

Incarceration and Reentry

One of the most dramatic public policy shifts (some refer to it as a "social experiment") during the last three decades in the United States has been the unprecedented increase of the number of people who are incarcerated. The national prison population grew by nearly six-fold between 1970 and 2000 and the combined prison and jail population in 2000 was 1.9 million.¹ Approximately 10 million people are booked into U.S. jails each year.²

The extraordinary growth of prison and jail systems has presented enormous challenges to corrections administrators. Of these challenges, few, if any, are more formidable than operating a comprehensive mental health service delivery system for inmates. Increasing budgetary pressures on corrections systems make this challenge especially daunting. Estimates regarding the number of

people with mental illness in prison or jail vary. The US Department of Justice reported in 1999 that about 16 percent have a mental illness.³

Like the policy statements in the preceding chapters, the following policy statements do not suggest that people with mental illness should not be held accountable for their behavior. Indeed, given the crime they committed, it is appropriate and necessary for some people with mental illness to be incarcerated.

The policy statements in this chapter adhere to the principle that identifying inmates with mental illness, treating them, and preparing them for release is good corrections policy. And it is the right thing to do. It improves corrections administrators' ability to protect people with mental illness while they are incarcerated, to maintain calm environments in the facilities, and to promote staff safety. Perhaps most importantly, the vast major-

1. The Sentencing Project, *State Sentencing and Corrections Policy in an Era of Fiscal Restraint*, available at: www.sentencingproject.org.

2. *Correctional Populations in the United States*, U.S. Department of Justice Statistics, NCJ-163916, 1997.

3. Ditton, *Mental Health and Treatment*, p. 1

ity of people in prison or jail will ultimately re-enter the community. Screening inmates for mental illness, delivering effective services, providing appropriate housing, and developing a comprehensive treatment plan improve the likelihood that an inmate with mental illness will return to the community (and to his or her loved ones) healthy and safely.

The policy statements in this chapter go beyond what should happen when a person with mental illness is incarcerated. They also address the role of community corrections officials in monitoring and assisting people with mental illness who are released from prison or jail under some form of supervision. Furthermore, they review the pivotal role of the mental health system in maintaining the person on a path toward recovery once the person is released.

17

Receiving and Intake of Sentenced Inmates

POLICY STATEMENT #17

Develop a consistent approach to screen sentenced inmates for mental illness upon admission to state prison or jail facilities and make referrals, as appropriate, for follow-up assessment and/or evaluations.

Every correctional system has procedures in place to receive a sentenced inmate admitted to an institution. These intake procedures typically are used for inmates who arrive at the institution from a detention facility immediately following their sentencing or for inmates who have been transferred from a different institution.

Recommendations under this policy statement explain how corrections administrators can ensure that each sentenced offender entering the institution is screened for potential mental illness. These recommendations include the following: the key elements of a screening instrument and its administration; procedures to follow up on the results; and protocols for evaluating its effectiveness.

Typically, when institutional intake staff receive inmates, they fingerprint them, conduct a medical exam, and review a host of issues in order to make decisions about classification, housing, and other programmatic or special needs. Determining whether the inmate needs mental health services should be a critical component of the inmate booking and receiving process. Immediately upon the inmate's arrival at the facility, it is especially important for staff to determine whether the inmate has any suicidal tendencies or poses a danger to self or others, and whether he or she is taking psychotropic medication.

Not adequately screening inmates to determine the possible existence of a mental illness jeopardizes the safety of personnel and inmates alike. Identifying and addressing mental illness among inmates will minimize the likelihood of an offender's risk of hurting him- or herself or others. It may also minimize the incidence of hospitalization, assaults on officers or other inmates, or other incidents that may generate considerable harm and costs. Responding to mental illness at a late stage requires the most expensive and intensive level of mental health care as well as collateral costs such as lost personnel time, overtime, and compensatory time when officers are injured.

In addition, with a consistent, system-wide approach in place for identifying inmates with mental illness, correctional administrators are able to compile the data needed to understand the scope of mental illness within their institutions. This, in turn, enhances their ability to project the future mental health needs of their agencies and communicate to policymakers the changing needs of prisoners.

Some correctional administrators fear that a mental health screening process may overstate the mental health needs of the inmate population, and thus generate excessively expensive use of mental health services. Aside from identifying those indi-

viduals who are of immediate concern and who should receive urgent attention, however, a properly designed and implemented screening function during the receiving and intake process only suggests when there may be a potential mental health problem that should be further assessed. It serves as a form of triage, ensuring a cost-effective use of resources. Screening alone is not intended to provide a diagnosis or determine the need for services or medication.

Implementation recommendations contained here are consistent with the American Psychiatric Association's (APA) Task Force for Psychiatric Services in Jails and Prisons, which, since 1990, has developed guidelines for the delivery of mental health services in jails and prisons. Consistent with the APA, recommendations under this policy statement recognize the varying levels of services provided upon admissions:⁴

- **Receiving Mental Health Screening.** Mental health information and observations gathered for every new admitted inmate during the intake procedures as part of the normal reception and classification process

by using standard forms and following standard procedures.

- **Referral.** The process by which inmates who appear to be in need of mental health treatment receive targeted assessment or evaluation so that they can be assigned to appropriate services.
- **Intake Mental Health Screening.** A more comprehensive examination performed on each newly admitted inmate within 14 days of arrival at an institution. It usually includes a review of the medical screening, behavior observations, an inquiry into any mental health history, and an assessment of suicide potential.

As a result of the above, the APA advises, professional clinicians would then conduct the following:

- **Comprehensive Mental Health Evaluation.** A face-to-face interview of the patient and a review of all reasonably available health care records and collateral information. It includes a diagnostic formulation and, at least, an initial treatment plan.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** Incorporate screening for mental illness and referral to mental health services into the existing receiving/admission protocol by integrating into the process a screening instrument along with observations by those charged with booking newly received inmates into the receiving/admission process.

The purpose of a screening instrument is to identify inmates with mental illness immediately upon their arrival at the institution and to prompt referral for further assessment of those inmates' mental health needs.⁵ Screening instruments typically are paper-and-pencil forms that may be completed by the inmate or used as a structured interview protocol by any trained staff person. It should take no longer than 10 to 15 minutes to conduct a screening.

There are no validated instruments for mental health screening in adult populations. Most correctional settings use a series of questions that seek in-

4. American Psychiatric Association, *Psychiatric Services in Jails and Prisons: A Report of the American Psychiatric Association Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons*, second edition, pp. 31-46.

5. American Psychiatric Association *Guidelines on Psychiatric Services in Jails and Prisons* provide that mental health and suicide screening should be completed immediately upon the inmate's arrival in prison. *Ibid.*, p. 40.

formation on past psychiatric services or current medications. Systematic attention to current psychiatric symptomatology is often cursory. The New York State Office of Mental Health has developed Suicide Prevention Screening Guidelines that have face validity as a screening measure for suicide, and the state trains its correctional staff in the application of this tool.⁶

Recognizing the need for a reliable screening tool, the National Institute of Justice has recently funded research at the University of Maryland to develop and test a nine-item Brief Jail Mental Health Screen. Correctional settings in Maryland and New York are participating in this study. Until a validated instrument emerges, correctional administrators should work with their mental health staff to ensure questions are asked early on in the process that are sensitive to critical mental health issues. The discussion that follows addresses other issues essential in an effective screening instrument.

Self-assessment should never entirely replace critical observations by staff. Use of a self-administered intake screening instrument does not absolve correctional or clinical staff of the responsibility to query and observe for mental illness at the time of intake. Training staff for such responsibilities is essential. (See Policy Statement 30: Training for Corrections Personnel.)

In general, when an effective screening instrument is implemented properly, staff will more often incorrectly identify someone as exhibiting signs or symptoms of mental illness than overlook someone who truly has a mental illness. Erring on the side of caution at the outset increases the likelihood that high-risk cases are discovered; only a relatively small percentage of mental health assessments are conducted when they are not needed. A useful screen will send a significant percentage of inmates (perhaps as many as 25 percent) forward for a more comprehensive evaluation.

Example: Screening Instrument, Oregon Department of Corrections

In Oregon, staff administer a group-led pen-and-pencil instrument to all offenders admitted at the time of intake. This instrument generally identifies 30 percent of the population as having a mental illness. When this 30 percent are referred for professional assessment, the percentage assessed as having a significant mental illness is reduced to 17 percent.⁷

A screening instrument should use an objective scoring system. Many jurisdictions use a straightforward numeric scoring system, resulting in a “red flag” or “green flag” determination of the possible presence of a mental illness. Though effective screening instruments currently in use vary considerably, each tool must address the following: suicidality; depression; use of narcotic drugs and alcohol; anxiety; history of hospitalization for psychiatric problems; trauma history; and the use of any medications prescribed for a mental illness.

Substance abuse greatly influences symptoms of mental illness. For this reason, and because the majority of people with mental illness who are incar-

6. Fred Osher, Director, Center for Behavioral Health, Justice and Public Policy, private correspondence, April 18, 2002.

7. Gary Field, Administrator, Counseling and Treatment Services, Department of Corrections, private correspondence, February 2002.

cerated have a co-occurring substance abuse disorder, staff should screen for substance abuse in tandem with mental health. Subsequent assessments should allow clinicians to observe the individual in a drug-free state over time in order to separate the causes and effects of substance abuse on mental health.

Ideally, the intake process would be seamless, incorporating health screening, mental health screening, classification procedures, and other protocols. This process could be captured in a single, integrated instrument, such as the one being developed by the University of Maryland.

In some states, properly trained correctional officers—especially those with close and sustained contact with inmates during the first few days of incarceration—serve as initial, informal screeners. They may be in the best position to observe behavior and to identify signs and symptoms of mental illness, particularly when such symptoms emerge several days after intake. Although this measure may seem inefficient, given the screening that mental health staff will perform later, such redundancy is in fact cost-efficient; it effectively narrows the pool of inmates who receive a professional assessment to those who are most likely to have a mental illness.

b Ensure consistency of screening protocols within correctional system by using the same screening instrument at all facilities statewide and training facility staff in their use.

In many correctional systems, a different mental health screening instrument is employed at each prison in the system. Such variation among the prisons is complicated and compounded by the procedures in use at county jails, where staff at each facility typically employ a distinct instrument and process (if one is used at all) to screen inmates for mental illness. Although it may be a challenge, particularly in states with an elaborate network of independent county jails, state officials should require the use of the same screening and assessment instruments and protocols at all correctional facilities in the state. The American Psychiatric Association recommends standardizing mental health screening procedures and instruments so that the responses can be documented in a consistent fashion.⁹

Uniformity in screening procedures has numerous advantages. It can provide valuable information about the impact of transfers, the incidence of inmate decompensation, and identify trends occurring over time. It also enables state correctional systems to collect data needed to inform research and evaluations and to support legislative advocacy and public education. To achieve uniformity, directors of state departments of corrections may be able to issue an administrative order. In other states, however, leadership from mental health

In 2001, at the request of the Pennsylvania Office of Mental Health and Substance Abuse, the Pennsylvania Department of Corrections assembled data on the mental health and treatment status of its inmate population in all Pennsylvania state prisons over a four-year period. The data revealed that 90 percent of the inmate population had an issue with substance use, of which they estimated about 75 percent had a substance abuse problem serious enough to warrant treatment. Concurrently, about 15 percent of the total Pennsylvania inmate population had a mental disorder. Of the 15 percent of inmates with mental health disorders, 90 percent also had a substance use issue and an estimated 75 percent warranted drug and alcohol treatment. These data were consistent over four consecutive years.⁸ This prevalence of inmates with co-occurring disorders is certainly not unique to Pennsylvania.

Although this chapter of the report does not assume that an inmate with a mental illness has a co-occurring substance abuse disorder, it does recognize that the assessment, housing, program, treatment, case management, and habilitation needs of inmates with mental illness must address substance abuse issues as well if they are to be effective.

8. Information cited by Charles Curie, Administrator, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (SAMHSA), and former Deputy Secretary for Mental Health and Substance Abuse Services for the Department of Public Welfare of the State of Pennsylvania, in an address to

the Council of State Government Criminal Justice / Mental Health Consensus Project Advisory Board Meeting in January 2002, and reported by Teddy Fine, M.A., Director of Communications Policy and Strategy, Substance Abuse Mental Health Services Administration (SAMHSA).

9. APA, *Psychiatric Services in Jails and Prisons*, p. 41.

agencies or statewide legislative advocacy may be necessary, especially when county government officials are unwilling to assume the financial implications of implementing such an order.

Example: Screening Instrument, New York State Office of Mental Health

In an attempt to encourage uniformity of mental health screening, assessment, and referral procedures, the New York State Office of Mental Health (OMH) has been developing model policies and instruments for use in New York's county and municipal jails. First, in 1985, OMH developed and field-tested a suicide screening protocol for use in the jails. The New York State Commission of Correction, which accredits and oversees the development of new technology for jails and prisons in the state, adopted the suicide screening protocol and now requires all county jails and penitentiaries and state prisons to employ it.

More recently, OMH, in association with the New York State Office of Alcoholism and Substance Abuse Services (OASAS), has been involved in sponsoring jail validation studies of two receiving screening instruments developed by the Nathan Kline Institute for Psychiatric Research for use in community settings. One, the "MINI Screen," was designed to identify individuals with substance abuse problems who are receiving services in community mental health settings. The second, the "DALI Screen," was designed to identify individuals with mental health problems who are receiving treatment in substance abuse settings.¹⁰ At the time of publication of this report, the jail validation study involving 400 newly admitted detainees and offenders at New York State county jails had just gotten under way.

In states and localities where correctional institutions are located at considerable distance from one another, some jurisdictions have relied on information technology to ensure consistent screening and assessment methods.

Example: Suicide Screening Initiative, Alaska Department of Corrections

There are 13 correctional facilities and pretrial facilities in Alaska, a state where geography and low population density present particular challenges. To ensure consistent, comprehensive inmate mental health screening, the Alaska Department of Corrections has developed a screening tool that trained, nonmedical staff can download, administer, and return completed almost immediately to the department's central office using handheld personal desk assistants or Palm Pilots. Mental health professionals in the central office can then make assessments and recommend or initiate appropriate interventions, if needed.

The Palm Pilot serves not only as an electronic means of keeping medical records, but as a platform for the entire management information system. All clinicians perform the same, standardized exam on the Palm Pilot. The information is then uploaded to a statewide computer network and becomes available for printing of medical files. The system makes it possible to generate information in summary and/or aggregate form, thereby facilitating quality assurance and research.

As is the case in many correctional facilities, Alaska's Suicide Screening Initiative relies exclusively on inmate self-reported information. It is important, however, to use sources other than the inmate alone to supplement self-reported mental health information. Self-reports are not always reliable, and

10. M.J. Alexander, "Validating the MINI Screen for Mental Health Problems in Chemical Dependency Treatment Settings" and "Validating the DALI Screen for Substance

Abuse in Mental Health Treatment Settings," The Nathan Kline Institute of the Center for the Study of Issues in Public Mental Health, Orangeburg, NY.

they rarely provide a complete picture of an inmate's mental health treatment history; sometimes, they also fail to shed light on co-occurring disorders. It is essential to obtain this information during the assessment phase, and it helps to inform decisions regarding classification and treatment plans.

