CT Feature

Releasing Inmates With Mental Illness and Co-Occurring Disorders Into the Community

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In his 2004 State of the Union address, President George Bush proposed a four-year, $300 million initiative for offender reentry into the community. He asserted that "America is the land of the second chance, and when the gates of the prison open, the path ahead should lead to a better life." However, many inmates with mental illness encounter serious obstacles that prevent them from finding that better life.[1]

These obstacles are highlighted in the settlement of the *Brad H. v. New York City* class-action lawsuit in which New York City agreed to provide mentally ill inmates with treatment and other supportive services when they are released from the city prisons. The plaintiffs charged that the prisons routinely discharged offenders with mental illness into impoverished neighborhoods without adequate release plans, government benefits, housing or other services. The prisons allegedly released offenders near subway stations between 2 and 6 a.m. with $1.50 and two subway tokens. The plaintiffs argued that failure to provide discharge planning to inmates with mental illness increases the risk that this group will relapse, engage in aggressive acts harmful to others, attempt or commit suicide, be unable to care for themselves, become homeless, and ultimately, be rearrested and returned to jail.[2]

New York agreed to provide psychiatric treatment, including outpatient treatment, and medication needed to maintain stability after release, assistance obtaining housing and access to and, in cases where the inmate is indigent, the means to pay for those services. This would be a monumental task for correctional agencies across the county considering the following data.

The number of offenders with mental illness is staggering. According to recent Department of Justice estimates, approximately 700,000 adults with mental illness entered U.S. jails, and approximately 75 percent of these individuals suffered from co-occurring disorders, particularly substance abuse.

Also, these offenders may display multiple health and mental health problems due to their lifestyles, which frequently include transient behavior, financial instability and high-risk behaviors such as intravenous drug use, smoking and multiple sex partners. Most offenders do not have health insurance and lack supportive, positive and enduring relationships, which contribute to their emotional and health instability.

Finally, the offenders are reentering communities where the mental health delivery system failed them in the first place. The shortage of community-based mental health services is epidemic. Community agencies that may be available often distance themselves from working with offenders and display reluctance to accept clients with criminal records. Frequently, offenders display excesses in bizarre, unusual and aggressive behaviors, and deficits in self-care skills.

Discharging From The Pennsylvania DOC

The Pennsylvania Department of Corrections comprises 26 prisons housing more than 40,000 inmates. Approximately 18 percent of the offenders carry a psychiatric diagnosis, and a subset of approximately 4 percent of the population is rated seriously mentally ill (i.e., they display "a substantial disorder of thought or mood that significantly impairs judgment, behavior capacity to recognize reality or cope with the ordinary demands of life," according to the DOC's official definition). The department tracks the inmates with mental illness via an automated mental health/mental retardation (MH/MR) tracking system. The DOC compared parole and max-out data for MH/MR inmates and non-MH/MR inmates during the 12-month period from April 2002 to May 2003. The data show that higher proportions of inmates with mental illness and serious mental illness are more likely to serve their full sentences rather than receive parole, as indicated by the following statistics:

- Inmates with no mental health history were paroled 81.7 percent of the time (n = 4,320) and maxed out 18 percent of the time (n = 969);
- Offenders with a mental health history, but who were no longer considered mentally ill, were paroled 73.7 percent of the time (n = 547) and maxed out 26.3 percent of the time (n = 195);
- Inmates diagnosed with mental illness were paroled 65.3 percent (n = 466) and maxed out 34.7 percent of the time (n = 248); and
- Inmates diagnosed with nonserious mental illness were paroled 45.1 percent of the time (n = 78) and maxed out 54.9 percent of the time (n = 95).

Preparation Behind Walls

During the past 10 years, the department has enhanced the continuity-of-care policies and procedures for inmates with mental illness and co-occurring disorders, and developed programs, described below, to assist inmates with reentry.

Continuity-of-Care Policy for Offenders Retuning to the Community Through Parole or Maxing Out. DOC staff collaborated with other agencies, including the Office of Mental Health and the Pennsylvania Board of Probation and Parole, to develop reentry protocols for inmates with mental illness and co-occurring disorders who either will be paroled in the community, or are unlikely to receive parole, and hence serve their full sentence. The policy requires the facility interdisciplinary mental health treatment team (comprising the facility chief psychologist, psychiatrist, health care administrator, unit management staff, drug and alcohol treatment specialist, and custody staff representative) to meet 12 months prior to the inmate's release, and again six months prior to release, to conduct continuity-of-care planning. The protocol outlines procedures for:

- Obtaining a release of information from the inmate;
- Contacting community MH/MR resources in the inmate's community;
- Completing entitlement applications for various benefits to which the inmate might be entitled (e.g., medical assistance, veterans benefits, Temporary Assistance to Needy Families and supplemental security income);
- Arranging civil commitments for clients who meet involuntary commitment criteria;
- Notifying law enforcement authorities regarding the release of inmates who were considered dangerous (but not committable); and
- Providing inmates with a 30-day supply of medication.

