Services has provided administrative support to the Board, including providing staff, funding, and facilities, it is not statutorily required to do so, and authority and responsibility for the Board's administrative support is not otherwise specified in statute. In contrast, statutes for 11 Arizona boards, commissions, and councils that receive administrative support from another state agency specify these administrative authorities and responsibilities.

Recommendation

The Legislature should consider revising statute to establish authority and responsibility for providing the Board's administrative support.



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Board oversees persons adjudicated guilty except insane

The Arizona Psychiatric Security Review Board (Board) was established in 1994 to maintain jurisdiction over persons the Superior Court of Arizona has found guilty except insane (GEI) who have caused or threatened to cause death or serious physical injury to another individual (see textbox). A.R.S. §13-502 requires GEI persons to be placed under the Board’s jurisdiction for the length of their presumptive sentence and to be committed to the Arizona State Hospital (ASH), which is operated by the Arizona Department of Health Services (DHS).¹ Statute authorizes the Board to release any GEI person under its jurisdiction from ASH to the community regardless of primary offense if the person meets statutory release criteria (see pages 2 and 3).²

Guilty except insane

A person may be found GEI for a criminal offense if at the time of the offense the person suffered from a mental disease or defect of such severity that the person did not know that the criminal act was wrong.

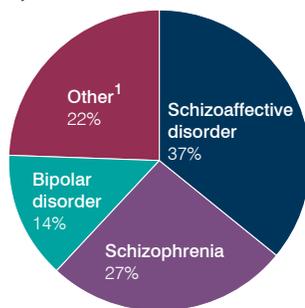
Source: Auditor General staff summary of Arizona Revised Statutes (A.R.S.) §13-502.

The Board’s key statutory responsibilities include:

- Conducting hearings to determine whether the GEI person may be released from ASH, and
- Monitoring and supervising the GEI person while on conditional release from ASH.

As of June 30, 2018, the Board had 120 GEI persons under its jurisdiction, with 100 residing in ASH, 19 residing in the community, and 1 transferred to the Arizona Department of Corrections (see Figures 1 through 3, pages 1 through 2, for information on these persons’ diagnoses, offenses, and sentences). These persons ranged in age from 21 to 74 years old and were predominately male.

Figure 1
Primary diagnosis of 120 GEI persons under board jurisdiction
As of June 30, 2018



¹ Includes disorders such as delusional disorder and depression.
Source: Auditor General staff analysis of board GEI person data.

Figure 2
Primary offense of 120 GEI persons under board jurisdiction
As of June 30, 2018

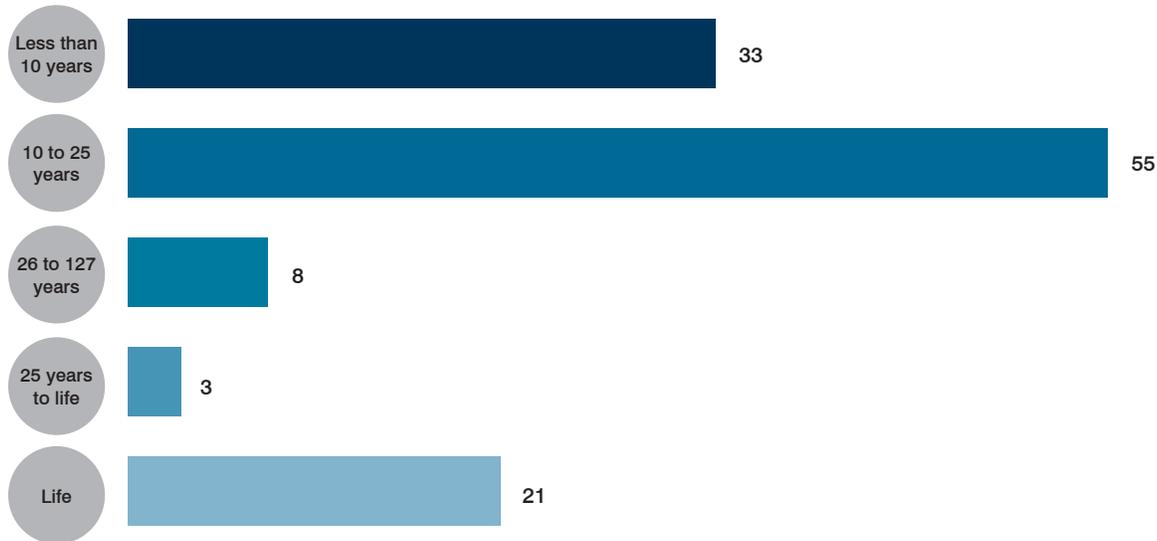


¹ Includes offenses such as arson, kidnapping, and molestation.
Source: Auditor General staff analysis of board GEI person data.

¹ A presumptive sentence is an appropriate or “normal” sentence for an offense that a judge uses as a baseline when determining a punishment. Persons who are found GEI are sentenced pursuant to A.R.S. §13-502 and remain under the Board’s jurisdiction for the entire length of their sentences. Accordingly, Arizona’s criminal sentencing statutes do not govern GEI persons with respect to requirements such as minimum mandatory sentences and community supervision.

² Release refers to release to the community either with or without conditions (see page 4 for more information on conditional release). As of June 30, 2018, all of the GEI persons under the Board’s jurisdiction who were living in the community were released with conditions.

Figure 3
Sentence duration of 120 GEI persons under board jurisdiction
As of June 30, 2018



Source: Auditor General staff analysis of board GEI person data.

Board holds hearings for GEI persons under its jurisdiction that include determining GEI persons' eligibility for release

The Board meets at least once a month to conduct hearings for the GEI persons under its jurisdiction, including hearings to determine if GEI persons under its jurisdiction are eligible for release from ASH to the community. Statute requires the Board's release decisions to be primarily based on public safety and protection and allows the Board to make one of four possible determinations (see textbox) based on whether the person:

- Still suffers or is in stable remission from a mental disease or defect;
- Is still dangerous; and
- Has a propensity to reoffend.

Board hearing determinations

Deny release if the Board finds that the person still suffers from a mental disease or defect and is dangerous.