When the screening results in a "red flag," staff should seek additional information, such as an existing treatment plan or information about medications the inmate has been prescribed, from supplemental sources. For example, the mental health professional conducting the subsequent mental health assessment should review information and reports from other criminal justice staff, such as the pretrial investigator, the presentence investigator, and county/municipal detention staff, who have previously had contact with the inmate. Reports from other criminal justice system personnel such as law enforcement or jail officials will provide details of mental health and behavioral issues pertinent to the screening and evaluation process of the inmate. Additionally, state departments of correction may wish to consider gathering supplemental information from the local or county corrections authority. It might be advisable for states to require county jail officials to inform receiving state correctional authorities if a person has been receiving mental health services. Such information is not considered confidential, and may well prove to be critical for the health and well-being of inmates with mental illness.

Staff should also obtain assessment and treatment history information from community mental health treatment providers. In at least some corrections systems, staff encourage the inmate to sign a release of records form, which allows correctional staff including clinicians to obtain mental health records from previous treatment providers in the community. In other cases, staff at the corrections center request the assistance of community mental health officials in cross-referencing the names of their clientele with the jail population (see Policy Statement 13: Intake at County / Municipal Detention Facility).

The individual charged with conducting the screening is most often the booking or receiving officer, intake nurse, or intake clinician; in general, any properly trained individual can administer a straightforward screening instrument and gather necessary information. As state mental health agencies become more involved in assisting, overseeing, and/or providing mental health services within the criminal justice system, professional credentialing and licensing requirements are more likely to be consistently enforced when addressing the needs of people with mental illness in correctional settings. A low-cost, high-quality solution involves making arrangements with educational institutions that can place graduate-level clinical psychology or social work student interns at facilities to conduct screening and assessment of inmates.

The extent to which any of these staff implement the screening procedures effectively, however, depends in large part on whether they understand their responsibilities and execute them properly. In short, training on issues such as the screening protocol, the appropriate use of information gathered, confidentiality issues, and cultural and gender sensitivity is key. (See Policy Statement 30: Training for Corrections Personnel.)

c **Develop a system of triage to ensure that follow-up responses to the screening results reflect the immediacy of the inmate's needs.**

An effective screening tool should enable screeners to distinguish between inmates in need of immediate mental health attention and inmates currently on medication or in treatment who will require a complete assessment within 24 hours of their screening. When staff members conducting the screenings determine that inmates are in need of immediate attention, they should ensure that these inmates are transferred to a specialty facility for 24-hour observation and care or placed on suicide watch until more suitable arrangements can be made. They should also check whether there is any indication that the newly admitted inmate is currently taking psychotropic medication and ensure that he or she receives it when ready for the next dose.

Inmates who display significant mental health disorders should receive a professional mental health assessment as soon as possible after admission. The APA recommends that a brief mental health assessment for individuals who screen positive for mental illness should be conducted within 72 hours, with a provision for immediate evaluation in cases of increased urgency.¹¹

These brief assessments may be conducted by qualified health professionals (e.g., general practitioner nurses or physicians) where specialty mental health staff are not available daily. After this brief assessment, the inmate should be placed on a medication review protocol and scheduled for a full treatment plan review within 30 days.

d **Evaluate periodically the effectiveness of the screening instrument employed, as well as the mental health assessment and mental health evaluation protocols.**

Staff can implement various mechanisms at the facility level to ensure that the instrument and protocols are successfully identifying inmates who have significant mental health issues and following up appropriately:

- **Inter-rater reliability review.** Comparison of the outcomes of screenings conducted by different staff.
- **Feedback from assessment results.** Determination of the rates at which a positive screening successfully identified an inmate with mental health needs and the rates at which a positive screen incorrectly flagged a mental illness or mental health problem.
- **Interdisciplinary review.** Interdisciplinary communication (i.e., among health and custody staff) about mental health screening issues.

Another key element in evaluating the effectiveness of screening and referrals is to determine the extent to which the screening instrument is sensi-

11. APA, *Psychiatric Services in Jails and Prisons*, p. 41.

tive to cultural variations and that those who administer the process are sensitive to inherent cultural biases. Inmates with mental illness are disproportionately African American, Hispanic, and Native American. Given the reality, it is incumbent on those who oversee and carry out the care and supervision of defendants and offenders with mental illness to ensure that the procedures undertaken and the services provided are done so in a nondiscriminatory way, while at the same time are sensitive about and responsive to cultural and linguistic differences. Similarly, the growing number of women who have a mental illness and who come to the attention of the criminal justice system deserve gender-specific and gender-competent care and treatment.

No matter how culturally competent or how culturally neutral a screening instrument may be, it will not substitute or supercede personnel's abilities when it comes to asking questions and making observations. It is critical that, in addition to training around the signs and symptoms of mental illness, specifics about screening, and preliminary assessment protocols, staff need to be trained to move toward cultural competency.

e

Conduct a comprehensive mental health evaluation of every inmate flagged as having significant mental health issues during the professional mental health assessment process.

A comprehensive mental health evaluation should include, at a minimum, the following:

- mental health history
- prior treatment
- medication history
- relevant psychosocial history (i.e., family, social, legal, relationships)
- functional assessment
- current situational stressors
- mental status examination
- current diagnosis
- relevant medical diagnoses
- current medication
- substance abuse status

The evaluation should include a structured interview with inmates and a review of any available mental health records and collateral information, including behavioral observations by institutional staff. The evaluation should result in a diagnosis and a preliminary treatment plan.

Early models of cultural competency were developed in the mid-1980s at Georgetown University's Child Development Center.¹² Cultural competence is something that must develop concurrently at policymaking, administrative, practitioner, and consumer levels. "The culturally competent system values diversity, has the capacity for cultural self-assessment, is conscious of the dynamics inherent when cultures interact, has institutionalized cultural knowledge and has developed adaptations to diversity."¹³

The language of any good screening instrument should, at least, be presented at a language comprehension level that enables inmates to understand what is being asked of them. It should also be available in Spanish and/or other language(s) prevalent in the community. In addition, cultural competency should be a part of the training curriculum for screeners. (See Policy Statement 43: Cultural Competency.)

12. See: www.georgetown.edu/research/gucdc/nccc/index.html

13. T. Cross, B. Bazron, K. Dennis, M. Isaacs, "Towards a Culturally Competent System of Care: a Monograph on

Effective Services for Minority Children who are Severely Emotionally Disturbed," Child and Adolescent Service system Program Technical Assistance Center, Georgetown University Child Development Center, March 1989, p. 19.

18

Development of Treatment Plans, Assignment to Programs, and Classification/Housing Decisions

POLICY STATEMENT #18

Use the results of the mental health assessment and evaluation to develop an individualized treatment, housing, and programming plan, and ensure that this information follows the inmate whenever he or she is transferred to another facility.

Correctional administrators should ensure that the results of the initial receiving mental health screening—along with subsequent screenings, assessments, and evaluations—inform the decisions that follow regarding housing, programming, and treatment. Mental health screeners serve as gatekeepers who, in turn, must communicate effectively with correctional staff responsible for housing and program decisions.

Once mental health staff have determined the inmate has a mental illness, several decisions follow. Mental health staff must develop an individualized treatment plan that recognizes the specific needs of each inmate. They also must work with correctional staff to determine the housing unit and programs to which such persons should be assigned. Information about decisions made at one institution must be passed along to the staff at the institution that next receives the inmate.

The first series of recommendations under this policy statement addresses the use of medications in correctional settings. The development over the previous 15 years of new types of psychotropic medications, such as atypical antipsychotics and selective serotonin reuptake inhibitors (SSRIs), has increased dramatically the prospects of recovery for people with mental illness.

The prescription of medications, however, should be only one component—not the central focus—of a treatment or case management plan. Historically, staff at many correctional facilities have overrelied on the use of psychotropic medications and, in many cases, sedative-hypnotic medications, simply to pacify and to control inmates with mental illness and others believed to be disruptive. This reveals a common prejudice about inmates with mental illness: they are noncompliant, difficult to manage, violent, and otherwise undeserving of clinical attention or services. This is a view current clinical research and practice does not support.

14. In *Estelle v. Gamble*, 429 U.S. 97 (1976), the Supreme Court addressed the medical needs of prisoners in the context of the Eighth Amendment. The court held that deliberate indifference to serious medical needs is prohibited “whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced,

deliberate indifference to a prisoner’s serious illness or injury states a [claim under the Constitution.] *Id.* at 104-105.” A prisoner must provide evidence of “acts or omissions sufficiently harmful” to show deliberate indifference in order to bring an Eighth Amendment claim.

Since *Estelle*, the Supreme Court has refined the “deliberate indifference” standard only once. In 1994 the Court said that deliberate indifference “[lies] somewhere be-

RECOMMENDATIONS FOR IMPLEMENTATION

a Include the most appropriate psychotherapeutic medications in prison and county correctional institution formularies.

A growing body of clinical evidence shows the benefits of widespread access to the newer generation of medications (see Policy Statement 35: Evidence-Based Practices). Fewer people taking these medications require hospitalization or rehospitalization, yielding substantial cost savings. More people taking them are able to enter the workforce and reduce their dependency on a wide array of social services. As the benefits of the newer medications have become more widely recognized the demand has increased, allaying concerns about higher costs.

Newer medications, which are considerably more expensive than older medications, are not used as frequently in prisons and in jails as they are in the general community. Using these newer medications in many instances, however, is in fact cost-effective; their ability to increase the likelihood that the inmate will adhere to his treatment plan may offset, at least in the long term, the difference in cost between the two generations of medications.

Correctional officials usually require that licensed staff in the jail or prison pharmacy fill prescriptions, including those for psychotropic medications, in accordance with a departmentally prescribed formulary. Policies should define procedures that ensure a balance between the higher cost and the more desirable results, including the lesser side effects of many of these new medications. At a minimum, pharmacies should maintain adequate stocks of the most commonly prescribed psychotropic medications. These should not be limited to the least expensive and generic brands. Sufficient supplies of newer medications that have been prescribed by the psychiatrist for individual patients should also be kept on hand.

Furthermore, regardless of whether a particular medication is on the jail or prison formulary, there should be provision for obtaining any medication that a physician deems appropriate to prescribe. If the medication is not on the formulary, the physician should be able to order it as a special request and receive it in a timely manner.¹⁴

tween the poles of negligence at one end and purpose or knowledge at the other”(Farmer v. Brennan, 511 U.S. 825, 1994). The Court affirmed an “adequacy” standard stating that “prison officials must ensure that inmates receive adequate food, clothing, shelter and medical care . . .” (id. at 833), but went on to emphasize that “deliberate indifference” requires a culpable state of mind. Federal District

Courts (the trial court in the federal system) may interpret “adequate” with wide discretion. On appeal to the Federal Circuit Courts—the layer of the judiciary just below the U.S. Supreme Court—this has led to vastly varying law, especially in regards to the treatment of HIV. See APA, Psychiatric Services in Jails and Prisons, p. 2

b **Develop and adopt jointly standardized clinical decision protocols (i.e., algorithms) that are based upon research conducted on a national level.**

In order to ensure consistency in the application of psychotropic medications, and to manage pharmacy costs, state correctional agency officials should work with leaders in the mental health system to develop and adopt jointly standardized clinical decision protocols (i.e., algorithms) that are based upon research conducted on a national level.

Example: National Formulary, Federal Bureau of Prisons

In an effort to deliver consistent and cost-effective medical care, the Pharmacy and Therapeutics Committee of the Federal Bureau of Prisons (BOP) established the National Formulary for the Bureau of Prisons. The committee's objectives are to ensure that inmate medical care will be delivered consistently and cost-effectively as a result of the formulary's implementation.

Implementation of the formulary includes review of evidence-based scientific literature for new and existing drugs and to determine their appropriate role in the Bureau's pharmacotherapeutic armamentarium. It is the committee's role, through the formulary, to stay current with BOP clinical treatment guidelines for medical and mental health conditions, as well as reflect the generally accepted professional practices of the medical community at large.

The committee meets and conducts reviews annually and is composed of pharmacists and clinicians from the bureau and other institutions and includes the chief physician and chief psychiatrist; it is chaired by the chief pharmacist. Responsibilities include reviewing the formulary and updating it to be in line with evidence-based medicine; new drugs are reviewed by conducting literature searches and cost/benefit analyses to determine whether the side effect of a given drug is worth the benefit of administering it.

Example: University of Texas Medical Branch, Texas Department of Criminal Justice

Beginning in 1995, the Texas Department of Criminal Justice (TDCJ) developed policy and guidelines for facility-level providers to obtain nonformulary drugs for offenders in the custody of the Texas Department of Corrections. TDCJ has incorporated the procedure for obtaining nonformulary drugs for inmates as part of the Pharmacy Policy and Procedure Manual. The prescribing physician must provide documentation in the offender's health record about what role the desired drug will have in the offender's treatment plan (e.g., diagnosis, special considerations) and also provide documentation confirming that no acceptable substitute is available on the formulary.

Procedures and a flowchart have been developed to show the protocols for what happens when such a request is made. Requests for nonformulary medication are made to the clinical pharmacist assigned, who, in turn, evaluates the request by a review of information provided by the prescribing physician/psychiatrist and/or a review of other relevant information including the target disease, previous medications used for the indication, dosages, compliance allergies, diagnostic procedure, TDCJ Disease Management guidelines, national standards and guidelines, and applicable scientific literature.

The Texas Department of Criminal Justice has evaluated the program through continued monitoring of nonformulary requests and denials. The initiative is funded through a contract with the University of Texas Medical Branch/Correctional Managed Care to provide mental health services for offenders in the TDCJ through the Correctional Managed Care Advisory Committee.

Much progress has been made in the area of clinical informatics as a result of managed care initiatives that have moved into pharmacy services.

Example: The Texas Medication Algorithm Project, Texas Department of Mental Health and Mental Retardation

The Texas Medical Algorithm Project (TMAP) is a public and academic collaborative effort headed by the Texas Department of Mental Health and Mental Retardation. TMAP is designed to improve the quality of care and achieve the best possible patient outcome by establishing a treatment philosophy for medication management. TMAP developed and instituted a set of algorithms to illustrate the order and method in which to use various psychotropic medications. The TMAP algorithms have been adopted by the Texas Department of Criminal Justice for use in the state's prisons.

The ultimate goal of TMAP is to optimize patient outcomes with the underlying assumption that resources will be most optimally utilized. It is intended to develop and continuously update treatment algorithms and to train systems to apply these methods to minimize emotional, physical, and financial burdens of mental disorders for clients, families, and health care systems.