The policy is consistent with both the American Correctional Association and the National Commission on Correctional Health Care standards that mandate correctional settings to show written policy, procedure and practice to provide continuity of care from admission to discharge from the facility, including referral to community care when that is needed.

Community Orientation and Reintegration Program. The Community Orientation and Reintegration program is a two-phase program designed to facilitate inmates' transition from the prison environment to their home community. The program provides for an individualized, targeted approach based on the inmate's risk factors. The first phase of the program is completed in the prison during the several weeks prior to discharge and addresses the critical issues of parole responsibilities, employment preparation, vocational evaluation, personal finances, substance abuse education, Alcoholics Anonymous/Narcotics Anonymous meetings, housing, family and parenting, mental health, life skills, antisocial attitudes and community (give back) services. The program's second phase includes two weeks of programming in one of the community corrections centers, which are described later in this article. Phase 2 prepares the inmate for a gradual return to family and community during the four- to six-week program. Staff of the community corrections centers, Pennsylvania Board of Probation and Parole and DOC community corrections determine the date in which the inmate is released from the community corrections center. Where necessary, program procedures are modified to meet the needs of offenders with special needs.

Model Collaborative Partnership Established With County MH/MR Administrators in Philadelphia and Allegheny Counties. The DOC developed special collaborative relationships with the MH/MR agencies in Philadelphia and Allegheny (Pittsburgh) counties, which receive approximately half of the offenders (40 percent and 10 percent, respectively) who reenter the community. In 2000, the Philadelphia MH/MR office approached the DOC to help the city agency develop a database of Philadelphia inmates with mental illness who were incarcerated in the DOC and the dates they were returning to the city. The department provides a list of MH/MR roster inmates who will max out in the next 12 months to assist the counties in identifying aftercare resources. In some cases, Philadelphia MH/MR

staff visit the facilities to review records, discuss the case with DOC staff members and interview the inmate.

The MH/MR agency in Allegheny County also provides "in-reach" services in which caseworkers visit all 26 DOC facilities to review the treatment records and interview the inmates and DOC staff. Moreover, Pittsburgh caseworkers also pick up the inmate at the prison on his or her discharge date and escort the inmate back to the city to obtain housing, make final arrangements for entitlement benefits and/or buy clothes.

The collaborative partnerships with Philadelphia and Pittsburgh MH/MR agencies address half of the DOC's reentry problems; however, the department houses inmates from 65 other, mostly rural, counties in the state. Mental health treatment resources are scarcer in rural counties, and MH/MR agencies are more often reluctant to provide services to offenders returning to their communities, probably because in many cases the county resources are strained to meet the needs of MH/MR consumers in the community who are not involved with the law enforcement or court systems.

FReD Program for Females. In 2000, the DOC obtained a federal grant to establish the Forensic Community Reentry and Development (FReD) project, which is located in Pennsylvania's largest women's facility, the State Correctional Institution at Muncy. Muncy houses the most seriously mentally ill females in the system. Most of the women on the MH/MR roster also suffer from co-occurring substance abuse disorders and many have mental retardation. The women are placed in the FReD program 12 months prior to release. The Muncy mental health staff evaluate the female offenders with special needs and assign a community placement specialist who works with the inmates to prepare them for community living, help them develop a reentry plan that addresses their needs, and identify and establish contact with resources for MH/MR treatment, substance abuse programming, housing and other services that will be needed in the community. The grant includes monies for subsidized housing as well.

Specialized Community Living Programs

Inmates with mental illness are closely supervised for years, and they are provided mental health services that are typically superior to those that they received prior to their incarceration. The offenders are well-protected from more predatory inmates, and their time is highly structured. When they reenter the community, they will move from two to six hours of free time per day to 24 hours of free time per day, with substantially less supervision. To facilitate the transition, the DOC operates an extensive system of community corrections centers (halfway houses) across the state to transition inmates from institutional life back into the community. Department staff operate 14 community corrections centers, and vendors run approximately 50 centers. In the past five years, the DOC has begun to fund community corrections centers for special needs offenders. So far, the DOC has sponsored the development of specialized transitional community corrections centers for inmates with mental illness and substance abuse problems in Philadelphia, Erie and Pittsburgh, which help inmates reenter the communities in the counties located in and around those three cities. Examples of these centers are presented below.

FIR-St Program. In 1999, the DOC funded the Forensic Integration and Recovery-State (FIR-St) Program to transition inmates with mental illness and co-occurring disorders back into the Philadelphia five-county area. FIR-St is a 25-bed program for men and women, which accepts referrals from the DOC and the Pennsylvania Board of Probation and Parole. The unit employs a modified therapeutic community treatment model, and where there are parole violations, the model employs graduated parole sanctions, whereby minor infractions of parole rules are dealt within the community, rather than by bringing the offender back into the prison.

Coleman Center. The Coleman Center is a 20-bed unit of mentally ill male offenders returning to the Philadelphia County area. The center houses the same clientele as the FIR-St program; however, it can also serve as a "halfway" back program, in which inmates who have encountered problems in the community can return briefly to the halfway house, rather than be reincarcerated. Based on the success of the FIR-St and Coleman Center programs in Philadelphia, similar programs are being planned in Allegheny County.