Grant conditional release if the Board finds that the person still suffers from a mental disease or defect but that the disease or defect is in stable remission and the person is no longer dangerous (see page 4 for more information on conditional release).

Grant release if the GEI person provides clear and convincing evidence that he/she no longer suffers from a mental disease or defect and is not dangerous; and the Board determines that the person does not have a propensity to reoffend. However, the person will remain under the Board's jurisdiction until the person's presumptive sentence ends.

Transfer the person to the Arizona Department of Corrections if the Board finds that the person no longer needs ongoing treatment for a mental disease but is dangerous or has a propensity to reoffend.¹

¹ This determination applies only to GEI persons who have been sentenced for a felony that is a dangerous offense, second-degree murder, or first-degree murder with a filing of intent to seek the death penalty. The Board had only one person under its jurisdiction as of June 30, 2018, who it had transferred to the Arizona Department of Corrections.

Source: Auditor General staff review of A.R.S. §13-3994.

Table 1 shows the Board’s decisions for the 23 release hearings it conducted in fiscal year 2018.

Table 1
Number and type of release decisions the Board made
Fiscal year 2018

Release hearing outcomes	
Deny release from the Arizona State Hospital	21
Grant conditional release to the community	2
Grant release to the community	0
Transfer person to the Arizona Department of Corrections	0
Total	23

Source: Auditor General staff analysis of board hearing data.

The Board also conducted 90 hearings to make other decisions related to GEI persons under its jurisdiction, including:

- Determining GEI persons’ ability to temporarily leave ASH**—ASH policy allows GEI persons certain privileges to temporarily leave ASH grounds while they are still committed to ASH. The Board holds hearings to review and approve ASH recommendations for granting these privileges to GEI persons under its jurisdiction.³ In fiscal year 2018, the Board approved 10 and denied 1 ASH recommendation for granting GEI persons temporary release privileges.
- Deciding if a GEI person can be released to the community when his/her presumptive sentence ends**—When a GEI person under the Board’s jurisdiction reaches the end of his/her presumptive sentence, the Board is statutorily required to conduct a hearing to decide whether to release the person into the community with no further action or order the committing county’s county attorney to initiate civil commitment proceedings, which could result in the person’s court-ordered institutionalization.⁴ In fiscal year 2018, the Board approved release into the community with no further action for 5 GEI persons and ordered county attorneys to initiate civil commitment proceedings for 7 GEI persons.
- Deciding whether to revoke a GEI person’s conditional release**—The Board conducts hearings to decide if GEI persons who have been released to the community should have their release revoked. In fiscal year 2018, the Board revoked conditional release to the community for 5 GEI persons because it found that these persons’ mental condition had deteriorated or that they had violated release conditions, such as by testing positive for drugs or alcohol.
- Reviewing and approving status changes and other requests related to GEI persons**—The Board conducts hearings to decide on any other status changes or requests related to a GEI person under its jurisdiction, such as modifying GEI persons’ conditions of release and reviewing travel requests from GEI persons who have been conditionally released to the community. In fiscal year 2018, the Board held 62 hearings for status changes and other requests.

³ ASH has three phases that provide GEI persons progressively more freedom to leave ASH grounds while still committed to ASH. These phases range from granting the GEI person passes to go into the community for therapy accompanied by ASH staff to going into the community unaccompanied for a specific duration of time.

⁴ Statute requires the court to consider all available and appropriate alternatives for the patient’s treatment and care and order the least restrictive treatment alternative available, ranging from an outpatient treatment program to inpatient treatment in a mental health treatment agency, in a hospital operated by or under contract with the United States Department of Veterans Affairs, in ASH, or in a private hospital.

Board monitors GEI persons on conditional release and may revoke release if person deteriorates mentally or violates release conditions

If the Board grants conditional release to a GEI person, the Board, ASH, and community behavioral health providers are statutorily responsible for determining the release conditions (see textbox for examples of release conditions). The Board is responsible for continuing to monitor and supervise the person while they are on conditional release. Community behavioral health providers assist the Board by providing it with monthly status reports on the mental status and compliance with conditions of release for those persons released to the community.⁵ The Board, ASH, and/or community behavioral health providers may have a GEI person on conditional release returned to ASH for evaluation or treatment if it appears to them or any other person responsible for the person's supervision that:

- The GEI person appears to be deteriorating mentally;
- The GEI person violates conditions of release; or
- There is reason to believe that the person needs immediate care, custody, or treatment.

The Board is statutorily required to hold a hearing within 20 days of the GEI person's return to ASH. The Board reported that during this hearing, it will determine whether the GEI person's return to ASH was justified and will hold a subsequent hearing to determine whether to reinstate, modify, or revoke the GEI person's conditions of release.

Board members include mental health and probation/parole professionals

The Board is composed of five governor-appointed members who are confirmed by the Senate.⁶ Board members are appointed for 4-year terms, and pursuant to statute, must include:

- A licensed psychiatrist and a licensed psychologist experienced in the criminal justice system;
- A person experienced in parole, community supervision, or probation procedures;
- A person from the public; and
- An additional licensed psychiatrist or psychologist experienced with the criminal justice system.

DHS provides administrative support for the Board including one full-time equivalent (FTE) staff position filled by the Board's executive director.

Conditions of release typically include:

- General conditions such as:
 - Complying with all required medication regimens;
 - Not owning or possessing firearms; and
 - Not having any contact with the victim(s).
- Individualized conditions such as:
 - Frequency of individual therapy sessions;
 - Frequency of drug and alcohol screening; and
 - Requirements to participate in employment and/or education.

Source: Auditor General staff review of board policy on standard conditions of release.

⁵ The State's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), is responsible for the State's behavioral health system, including contracting with community behavioral health providers to monitor and treat GEI persons under the Board's jurisdiction who have been conditionally released to the community. The Legislature transferred responsibility for the State's behavioral health system from DHS to AHCCCS in 2016. Before AHCCCS took over this responsibility, DHS was responsible for overseeing the monitoring and treatment of GEI persons under the Board's jurisdiction who were conditionally released to the community.

⁶ A.R.S. §31-501(A).

