# REENTRY PLANNING FOR OFFENDERS WITH MENTAL DISORDERS

## Policy and Practice

**Edited by**
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*To the dedicated professionals I've met over the years working in correctional institutions. They toil each day with little recognition, knowing all the while that our society would be better off if the need for their services were less pressing. And, as always, to Luisa, Isaac, and Noah.*

# Acknowledgements

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# Introduction

## PROLOGUE

Much has changed since I first started working in this field in 1981. At that time, there were just over half a million people incarcerated in the United States on any given day. Public awareness of the human and fiscal costs of incarceration was limited. The same was true of the large number of people with mental disabilities who found themselves confined within correctional institutions—"out of sight, out of mind" was the prevailing view. Rehabilitation was widely seen as a naive, failed approach. Those in charge of public policy were embarking on a little-questioned policy of mass incarceration, seemingly with little regard for the cost. The desire to appear "tough on crime" was instrumental to the development of sentencing guidelines and parole policies that emphasized fixed and longer periods of confinement.

Around that time, I was privileged to be part of a team employed by a local voluntary medical center working in partnership with a large city's department of health, charged with developing a system for the identification, stabilization, and short-term treatment of people with mental disabilities entering a busy intake jail. Many inmates were suicidal, and, in the preceding years, too many inmates had in fact taken their own lives. A large percentage had serious medical problems, and many were addicted to drugs; many of these people had spent the night before their arrest in places unfit for human habitation such as vacant buildings or abandoned cars. We noticed that many had not been receiving psychiatric treatment before being incarcerated, but we focused on the fact that this meant that many were in an acute (untreated) condition. We took note of the frequent lack of family or other social supports, aware that this might elevate the risk for suicide, but failed to look further into the long-term consequences of this observation.

Those of us involved in what, for the time, was an innovative project were initially satisfied with our ability to institute a successful system to identify those at greatest risk, engage in crises intervention, and dramatically reduce the number of inmates who were so despairing that they saw suicide as the only viable option. In retrospect, what was missing was an ability to put all these pieces into a coherent whole. The multiproblem nature of the population, coupled with a deep social disruption, lack of connection to treatment, and the means to pay for needed treatment in the community meant far too often only one thing: Despite our collective best efforts (and, in saying that, I include the inmates themselves), people were reincarcerated again, and again, often returning in severely decompensated condition. Seeing people with whom I had spent many hopeful hours discussing plans for a more productive future return to the jail's intake area, so ashamed that they would not show their faces, convinced me that something more was required. The importance of planned reentry, while obvious in retrospect, was unrecognized at that time.

In the decade since leaders in the field lamented the lack of attention paid to reentry, much has changed.[1] We see many studies documenting the high rates of serious mental illnesses among what are now 2.3 million people incarcerated on any given day in our country. While estimates of prevalence vary widely depending upon definitions and methodology employed, one recent, rigorous study using stringent criteria put the estimate of current serious mental illnesses for male jail inmates at 14.5 percent, with a 31.0 percent rate for women.[2] Further, there is broad, bipartisan acceptance that, at least in theory, planning for a prisoner's almost inevitable return to society is sound public policy. Approximately 750,000 inmates are discharged back to our communities each year. Once out, this group does not fare well. One recent study of a large prison system found that inmates with major psychiatric disorders (major depressive disorders, bipolar disorders, schizophrenia, and nonschizophrenic psychotic disorders) had substantially increased risks of multiple incarcerations over the six-year study period.[3] This highly elevated risk of reincarceration calls out for additional research and an eclectic, creative approach, particularly when seen in the context of research indicating that mental illness per se is not a major risk factor for recidivism.

Clearly, there is a growing consensus that new approaches to diversion, reentry, and preparation of the offender to lead a productive, lawful life upon release from confinement, as well as modified methods of community supervision, are necessary. This is in part connected with the staggering costs associated with this fourfold increase in inmate population. We can no longer afford to ignore this issue; business as usual will not suffice. Mental health treatment for incarcerated people with mental illnesses is inextricably bound with reentry planning. By the same token, reentry and retention go hand in hand. Without programs designed to reintegrate released offenders into their communities, reentry planning is an empty exercise.