TMAP consists of four phases. During Phase 1, guidelines were developed through scientific evidence and expert clinical consensus, resulting in the development of algorithms for use of various psychotropic medications for three major psychiatric disorders: schizophrenia, major depressive disorder, and bipolar disorder. Phase 2 was the feasibility trial of the project and evaluated the suitability, applicability, and costs of the algorithms. The third phase was a comparison of the clinical outcomes and economic costs of using these medication guidelines vs. traditional treatment/medication methods. The fourth and final phase is the implementation of TMAP throughout clinics and hospitals of the Texas Department of Mental Health and Mental Retardation and is known as the Texas Implementation of Medication Algorithms (TIMA). Collaboration for this project included public sector and academic partners, parent and family representatives, and mental health advocacy groups.¹⁵

In order to ensure quality and objectivity, correctional agencies should enlist the services of a licensed pharmacist to review policies and procedures, and to assist in a review of the use of medications in the facilities. For example, there may be some instances when physicians prescribe the newer, more expensive medications even though the older medications may achieve the same desired clinical outcome. If replacement medications are considered, prescribing physicians should keep in mind the potential impact of side effects associated with switching medications. Checks and balances must be established and enforced to ensure that physicians are not overprescribing medications that yield little additional salutary effect.

15. Graphic presentations of algorithms and explanatory physicians' manuals are available on the TMAP Web site: www.mhmr.state.tx.us/centraloffice/medicaldirector/TMAPtoc.html.

C

Require, at a minimum, that (1) mental health-specific case management services and (2) effective, research-based behavioral and counseling interventions accompany the use of medication.

To ensure that mental health and correctional facilities staff members do not become overly dependent on medications alone to modify or to control inmate behavior, mental health services should include an array of interventions designed to meet the unique needs of inmates with mental illness. When interdisciplinary teams work together to develop a treatment plan, the services delivered are more likely to be balanced and tailored to the specific needs of the inmate

Interventions that have proven to be effective in a correctional setting include the following:

- cognitive-behavioral therapy, particularly those interventions that improve basic problem-solving skills and reduce maladaptive (criminal) thinking
- individual and group therapy that is skill acquisition oriented
- independent living-skills training
- medication self-management
- relapse prevention
- physical exercise programs

Example: Behavior Modification Treatment Level System, West Virginia Division of Corrections

The West Virginia Division of Corrections has implemented a Behavior Modification Treatment Level System at the Mount Olive Correctional Complex. Mental health staff at the facility put this system in place to facilitate effective inmate management and to provide an incentive for inmates placed in the Mental Health Unit (MHU) to achieve an appropriate functioning level.

Programming is offered at various levels for some inmates who used to be locked down in their cells for 23 hours a day. Since the program has started there has been only one four-point restraint utilization, no cell extractions, and inmates that used to be housed in single cells are now stabilized and socialized to be double bunked. To increase success, the warden was asked to forgo disciplinary infractions for inmates receiving mental health treatment on the unit. This approach has empowered mental health staff to implement programming without having punitive restrictions. Critical to this approach is the ability to select staff who are philosophically aligned with a habilitation model as opposed to a punitive model.

At most institutions, correctional staff members provide general case management services. When inmates have a mental illness, however, they should be assigned to case managers specially trained to understand the distinct service needs of this population.

"Effective treatment makes our prisons safer and easier to manage. Prison wardens are keenly aware that inmates exhibiting symptoms of mental illness can cause unrest and tension in the general population. It is obvious that a large proportion of those inmates have better control over their actions when they receive the appropriate treatment for their illness."

REGINALD A. WILKINSON

Director, Ohio Department of Rehabilitation and Correction

Source: U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*, September 21, 2001

d Develop and provide programs for inmates with co-occurring disorders.

All programs for inmates with mental illness should also address inmates with co-occurring substance abuse disorders. Over the past decade, virtually every state department of corrections has implemented residential substance abuse treatment programs within their prisons. Some of these programs specialize in treating the dually diagnosed—those with co-occurring substance abuse and mental health problems. These programs generally serve inmates whose primary problem is substance abuse, and whose mental health problems tend to be less severe but there are clearly examples of offenders with co-occurring disorders whose mental illness is the primary concern. Some of these residential programs are specifically designed for women—a large percentage of whom are dually diagnosed—with depression as the primary psychiatric diagnosis.¹⁶

Key program components for co-occurring disorders include the following: an extended assessment period; orientation/motivational activities; psychoeducational groups; cognitive-behavioral interventions, such as restructuring of “criminal thinking errors”; self-help groups; medication monitoring; relapse prevention; and transition into institution or community-based after-care facilities. Many programs use therapeutic community approaches that are modified to provide greater individual counseling and support, less confrontation, smaller staff caseloads, and cross-training of staff.¹⁷ (See Policy Statement 37: Co-Occurring Disorders.)

Example: Co-occurring Disorder Programs, Columbia River Correctional Institution (OR)

In 1998, the Oregon DOC combined state and federal grant resources to create a system of four co-occurring disorder programs at a single institution (the Columbia River Correctional Institution). Two of these programs are for men, and two for women. One program for each gender is targeted at inmates whose problems are more heavily weighted toward addiction and criminality, but who also have some mental health problems (the Turning Point programs). Another two programs (again, one for each gender) are designed to address the needs of offenders with serious and significant mental health problems who also have problems with addiction. Mental health and substance abuse treatment in all four programs is provided in an integrated manner, with much cross-pollination of ideas and information among supervisors and staff of all four.

At the Oregon Department of Corrections (DOC), substance abuse and mental health services are administratively and functionally integrated. This allows for fast and efficient communication between planners and policymakers at the agency level, as well as treatment supervisors and treatment providers at the facility level. Each year, the Oregon DOC brings together its substance abuse and mental health planners and providers for a two-day “integration seminar,” where matters of mutual concern are considered and discussed. Last year, the seminar focused on relapse prevention.

16. GAINS Center, Women’s Program Compendium, Delmar, NY, Policy Research Associates, Inc., 1997; L.A. Teplin, K. M. Abram, and G.M. McClelland, “Prevalence of Psychiatric Disorders Among Incarcerated Women,” *Archives of General Psychiatry* 53, 1996, pp. 505-12.

17. John F. Edens, Roger H. Peters, and Holly A. Hills, “Treating Prison Inmates with Co-occurring disorders: An Integrative Review of Existing Programs,” *Behavioral Sciences and the Law* 15, 1997, pp. 439-57.

e Facilitate access to professional psychiatric services by using telepsychiatry in systems where inmates are distributed across a large geographical area or in locations where there is a shortage of psychiatric service providers.

Qualified, licensed mental health staff can be hard to come by in jails and prisons located in remote, rural areas. As a result, some jurisdictions, including some in Texas, have resorted to electronic communications as a means of providing professional, clinical services to such institutions. (See Policy Statement Section 41: Workforce.)

Example: Telemedicine, Texas Department of Criminal Justice

Texas Tech University Health Sciences Center (TTUHSC) is responsible for providing medical care in the western portion of Texas to inmates in the Texas Department of Criminal Justice and to juveniles in five Texas Youth Commission facilities. In 1994, TTUHSC began delivering health services to inmates via telecommunications technology. As of 2002, TTUHSC conducts approximately 2,000 prison telemedicine consultations a year for the 33,000 inmates that are housed in the 26 prison units for which TTUHSC is under contract. Approximately one-third of all telemedicine consultations are in telepsychiatry and telepsychology. This expansion has significantly reduced the amount of time clinicians spend driving to distant prison sites.

Psychotropic medications should be prescribed by, or in consultation with, a psychiatrist or other licensed mental health professional having training in psychotropic medications and authority to prescribe them as determined by the state. Given the shortage of psychiatrists, doctors who provide general health care, but who are not credentialed in psychiatry, are allowed to prescribe psychotropic medications for inmates with serious mental illness. It is essential that physicians who specialize in psychiatric medicine oversee mental health treatment, in addition to psychotropic medication prescription, administration, and monitoring.

f Review mental health services provided to ensure that they are evidenced-based.

Like their counterparts in the community, mental health professionals working in correctional settings have access to a growing body of research documenting the effectiveness of certain interventions and the promise of others. Similarly, researchers have demonstrated that various service models have little or no impact on the behavior or health of a person with mental illness. To ensure provision of the most effective possible services to people with mental illnesses in prisons and jails, correctional mental health officials should stay abreast of the work of research efforts on evidence-based practices such as those conducted at the New Hampshire Dartmouth Psychiatric Research Center and at the National Association of State Mental Health Program Directors

(NASMHPD) Research Institute.¹⁸ Researchers affiliated with these organizations have identified services that have been shown in a variety of settings to provide treatments and supports that will enhance the ability of a person with mental illness to live successfully in the community. (See Policy Statement 35: Evidence-Based Practices.)

g

Ensure the cultural competency of all programs for inmates with mental illness.

As stated earlier in this chapter, the majority of people incarcerated in the United States are African American or Latino. In some states, people of color make up nearly 80 percent of the prison population. Cultural competency has generally been shown to improve client receptiveness to services and counselor effectiveness (see Policy Statement 40: Cultural Competency). Mental health services in correctional settings should recognize the effects of culture on all aspects of mental illness and, in order to treat inmates effectively, should organize and design their approaches accordingly. In particular, clinicians and other correctional staff who are in routine contact with inmates with mental illness should receive training to enhance their “cultural competency” and their ability to recognize and respond to the needs of people from different cultural backgrounds who come under their care or control.

h

Provide mental health treatment and services that are gender-specific.

Male and female inmates may have similar mental illnesses and custody levels, but their treatment plans, housing situations, and programming needs will be distinct. For example, the Bureau of Justice Statistics has found that histories of trauma and abuse are particularly high among females in prison and jail: more than 78 percent of female state prison inmates and more than 72 percent of the female population in jail reported such histories.¹⁹

In response, a growing number of jurisdictions have instituted programs intended to identify women who are victims of past abuse and to offer interventions that meet their specific needs. These programs provide training that helps correctional administrators and officers to understand the high prevalence of trauma history among their inmates as well as the relationship between abuse, substance abuse, mental illness, and criminal behavior. The programs also include interventions that help inmates with histories of abuse to better understand their own situations, often through group meetings.

18. Available at: www.dartmouth.edu/dms/psychrc;www.nasmhpd.org

19. Ditton, *Mental Health and Treatment*, p. 6. Although the prevalence of histories of abuse is much higher among females than males, male inmates with mental illness were also significantly more likely than inmates without mental

illness to report a history of abuse. More than 32 percent of male state prison inmates and more than 30 percent of male jail inmates reported such histories, as compared with 13 percent and 10 percent, respectively, of male inmates without mental illness.

20. Travis et al., *From Prison to Home*, p.14

Example: The TAMAR Project, Maryland Mental Hygiene Administration, Division of Special Populations

The TAMAR (Trauma, Addictions, Mental health, And Recovery) Project was initially piloted in one rural and two suburban counties in Maryland and has now spread to a number of counties in the state. Its goal is to provide integrated services for women who typically have interrelated trauma, substance abuse, and mental illness issues. Meeting in groups, the women are encouraged to share their stories with one another and to engage in therapeutic activities such as art therapy and journal writing. Once released from jail, women in TAMAR are able to continue to meet in groups in the community that provide continuing support.

i

Recognize the distinct programming needs of special populations with mental illness, such as the elderly, the developmentally disabled, those with chronic medical problems, substance abusers, and sex offenders.

Prisons have increasing numbers of inmates with mental illness who also are elderly, developmentally disabled, or sex offenders. The clinical needs, treatment approaches, strengths and deficits, and general goals of programs for inmates in these groups differ significantly. Correctional administrators should ensure that mental health programs and services provided to these special populations are distinct from programs and services provided to other inmates with mental illness

Some program approaches that serve sex offenders and those with developmental disabilities may provide useful guidance for approaches for offenders with co-occurring disorders.

Example: Program for Inmates with Developmental Disabilities, Texas Department of Criminal Justice

This program was established to minimize the negative effects of incarceration on offenders who have developmental disabilities and to maximize the likelihood of their successful reintegration into the community. An Interdisciplinary Team (IDT) includes a physician or registered nurse, licensed or certified psychologist, social caseworker, vocational supervisor, social work supervisor, and rehabilitation aide. Occupational therapists and speech pathologists are included as necessary. The IDT performs a needs assessment to determine what services are best suited to meet the needs of the individual. A vocational evaluation is completed, which takes into account the inmate's assets and limitations. Offenders with developmental disabilities are housed in the least restrictive environment appropriate to their habilitation, treatment, and safety and security needs. Available services include: medical care; psychiatric services; educational programming; occupational therapy; substance abuse treatment; treatment planning and monitoring; and continuity of care (transitional planning).

Example: ASEND Program, Utah Department of Correction

Since 1986, the Utah Department of Corrections has been operating the Advantage Program at the Utah State Prison to address the needs of offenders with an IQ below

70. In 1999, space was designated at the prison and new policies and procedures were implemented for an expanded program, called ASEND, operating in a segregated living unit.

The ASEND Program provides programming for those inmates lacking the skills and knowledge to meet the standards of self-sufficiency and acceptable social responsibilities, not only in society but also within this institutional environment. The goal of the ASEND Program is to assist inmates to live successfully in the prison population and to prepare for their eventual release to the community.

The program comprises the following components: 1) a written individual habilitative plan; 2) an education program component; 3) a cognitive programming component; 4) an employment job readiness component; 5) modified behavior privilege matrix; 6) additional services coordination for inmates who have a mental illness, or who have sexual or drug abuse histories; 7) recreation and physical activities; 8) aftercare services; and 9) appropriate training and habilitative specialist status for block officers.

Example: Sexual Offender Accountability and Responsibility (SOAR) Program, North Carolina Department of Corrections

SOAR is a voluntary day treatment program for incarcerated sexual offenders referred by psychological staff from state prisons. Two program sessions are held each year, with a total of 72 offenders participating. Inmates are housed in a segregated unit while participating. Group therapy conducted by a program staff psychologist is the primary mode of treatment. The program, which has been in existence since 1991, is relatively inexpensive to operate (\$7.16 per day per inmate) and has been demonstrated to be reasonably effective. The latest outcome study reported that by April 2000, 302 of a total of 501 participants who had completed the program had been released to the community. Of these 302 men, only 7, or 2.3 percent, had been returned to prison for a new sexual offense charge. This compares very favorably with the return rate of general population inmates in North Carolina. According to a 1996 study, 47 percent of all inmates leaving North Carolina prisons are reconvicted within three years. A youth SOAR program designed to serve offenders between the ages of 16 and 21 is planned.

Example: Sexual Offender Residential Treatment (SORT) Program, Virginia Department of Corrections

SORT provides comprehensive assessment and treatment services for inmates who are a moderate to high risk for reoffense. The program operates in five phases: orientation; assessment; treatment readiness; treatment; and release planning. The program begins with the development of an individualized treatment plan, then progresses through the participation by offenders in various psychoeducational groups, and, finally, in a program of treatment having the Trans-theoretical Model and Cognitive Behavioral Techniques as its basis. The release planning phase, which includes the participation of the offender's community supervision officer and family members, includes an evaluation of future needs and the identification of programs and providers to address such needs.

j **Develop graduated housing options for inmates with mental illness that ensure the safety of staff and inmates and prepare inmates, when appropriate, for transition from specialized housing to general population units.**

Beyond general population beds, correctional administrators usually have few housing options, especially in overcrowded facilities, for inmates with mental illness. In those units, staff members generally are not trained adequately to address these inmates' needs. Inmates suffering from severe mental illness who are housed in general population, especially when their illness is undiagnosed or untreated, often decompensate more quickly than they would in housing designed and operated for inmates with mental illness. When inmates with mental illness in general housing decompensate they are likely to incur disciplinary infractions, which in turn prompts their reassignment to segregation cells, where their mental health is likely to deteriorate still further and more rapidly.