Board funded with State General Fund monies appropriated to the Arizona Department of Health Services

The Board does not receive a specific appropriation. Instead, DHS pays for the Board's operations, board-member compensation, and staff salary and benefits with State General Fund monies appropriated to DHS. In fiscal years 2016 through 2018, payroll and related benefits accounted for nearly all the Board's expenditures with minimal expenditures for other operating and noncapital equipment. See Table 2 for more information.

Table 2
Schedule of revenues and expenditures
Fiscal years 2016 through 2018

	2016	2017	2018
Revenues			
State General Fund appropriations ¹	\$80,526	\$90,251	\$89,171
Total revenues	80,526	90,251	89,171
Expenditures			
Payroll and related benefits	79,317	87,990	87,820
Other operating	1,209	1,486	1,200
Furniture, equipment, and software		775	151
Total expenditures	\$80,526	\$90,251	\$89,171

¹ Amount is the portion of DHS' State General Fund appropriations it used to pay for the Board's expenditures.

Source: Auditor General staff analysis of the Arizona Financial Information System *Accounting Event Transaction File* for fiscal years 2016 through 2018.



Board should take steps to ensure it receives needed information to inform its decisions regarding GEI persons

Statute requires practitioners to provide mental health reports to inform Board's decisions regarding GEI persons

As discussed in the Introduction (see pages 1 through 3), A.R.S. §13-3994 requires the Board to determine if GEI persons under its jurisdiction are eligible for release from ASH based on several criteria, including whether the GEI person still suffers from a mental disease or defect, is still dangerous, and has a propensity to reoffend. To help inform the Board's decisions, ASH or the applicable community behavioral health provider is statutorily required to provide the Board with a report on the GEI person's mental health (mental health report) at least 15 days prior to the GEI person's scheduled hearing.⁷ Statute does not specify the required content of mental health reports, but the Board has developed hearing notification letters that outline the information that should be included in the mental health report (see textbox).

Examples of information practitioners should include in mental health reports

- The person's current diagnosis;
- Whether the person's mental disease or defect is in stable remission, including reasoning to support this assessment;
- The person's risk of dangerousness, including the propensity to re-offend if released;
- Whether the person can be maintained safely outside of a secure facility, including reasoning to support this conclusion; and
- If applicable, the recommended conditions of release for the person.

Source: Auditor General staff review of board hearing notification letters.

Board does not consistently receive sufficient information in the mental health reports

Auditors' interviews with board members and review of mental health reports provided to the Board, board hearing minutes, and observations of board hearings noted the following issues with the consistency and sufficiency of the information provided to the Board in some mental health reports:

- **Inconsistent level of detail provided in some mental health reports**—Auditors reviewed 14 mental health reports provided to the Board between October 2015 and February 2018 and found that the reports did not provide a consistent level of sufficient detail in response to the information the Board requested and to support the reports' conclusions.⁸ Some reports included detailed information and support for conclusions being made, some reports included a mix of detailed and general information to support conclusions, and other reports provided only general conclusion statements with little or no support. For example, one report's conclusions regarding a GEI person's risk of dangerousness and propensity to reoffend included a detailed

⁷ The Board is also statutorily authorized to subpoena witnesses to testify at hearings.

⁸ The 14 reports were for 10 GEI persons.

assessment of the person's primary risk factors for violence, destabilizing factors that would elevate the person's risk for violence, an overall rating of dangerousness, and examples of how the person's treatment had mitigated several of the risk factors.⁹ Board members indicated that this was the level of detail they needed and were expecting to help inform their decisions. Conversely, another report indicated that the GEI person was dangerous and did not recommend release but provided no other information to support this conclusion.¹⁰ Board members indicated that this level of detail was not sufficient to help inform their decisions.

- **Board members expressed concerns with mental health reports during public hearings**—Auditors' review of board hearing minutes from January 2016 through May 2018, and observations of the April, May, June, and July 2018 board hearings also noted several instances of board dissatisfaction with the mental health reports that were provided. For example, according to board hearing minutes from a January 2016 hearing, a board member expressed concern with the information provided in some mental health reports, stating that she expected the mental health reports to provide sufficient data to support the report's conclusions, including the GEI persons' risk of dangerousness and propensity to reoffend. Similarly, in June 2018, auditors observed board members discuss their concern that the Board did not receive the information it requested to support conclusions in two different mental health reports.

Lack of sufficient information jeopardizes timely and consistent decisions regarding GEI persons

Insufficient information in mental health reports may result in the Board:

- **Delaying its decision regarding the GEI person's release**—If the information in mental health reports is not sufficient for the Board to determine whether it should release a GEI person, the Board may attempt to obtain the information through questioning individuals involved in the GEI person's treatment. However, auditors observed during hearings that if the Board was not satisfied with the information obtained from the individuals, it ordered continuances until the next month to allow time for additional information to be provided. These types of delays may result in postponing an eligible GEI person's release and are potentially inefficient and inconvenient for the parties involved in the hearings.
- **Denying a GEI person's release**—If the information in mental health reports is not sufficient for the Board to make its decision, the Board has reported that it will err on the side of caution and deny release. Specifically, if the GEI person met the criteria for release or conditional release, but not enough information was provided to the Board to support a decision to release, he/she could unnecessarily be confined to ASH for nearly another 2 years because statute prohibits the GEI person from requesting another release hearing for at least 20 months.¹¹
- **Appearing to make inconsistent decisions regarding a GEI person's release**—When the Board makes decisions based on inconsistent or insufficient information, it is at risk for making or appearing to make inconsistent release decisions. As a result, the Board's decisions could be seen as unfair, arbitrary, or capricious.

Board's hearing notification letters do not clearly communicate its expectations for mental health report content

The Board's hearing notification letters do not clearly explain the Board's expectations about the level of detail or type of support it expects to be included in the mental health reports. For example, the Board does not provide guidance on what type of evidence or information a mental health report should include to demonstrate that

⁹ This mental health report included a similar level of detail for all areas addressed within the report.

¹⁰ Although this report included little to no support for its conclusions, the report did include a detailed summary of the GEI person's current mental condition.