## WHERE DO WE GO FROM HERE?

As the diverse, thoughtful, interdisciplinary chapters in this book reflect, this growing awareness is taking place on many fronts. The mass incarceration of so many people with mental disabilities presents opportunities related to public health, public safety, compliance with legal and professional standards, and the responsible stewardship of public funds. The policies described above led to the large-scale incarceration of many people; caught within this web were many with severe mental illnesses. While jails and prisons were the first to feel the pressure, the rising tide spilled over into communities next. Beginning around 2000, the first wave of prisoners sentenced under the new laws began to be released. Communities saw severely mentally ill ex-prisoners with profound deficits and minimal life skills. The agencies and organizations designed to serve them were overmatched. The breadth and depth of the needs of offenders with mental illnesses who cycle rapidly through jail or are released from prison makes them heavy resource users. This problem is exacerbated by discontinuity of treatment and when

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[1] Joan Petersilia, "Prisoner Reentry, Public Safety and Reintegration Challenges," 81 *Prison J.* 360 (Sept. 2001).

[2] Henry J. Steadman et al., "Prevalence of Serious Mental Illness Among Jail Inmates," 60 *Psychiatric Servs.* 761 (June 2009).

[3] Jacques Baillargeon, et al., "Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door," 166 *Am. J. Psychiatry* 103 (Jan. 2009).

the released offender does not have the means to pay for needed treatment or housing. Each individual may require the sustained attention of at least three agencies.

Concern over the fiscal as well as legal, public health, and public safety consequences of these policies converged, leading to a nationwide reexamination of how we handle crime. States and municipalities are at the forefront of this change because they had to do something to respond to a dire situation in their communities. The corollary of the dramatic rise in the incarcerated population is that a large number of offenders are released from jails and prisons every year.

Further change is afoot in the legislative and executive branches of state governments across the United States. During the past fifteen years, many states and municipalities changed their approach to handling offenders with mental disorders released from jail or prison. Those reforms are not necessarily comprehensive. Some take the form of demonstration or pilot projects; others are under way in a single county or a region to provide information to policy makers intent upon making wide-ranging changes. Counties have made improvements in handling offenders with mental illnesses by integrating not just services, but the agencies and organizations that provide services to this group. Information sharing, a unified records system, and reorganizing to share staff and funds among systems have helped some counties and regions manage offenders with mental illnesses.

As this book went to press, federal initiatives to revamp the criminal justice system, including aspects that bear directly on offenders with mental disorders, were under way. State and local changes will be aided by shifts in federal funding and incentives. Many will continue the direction in which they are moving, but their paths will be smoothed. Departments of parole and probation, for instance, will be one locus of change. The goals of probation and parole have shifted markedly over the past twenty years. For instance, the goal of community supervision is to retain offenders in the community rather than assuring the swift imposition of consequences that typically include return to custody. The policies of some states are outmoded. Many states rely upon a mix of old and new approaches but lack a set of widely embraced, coherent goals. This shift can be constructive for offenders with mental disorders and the entities charged with monitoring and serving them because the emphasis is on maintaining offenders in the community and imposing sanctions that further the goal of community reintegration.

Entities charged with protecting public safety, providing health care, and administering justice often have divergent goals. This at times leads to a lack of coordination. Sometimes the problem may be one of simple communication—for example, corrections and community-based treatment providers sometimes seem to be speaking a different language. Regardless of cause, the visible signs of failure have become inescapably obvious over the past twenty years, most prominently the mentally disordered citizens with criminal records who struggle to survive in the community without access to adequate housing or treatment. That group is a direct result of the mismatch between bureaucratic organization (and funding sources) and how basic services are best provided to the neediest citizens. One overarching flaw is the assumption that the same organizational structure that facilitates sensible governance would also be a good vehicle for the delivery of services to the most troubled citizens with pressing unmet needs. Multiple, uncoordinated organizations serving a single recipient have, not surprisingly, proven to be an ineffective management strategy and have resulted in the widely deplored revolving door.

In order to deal effectively with this small group of high-needs offenders, states and municipalities must abandon the traditional separation between public health and public safety. One mission statement, identical goals, and a single set of policies, regulations, and practices must be adopted across the board to prevent publicly funded entities from working at cross-purposes. Community reintegration offers a pathway for states and municipalities to revamp their approach. A unified, collaborative, coherent approach that builds upon current structures and incorporates empirically supported practices can be devised. A small group that includes representatives of all three branches of government—legislative, executive, and judicial—and that maintains a narrow focus can develop a better way for a state or a municipality to handle the small proportion of offenders who are seriously mentally ill and who will remain so after release to the community.