Centralized and noncentralized approaches to housing inmates with mental illness each have benefits and drawbacks. Generally, it is more cost-efficient to hold people with significant problems in specialized units at a central facility. On the other hand, decentralizing services provides greater administrative flexibility. Furthermore, "mainstreaming" inmates who can safely be housed in the general population reduces the stigma associated with mental illness.

An ideal approach to this issue is to have both options available. Depending upon the size of the system and facilities, correctional administrators should provide separate residential services to inmates with serious mental illness, as well as a range of counseling activities in day and outpatient levels of care. Several states have developed multilevel housing systems for inmates with serious mental illness. These include maximum-security medical units, step-down, post-acute housing, and transitional housing units.

In order to make the most appropriate housing assignment for an inmate with mental illness, staff should first take into account the medical requirements of the inmate, including concurrent nonpsychiatric conditions (e.g., HIV, TB, etc.). For example, inmates whose medical needs are within reasonable limits, are medication compliant, and are responsive to supervision could likely be assigned appropriately to general population units. Cross-discipline participation on panels and committees that make decisions regarding the handling of inmates with mental illness should be a standard practice.

Correctional staff should reevaluate the housing assignments of inmates with mental illness routinely to ensure the assignment is properly serving their changing needs. Inmates assigned to a specific unit because of their mental illness should be evaluated regularly for changes in their mental health needs.

k**Provide disciplinary hearing officers with the proper orientation and training to make informed decisions about offenders with mental illness.**

Custody and program staff, whether they are assigned to special housing units or to general population, should receive training in basic mental health issues. In order to have an impact on problem inmates with mental illness receiving disciplinary actions due to their illness, it is recommended that hearing officers, and others involved in the work of disciplinary committees, also receive this training. These officers should have discretion to consider the presence of mental illness as a mitigating factor in imposing sanctions (see Policy Statement 30: Training for Corrections Personnel).

l**Ensure continuity of services when inmates are transferred to a different facility.**

When inmates are transferred to a new institution, it is critical that information regarding their mental illness and treatment history accompany them. When this information does not follow the transferred inmate, the receiving facility must undertake the inefficient and expensive step of conducting another evaluation.

Service delivery between the two institutions should also be seamless. Without continuity of care, an inmate's condition can worsen.

Employing one of three mechanisms will enable corrections administrators to ensure that an inmate's mental health information will be forwarded to a receiving institution whenever he or she is transferred:

- Establish a central, computerized tracking system, which alerts the mental health case manager at the receiving institution that an inmate with mental health needs will be arriving at the facility; or
- Send with the inmate a summary form that alerts the mental health case manager at the receiving institution. When mental health information is not maintained in a system-wide database, staff will need to include in this form a clinical summary of assessment results and a brief description of treatment and services received at the previous institution; or
- In jurisdictions that do not have a central computerized tracking system, the mental health record should accompany the inmates at the time of their transfer.

Example: Wisconsin's Health Transfer Summary

Wisconsin's Health Transfer Summary, a form and protocol used to ensure continuity of care when inmates are transferred from one correctional facility to another, pertains to transfers between county jails, between state prisons, and between county jails and state prisons. In particular, the summary provides necessary information to health care providers and custodial staff at correctional facilities to ensure their proper

care—such as current health and mental health status; medications in use; and treatments—while maintaining the confidentiality of inmate health care information in compliance with state law. At the time of a transfer, the Health Transfer Summary is prepared by a facility health care professional and delivered along with the inmate by the transportation officer assigned to transport the inmate to the receiving facility. If the transfer is completed at a time when the health care professional is not available, the form is prepared and dispatched with alternative means within 24 hours.

Once received, a health care professional at the receiving facility logs in the summary, notifies the sending facility that it has been received, and makes follow-up assessments, investigations, and requests for information concerning the inmate's health care status or condition as required. The summary is maintained in the inmate's medical files as a confidential record following guidelines set forth in Wisconsin law. According to the statute, inmate consent for the transfer of his or her health care information between correctional facilities is not required. The statute also authorizes the sharing of the inmate's complete health record, but specifically excludes the mental health information from being included when that complete record is shared. The exclusion can be waived only with the inmate's consent.

Confidentiality regulations designed to protect the privacy and rights of those receiving treatment for mental illness and substance abuse are often misinterpreted, and, in some cases, such regulations unnecessarily impede the flow of information needed to ensure the quality and continuity of care for offenders who are transferred between facilities. Mechanisms can be used that enable correctional agencies to share important and relevant information while maintaining an appropriate level of confidentiality for the inmate. Information sharing should be understood here as sharing between clinical treating providers at two different sites, and not as sharing with administrative or other correctional staff. Clinical files (whatever form they take) should be sealed and opened only by qualified personnel who have appropriate training in confidentiality issues. Inmates who receive services for their mental illness should be encouraged to provide written consent in order for agencies to release treatment records to another program. Even when a statute allows sharing without consent, it is still a good idea to obtain it. (See Policy Statement 25: Sharing Information.)

It is particularly important to facilitate the transfer of records from jails and other facilities that are not operated by the state correctional agency. Similarly, state corrections directors should also consider developing memoranda of agreement between state agencies, such as the agency for mental health services, to ensure the transfer of patient records when an individual who is being served in a state institution is transferred to a correctional facility.

Corrections administrators and their counsel often have a difficult task in determining how federal and state statutes regarding the confidentiality of inmate mental health information applies to inmates. State statutes—or administrative regulations—should be established to clarify how the information of this distinct population can be used.

In addition, states should consider establishing statutes or administrative regulations that require the transfer of inmate mental health records between facilities under the purview of the state correctional agency. In Arizona, a statute requires transfer of records either prior to or at the time of the transfer; it also authorizes the records to be transferred between county and state facilities.

Example: Duty to Deliver Medical Records, Arizona State Law

Arizona state law requires the transfer of a prisoner’s “medical record file, including the prisoner’s mental health file or a standardized medical record.” The file must be transferred prior to or at the same time as transfer of the prisoner. This requirement applies to all transfers between jail and state department of correction facilities.

Louisiana takes this process a step further, allowing the correctional agency to obtain information from other state agencies, as necessary, while ensuring reasonable confidentiality protection.

Example: Access to Records, Louisiana State Law

Louisiana state statute gives the department of corrections access to “information and records under the control of any state or local agency which are reasonably related to the rehabilitation of the individual.” Access to such information may be obtained “during the course of any investigation which the department of corrections is authorized by law to conduct or any investigation necessary to the rehabilitation of persons in the custody of the department of corrections.” The statute also requires that all information obtained under this provision “be held as confidential and not be disclosed directly or indirectly to anyone except” when required by statute.

These examples illustrate how a state essentially can define the department, and/or the state as a whole, as a unified system of care, thus enabling mental health information to be freely passed between facilities and departments as though they were part of a provider enterprise, as occurs in community health systems. Confidentiality assurances can be established simply through policies and procedures that are consistent with statutes.

In cases where statutes do not provide for transfers across agencies, one solution would be for the agencies to enter into memoranda of agreement that include Qualified Services Agreements (QSA). QSA’s are agreements between providers that allow for the release of confidential information between the agencies, while transferring responsibility for adherence to federal and state confidentiality regulations.

m **Require appropriate staff to review mental health information received with the transferred inmate and to respond accordingly.**

Departmental policies and procedures should define what specific information is required at intake, who is responsible for reviewing and following up on obtaining complete mental health records, and what immediate services are to be provided. Time frames for conducting clinical review and approval of

medications should be specified throughout the intake process. Lastly, the procedures should specify a protocol for interinstitutional communication when proper documentation does not accompany the inmate at the time of intake.

Example: Statewide Weekly Mental Health Staff Teleconference, Arizona Department of Corrections

By administrative order, the facility health services administrators and other relevant mental health professionals at the Department of Corrections' (DOC) Alhambra Behavioral Health Treatment Facility, and all other correctional complexes and facilities teleconference every week to discuss the mental health treatment needs and issues of inmates being referred to or from the Alhambra complex and other Arizona DOC facilities and provide a forum for peer consultation on difficult cases.

Health Insurance Portability and Accessibility Act (HIPAA)

Federal Health Insurance Portability and Accessibility Act (HIPAA) regulations were promulgated in final form in March 2002 and are likely to have an impact on the way mental health information will be handled in the future. Not only are these regulations extremely complex, but legal experts disagree on their ramifications for prison and jail populations. Correctional administrators and correctional health officials should work with their legal counsel to familiarize themselves with these regulations and to consider their implications for their facilities.

n Identify appropriate technology and protocols for the development of an electronic patient records system.

Several jurisdictions have developed electronic data systems to improve records management and facilitate the instant flow of clinical records. To ensure a successful records transfer, electronic communication should be used in conjunction with the personal transfer of information between clinicians at the institutions. Officials should be mindful that most confidentiality regulations apply equally to paper and electronic records (HIPAA regulations specifically cover electronic records), and thus develop their electronic information protocols accordingly.

Example: Mental Health Record and Referral/Evaluation Systems, Michigan Department of Corrections

The Health Management Information System (HMIS) is a computer-based management system, which contains health care data for persons incarcerated in Michigan correctional institutions. Two mental health-related components of HMIS are the mental health record system and the referral/evaluation system. Staff from DOC Psychological Services and DCH Corrections Mental Health Program use these components. The Mental Health Record system enables mental health care services providers to systematically identify and track prisoners with mental illness at different levels and units within the correctional system. The referral and evaluation system ensures the identification and tracking of prisoner referrals for evaluations as well as the evaluation outcomes.

Example: Process of Transmitting Mental Health Treatment Histories of Inmates When Transferred to Other Facilities, New Jersey Department of Corrections

The New Jersey Department of Corrections uses an electronic medical record system that allows any professional health care practitioner within the Department to view any inmate's health record at any time. When an inmate is transferred from one facility to another, mental health professionals send an e-mail stating that the inmate has been transferred and the health record can be immediately accessed. Case conferences occur on the more difficult management cases.

Example: Interagency Case Conferencing, New Jersey Department of Corrections

When the New Jersey Department of Corrections participates in interagency transfers (e.g., between correctional and mental health agencies), it often organizes case conferences, in conjunction with the electronic transfer of data between the agencies, to enable clinicians from both sending and receiving institutions to meet to discuss and develop individual treatment plans.

State mental health agencies recognize the benefits to be gained from the development of an integrated and automated patient records systems that is operated system wide. The establishment of such a system is expensive, however, and the work on such systems in most states is far from complete. Indeed, implementation of electronic patient record systems is inconsistent across local agencies, making it impossible for state mental health authorities to gather complete information or to realize the gains that could be reaped from a state-wide system. Additionally, seemingly simple problems such as the incorrect spelling of a patient's name or an inaccurate social security number can create significant headaches for staff. In some states, efforts are under way to include state correctional agencies in the development of electronic patient/inmate record systems.

19

Subsequent Referral for Screening and Mental Health Evaluations

POLICY STATEMENT #19

Identify individuals who—despite not raising any flags during the screening and assessment process—show symptoms of mental illness after their intake into the facility, and ensure that appropriate action is taken.

Even when staff adhere to the most effective screening and assessment protocols, they may yet overlook a small proportion of inmates with mental illness that enter the facility. Some inmates, concerned about the stigma associated with mental illness, may conceal symptoms of their disease. In addition, inmates may not present symptoms of mental illness until they have been incarcerated for some time. In other cases, an inmate's mental status can change dramatically during the course of incarceration. The prison experience itself, and the inevitable exposure to intimidation, isolation, separation from family, violence, and sometimes victimization can precipitate serious depression or suicidal thoughts.

Furthermore, some inmates' symptoms may reappear as a result of change in medication, discontinuation of a prescription, or noncompliance with the treatment plan. In jails, offenders who are admitted directly from the streets are often under the influence of alcohol and/or other drugs. Once they are detoxified, mental illness symptoms can appear—sometimes several days later.

While it would be valuable to conduct periodic mental health screenings on all general population inmates, this is costly and rarely done in most correctional facilities. Nevertheless, there are several measures correctional administrators and mental health staff can implement, at relatively little cost, to identify these cases that may initially fall through the cracks.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** **Reassesses periodically the mental health status of inmates who are at the highest risk of showing signs of mental illness.**

Correctional mental health staff should incorporate regular, informal mental health screening into existing practices without burdening the service delivery system. Corrections administrators should also consider establishing a system

to code the mental health status (and risk of exhibiting signs of mental illness) of all inmates.

Example: Virginia Department of Corrections

Since 1992, all inmates in the Virginia correctional system are periodically assessed and a determination is made as to their mental health status and mental health needs. The determination is alphanumerically coded and sorted by the least to the greatest need for mental health services. The code is reviewed and, if necessary, updated annually. The code is used for programmatic and institutional assignments, as well as for release planning and community supervision.

Reassessing the mental health status of inmates enables corrections officials to maintain accurate, current data regarding the demand for services within the prison system, and it facilitates a projection of the need for community-based mental health services for inmates approaching their release date.

b **Conduct brief mental health assessments upon request of an inmate or by referral from any staff person.**

Prisons and jails should have effective mechanisms to permit and encourage inmates and detainees to self-refer for a confidential mental health assessment. Self-referral forms provided to inmates should be culturally sensitive and, given the generally low reading level of inmate populations, easily understandable. Institutional health staff might also consider instituting clinical rounds at intake facilities.

Example: Referral for Mental Health Services, Albany County (NY) Correctional Facility

The Albany County Correctional Facility utilizes a mechanism whereby facility staff, correctional officers, medical staff, inmate service unit staff, and the inmates themselves are able to put in requests for mental health contact. All written requests are followed up, and any inmate referred is seen face to face by a mental health staff member.

c **Minimize the stigma that staff and inmates may harbor regarding mental illness.**

Over the previous two decades, many corrections systems have successfully educated staff about HIV and AIDS, about how the virus is transmitted and how it is treated. Correctional systems should undertake a similar public health education initiative regarding mental illness. (See Policy Statement 30: Training for Corrections Personnel; also Policy Statement 32: Educating the Community and Building Community Awareness and Policy Statement 43: Advocacy, for more on stigma.)

20

Release Decision

POLICY STATEMENT #20

Ensure that clinical expertise and familiarity with community-based mental health resources inform release decisions and determination of conditions of release.

Inmates typically are released from prison through one of the three following ways:

- statutorily mandated release to supervision;
- discretionary parole; or
- mandatory release at the completion of a sentence without supervision.