¹¹ Statute allows the ASH chief medical officer to request a release hearing at any time.

a person could be safely released to the community. The Board also does not define critical concepts such as dangerousness and stable remission on which practitioners are being asked to opine/conclude.

Additionally, the hearing notification letters do not specifically request all the information the Board expects and needs to receive to make appropriate decisions. For example, auditors observed instances where the Board expected risk assessments to be provided because they had some indication a risk assessment of the GEI person had been conducted and would be relevant to its decision.¹² However, the Board's hearing notification letters do not specifically request the risk assessments or explain under what circumstances they should be provided. Instead, the hearing notification letters request a summary of risk assessment conclusions, which could be as simple as providing a rating of the person's dangerousness, such as low, medium, or high. In contrast, a risk assessment may provide information on factors that are likely to increase the risk for violence, factors that are likely to reduce the risk for violence, the severity of any likely violence, and the ways in which the violence can be managed.

Similar boards in other states more clearly communicate expectations for needed information to inform their decisions

The Connecticut Psychiatric Security Review Board (PSRB) and Oregon PSRB clarify their information needs related to hearings in rules, handbooks, and other guidance documents.¹³ For example, both the Connecticut PSRB and Oregon PSRB have defined in their rules some of the key concepts they use to inform their hearing decisions, such as dangerousness. The Oregon PSRB has also developed a handbook for use by Oregon PSRB members and staff, state hospital staff, and community service providers. The handbook outlines the Oregon PSRB's processes, including specifying the information that should be provided to it prior to hearings regarding persons under the Oregon PSRB's jurisdiction. The handbook also includes links to the Oregon PSRB website where additional resources are available, such as information on how to prepare reports that it uses to inform its release decisions and examples of reports that demonstrate the Oregon PSRB's expectations regarding report content.

Recommendation

1. The Board should revise its hearing notification letters and develop other written guidance, such as rules, procedures, and/or examples of well-written reports, to clarify its expectations for the information that should be provided to it in mental health reports. At a minimum, the guidance should indicate the level of detail and any supporting information and/or documents that should be included as part of the mental health report.

Board response: As outlined in its [response](#), the Board agrees with the finding and will implement the recommendation.

¹²The risk assessments included in some GEI persons' files that auditors reviewed assessed the GEI persons' dangerousness and risk of violently reoffending based on several factors, such as history of violence and substance abuse and recent response to treatment.

¹³The Connecticut PSRB and Oregon PSRB are the only other quasi-judicial state boards in the nation that serve a similar function as the Board.



In accordance with A.R.S. §41-2954, the Legislature should consider the following factors in determining whether the Board should be continued or terminated. The analysis of the Sunset Factors also includes findings and recommendations not discussed earlier in the report.

1. The objective and purpose in establishing the Board and the extent to which the objective and purpose are met by private enterprises in other states.

The Board was established in 1994 to protect public safety and welfare by overseeing persons who the courts have found GEI and placed under its jurisdiction.¹⁴ The Board is responsible for:

- Holding hearings to determine if GEI persons under its jurisdiction can be safely released into the community;
- Establishing conditions for GEI persons' release into the community; and
- Monitoring GEI persons' mental health status and compliance with release conditions if they have been released into the community.

Auditors did not identify any states that met the Board's objective and purpose through private enterprises.

2. The extent to which the Board has met its statutory objective and purpose and the efficiency with which it has operated.

The Board has met its statutory objective and purpose to conduct the release hearings auditors reviewed as statutorily required but it should make improvements related to hearing decisions and in other areas. Specifically, A.R.S. §13-3994 requires that a person under the Board's jurisdiction receive a hearing at least every 2 years but not until at least 120 days after his/her initial commitment to determine if the person should be released.¹⁵ Auditors randomly selected 10 of the 120 GEI persons under the Board's jurisdiction as of June 2018 and reviewed board files related to these 10 persons. The board files indicated:

- All 10 GEI persons received hearings at least every 2 years between June 2008 and May 2018, and
- All 10 GEI persons received their initial release hearing more than 120 days after their initial commitment.

However, auditors recommended that the Board take steps to ensure it receives needed information to inform its hearing decisions regarding GEI persons (see Finding 1, pages 7 through 9).

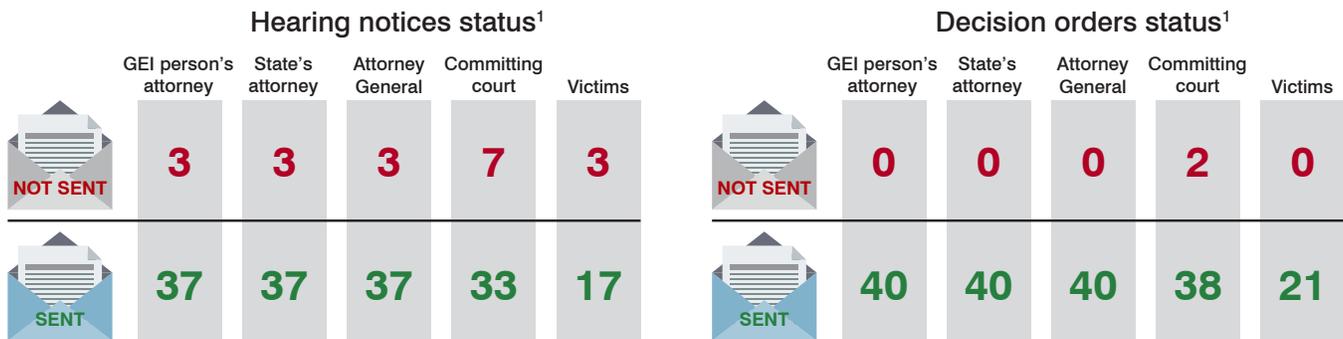
In addition, the Board can make improvements in the following areas:

- **Issuing hearing notices and board decision orders as statutorily required**—A.R.S. §31-502 requires that the Board provide written notice of all hearings to the attorney representing the person, the Attorney General or other attorney representing the State, the victim, and the court that committed the person to the Board's jurisdiction. Statute also requires that within 15 days after a hearing's conclusion, the Board provide its decision to the GEI person, the attorney representing the person, the victim, the Attorney General and any attorney representing the State, and the court that committed the person to

¹⁴ Laws 1993, Ch. 256, §§7 and 11.