A number of states have benefited from an empirical analysis of current trends and practices. In many instances, the imbalance of expenditures on incarceration in relation to other public spending forced a reexamination of business as usual and led to a number of changes. Some states use outside agencies to assist them in revamping parts of their criminal justice system. Collaborative assistance offered by a number of public and private organizations and agencies that offer expertise in policy analysis and policy change has resulted in empirically based policy changes. Typically, states form a working group small enough to be nimble and narrowly focused but large enough to include all three branches of government as well as agencies charged with public safety and health care. The state's work group typically collaborates with an external work group. The Bureau of Justice Assistance, the Council of State Governments' Justice Center, the Pew Charitable Trust's Center on the States, the National Institute of Corrections, and the Substance Abuse and Mental Health Services Administration (SAMSHA), through the GAINS Center, among others, provide such collaborative assistance.

Jurisdictions across the nation struggle to improve this situation within their means. Early on, states shared information with one another about how they dealt with the problems posed by reentry, and, in collaboration with private and public entities, disseminated for general use findings and recommendations based on their experiences.[4] Although every state is unique, common findings emerged. The cost of longer sentences and larger numbers of prisoners has broken, or threatens to break, state budgets. Protecting public safety and handling a larger proportion of offenders in the community are compatible. Back-end sentencing is proving to be an unexpected but significant factor in rising corrections costs. Fiscal responsibility and public safety depend upon putting more resources into community reintegration of offenders released from prison and maintaining those on parole outside rather than returning them to custody. The basics are a parole/probation system that shares these goals and adopts regulations that further them, plus housing, treatment, and meaningful daily activity that are accessible to released prisoners.

The reentry plan should attempt to provide for an orderly transition to community life. Ideally, housing would be available, and services must be in place. Public safety and public health systems must develop connected infrastructure. The internal infrastructure carries out the goals of the government and integrates the operations of disparate agencies and their programs. The infrastructure of the community, which includes housing, health care, and other necessary services, must be structured to serve

[4] Council of State Governments, *Criminal Justice/Mental Health Consensus Report* (June 2002).

the whole person and should be seen a part of the continuum of care that, unfortunately, will frequently include corrections-based providers of care. Agencies, not just the services they provide, must be integrated in order to meet the needs of the community as well as the offenders who reside there.

Offenders with mental disorders, although a small subset of all offenders released from jails and prisons, are among the most visible offenders in the community. They have the greatest need for assisted reentry planning and community reintegration. Historically, this group falls through the cracks between agencies. Many individuals in this group do not receive the services that are required for successful community integration; too often, they receive treatment in emergency rooms or upon rearrest. Furthermore, by virtue of their disability, many do not take the initiative to seek the services they need; many cannot advocate for themselves. This is compounded by an understandable mistrust of "the system" and points to the importance of peer and consumer involvement in the process. Because mental illness waxes and wanes, it is not uncommon for people with serious, chronic conditions to exhibit fluctuating capacity to conform their actions to expected standards of behavior. Attempts to maintain continuity in performance or remain in compliance with a set of expectations, no matter how reasonable or therapeutic, are eventually thwarted. Offenders whose levels of adaptive and intellectual functioning are low may manifest different disabilities. They may, for instance, have a deficit in initiative or self-advocacy but maintain consistency of performance. A reentry plan must consider each individual's constellation of strengths and weakness as well as accurately assessing the person's basic needs. It must also consider the practical needs of the individual upon release. A fair examination of some instances of inmates with mental disabilities refusing to participate in reentry plans can tie this lack of "cooperation" with a quite rational decision that the proposed plans do not meet important postrelease needs.

## ESSENTIAL ELEMENTS OF REENTRY PLANNING

Two invaluable resources are the Urban Institute's compilation of research findings and programs and the Reentry Policy Council's comprehensive, user friendly report that offers step-by-step guidance.[5] The Reentry Policy Council was established by the National Council for State Governments to continue helping states develop better reentry strategies. Planners can choose from a number of reasonably good community reintegration models; nearly all include these elements:

- *Transition planning.* In jails, reentry planning begins at intake. In prisons, it typically begins in earnest 150 to 180 days prior to release. In cases of rapid cycling through jails and prisons, planning should not be scrapped upon discharge but continued in anticipation of the next admission. Planning for offenders with a pattern of rapid cycling may require a discharge planner with specialized training employing a modified approach.