Over the past two decades, numerous state legislatures have limited the discretion available to parole boards, or have eliminated discretionary parole altogether (see sidebar on following page).²⁰ A collateral consequence of limiting this discretion has been to reduce the opportunity to tailor release conditions for inmates who have a mental illness. In those states where parole boards still have some discretion, parole decision makers may be reluctant to exercise it when the potentially eligible inmate has a mental illness. Parole board members' lack of confidence in community-based mental health services also contributes to their reluctance to release from prison a person with mental illness. In the face of incomplete information, inadequate assessments, lack of confidence in community resources for this population, misconceptions about mental ill-

ness, or fear of a negative public response, parole board members may choose not to release the inmate, thereby compelling him or her to serve the maximum sentence allowed by law.

A study conducted in Pennsylvania illustrates this phenomenon. In 2000, 16 percent of all releasees in Pennsylvania served their maximum sentence. For inmates with mental illness, however, 27 percent served their maximum sentence; of those diagnosed as having a serious mental illness, 50 percent served their maximum sentence. Often, inmates with mental illness served their maximum sentence because they did not have an approved parole housing plan, which was due to the lack of housing, mental health, and substance abuse services available in the community, especially in rural areas.²¹

Determining the level of risk that an offender poses to the community is one of the central responsibilities of parole board members in making their decision as to whether to release an offender and the types of conditions of release that should be imposed. Even in states that do not have a discretionary parole system, corrections departments often use

21. From unpublished description of Forensic Community Re-Entry and Rehabilitation for Female Prison Inmates with Mental Illness, Mental Retardation, and Co-occurring Disorders program, courtesy of Angela Sager, grants manager, May 12, 2002.

a validated instrument to assess the risk of offenders who are eligible for release. These corrections departments and releasing authorities, however, rarely take into account factors involving the person's mental illness.

The recommendations that follow describe how to address these obstacles that impede effective release decision making: 1) the lack of professional,

clinical expertise as part of the prerelease consideration process; 2) the lack of sufficient, reliable information regarding the treatment history and needs of the offender; and 3) the lack of sufficient community-based resources and options for this population.

RECOMMENDATIONS FOR IMPLEMENTATION

a Develop guidelines regarding release decisions that address issues unique to inmates with mental illness, and consult with mental health professionals during the decision-making process.

State statutes and administrative orders, usually in the form of structured parole release guidelines, generally frame the parole board members' decision-making process. Such guidelines typically address the general offender population only, however, without recognizing the special needs of offenders with mental illness. For example, a person whose mental illness is particularly serious may have been unable to participate in job-training classes or other inmate programming opportunities that would improve the likelihood of the inmate's timely release. Existing guidelines, however, typically emphasize participation in such programs as nearly essential for release.

Many states are beginning to employ validated risk assessment instruments that can help guide their estimation of the potential risk offenders pose to the community upon release. As with structured parole release guidelines, however, employing risk assessment instruments designed for the general offender population may not adequately take into account the circumstances of offenders with mental illness. In fact, no known risk assessment instrument has been validated by research to predict accurately the nexus between mental illness and risk.²²

Until corrections systems develop or replicate such an instrument, they should rely on mental health experts to evaluate the instruments they are currently using to ensure that they take into account mental health issues appropriately. In addition, releasing authorities should engage appropriate mental health professionals to assess on a case-by-case basis offenders' mental health and potential risk. At least four states (Washington, Florida, Kansas, and Nebraska) require, by statute, evaluation of the mental health status of all in-

22. Polly Phipps and Gregg Gagliardi, *Implementation of Washington's Dangerous Mentally Ill Offenders Law: Preliminary Findings*, Olympia, WA: Washington Institute for Public Policy, March 2002, Appendix G.

mates prior to release to the community. Three of these states further require the development of individualized treatment plans and the identification of programs and resources in the community to carry out such plans.

Releasing authorities should enlist the support of a mental health professional to assist in conducting the hearing, reviewing the inmate's medical history within the institution, assessing the specific challenges he or she will face when returning to the community, and identifying community resources to help address the offender's needs.

Example: Pre-Release Risk Assessment, the National Parole Board of Canada

The National Parole Board of Canada incorporates psychological and psychiatric assessments into its risk assessment procedure, when appropriate, for all offenders being considered for parole. Certain categories of offenders receive mandatory prerelease psychological assessments, including those who have exhibited persistent or gratuitous violence or those serving indeterminate of life sentences. Offenders who have undergone treatment while incarcerated are required to have a post-treatment report completed by a psychologist, case manager, or program officer to address any changes of risk. A supplemental prerelease assessment is required only if the post-treatment report is considered insufficient to address the offender's progress. Psychiatric assessments are required for any offender with a life or indeterminate sentence seeking parole. Other issues that the parole board considers include the effects of any current medications prescribed, the risk if the medication is no longer used, and the programs and interventions in the community that will help the offender have a successful reintegration.

Example: Contract for Risk Assessment Services, Missouri Parole Board

The Missouri Parole Board contracts for independent mental health assessment services to assist in identifying risk associated with the release of persons with mental illness. The contract includes provision for the board to consult in person with psychiatrists when seeking information on particular cases, should they desire to do so.

b Develop protocols to share information and resources among parole agencies, departments of corrections, and mental health organizations.

The value of risk assessments for inmates with mental illness depends on the quality of information regarding an offender's mental illness and the assistance of a clinician to evaluate and interpret that information for a releasing authority. Nevertheless, releasing authorities (especially parole boards) report considerable difficulty in gaining access to this information or mental health expertise.

Terms of Release

Prior to the late 1970s, most prisoners were offered conditional (i.e., supervised) release through the decisions of parole boards that assessed individual risk and took into account behavior in prison. During the 1980s and 1990s, parole fell out of favor and at least 40 states passed "truth-in-sentencing" laws intended to lessen the disparity between the sentence imposed and the time actually served. In 1990, 39 percent of inmates were released via parole board decisions; by 1998 that fraction had dropped to 26 percent. Inmates are increasingly likely to leave prison after mandatory release, which is determined by statute or sentencing guidelines, not panel or board decisions. From 1990 to 1998 the rate of mandatory releases rose from 29 percent to 40 percent of prisoners. In addition, the rate of unconditional release (i.e., requiring no supervision) rose from 16 percent to 24 percent of prisoners during the same period. Though parole has decreased in popularity, in most states the parole reforms have not been retroactive, so many prisoners continue to be eligible. Many states also continue to perform some kind of supervision of prison releasees. The term "community corrections" refers to the multiple supervision strategies employed by different states including, but not limited to, parole.²³

23. Travis et al., *From Prison to Home*, p.14.

Parole officials typically rely on correctional health officials for information regarding an offender's mental health. Such information, however, is often dated and incomplete. Mental health information from community-based treatment agencies and providers would provide releasing authorities with a greater understanding of the inmate's mental health history. To that end, releasing authorities should enter into agreements with mental health organizations to ensure the confidential and appropriate sharing of information regarding a person's mental illness.

Several state parole boards have addressed these issues by collaborating with their counterparts in the state mental health agencies.

Example: Memorandum of Understanding Between the New York State Office of Mental Health and New York State Division of Parole

In 1994, the New York State Office of Mental Health and the New York State Division of Parole signed a Memorandum of Understanding (MOU) to identify and better serve people with mental illness. The MOU enhanced coordination of mental health evaluations for the board of parole; increased discharge planning for inmates with serious mental illness; implemented mental health training for parole officers; and established a Dedicated Parole Caseload initiative.

Example: Multidisciplinary Team, Missouri Parole Board

The Missouri Parole Board employs a specially trained staff person who sits on a team with institutional staff to develop a continued-care plan for inmates with mental illness. The continued-care plan is holistic, addressing all areas of the offenders' life connected to his/her success in the community. The program consists of both an institutional and a community release center phase. The institutional phase lasts for four months and selected inmates spend two months in the community phase for a combined minimum of six months. The program is used by the parole board as a pre-release planning mechanism, as well as an alternative to revocation for those who are parole violators.

Example: Forensic Mental Health Coordinating Council (UT)

In 2002, the Utah legislature expanded the membership and scope of the Mental Health and Corrections Advisory Council and renamed it the Forensic Mental Health Coordinating Council. The Forensic Mental Health Coordinating Council includes representatives from the Department of Human Services Division of Mental Health, the State Hospital, the Board of Pardons and Parole, the Attorney General's Office, Department of Corrections (DOC), Services for People with Disabilities, community mental health agencies, Division of Youth Corrections, and the state court administrator's office. The council was formed to develop policies for coordination between the Division of Mental Health and the Department of Corrections, advise the DOC on care for inmates with mental illness, promote interagency communication around issues of mental illness and mental retardation, address civil commitment issues, and oversee coordination of services and placement options for particular individuals.

Example: Texas Council on Offenders with Mental Impairments (TCOMI), Post-Release Aftercare

The TCOMI's Continuity of Care (COC) program provides a pre- and postrelease aftercare system for all offenders with special needs released from TDCJ jails and prisons. By identifying offenders prerelease who will need aftercare treatment, the chances for a more successful reintegration into the community are improved. When these offenders are identified prior to release, conditions may be imposed by the parole board or the courts that require mandatory participation in mental health treatment or other similar rehabilitative programs. TCOMI has set up a regionalized continuity of care system. Now, instead of a worker having to make repeated trips across the state, his/her counterpart in that area conducts the prerelease activities. This strategy is being implemented on a statewide basis. The majority of offenders released from TDCJ facilities are returned to communities where TCOMI and, in some cases, parole jointly operate community-based treatment programs. As a result, offenders are immediately enrolled in treatment services that are targeted exclusively for them, thus eliminating service delays. This approach, which was centrally developed but regionally implemented in association with community-based service providers, exemplifies what can be accomplished when interagency partnerships and cooperation are established at both the state and local levels.

"Offenders with mental illness will likely fail attempts at community supervision unless the conditions of probation or parole placed on them are realistic, research-supported and relevant considering their specific needs and capacities."

CARL WICKLUND
*Executive Director,
American Probation and
Parole Association*

Source: Personal
Correspondence, May 29, 2002

C

Establish special conditions of release that are realistic, relevant, and research-based to address the risks and needs of parolees with mental illness.

Conditions of parole are the centerpiece of the release plan for a person reentering the community from prison under supervised release. It is essential, especially when the parolee has a mental illness, that these conditions of release be tailored to the risks and needs that the individual presents. A parolee should not be set up for failure; the conditions of release must be realistic and enforceable. If the parolee has a mental illness, board members must confirm that the services can be made available before imposing conditions of release that require participation in certain community-based programs or treatment, and that the parolee can meet those conditions.

While release conditions will vary depending on the risks/needs of the individual parolee, outpatient and inpatient treatment, and methods to assure that any necessary medications are taken should be requirements of any release plan for parolees with mental illness.

Example: Medically Recommended Intensive Supervision Program, Texas Parole Board

The Texas Parole Board works in conjunction with the Texas Council on Offenders with Mental Impairments (TCOMI) to identify offenders who are eligible for the Medically Recommended Intensive Supervision Program. A special mental health panel, comprised of three members, considers special release conditions for these offenders. The conditions are imposed when the board determines that a mental impairment contributed to the commission of the instant offense(s) or may adversely affect a parolee's potential for success after release. The components of the conditions call

for the parolee to participate in psychological or psychiatric evaluation, participate in mental health treatment, and use medication as proscribed by the attending physician or psychiatrist.

In some jurisdictions, parole boards have the discretion to refer offenders with mental illness for assessment, treatment and hospitalization. State law in Utah authorizes the Utah Parole Board to place parolees with mental illness in state hospitals for treatment as a condition of release if deemed medically necessary.

Access to income through a job or benefit program and to housing are other key factors that should be reflected in the conditions of release. (See Policy Statement 36: Integration of Services and Policy Statement 38: Housing, for further discussion of employment and housing programs for people with mental illness.)

d Ensure that the releasing authority can identify and obtain access to community-based programs and resources adequate to support the treatment and successful community reintegration of parolees with mental illness and that such programs and resources are available in the communities to which parolees return.

Lack of resources in the community is a major obstacle in addressing the special needs of this group of offenders. When asked, “What community resource is most lacking in regard to placing parolees back into the community?” state parole directors polled in the year 2000 identified the inadequacy of services for people with mental illness. The two resources they identified most frequently—housing and licensed substance abuse treatment—are key to successful community reintegration for parolees with mental illness.²⁴

For instance, paroling authorities are put in a difficult position when prerelease program staff at the prison recommend specific conditions of release that are difficult to implement or enforce, given limited resources available. In these situations, the releasing authority may be understandably reluctant to approve the inmate’s release. In some cases, the inmate’s release is delayed due to the lack of an appropriate placement plan until they have completed their sentence, causing them to return to the community without any structured plan or supervision. Such delays serve neither the offender’s treatment needs nor the interests of justice.

Before placing an individual in the community, parole board members need to be assured that the services required for the successful reintegration of the offender with mental illness are available in the communities to which they return. Most jurisdictions engage staff or consultants to the parole board to

24. Information gathered from an informal survey of state parole directors taken at the winter 2000 meeting of the Association of Paroling Authorities International, as

reported by Gail Hughes, director, private correspondence, 2001.

investigate and report to the board the existence and adequacy of local services. Boards need this assistance to help them know and understand the degree of mental illness, needed elements of a release plan to the community, and alternatives to revocation.

Example: Forensic Community Re-entry and Rehabilitation for Female Prison Inmates with Mental Illness, Mental Retardation, and Co-occurring Disorders, Pennsylvania Department of Corrections

Due to the lack of sufficient community-based mental health services and adequate housing, inmates with mental illness in Pennsylvania state prisons are significantly more likely than other inmates to serve their maximum sentence. In response to this problem, the Pennsylvania Department of Corrections (DOC) developed the Forensic Community Re-entry and Rehabilitation program, which is a collaborative effort between the DOC, the Pennsylvania Board of Probation and Parole (PBPP), and the Pennsylvania Community Providers Association (PCPA). The program will employ a community placement specialist to develop, in conjunction with the parole board and community-based providers, comprehensive transition plans and conduct follow up for program participants. When necessary, the program will provide transitional housing for up to 60 days. Once the offender is paroled, the placement specialist will conduct follow up interviews with community-based providers to monitor the offender's progress.

The program will be launched in May 2002.

e Train parole board members to increase their knowledge of the risks/needs of persons with mental illness and factors that mitigate that risk so release decisions and special conditions can be determined appropriately.

Parole board members should have some familiarity with the nature and types of mental illness, and how these disorders can be diagnosed and treated. Training curricula should be developed and, depending on the jurisdiction, tailored for individuals appointed to serve as parole board members, both for new appointees as well as on an annual or on-going basis for all members. (See Policy Statement 30: Training for Corrections Personnel, for discussion and examples of training for parole boards and parole officers.)

21

Development of Transition Plan

POLICY STATEMENT #21

Facilitate collaboration among corrections, community corrections, and mental health officials to effect the safe and seamless transition of people with mental illness from prison to the community.

This policy statement addresses transition planning for sentenced inmates with mental illness who are released from state prisons and county jails. These releasees include inmates with mental illness who will remain under some form of supervision by the criminal justice system and inmates with mental illness who complete their sentence while in prison or jail. (See Policy Statement 13: Intake at County / Municipal Detention Facility, for a discussion of transition planning issues unique to jail detainees.)