¹⁵ The Board conducts 2-year hearings for all GEI persons under its jurisdiction.

the Board’s jurisdiction. Auditors reviewed the hearing notices, board decision orders, and associated emails used to send the hearing notices and board decision orders to the persons statutorily required to receive them for a judgmental sample of 40 of the 67 cases the Board heard between November 2017 and May 2018 and found that some hearing notices and board decision orders were not sent as required.



¹ Hearing notices and board decision orders are required to be sent only to victims of GEI persons who request to receive them. According to board records, the victims associated with 20 of the 40 hearings requested to receive hearing notices and the victims associated with 20 of the 40 hearings requested to receive board decision orders.

According to board staff, the instances of noncompliance were caused by staff error, due in part to board staff following a manual process for generating and sending the emails. Given the Board’s 1 FTE, it may lack sufficient staff resources to either help its one staff person generate and send the emails or conduct a supervisory review to ensure the emails are appropriately generated and sent.

Of the board decision orders sent to the applicable parties, the Board sent all but one order within the required 15 days after the hearing. Specifically, one board decision order was sent 17 days after the hearing due to a delay in receiving an amended conditional release plan from ASH. Statute does not specify a required time frame for sending hearing notices to applicable parties.¹⁶

- **Developing and implementing internal controls**—The Board’s lack of or limited internal controls such as rules and policies/procedures, places its ability to operate in an efficient, appropriate, and consistent manner at risk. Specifically, the Board:
 - **Lacks rules**—Although the Board has authority to adopt rules to implement its responsibilities, it has not established any rules. However, rules are important for clarifying and operationalizing the Board’s statutes, such as by clarifying its expectations for the information that should be provided to it in statutorily required mental health reports. In 2017, the Board met with stakeholders and discussed, among other things, the need for and possibility of developing rules, but no further action was taken. Board members told auditors that they do not believe they have the resources to develop rules given that they have only one staff person who is responsible for the Board’s day-to-day operations, and four of the five board members have full-time careers in addition to their board responsibilities. In addition, the Board lacks statutory authority to enter into contracts and agreements and to control its funding, both of which it would need to contract for assistance with developing and adopting rules.

Conversely, the Connecticut PSRB and Oregon PSRB have developed rules to clarify their statutes and provide additional information to their stakeholders and the public regarding their processes and procedures. For example, the Connecticut PSRB rules cover issues such as the chair’s and executive director’s powers and duties, hearing time frames, who should receive hearing notices and what information they should contain, what information a mental health evaluation report should contain, the standard conditions of release, procedures for executing a revocation order, and extensive guidance on maintaining and using automated and manual data. Oregon PSRB rules address many of the same areas.

¹⁶ Although statute does not specify a time frame for sending the hearing notices to applicable parties, it is the Board’s practice to send the notices at least 2 weeks prior to the scheduled hearing. Of the hearing notices sent to the applicable parties, all but one were sent at least 2 weeks prior to the hearing.

To adopt rules, the Board would need to seek an exemption to the rule-making moratorium.¹⁷ Although the moratorium restricts rulemaking without the prior written approval of the Governor's Office, it provides justification for exceptions to the rulemaking moratorium, including complying with a state or federal statutory requirement and/or preventing a significant threat to the public health or safety.

- **Has established minimal policies/procedures**—As of October 2018, the Board has six policies/procedures that address office operations, board member compensation, and standard conditions of release. Board staff reported working on drafts of two additional procedures for setting hearings and maintaining information on the GEI persons under the Board's jurisdiction. However, the Board has not established policies/procedures for other important responsibilities, such as its hearing process and process for determining whether a GEI person is indigent.¹⁸ Policies/procedures are important for ensuring the Board consistently and appropriately implements its responsibilities.

In comparison, the Connecticut PSRB and Oregon PSRB have more documented policies/procedures. The Connecticut PSRB developed a document outlining several office procedures and is in the process of updating its conditional release manual, which provides Connecticut PSRB processes, forms, and document examples, to help community providers understand their responsibilities as they relate to persons under the Connecticut PSRB's jurisdiction and who are on conditional release. The Oregon PSRB has several policies relating to the persons under its jurisdiction and general board operations. In addition, the Oregon PSRB has developed handbooks documenting processes, forms, and examples for Oregon PSRB members and staff, state hospital staff, community service providers, judges, and attorneys.

Recommendations

The Board should:

2. Take steps to reduce errors in its process for sending hearing notices and board decision orders, such as requesting assistance for board staff and/or providing supervisory review of the process. Alternatively, the Board could request technological assistance to automate the process. If the Board is able to obtain technological assistance to automate the process, it should ensure that board staff receive training on the automated process.
3. Work with its Assistant Attorney General to determine whether and when it can develop and adopt rules to clarify its statutes and processes.
4. Contingent on receiving an exemption to the rulemaking moratorium, develop and adopt rules to clarify its statutes and processes.
5. Take steps to obtain resources that may be needed to adopt rules, such as requesting assistance from other state agencies to help develop rules or obtaining assistance with board staff's other duties and responsibilities to provide board staff with time to develop rules. If the Board is unable to identify any additional resources through these efforts, it should then work with the Legislature to obtain funding and authority to enter into contracts and agreements so that the Board may contract for assistance with developing rules.
6. Develop and implement policies, procedures, and other written guidance to outline its processes for meeting its key responsibilities and provide training on them to board members, staff, and other stakeholders, as appropriate.

Board response: As outlined in its [response](#), the Board agrees with the findings and will implement the recommendations.

¹⁷ Executive Order 2018-02 established the rulemaking moratorium on February 12, 2018. It expires on December 31, 2018.

¹⁸ A.R.S. 31-502(A)(8) requires the Board to determine if the GEI person about whom a hearing is being held is indigent and, if so, request the committing court to appoint an attorney to represent the person.