CROMISA Programs. In 1999, the Pennsylvania Board of Probation and Parole, and the Office of Health initiated the Community Re-Integration of Offenders with Mental Illness and Substance Abuse (CROMISA) programs for parolees returning to the Erie County area. The establishment of a second program in Allegheny County followed this. The focus of the CROMISA programs is to treat primary serious substance abuse disorders in offenders who also have a less serious form of mental illness.

Collaboration Among Agencies For a Safer Transition

Mentally ill offenders show high rates of recidivism and cycle through a variety of criminal justice and psychosocial settings, due in part to poor coordination among service providers. Forensic clients have multiple needs for treat-

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ment and supervision, and multiple public and private sector agencies must be involved in those services. The Council of State Governments has conducted pioneering work on the problem of offender reentry and recommends "collaboration among correction, community corrections and mental health officials to effect the safe and seamless transition of people with mental illness from prison to community."[3] Unfortunately, public service agencies frequently do not coordinate their mandated activities, and many agencies work unilaterally, rather than employing intra-agency coordination and case management.

In 1999, the Pennsylvania DOC and the National Alliance of Mentally Ill established the Forensic Interagency Task Force comprising commonwealth stakeholders interested in continuity of care for MH/MR inmates. The task force members include representatives from the DOC as well as numerous other state agencies. The members collaborated in planning the development of new continuity-of-care initiatives described below.

The success of the Forensic Interagency Task Force in developing collaborative relationships among agencies, minimizing turf warfare and addressing forensic problems on a state level, prompted the Office of Mental Heath and Substance Abuse Services to establish a pilot task force to address local forensic problems in the five-county Philadelphia area. The Southeast Regional Task Force included representatives from the Office of Mental Health and Substance Abuse Services, the DOC, MH/MR administrators from the counties, mental health and substance abuse services providers, emergency staff, public defenders, district attorneys, prison staff and mental health advocates in the area. The task force has sponsored a local forensic conference, and two of the counties have joined to obtain grant monies to fund a collaborative continuity-of-care program.

The Pennsylvania DOC, Department of Public Welfare, and Board of Probation and Parole are partnering with the Council on State Governments and three other states (New York, Texas and Minnesota) to develop strategies to connect inmates with federal entitlements, including Medicaid, supplemental security income and Social Security disability insurance. Representatives of the four states convened in September 2004 to share strategies and develop action plans to connect/reconnect offenders with benefits when they are discharged. One promising strategy that the DOC is piloting is the use of the online Commonwealth of Pennsylvania Application for Social Services. This online resource is a single-point access where inmates can apply for a wide variety of programs, including health care coverage, food stamp benefits and cash assistance, prior to their release. The DOC is also seeking to establish a seamless relationship with Social Security offices near each prison to re-initiate benefits prior to release.

Discussion

Prisons and psychiatric hospitals have deleterious effects upon inmates and patients serving long terms of incarceration, which include the development of dependency on the institution to meet their basic needs; acquisition of antisocial attitudes and values that might may be incompatible with the residents' family culture; isolation from family, friends and contacts in the community; and estrangement from the outside world in which the family and/or community may have changed while they were away, making their later readjustment more difficult. These problems are compounded by prison locations that are frequently remote from the offenders' home communities.

Both the American Correctional Association and the National Commission on Correctional Health Care recognize the problem of offender reentry into the community. Both organizations have promulgated standards that mandate correctional settings to show written policy, procedure and practice to ensure continuity of care from admission to discharge from the facility, including referral to appropriate community resources. Offenders with mental illness also carry the dual stigmas of mental illness and incarceration. They are likely to be extremely anxious about returning to the community where they failed before. Many may suffer from substance abuse and medical problems, which make their treatment needs more complex. Unfortunately, these treatment services are limited or nonexistent in some communities, and some agencies are available, but may be reluctant to provide services to these clients. While offenders have a constitutional right to receive mental health treatment while they are incarcerated, they do not enjoy a similar right to treatment in the community.

There are multiple obstacles to reentry for inmates with mental illness. Pennsylvania's strategies to addressing this issue include improving aftercare planning while the offender is behind the walls and providing a better "hand-off" from the DOC to the community agencies, developing community corrections centers located near the offender's community, and collaborating better with community mental health agencies, advocacy groups and families. Pennsylvania's newest activity is developing mechanisms to enroll the inmates in entitlement programs, including disability payment programs to pay for housing, food and other needs, and health coverage through Medicaid and Medicare. It is anticipated that success in these endeavors will embark the offenders on the path ahead to a better life and promote public safety through reducing recidivism.

ENDNOTES

[1] Honberg, R. 2004. Community reentry from prison. *Advocate*, 2(2):9-11.

[2] Reed, D.B. 2001. Class action lawsuit seeks discharge planning for jail inmates with mental disorders. *Community Mental Health Report*, 1(3):39-40.

[3] Council of State Governments. 2002. *Criminal Justice/Mental Health Consensus Project*. New York: Council of State Governments.

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