Comprehensive transition planning is of paramount importance—especially when the inmate will finish his or her sentence in prison and not be subject to conditions of release. For inmates with mental illness, whose community adjustment issues are even more complex than inmates in the general population, the need for systemic discharge planning is particularly crucial. For example, individuals with mental illness leaving prison without sufficient supplies of medication, connections to mental health and other support services, and housing are almost certain to decompensate, which in turn will likely result in behavior that constitutes a technical violation of release conditions or a new crime.

Engaging the personnel and resources of institutional corrections, community corrections, and community mental health providers in developing and implementing comprehensive transition plans for offenders with mental illness can maximize the likelihood of a safe and successful transition to the community. Release planning, in principle, can begin upon intake. In practice, jurisdictions initiate and engage in prerelease planning at different times prior to the release date (e.g., one year, six months), and prerelease planning intensifies as the inmate approaches the release date.

The nature and function of discharge planning for inmates vary significantly depending upon whether the individual is being released from a detention facility, a county penitentiary (following completion of a jail sentence at a county correctional institution), or a state prison.²⁵ The extent of postrelease criminal justice supervision prescribed for the inmate will determine the extent to which a plan can or will be developed collaboratively among criminal justice and mental health agency staff, as well as the possibility of treating the discharge plan as a condition of continued release.

25. In the case of the detainee, there is rarely any warning of the timing of his or her release, resulting in little or no criminal justice supervision following release. Oftentimes, the best that can be done is for the discharge planner to provide the detainee with referrals for use post-release. In such cases, the provision of ongoing

case management is unlikely. Issues related to release planning for pretrial defendants and defendants sentenced to time served are discussed in Policy Statement 13: Intake at County / Municipal Detention Facility.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** Identify transition planners in each institution and charge them with coordinating a case management process, which incorporates representatives of institutional corrections, community corrections, social service agencies, and community-based mental health providers.

The position charged with transition planning varies among corrections systems. In some jurisdictions, correctional staff provide both transition planning and case management services. The most common arrangement is for prison staff to assume the lead role in transition planning, with some assistance from community corrections staff; once the inmate is released, community corrections staff assume the case management responsibilities. Regardless of the specifics of the arrangement, collaboration between the various agencies and service providers who will be involved in the release, supervision, treatment, and support of the releasee is essential to a successful transition planning process.

Example: Forensic Transition Team, Massachusetts Department of Mental Health

The Forensic Transition Team program was established in 1998 to provide transitional release planning services for offenders about to be released from correctional custody. The Forensic Transition Team conducts client interviews of inmates identified by mental health staff and coordinates appropriate community mental health resources. Team members work with offenders at least three months prior to their release, providing them with case coordination and consultation to community providers for up to three months after release to address any obstacles to client community adjustment. Arrangement of programs, treatments, and social support services is done in coordination with criminal justice officials to address public safety concerns. The team collaborates both with institutional corrections authorities and with probation and parole officials to coordinate the linkages for offenders with mental illness to receive community-based services upon release. The Massachusetts Department of Mental Health maintains a statewide database to track the progress of offenders served by the program, as well as to inform further program development and research efforts.²⁶

One particularly promising, albeit uncommon, strategy is to have the transition planner working with the inmate during the last months of his or her incarceration continue as a case manager (coordinating the delivery of services and facilitating the person's compliance with conditions of release) after the offender's release to the community. As part of such a strategy, community-based agency staff, who will eventually provide postrelease case management, can be brought into the institution to work with institutional-based discharge planners in devising and carrying out a comprehensive case management plan.

26. Stephanie W. Hartwell, Donna Haig Friedman, Karin Orr, "From Correctional Custody to Community: The Massachusetts Forensic Transition Program," *New England Journal of Public Policy*, Spring/Summer, 2001, pp. 73-81.

Example: Women's Discovery and Safe Release Programs, Rhode Island Department of Corrections

The Women's Discovery Program is a voluntary substance abuse treatment program offered to all women incarcerated in Rhode Island state prisons. All inmates who spend at least 30 days in the Discovery Program are eligible for an additional component called Safe Release. The Safe Release Program provides mental health treatment services and specialized mental health discharge planning services to inmates with mental illness. Case managers from a local community-based mental health provider, the Providence Center, work with corrections staff to oversee the discharge planning for these inmates as well as providing post-discharge case management services for up to one year, thus ensuring continuity of care.

Regardless for whom the transition planner works, it is essential that he or she be required to coordinate a team of people who, collectively, represent the agencies and organizations whose support and assistance are essential to the successful implementation of the transition plan.²⁷ These agencies usually include, at a minimum, corrections, parole (or releasing authority), mental health agencies, housing, employment, health and welfare agencies and private providers of treatment and support services all have a part in the individual's life.

The collective participation of representatives of the community in the development of treatment plan—and their subsequent investment in its success—serves many purposes. First, it encourages coordination between local outpatient services and correctional facilities. Second, it promotes the mutual accountability of correctional administrators and mental health treatment officials for the treatment of offenders with mental illness. Third, it facilitates the sharing of important information regarding the treatment history of the individual and his or her progress following release.

Missouri employs multidisciplinary teams to assess clients, plan interventions, and carry out services for parolees both in the institution and in the community.

Example: Multi-disciplinary Team, Missouri Parole Board

The Missouri Parole Board has a staff person who sits on a team with institutional staff to develop a continued care plan for persons with mental illness. The continued-care plan is holistic in nature, addressing all areas of persons with mental illness offenders' life connected to his/her success in the community. Once planned, the multidisciplinary team oversees the parolee's progress and the delivery of services. The program consists of both an institutional and a community release center phase. The institutional phase lasts for four months and selected inmates spend two months in the community phase for a combined minimum of six months. The program is used by the parole board as a prerelease requirement as well as an alternative to revocation for those who are parole violators.

27. Individuals who are able to coordinate cross-systems activities such as transition planning are often referred to as boundary spanners. Boundary spanners must be able to understand and work within the different cultures, policies, and procedures of multiple areas (e.g., corrections, parole, and community mental health) and successfully bridge the gaps between different services systems that individuals

with mental illness often fall through. For more on boundary spanners see Henry J. Steadman, "Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems," *Law and Human Behavior* 16:1, 1992, pp. 75-86.

Successfully coordinating each of these teams and developing a transition plan that addresses the complex needs of people with criminal records who have a mental illness requires careful work and is extremely time consuming. Accordingly, the ratio of individuals conducting discharge planning and case management services to releasees should be low, ideally with caseloads no higher than 20 releasees per supervision officer.

b **Involve all relevant agents and individuals who will assist in carrying out the transition plan, including family members, in its development.**

If possible, all parties, including the inmate, should participate in a discharge planning meeting just prior to the inmate being released. This provides all parties with the opportunity to understand one another's roles and responsibilities set forth in the treatment and community integration plan, as well as to establish a working relationship to carry out the conditions of the arrangement. Ideally, family members should be part of this process. The offender or family may decline, however, especially if family members do not feel they are prepared to support the inmate upon his or her release.

c **Take steps to ensure that the inmate's release from secure housing to the community progresses in a gradual sequence of planned steps.**

Corrections systems have developed different approaches to ensure that an inmate's release into the community is gradual. In many state departments of correction, inmates nearing their statutorily mandated release date or those who have been granted a parole are assigned to prerelease programs. Some of these programs involve assignment to a prerelease housing unit either within a minimum-security unit or in a community-based setting (such as a halfway house). Correctional discharge planners assigned to these programs help make community contacts and referrals for housing, employment, and services.

d **Develop a transition plan that includes the inmate's assignment to a community-based provider whose resources and assets are consistent with the needs and strengths of the inmate.**

Transition planners' responsibilities include assessing offenders' needs and strengths and facilitating linkages to appropriate community-based services. Given the special needs of this population, transition planners need to be aware of what services are available in the jurisdictions they serve and which community-based mental health and habilitation services are necessary for the care and treatment of people with mental illness.

While institutional release planning staff reach out to identify resources in the community, it is equally important to establish a working relationship between the offender and a community mental health provider prior to his or her release to ensure continuity of care. As discussed above, encouraging and facilitating providers' access ("in reach") to the facility will foster community linkages and increase the likelihood that the offender will be engaged and served effectively upon his/her release from the institution.

Example: Dangerous Mentally Ill Offender Program (WA)

In 1999 officials in Washington State enacted legislation regarding "dangerous mentally ill offenders" released from Department of Corrections (DOC) facilities. The statute directed the Department of Social and Health Services (DSHS) and DOC to work together to expedite financial and medical eligibility for the offender and establish interagency teams for pre-release planning. The interagency planning teams include DOC Risk Management Specialists, a community corrections officer, a representative of the relevant Regional Support Network (RSN), representatives of community-based mental health and substance abuse providers, family members, and law enforcement. The interagency team begins to develop comprehensive release plans at least three months prior to release, including detailed plans for the 48 hours postrelease, service plans (housing, treatment, etc.), victim services, financial resources, and community corrections information. Case managers, community-based mental health and chemical dependency providers, and community corrections officers visit the offender where he or she is incarcerated, facilitating the development of relationships prior to release.

The case management plan should include dates, times, and locations for follow-up appointments with community supervision agencies and for appointments with treatment providers. Mental health case managers also can then be on hand to ensure that the releasee is engaged in the planned treatment and service programs and to monitor the initial delivery services.

Since such a large proportion of offenders with mental illness also have histories of substance abuse, it is likely that the community transition and case management plan will also include provision for substance abuse treatment (see Policy Statement 17: Receiving and Intake of Sentenced Inmates, for more on co-occurring disorder statistics in prisons; also Co-Occurring Disorders). Substance abuse treatment services may be provided at one site as part of a comprehensive program for dually diagnosed offenders. If substance abuse treatment is to be provided off site and/or by a separate agency, or if the releasee is to participate in 12-step or other community-based fellowship programs, the community-based case manager should also make arrangements for the offender to receive escort to initial meetings and appointments and ensure that engagement has occurred. Twelve-step fellowship programs, such as Alcoholics Anonymous and Narcotics Anonymous, provide escort services as part of their regional World Fellowship Networks. These organizations list local groups and fellowship networks in the white pages of regional phone books.

At a minimum, discharge planners can facilitate case conferences that include participating treatment and social service providers as well as the of-

"When I discovered that mentally ill inmates were dropped off in the middle of the night with two subway tokens and a few days worth of medication, I thought it was a joke. After all, what kind of system could be that apathetic to the needs of the mentally ill and society alike?"

KIM WEBDALE

Victim Advocate, NY

Source: U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*, September 21 2001

fender. When face-to-face case conference is not feasible (for instance, due to prohibitive distances between the institution and the home community), it may be conducted as a teleconference. A number of jurisdictions recognize the importance of case conferencing, and have taken steps to make sure that it occurs.

e

Integrate housing support services into the transition plan and provide releasees with mental illness an arrangement for safe housing or at a minimum, shelter.

Adequate housing is the linchpin of successful reentry for offenders with mental illness. Housing, especially when it is combined with support services, provides a stable base from which individuals can access treatment in the crucial days immediately succeeding release. Every person with mental illness leaving jail or prison should have in place an arrangement for safe housing (or, at the least, shelter).

Unfortunately, locating suitable housing for their clients is one of the greatest challenges for discharge planners and community-based case managers (see Policy Statement 38: Housing). They will need to know what type of housing arrangements are available in the communities they serve; how to make the appropriate connections between the offender and the landlord; and what provisions there are for indigents unable to pay the rent. Perhaps even more important, the discharge planners and community case managers must know how to overcome explicit or implicit prejudices and exclusions based on either mental illness or criminal history. For example, individuals convicted of certain violent, drug-related, or sex-related offenses are not eligible for federal housing subsidies.²⁸ Transition planners are likely to encounter considerable resistance from private-sector individuals and agencies, and, to be effective, will have to assume the role of housing and social services advocate for the releasee. At least one jurisdiction is developing a program to address this crucial issue.

Example: Parole Support and Treatment Program (PSTP), Project Renewal, New York City (NY)

Project Renewal is a New York City based nonprofit that provides an array of services for individuals who are homeless and have mental illness and substance abuse problems. The Parole Support and Treatment Program is a joint effort between Project Renewal, the New York State Office of Mental Health, and the New York State Division of Parole. The PSTP will provide 50 new units of transitional, supportive housing and intensive clinical services to newly released parolees who suffer from serious and persistent mental illness and co-occurring substance abuse disorders. The program will combine an “ACT-like” treatment team and 50 scattered-site supported transi-

28. Any offender who is subject to a lifetime registration requirement under a state sex-offender program is ineligible for public, Section 8, and other federally assisted housing. Similarly, anyone who has engaged in drug-related, violent, or other criminal activity that would “adversely affect the health, safety, or right to peaceful enjoyment of the premises” may be denied federal housing

assistance. The decision to deny this assistance is based on how recent the conviction for these crimes. See Legal Action Center, “Housing Laws Affecting Individuals with Criminal Convictions,” available at: www.enterprisefoundation.org/model%20documents/1150.pdf

tional housing beds. During their time in transitional housing parolees will work with the clinical team to transition into permanent housing, ranging from community residences to Section 8 apartments.

All individuals with serious mental illness leaving jail or prison should be physically transported to their housing arrangement or shelter and provided with a short-term supply of medication and a prescription (or provision) for long-term supply. In such cases, the mental health agency assigned to provide the offender with community services is the appropriate agency to provide transport from the jail or prison to the place where the offender will reside.

"If you have a schizophrenic walking the streets, do you think that person can hold themselves together until their benefits are reinstated?"

DAVE BRENNAN

Salt Lake County Mental Health Director, UT

Source: Amy Joi Bryson, "Jails of the mind: End of incarceration brings end of meds—and new problems," *Desert News*, Sunday, May 19, 2002,

f **Make arrangements for at least a week's supply of important medications, along with refillable prescriptions, to be provided to inmates at the point of release.**

Offenders should have an adequate supply of essential psychotropic medications upon their release. They should be given at least a seven-day supply and prescriptions sufficient for the period up to when entitlements may reasonably be expected to be reinstated, typically within 90 days after release to the community. States that contract with private correctional health care providers for the provision of institutional health care should include in their contracts a requirement that these extra medications are provided to discharged inmates. Also, if it has not already been done by agents of the detention or corrections authority, the community-based agency or case manager responsible for the released offender should take steps to reinstate the individual on Medicaid in order to pay for necessary medications.

g **Develop a process to ensure that inmates eligible for public benefits receive them immediately upon their release.**

Community-based mental health providers are reluctant to provide services to people with criminal records for numerous reasons. Near or at the top of this list of reasons is this population's inability to pay for treatment. State and county government officials attempting to control the explosive growth of health care expenditures routinely warn providers about delivering services to individuals who ultimately do not qualify for federal benefits; providers will not receive back-payments for the delivery of these services. Given the crushing demand that they are attempting to accommodate, providers are understandably hesitant to deliver services to a person who does not have health insurance and whose eligibility for public benefits is not immediately apparent.