3. The extent to which the Board serves the entire State rather than specific interests.

The Board serves the entire State by overseeing persons adjudicated GEI and placed under its jurisdiction by the Superior Court of Arizona. See Figure 4 for the distribution of GEI persons by committing county.

4. The extent to which rules adopted by the Board are consistent with the legislative mandate.

Although A.R.S. §31-502(B)(1) authorizes the Board to adopt rules to carry out its responsibilities, as of October 2018, the Board had not established any rules or initiated any rulemaking.

5. The extent to which the Board has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.

As of October 2018, the Board had not established any rules or initiated any rulemaking. Therefore, it has not needed to encourage input from the public before adopting rules. However, the Board provides the public with information on its actions and impact through its website, which includes board meeting agendas and minutes, annual reports, and resources for victims; and through its public hearings during which it makes decisions regarding the GEI persons under its jurisdiction.

Auditors assessed the Board’s compliance with various provisions of the State’s open meeting law for its April, May, June, and July 2018 board meetings and found that the Board complied with the open meeting law requirements reviewed for these four meetings.

6. The extent to which the Board has been able to investigate and resolve complaints that are within its jurisdiction.

The Board has no statutory authority or responsibility to investigate and resolve complaints.

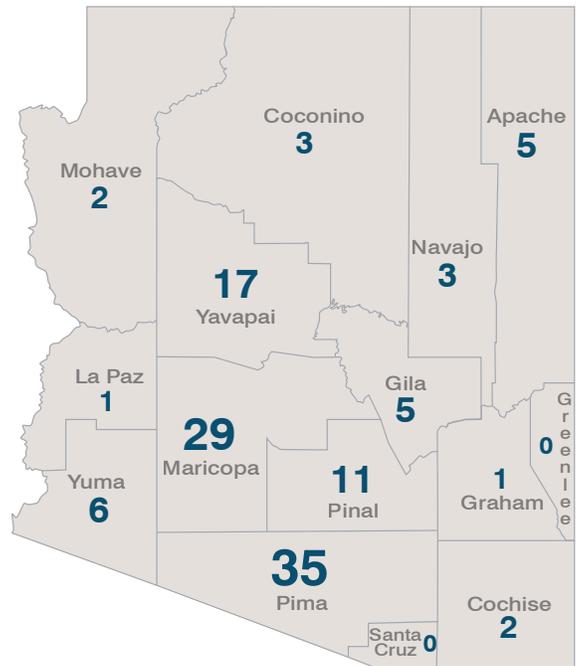
7. The extent to which the Attorney General or any other applicable agency of state government has the authority to prosecute actions under the enabling legislation.

The Attorney General serves as the Board’s legal advisor and provides legal services to the Board, as needed, according to A.R.S. §41-192(A)(1).

8. The extent to which the Board has addressed deficiencies in its enabling statutes that prevent it from fulfilling its statutory mandate.

The Board determined that it has statutory deficiencies in both its enabling statutes and relevant criminal code statutes. For example, the Board reported that the lack of definitions for release criteria such as “stable remission” leads to disagreements during hearings about whether GEI persons meet the criteria for release. In September 2017, the Board held a public meeting that included several stakeholders, including attorneys who regularly appear before the Board, to review and discuss changes to its statutes, but it has taken no other formal action to address the identified deficiencies since that time and does not have any formal plans to do so.

Figure 4
Distribution of GEI persons under board jurisdiction as of June 30, 2018, by committing county



Source: Auditor General staff analysis of board committing county data.

9. The extent to which changes are necessary in the laws of the Board to adequately comply with the factors listed in this sunset law.

Responsibility for the Board's administrative support is not specified in statute like other Arizona boards, commissions, and councils reviewed by auditors that receive administrative support from another agency. Although DHS has provided administrative support to the Board since the Board's inception, including providing staff, funding, and facilities, it is not statutorily required to do so. In contrast, statutes for 11 Arizona boards, commissions, and councils that receive administrative support from another state agency specify these administrative authorities and responsibilities. For example, statute authorizes:

- The Arizona Iceberg Lettuce Research Council (Council) to enter into an interagency agreement with the Arizona Department of Agriculture for the provision of administrative services including assistance in adopting rules; providing accounting, financial, and procurement services; and arranging for meeting space. Statute also authorizes the Council to employ staff who serve at the pleasure of the Council.
- The Arizona Department of Public Safety to provide administrative services and support for the Arizona Peace Officer Standards and Training Board (AZPOST), including financial, procurement, information technology, and human resources services, and facilities. Statute also authorizes AZPOST to hire staff and enter into contracts.
- The Arizona Department of Water Resources (ADWR) and Arizona State Land Department (ASLD) to provide staff support for the Arizona Water Protection Fund Commission (Commission). Statute authorizes the Commission to coordinate its staffing needs with the ADWR and ASLD and enter into contracts and intergovernmental agreements.

In addition, the Connecticut PSRB, which fills a similar function to the Board, receives administrative support from Connecticut's state mental health agency as outlined in statute and in an administrative agreement between the Connecticut PSRB and Connecticut's state mental health agency. Connecticut state statutes authorize the Connecticut PSRB to exercise its authority independent of Connecticut's state mental health agency, prepare its budget, and hire its own personnel or enter into contracts contingent upon funding. These statutes also authorize Connecticut's state mental health agency to provide administrative and clerical functions to the Connecticut PSRB, provide staff as requested, and submit the Connecticut PSRB's budget as a separate part of its budget.

Further, as discussed in Sunset Factor 2 (see pages 12 through 13), the Board lacks statutory authority to enter into contracts and agreements and to control its funding, and if it is unable to identify any additional resources to help it adopt rules, the Board should work with the Legislature to obtain funding and authority to enter into contracts and agreements so that the it may contract for assistance with writing rules.

Recommendation

1. The Legislature should consider revising statute to establish authority and responsibility for providing the Board's administrative support, including granting the Board authority to enter into contracts and agreements, so that administrative support roles and responsibilities may be clarified through agreements with other agencies that provide it with administrative support, as needed.

10. The extent to which the termination of the Board would significantly affect the public health, safety, or welfare.

Terminating the Board would affect public safety and welfare if its responsibilities were not transferred to another entity. The Board's purpose is to oversee the GEI persons under its jurisdiction, including holding hearings to determine if these persons can be safely released into the community and monitoring these persons if they are released. As of June 2018, the Board had jurisdiction for 120 GEI persons, with 19 residing in the community. Persons under the Board's jurisdiction committed crimes that caused death or serious physical injury of another person or caused the threat of death or serious physical injury to another person; are mentally ill; and require monitoring to ensure compliance with conditions such as taking medications,

participating in substance abuse treatment, and attending psychiatric appointments and group and individual therapies. If a GEI person on conditional release appears to be deteriorating mentally or violates conditions of release, the Board may order the person be returned to ASH for evaluation or treatment.

11. The extent to which the level of regulation exercised by the Board compares to other states and is appropriate and whether less or more stringent levels of regulation would be appropriate.

This factor does not apply because the Board is not a regulatory agency.

12. The extent to which the Board has used private contractors in the performance of its duties as compared to other states and how more effective use of private contractors could be accomplished.

The Board does not have authority to enter into contracts and agreements; therefore, it does not use private contractors in the performance of its duties. However, AHCCCS contracts with community behavioral health providers to monitor and treat GEI persons under the Board's jurisdiction who have been conditionally released to the community.

Auditors contacted the two other state psychiatric security review boards, which are located in Connecticut and Oregon, to determine to what extent they use private contractors to oversee those individuals in their state that are placed under their jurisdiction. Similar to Arizona, neither of these entities use private contractors to fulfill their oversight role, which includes granting conditional release and monitoring these persons while conditionally released in the community. Other state agencies and/or counties in Connecticut and Oregon are responsible for providing or contracting for the monitoring and treatment of the persons under the Connecticut PSRB's and Oregon PSRB's jurisdiction.



SUMMARY OF RECOMMENDATIONS

Auditor General makes 6 recommendations to the Board and 1 recommendation to the Legislature

The Board should:

1. Revise its hearing notification letters and develop other written guidance, such as rules, procedures, and/or examples of well-written reports, to clarify its expectations for the information that should be provided to it in mental health reports. At a minimum, the guidance should indicate the level of detail and any supporting information and/or documents that should be included as part of the mental health report (see Finding 1, pages 7 through 9, for more information).
2. Take steps to reduce errors in its process for sending hearing notices and board decision orders, such as requesting assistance for board staff and/or providing supervisory review of the process. Alternatively, the Board could request technological assistance to automate the process. If the Board is able to obtain technological assistance to automate the process, it should ensure that board staff receive training on the automated process (see Sunset Factor 2, pages 11 through 13, for more information).
3. Work with its Assistant Attorney General to determine whether and when it can develop and adopt rules to clarify its statutes and processes (see Sunset Factor 2, pages 11 through 13, for more information).
4. Contingent on receiving an exemption to the rulemaking moratorium, develop and adopt rules to clarify its statutes and processes (see Sunset Factor 2, pages 11 through 13, for more information).
5. Take steps to obtain resources that may be needed to adopt rules, such as requesting assistance from other state agencies to help develop rules or obtaining assistance with board staff's other duties and responsibilities to provide board staff with time to develop rules. If the Board is unable to identify any additional resources through these efforts, it should then work with the Legislature to obtain funding and authority to enter into contracts and agreements so that the Board may contract for assistance with developing rules (see Sunset Factor 2, pages 11 through 13, for more information).
6. Develop and implement policies, procedures, and other written guidance to outline its processes for meeting its key responsibilities and provide training on them to board members, staff, and other stakeholders, as appropriate (see Sunset Factor 2, pages 11 through 13, for more information).

The Legislature should:

1. Consider revising statute to establish authority and responsibility for providing the Board's administrative support, including granting the Board authority to enter into contracts and agreements, so that administrative support roles and responsibilities may be clarified through agreements with other agencies that provide it with administrative support, as needed (see Sunset Factor 9, page 15, for more information).



Objectives, scope, and methodology

The Office of the Auditor General conducted this performance audit and sunset review of the Board pursuant to a September 14, 2016, resolution of the Joint Legislative Audit Committee. The audit was conducted as part of the sunset review process prescribed in A.R.S. §41-2951 et seq. This audit addresses actions the Board should take to help ensure it receives necessary information to inform its decisions regarding GEI persons. It also includes responses to the statutory sunset factors.

Auditors used various methods to review the issues in this performance audit and sunset review. These methods included reviewing board statutes, annual reports, policies and procedures, and information from the Board's website; interviewing board members and staff, and stakeholders; and observing various board processes. Auditors also attended four board meetings held in April, May, June, and July 2018, and reviewed meeting minutes from the Board's January 2016 through July 2018 meetings. Auditors used the following specific methods to meet the audit objectives:

- To assess the level of detail and supporting information in the mental health reports provided to the Board, auditors judgmentally selected and reviewed 14 mental health reports for ten GEI persons, which were provided to the Board between October 2015 and February 2018. Auditors also reviewed Connecticut PSRB's and Oregon PSRB's regulations, handbooks, and other guidance documents they use to clarify the information they require to inform their hearing decisions.¹⁹
- To obtain information for the Introduction, auditors compiled demographic data on the GEI persons under the Board's jurisdiction as of June 30, 2018, and board actions taken in fiscal year 2018. In addition, auditors compiled and analyzed unaudited information from the Arizona Financial Information System *Accounting Event Transaction File* for fiscal years 2016 through 2018.
- To obtain information for the Sunset Factors, auditors:
 - Assessed the Board's compliance with the statutory requirements for issuing hearing notices and board decision orders by reviewing the notices, decision orders, and associated emails for a judgmental sample of 40 of the 67 cases the Board heard between November 2017 and May 2018.
 - Assessed the Board's compliance with the statutory requirements for holding hearings by randomly selecting 10 of the 120 GEI persons under the Board's jurisdiction as of June 2018 and reviewing their hearing histories to determine if they received hearings at least every 2 years between June 2008 and May 2018, and if they received their initial release hearing more than 120 days after their initial commitment.
 - Assessed the Board's compliance with various provisions of the State's open meeting law for board meetings held in April, May, June, and July 2018.