Corrections administrators and health officials can take several steps to facilitate inmates' participation in federal benefit programs (see Appendix C: Explanation of Federal Benefit Programs). First, state officials should require

corrections staff to distribute to inmates information and application forms for all relevant federal and state benefit programs, including Medicaid; federal SSI and SSDI benefits; Temporary Assistance to Needy Families (TANF); food stamps; veterans programs; and state general assistance. Staff should provide additional assistance, and in general pay particular attention, to subsets of the inmate population with mental illness who are especially likely to qualify for benefit programs, including those who meet the following criteria: 1) received federal benefits at the time of incarceration; 2) have very low incomes, particularly those under age 21; 3) are veterans; or 3) are parents of children under 18 and likely to be custodial parents upon release.

Example: Partners Aftercare Network (SPAN), San Bernadino (CA)

This initiative established a multi-agency team whose purpose is to link inmates with serious mental illness to needed mental health services upon their release from jail. The aftercare management team serves as a “bridge” between custody and community integration by providing, among other things, financial advocacy to assist clients in obtaining Social Security and medical and other benefits.

Second, appropriate authorities should establish a process through which the state Medicaid agency will accept applications from inmates while they are still in custody and will process these applications in a timely manner to ensure that those found potentially eligible are then able obtain access to the benefits immediately upon release. Corrections administrators must appreciate the difficulty in timing a person’s participation in benefit programs. Accordingly, corrections officials should inform local social security offices and the state Medicaid agency as early as possible of the exact date of release of inmates who qualify, or may qualify, for benefits.

Example: Medicaid Reenrollment for Inmates at Hamden County Correctional Center (MA)

At Hamden County Correctional Center, discharge planning begins at least three months before an inmate’s scheduled release. The mental health treatment division in the jail employs one social worker who focuses on discharge planning for inmates with mental illness. The discharge planner helps inmates to apply for Medicaid, SSI, Mass Health, and other appropriate entitlement programs. The goal is to have inmates considered eligible for entitlement programs at the time of their release.

In establishing this process, corrections administrators should work with local mental health authorities to arrive at an agreement regarding diagnoses of people who are disabled and therefore may be eligible for SSI (and, by extension, Medicaid). Corrections administrators should also assist inmates in applying for state identification cards, which will be provided upon the inmate’s release. Without such proof of identification, it is nearly impossible for a person to avail him or herself of many benefits or services.

Several federal benefit programs are particularly relevant for people with mental illness who will be released from a corrections facility: Supplemental Security Income (SSI) disability benefits; Social Security Disability Insurance (SSDI); Medicaid; Medicare; Temporary Assistance for Needy Families (TANF); Food Stamps, and Veterans Benefits. Implementing the recommendations under this policy statement requires an understanding of who is eligible to participate in these programs and how they qualify. These complex issues are described in Appendix C, a reprint of a policy brief that the Bazelon Center for Mental Health Law published. Recommendations regarding Medicaid eligibility of pretrial detainees who were enrolled in Medicaid immediately prior to their incarceration appear in Policy Statement 13: Intake at County / Municipal Detention Center.

h Notify the victim before the offender is released from prison, consistent with the requirements of the state's law or constitution, prior to release.

The vast majority of states have a statute or a constitutional amendment requiring that the victim be notified before the offender is released from prison.²⁹ Regardless of whether the inmate to be released has a mental illness, releasing authorities and correctional staff must comply with victim notification requirements.

Efforts should be made through correctional crime victim specialists and community-based crime victim agencies to reach out to crime victims and inform them of the pending release date of those who have victimized them, to educate them as to the decisions being made on behalf of the offender, and to provide them information about the measures being taken to ensure their safety.

"Our treatment programs tell us that...the *single* issue that is an impediment to the continuity of care is Medicaid eligibility."

GARY FIELD

Administrator, Counseling and Treatment Services, Department of Corrections, OR

Source: Interview, January 11, 2002

i Monitor the inmate closely in the days approaching release and modify the discharge plan when appropriate.

Successful implementation of the transition plan is usually contingent on the following:

- updated examinations, which closely reflect the status of the inmate's mental health and psychotropic medication requirements on or near the release date;
- cooperation among at least two agencies to enable representatives from one agency to navigate another system credibly; and
- provision of a mental health status evaluation for the purpose of risk assessment and/or supervision. (See Policy Statement 19: Subsequent Referral for Screening and Mental Health Evaluation.)

A mental health professional should conduct a mental health assessment of the inmate at a point just prior to release to ensure that the discharge plan is fully adequate to addressing the inmate's current needs and circumstances. If it is not, the mental health professional should work with the releasing authority to modify the discharge plan accordingly.

j Provide enhanced discharge planning, including extensive coordination with the community treatment provider, to ensure continued case management for inmates with mental illness who will complete their sentence in prison.

Approximately one out of every five sentenced inmates in the United States is released from a correctional facility without any continued community-based

²⁹. See National Center for Victims of Crime, *Crime Victims Source Book*, Section 3, Right to Notice.

supervision.³⁰ These inmates complete their sentence in prison because, through the abolition of parole and other measures, state law prohibits the release of an offender from prison before his sentence is completed or because releasing authorities denied the inmate's request for release. Due to disciplinary histories and reluctance of authorities to release people with mental illness to the community before their sentence has expired, issues discussed earlier in this report, the percentage of inmates with mental illness who complete their sentence while in prison is probably greater than the 20 percent figure that applies to all general population inmates.³¹ (See Policy Statement 20: Release Decision.)

Offenders with mental illness released to the community without community supervision are particularly difficult cases to manage, both because supervision and participation in treatment and social service programs are completely voluntary and because many newly released offenders resist services and treatment. For those releasees who are unwilling to seek traditional mental health system services, an approach to consider is to link them to consumer-run programs, like a drop-in center, or to create peer (i.e., individuals with mental illness who has themselves once been incarcerated) contacts for outreach. Such programs or outreach provide contacts, appropriate socialization experiences, and can link individuals to services once they are ready. (See Policy Statement 39: Consumer and Family Member Involvement.)

Releasing authorities should strongly encourage offenders with mental illness to continue services after release, as well as encourage the community mental health programs as much as possible to conduct active monitoring and outreach to recently released offenders referred to them and otherwise attempt to provide such services.

Absent criminal justice oversight and supervision, referral to community-based mental health case management and advocacy programs is perhaps the best recourse. Again, reaching out to community-based organizations and agencies that would serve this population and facilitating their access to the institution/inmate prior to release will enhance the likelihood that an individual, upon release, would seek out services. It is also an attractive alternative to and adjunct of criminal justice supervision since community mental health case management services are often eligible for Medicaid reimbursement. (See Chapter VII: Elements of an Effective Mental Health System, especially Policy Statements 36, 37, and 39, for further discussion of mental health case management services.)

30. Travis et al., *From Prison to Home*, p. 15.

31. Based on the time of admission to the time of expected release, offenders with mental illness were expected

to spend 15 months longer in state prison than were offenders without mental illness. Ditton, *Mental Health and Treatment*, p. 8. See also note 21.

22

Modification of Conditions of Supervised Release

POLICY STATEMENT #22

Monitor and facilitate compliance with conditions of release and respond swiftly and appropriately to violations of conditions of release.

As explained earlier in this report, approximately 80 percent of sentenced inmates are released under some form of community supervision.³² Successful completion of a period of community supervision is particularly difficult for offenders with mental illness. The transition planning process described in the preceding policy statement often is not in place, and people with mental illness who are released from prison sometimes wonder whether they have been set up to fail. They must find a mental health provider willing to deliver services to a person who not only has a criminal record but who also is (often) without the resources to pay for treatment and has yet to demonstrate eligibility for Medicaid. Oftentimes, when a provider does accept a parolee, the person with the criminal record learns that he must identify a second provider who will treat his or her substance abuse problem.

Offenders with mental illness recently released from prison also must find housing and, despite not having any savings or a paycheck, pay the first month's rent in advance. Furthermore, to maintain some form of public assistance, they need to demonstrate that they are actively seeking a job. Yet

few employers are willing to hire anyone with a criminal record, and the stigma that surrounds mental illness compounds the problem. Overcoming these obstacles to successful reintegration into the community, while attempting to coordinate appointments in a schedule already crowded with meetings with a supervision officer, a mental health clinician, and a peer substance abuse support group is nearly impossible—and especially so for someone without access to transportation. Not surprisingly, these individuals often return to the types of criminal behavior that originally prompted their incarceration.

Community corrections officers also feel like they have been presented with an impossible situation. With caseloads sometimes reaching into the hundreds, supervision officers are without the time or resources to facilitate an offender's compliance with conditions of release. Furthermore, they are unable to observe the offender closely either to gain an improved understanding of the individual or to spot dangerous behavior.

At the same time, parole administrators are under significant political pressure to hold parolees accountable for violations of conditions of release

32. Travis et al., *From Prison to Home*, p. 20.

and to ensure that a parolee does not become a front-page news story. The absence of coherent policies regarding parole revocation decisions for parole violators who have a mental illness exacerbates the problem.

Given this situation, supervision officers often respond to any violation of supervision by recommending the reincarceration of the offender. Although in many cases these violations (“technical violations”) do not constitute a new crime, they demonstrate behavior (e.g., homelessness, substance abuse, lack of employment, or failure to take medication) to a community corrections officer that indicates the releasee is returning to a lifestyle that, if not changed, will result in recidivism. As a result,

many such parolees are returned to prison not for new offenses but rather for technical rule violations—such as missed appointments with a parole officer or testing positive for substance abuse.

Recognizing the complexity of this task, and the extent to which supervision officers lack many of the resources they need to perform their responsibilities, the following recommendations for implementation explain the value of tapping community-based resources such as mental health providers and family members. They also outline elements of a collaborative relationship among these entities, with the aim of encouraging an offender with mental illness to comply with conditions of release and to hold him or her appropriately accountable.

RECOMMENDATIONS FOR IMPLEMENTATION

a Assign small, specialized caseloads of parolees with mental illness to parole officers who have received advanced training in mental health issues.

As discussed in the preceding policy statement, people with mental illness released to the community usually have a long, complicated list of needs; monitoring and facilitating the releasee’s progress in the community is a complex, time-intensive responsibility. It is unrealistic to assume that, in their current situation, community corrections officers will have the time or the expertise to devote to all these cases.

Specialized training for these supervision officers is essential (see Policy Statement 30: Training for Corrections Personnel). Supervision officers who are trained and experienced in working with offenders with mental illness are much more likely to be attuned to available treatment options, signals of distress, and signs of decompensation. Under these circumstances, supervising officers are much more likely to seek out and arrange revised treatment options and other relevant remedies in lieu of issuing a warrant and instituting violation proceedings that would likely result in reincarceration. It is also worth noting that parole officers who seek specialized training are especially interested in working with this population and thus are likely to engage them in a particularly constructive way.

Example: Specialized Caseloads, New York State Division of Parole

The New York State Division of Parole (DOP), in conjunction with the New York Office of Mental Health (OMH), has established specialized caseloads in certain metropolitan areas to service parolees with mental illness. Parole officers in this program receive specialized training on mental illness and carry a reduced caseload of approximately 25 cases. The specialized parole officers work with community mental health agencies to link parolees to appropriate services. (See also Policy Statement 20: Release Decision, for more on collaboration between the New York DOP and the New York OMH.)

Example: Special Management Unit, Connecticut Board of Parole

The Connecticut Board of Parole has established a Special Management Unit to supervise parolees requiring ongoing intensive supervision or specialized treatment. The unit focuses primarily on supervision of paroled sex offenders but also works with parolees with severe mental illness. Special Management Unit parole officers receive training in supervision and in medical, and mental health issues and maintain a caseload of no more than 25 parolees. The unit emphasizes interaction between treatment providers and parole officers; officers participate in both group and one-on-one counseling sessions with offenders.

Small, specialized caseloads can also enable community corrections officers to develop effective working relationships with community service providers. Mental health providers, whose time and resources are already spread thin, are often untrained on how to take into account the criminal history (and the providers' obligations to the criminal justice system) of clients referred to them by the criminal justice system. (Training for mental health providers on working with criminal justice populations is essential to address this issue. See Policy Statement 31: Training for Mental Health Professionals.) Some community-based mental health providers, often citing liability concerns, explicitly refuse to serve individuals with criminal histories.³³ (See Policy Statement 1: Involvement with Mental Health System, for more on access to services and priority populations.)

In rural jurisdictions, where there may not be enough offenders with mental illness to merit a specialized caseload, supervision officers at a minimum should receive orientation and training to monitor and assess offenders on their caseloads who have mental illness. Like their urban counterparts, they should be prepared to make appropriate referrals in the event of new problems and/or technical violations rather than relying on revocation of parole. The availability of specialized services and resources for offenders in rural jurisdictions poses difficult transportation issues. Rural jurisdictions may be able to establish special services, transportation, and supervision arrangements in facilitating collaboration between criminal justice agencies and mental health service providers or other social service providers for whom the parolee is a member of a shared population.

33. According to Doug Bray, Court Administrator, Multnomah County, Oregon, community-based service providers' refusal to serve individuals with criminal records

contributed to the founding of the Multnomah County pretrial diversion program. Information provided in private correspondence, May 7, 2002.

b Encourage community corrections staff to conduct field supervision and other monitoring responsibilities within the communities, homes, and community-based service programs where the releasee spends most of his or her time.

Supervision officers should maintain contact with ex-offenders in their communities rather than monitoring them remotely from a centralized office. Community-based supervision enables the officer to monitor the offender more closely, thus improving the officer's familiarity with the unique obstacles that often impede the released offender's compliance with the conditions of his/her release. In addition, frequent contact with mental health treatment providers improves supervision officers' understanding of these services. It can also help them ascertain whether mental health treatment providers are offering the services needed.

In addition to the benefits derived from close community monitoring of ex-offenders, there has been some recent success in community mapping. Following the example of crime mapping in law enforcement, some jurisdictions have begun to use similar mapping techniques to identify specific districts and neighborhoods where significant numbers of ex-offenders are located. This information may be used to design community-based initiatives focusing on these neighborhoods. Such a technique might be used to identify clusters of offenders with mental illness who live in specific neighborhoods and where specialized field supervision and mental health services might be located and deployed. The mapping function can be a collaborative effort as well between criminal justice providers and social service agencies, with the dual benefit of collaboration and a work product in the end useful to all parties involved.

c Work closely with mental health administrators and providers to ensure that parolees receive services and resources specified in community reintegration and supervision plans.

The successful reintegration of offenders with mental illness back into the community depends, in large part, on their ability to obtain access to a range of mental health and related services. Oftentimes, it is the lack of adequate mental health resources—within both correctional institutions and the community—that impedes the decision to release offenders with mental illness who might otherwise be eligible for release. Those offenders with mental illness who are released to supervision are often required to maintain some level of mental health treatment. If mental health service providers do not make adequate services available to the offender, he or she may be violated and unnecessarily reincarcerated.

Institutional corrections, parole boards, and community corrections agencies can encourage mental health agencies and providers to provide adequate services through improved cross-system collaboration. The Texas Council on Mentally Ill Offenders (Policy Statement 20) and the Washington Dangerous Mentally Ill Offender Program, and Massachusetts Forensic Transition Team (Policy Statement 21) all help community corrections agencies work together with mental health service providers to ensure that offenders under community supervision receive the services that they need. The Rhode Island Fellowship Health Resources program is a similar model of collaboration between corrections and mental health providers.