¹⁹ The Connecticut PSRB and Oregon PSRB are the only other quasi-judicial state boards in the nation that serve a similar function as the Board.

- Reviewed the statutes of 11 Arizona boards, commissions, and councils, and the Connecticut PSRB, which receive administrative support from another agency, to determine whether their administrative authorities and responsibilities are outlined in statutes.²⁰
- Contacted management at the Connecticut PSRB and Oregon PSRB to obtain information about their use of private contractors to oversee persons placed under their jurisdiction.
- Auditors' work on internal controls included reviewing the Board's existing policies and procedures for ensuring compliance with board statutes and supporting consistent day-to-day operations, and confirming the Board has not established any rules. Auditors reported their conclusions on these internal controls in Sunset Factor 2. In addition, auditors assessed the reliability of the Board's electronic information for performing audit work. Specifically, auditors interviewed board staff, reviewed information system controls, and compared information in the Board's information system against information in the hearing meeting minutes and board annual reports. Through this work, auditors determined that the information in the Board's information system was sufficiently reliable for audit purposes.

Auditors conducted this performance audit and sunset review of the Board in accordance with generally accepted government auditing standards. The standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Auditor General and staff express their appreciation to the Board and its executive director for their cooperation and assistance throughout the audit.

²⁰ The 11 Arizona boards, commissions, and councils were the Arizona Beef Council; Arizona Cotton Research and Promotion Council; Arizona Grain Research and Promotion Council; Arizona Peace Officer Standards and Training Board; Arizona Oil and Gas Conservation Commission; Arizona Commission on Salaries for Elected State Officers; Arizona Citrus, Fruit, and Vegetable Advisory Council; Arizona Iceberg Lettuce Research Council; Arizona Citrus Research Council; Arizona State Board on Geographic and Historic Names; and Arizona Water Protection Fund Commission.

BOARD RESPONSE



Psychiatric Security Review Board

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DOUGLAS A. DUCEY, GOVERNOR
JAMES P. CLARK, M.D., CHAIRPERSON
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December 17, 2018

Lindsey A. Perry, C.P.A., Auditor General
State of Arizona Office of the Auditor General
2910 N. 44th St., Suite 410
Phoenix, AZ 85018

Re: Arizona Psychiatric Security Review Board
2019 Sunset Review

Dear Ms. Perry:

The Psychiatric Security Review Board (“PSRB” or “Board”) would like to thank you for the opportunity to respond to the revised preliminary draft report of the performance audit and sunset review dated December 11, 2018. The PSRB is in agreement with the findings in the report and will develop a strategic plan to implement the recommendations.

Finding 1: Board should take steps to ensure it receives needed information to inform its decisions regarding GEI persons.

Recommendation 1: The Board should revise its hearing notification letters and develop other written guidance, such as rules, procedures, and/or examples of well-written reports, to clarify its expectations for the information that should be provided to it in mental health reports. At a minimum, the guidance should indicate the level of detail and any supporting information and/or documents that should be included as part of the mental health report.

Board Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Board and its staff will work together to revise its hearing notification letters and develop other written guidance and educate stakeholders.

Sunset Factor 2: The extent to which the Board has met its statutory objective and purpose and the efficiency with which it has operated.

The Board should:

Recommendation 2: Take steps to reduce errors in its process for sending hearing notices and board decision orders such as requesting assistance for board staff and/or providing supervisory review of the process. Alternatively, the Board could request technological assistance to automate the process. If the Board is able to obtain technological assistance to automate the process, it should ensure that board staff receives training on the automated process.

Board Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The PSRB will request additional staff to ease workload so the Board's executive director can provide supervisory review. Additionally, PSRB staff is currently working with a Department of Health Services (DHS) staff person to develop a relational database that may eventually have the ability to automate and simplify processes.

Recommendation 3: Work with its Assistant Attorney General to determine whether and when it can develop and adopt rules to clarify its statutes and processes.

Board Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The PSRB members and staff will work with its Assistant Attorney General to determine whether and when it can develop and adopt rules to clarify its statutes and processes.

Recommendation 4: Contingent on receiving an exemption to the rule-making moratorium, develop and adopt rules to clarify its statutes and processes.

Board Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The PSRB and its staff will apply for an exemption to the rule-making moratorium. Contingent upon receiving an exemption, the PSRB and its staff will work with DHS and other stakeholders to develop rules to clarify its statutes and processes. The implementation of Recommendation Four is contingent upon the PSRB obtaining additional assistance from other state agencies, additional support staff, and other necessary resources as specified in Recommendation Five.

Recommendation 5: Take steps to obtain resources that may be needed to adopt rules, such as requesting assistance from other state agencies to help develop rules or obtaining assistance with board staff's other duties and responsibilities to provide board staff with time to develop rules. If the Board is unable to identify any additional resources through these efforts, it should then work with the Legislature to obtain funding and authority to enter into contracts and agreements so that the Board may contract for assistance with developing rules.

Board Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The PSRB will request an additional administrative support person to assist with Board staff duties and responsibilities to allow for time to develop rules. If necessary, the Board will work with legislature to obtain funding and authority as specified in the recommendation.

Recommendation 6: Develop and implement policies, procedures, and other written guidance to outline its processes for meeting its key responsibilities and provide training on them to board members, staff, and other stakeholders, as appropriate.

Board Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Board and its staff will work together to develop and implement policies, procedures, and other written guidance and provide training to board members, staff, and other stakeholders.

Sunset Factor 9: The extent to which changes are necessary in the laws of the Board to adequately comply with the factors listed in this sunset law.

Recommendation 1: The Legislature should consider revising statute to establish authority and responsibility for providing the Board's administrative support, including granting the Board authority to enter into contracts and agreements, so that administrative support roles and responsibilities may be clarified through agreements with other agencies that provide it with administrative support, as needed.

The Psychiatric Security Review Board wishes to thank the Auditor General's Office and its staff for its consideration, thoroughness, and professionalism during this process.

Respectfully,

James P. Clark, M.D.
Chairman of the PSRB