Example: Fellowship Community Reintegration Services (RI)

Operated under contract with the Rhode Island Department of Mental Health, Retardation, and Hospitals by Fellowship Health Resources, a nonprofit agency, Fellowship Community Reintegration Services (CRS) provides discharge planning and advocacy for released offenders to ensure that they receive appropriate community placements and services as well as assistance with applications for entitlements and any needed education or employment referrals. Clients may be placed in any of a variety of community agencies, including residential substance abuse treatment facilities, or may be placed on home confinement with provisions made for service delivery. Fellowship CRS tracks its clients for one year postrelease to gather outcome data and determine the appropriateness of available placements.

"We would never tell a man with a broken leg, 'we'll give you treatment if you walk to the hospital.' Yet we tell a person in the most severe throes of mental illness, 'we'll give you treatment if you first think your way there.'"

CARLA JACOBS

*Board Member,
National Alliance for
the Mentally Ill*

Source: *Los Angeles Times*,
Monday, August 3, 1998

d **Ensure that released offenders are connected to a 24-hour crisis service.**

Crisis services provide community corrections officers with a quick intervention that enables them to respond effectively—without depending on reincarceration exclusively—to address technical violations, such as a missed appointment, of conditions of release. Correctional mental health professionals maintain that this type of brief intervention during points of crisis will reduce subsequent (and likely more serious) violations of conditions of supervised release.³⁴

e **Establish protocols to share information between community supervision agencies and community mental health providers regarding compliance with conditions of release.**

For community corrections officers to develop confidence in a community-based service, they must trust that providers will inform them about behavior that constitutes violations of conditions of release. At the same time, providers

34. Gary Field, Administrator of Counseling and Treatment Services, Oregon Department of Corrections, private correspondence.

do not want to be in a position of monitoring a parolee's conditions of release; that would likely undermine their relationship with the client.

Various jurisdictions have developed compromises between community corrections agencies and service providers, which enable both groups to adhere to their responsibilities.

Typically, community corrections officers do not need or want detailed information about the mental health treatment process. What they are most interested in are brief progress reports, and to be notified about behaviors that violate conditions of supervision. A transition plan should involve a written release from the offender, permitting mental health providers to share this information with community corrections agencies. (See Policy Statement 25: Sharing Information.)

Example: Forensic Transition Team, Massachusetts Department of Mental Health

The Forensic Transition Team in Massachusetts ensures that offenders participating in the program sign a release that allows open communication between mental health providers and parole staff. No information is exchanged without a written release except as required under mandatory reporting statutes. Parole field-staff are often involved in a primary way with treating staff upon release. Occasionally they are invited to case conferences or other gatherings of the treatment community to offer oversight on a case. In general, the parole officers are most interested in compliance with treatment as part of the conditions of release.

f

Develop a range of graduated sanctions to compel (and incentives to encourage) compliance with conditions of release.

Community supervision staff members need to be prepared to address the needs of the offender with mental illness who may be unable to comply with the traditional mandates of community supervision. Although reincarceration of the offender may be the most expedient response in the short run, it may not be the best use of criminal justice resources or, in the long term, be the response most likely to prevent the person from reoffending. Absent new criminal behavior by the probationer or parolee, alternative responses should be considered. Incarceration should be reserved for those cases that represent a threat to public safety.

To provide the most effective intermediate sanctions, criminal justice officials should develop agreements with case management service providers, advocacy organizations, specialized employment/vocational providers, crisis services, and mental health treatment programs to provide support for individuals with mental illness when problems arise. If a probationer or parolee with mental illness decompensates considerably after his or her release, increasing treatment should be considered prior to recommending the offender be returned to

custody. Providing aggressive treatment may stabilize the offender's mental condition much more effectively and economically than reincarceration.

Offenders with mental illness who are returned to the community may need more intensive services and supervision than originally planned prior to their release, particularly in relation to their reaction to the stresses of returning to the community. An effective approach to violations of conditions of supervision is to increase gradually the level of treatment intervention in combination with a graduated series of predetermined responses (rather than violating them immediately upon the first technical violation). There should be some flexibility for the officer to use a reasonable level of discretion while maintaining program consistency.

Agencies such as New York City's Center for Alternative Sentencing and Employment Services (CASES) provide interagency case planning and management services for "special needs" offenders, such as offenders with mental illness, who are in jeopardy of parole revocation due to noncriminal violations of conditions of community supervision.

Example: Parole Restoration Project, Center for Alternative Sentencing and Employment Services (CASES), New York City (NY)

CASES recently developed the Parole Restoration Project for technical parole violators incarcerated in New York City jails whose parole status would otherwise be revoked. The project attempts to increase the number of special needs parole violators returning to parole community supervision instead of state prison. The project's clients include substance abusers, people with a mental illness, people with co-occurring disorders, and women. Project staff identify eligible participants, assess their treatment needs, link them to community-based service providers, gain support for the treatment plan from parole field staff and assigned counsel, submit a comprehensive report to the administrative law judge and the board of parole advocating for restitution of parole under the recommended treatment program, and coordinate the release and monitoring of compliance.

Other agencies, such as the Cook County, Illinois, Department of Adult Probation and the Maricopa County, Arizona, Probation Office, employ a graduated ladder of sanctions and special, individualized services for probationers or parolees with special needs. Still others, like the Hawaii Paroling Authority and the Kentucky Department of Corrections, offer a structured living environment to parolees with mental illness where care, treatment, and housing are provided.

Incentives and positive reinforcement can also be useful tools in helping offenders with mental illness adhere to the conditions of their release.

Example: Dangerous Mentally Ill Offender Program (WA)

As part of the Dangerous Mentally Ill Offender legislation, Washington State appropriated additional funds to support the transition of offenders with mental illness back into the community. Regional Support Networks, components of the Washington mental health system, have used a portion of these funds for incentives (such as new clothing) as a means to increasing compliance with treatment plans.

23

Maintaining Contact Between Individual and Mental Health System

POLICY STATEMENT #23

Ensure that people with mental illness who are no longer under supervision of the criminal justice system maintain contact with mental health services and supports for as long as is necessary.

People with mental illness who come out of prison must have access to services they need to reintegrate into community settings successfully. The preceding policy statement discusses the importance of collaboration between mental health and community corrections agencies in ensuring that individuals with mental illness who are granted supervised release receive appropriate mental health services. This policy statement addresses the role of the mental health system in providing services and support for individuals released from prison who are no longer under continued supervision from the criminal justice system. This group includes those who have completed their sentence in prison or jail and are released without conditions as well as those who have successfully met the conditions of release and are no longer under supervision in the community.

Once offenders have completed the terms of their sentence or conditional release, ongoing monitoring by and reporting to the criminal justice system is neither warranted nor justifiable. However, in light of the high recidivism rates of offenders with mental illness, it is crucial that the mental health system maintain contact with individuals who have been incarcerated to prevent their renewed involvement with the criminal justice system.

As is true of anyone with mental illness attempting to live independently in the community, offenders have basic needs for housing and supports that must be adequately met if reentry is to succeed. By ensuring access to appropriate services and necessary supports, especially housing, and by developing and utilizing mechanisms to ensure ongoing contact, community mental health providers can play an important role in successful community reintegration of former prisoners who have mental illness.

Community mental health providers must be attuned to the special needs and circumstances of released offenders with mental illness and provide services that enhance their ability to live independently. By identifying recently incarcerated clients with mental illness as a “special needs” or “priority” population, community providers can develop treatment plans and provide services that ensure monitoring and outreach to fit an individual’s circumstances.

While services available to released offenders ultimately may not need to be more intensive than those available to other clients, mental health care providers should be prepared to help these clients meet challenges related to the transition to commu-

nity life. Treatment and rehabilitative models such as Assertive Community Treatment should be employed when appropriate to monitor the client's transition and address problems that could lead to rearrest and incarceration (see Policy Statement 35: Evidence-Based Practices, for more on Assertive Community Treatment). Special attention should be given from the outset to provision of rehabilitative services that will both address specific needs and help establish a routine for the released offender attempting to grow accustomed to new freedom.

Mental health providers have both an opportunity and an obligation when an offender with mental illness is released from prison. The opportunity arises from the fact that, unlike those people with mental illness with no prior criminal justice contact who seek services, released offenders with mental illness will have treatment histories and may have additional incentives to engage in care. Their criminal histories and service provision while incarcer-

ated are relevant to the mental health system in effectively designing an individual treatment plan. Whether an offender will be supervised in the community or released unconditionally, communication between the systems is key. (See Policy Statement 20: Release Decision and Policy Statement 21: Development of Transition Plan.)

It is the providers' obligation to seize the opportunity and to provide the services needed to ensure that the released offender does not return to the criminal justice system because services were not available, accessible, or effective. For mental health service providers to meet their obligation to people with mental illness who are leaving prison, sufficient resources must be made available to fund effective services and programs. Success in this endeavor should result in a reduction in demand for crisis services as well as in recidivism and the resultant drain on criminal justice resources. . (See Policy Statement 1: Involvement with the Mental Health System.)

RECOMMENDATIONS FOR IMPLEMENTATION

a Develop mechanisms to engage ex-offenders with mental illness who have been released to the community.

Systems need to be in place to allow mental health and social service providers to coordinate with correctional and law enforcement agencies prior to and following the release of people with mental illness from correctional facilities. At a minimum, this means that community service agencies should be informed of the impending release of prisoners with histories of treatment for mental illness while in prison who will not be under community supervision. Mental health service providers should then maintain records documenting contact and treatment subsequent to release. There is no reason for these records to differ in form or content from the records kept on contacts with any community client.

Depending on the system configuration, a community reintegration program may require considerable spanning of both jurisdictional and systemic boundaries. Incentives should be created for the community providers to do "inreach" to the correctional setting and begin the process prior to release. Ex-offender contact information following release should be explicitly defined and

a mechanism should be developed for locating individuals who do not keep their first scheduled appointment.

The “moment of release” from prison is often a crucial juncture in an offender’s transition back to life in the community. This is especially true for offenders with mental illness; it is important that these individuals are connected as seamlessly as possible with housing and services. Mental health providers should be aware of the importance of the period immediately following a prisoner’s release and work with corrections officials to develop transition plans, even for individuals who will not be under community supervision, that provide detailed strategies for the first days after a prisoner’s release. Responsibility to assume care of the individual between the time of release and the first outpatient appointment must be explicit. This initial period of reintegration provides an opportunity for the mental health system to engage former prisoners from day one. (See Policy Statement 21: Development of Transition Plan.)

b **Develop programs to provide appropriate levels of service and supports to ex-offenders with mental illness who have re-entered the community.**

Ex-offenders with mental illness return to the community burdened by a double stigma. The problems posed by their criminal history and mental health condition to finding housing and employment have already been discussed. More subtly, their status as ex-offenders with histories of mental health treatment can affect their social networks and family relationships as well, often leaving them in the same social situation that led to their arrest in the first place.

People with mental illness emerging from prison also frequently report particular discrimination on the part of the mental health service community. In many instances, mental health providers are reluctant to take on the perceived risks associated with clients who have criminal histories, especially if they include violence.³⁵

It is important that programs be developed to meet the specific needs of offenders with mental illness who are transitioning from prison to the community. Correctional settings have had the responsibility for screening and identification of mental health issues as well as for providing treatment while incarcerated. After those functions, the principle transition planning responsibility is to establish linkages between the ex-offender and future community services. Working partnerships among probation, parole, the courts, neighborhood businesses, community housing organizations, and service providers can provide

35. Erik Roskes and Richard Feldman, “A Collaborative Community-Based Treatment Program for Offenders with Mental Illness,” *Psychiatric Services* 50:1, 1999, pp. 1614-19.

opportunities for the released offender to participate in restorative and therapeutic activities and community service projects. Transition planning is equally important for individuals who will not be under community supervision as it is for those who will have some conditions placed on their release.

Programs serving released offenders need to develop a broad menu of services that can be matched to offender needs. The service array should include attention to housing, health care, medications, case management, employment, income supports and entitlements, food and clothing, transportation, and child care. The result should be a community-based mental health service and support program that does not differ greatly from any intensely monitored community treatment program. If it is staffed by knowledgeable professionals and client-centered in its approach, it will best meet the needs of the released offenders with mental illness it serves.

Mental health staff need to be prepared to work with individuals who have been involved in the criminal justice system. This requires training that will help to overcome the stigma attached to incarceration, address the special needs of individuals who have been incarcerated, and promote appropriate coordination with criminal justice agencies. (See Policy Statement 31: Training for Mental Health Professionals.)

Mental health service providers should also consider encouraging development of a system of peer support for ex-offenders with mental illness. Finding that one is not alone in facing identifiable challenges associated with reentry can itself be an important support for men and women with mental illness coming out of prison. Peer support of this nature provides a ready and accepting social network, while those who have shared the experience can offer advice and suggestions likely to be received positively by the reentering ex-offender. (See Policy Statement 39: Consumer and Family Member Involvement, for more on peer services.)

C**Develop an understanding of the factors leading to community re-integration success or failure for clients with mental illness who have been released from prison.**

Much is already known about the factors that affect a client's chances of establishing him or herself in the community upon release from prison. For instance, many clients have an immediate need for income-assistance, so re-establishment of benefits is an important step to be addressed at the earliest possible opportunity. Similarly, safe, affordable, permanent housing is closely correlated with success in the community. For almost all persons with mental illness leaving prison, addressing housing needs must be seen as a high priority.

Maintaining contact between the mental health system and individuals who have entered it from prison also provides opportunities for other factors to be more clearly understood. It is important for the community provider to understand the factors that led up to arrest. The planning of effective services involves attention to these matters to ensure services are delivered that reduce the likelihood of rearrest. Community providers must incorporate this understanding into an individualized treatment plan. The needs of a mother who has been incarcerated for crimes directly related to substance abuse will necessarily differ from those of a young male imprisoned on a personal assault conviction. It is important for any service provider to systematically evaluate its approaches, and in this area especially it is necessary to build training curricula on the experiences of those staff, clients, and families attempting to bridge the worlds of prison and mental health. In a well-functioning system, recognition of individual needs will come with experience, and responsiveness will thus become more effective.

Example: Massachusetts Forensic Transition Program, Massachusetts Department of Mental Health

Operated by the Massachusetts Department of Mental Health (DMH), the transition program is a statewide initiative that assists DMH-eligible preadjudicated and convicted inmates. It provides tracking and release planning services. Program staff collaborate with relevant departments, agencies, and vendors to facilitate the transition of ex-offenders with mental illness into communities across the state. They work with inmates with mental illness in correctional facilities at least three months before release to coordinate relevant psychosocial and criminal information for the transition and treatment planning process after release. Staff also provide case coordination and consultation to community providers for up to three months after release to address any immediate obstacles to client community adjustment. The Forensic Transition Program works with inmates who will be under community supervision as well as those who have completed their sentence.³⁶

By maintaining contact with recently released offenders with mental illness and providing effective services for them, community mental health providers demonstrate their willingness and ability to perform an important public safety function.

36. Hartwell et al., pp. 73-81.