[5] Justice Policy Center. *Understanding the Challenges of Prisoner Reentry: Research Findings From the Urban Institute's Prisoner Reentry Portfolio,* http://www.urban.org/UploadedPDF/411289_reentry_portfolio.pdf; Council of State Governments, Reentry Policy Council, *Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community* (Jan. 2005).

- *Risk assessment, required if offender is released on probation.* Results may inform housing or treatment options.
- *Housing.* Community reintegration depends upon permanent housing. An array of sophisticated services cannot compensate for lack of housing. Residential treatment programs have beds for only a fraction of offenders with mental disorders released to the community. Shelters and other emergency measures are not equivalent to permanent housing. Transitional housing is less effective than permanent housing.
- *Benefits.* Timely and complete applications for benefits, benefits to which many individuals in this group are entitled, must be filed with their consent and on their behalf by staff that know how to file successful applications. Follow-up is usually required and should be done by qualified staff.
- *Release of medical information.* Accurate health care information should be conveyed to community providers shortly before release, provided consent is obtained. Offenders with serious mental disorders, substance abuse problems, medical problems, or all three, should have a summary of needs, diagnoses, current medication, and recent history of treatment on file with their community treatment providers.
- *Supply of medication.* Upon release from jails or prisons, offenders with mental illnesses should be provided with a supply of medication that will last a few days beyond their first appointments with providers.
- *A fixed appointment with a health care provider should be arranged.*
- *A fixed appointment with the supervising agent, such as parole agent or case manager, should be made.*
- *Planning must be individualized.* There is no one-size-fits-all approach. Incarcerated people with mental illnesses are neither symbols of "all that is wrong" with our society's problem with criminal behavior, nor are they objects reflecting society's discrimination against marginalized groups. Rather, they are individuals—someone's son, daughter, mother, or father, some of whom have committed serious crimes causing great pain to others, some of whom have not—each with his or her own unique strengths and disabilities. A successful reentry plan is tailored to the person in his or her community, not to the symbol or the organization.

All offenders with mental disabilities who may be eligible should apply for benefits and entitlements or apply for their reinstatement to the extent practicable. Constraints associated with incarceration as well as functional impairment conspire against accurate and timely completion of paperwork. Staff inside the institution should attempt to ensure that paperwork is complete and filed well in advance of release from prison, or, in jail, it should be completed as lengths of stay hit trigger points that affect suspension and reinstatement of benefits.

At a minimum, reentry planning for all offenders with mental disabilities who may be eligible should include obtaining the requisite consent and efforts to file for Social Security disability benefits, veterans' benefits, state-sponsored medical benefits; making an appointment for mental health follow-up; and conveying pertinent clinical

information. If the disability is primarily intellectual and adaptive functioning is low enough, reentry planning must involve the state agency that serves individuals with developmental disabilities. If requirements include an evaluation for eligibility or enrollment, arrangements must be made to have the evaluation completed well before the release date so that reentry plans are informed by actual rather than theoretical services and options. Some jurisdictions use an in-reach model; reentry planning is done by community-based staff sent into correctional facilities to help disabled offenders file for benefits and to perform intake evaluations.

The offender and ultimately society at large will benefit if staff view advocacy as part of their role when working with inmates who are genuinely eligible for benefits. It is not easy to apply for public benefits. Advocacy is as important as accuracy and timeliness in completions of required paperwork. A large proportion of persons with mental disabilities have skills deficits in the area of self-advocacy. Monitoring applications, correcting the inevitable errors introduced during processing, filing appeals, and complaining about delays is as essential as filing the paperwork in the first place. Absent diligent follow-up and vigorous advocacy, the resources expended assessing needs, obtaining accurate information, and filing applications will, in some instances, be wasted.

## FAILED REENTRY PLANNING/COMMUNITY REINTEGRATION

The omission of any one of the above elements (see "Essential Elements of Reentry Planning") may be pivotal in a particular case, setting off a chain of events that leads to recidivism. On the whole, however, the bulk of persons with mental disabilities who return to custody did not commit a new crime. Most return to custody due to poorly functioning systems. Lack of communication or miscommunication between parole agents, parole boards, and judges is one cause of recidivism. Overreliance on violations, particularly technical violations, coupled with lack of intermediate or remedial sanctions sends tens of thousands of offenders back to jail or prison each year. Additional systemic factors are too few health care or mental health professionals to honor appointments, poverty, erroneous denial or lengthy delays in services, and poor access to community resources.

## ORGANIZATION OF THE BOOK

As it is hoped the above makes clear, any meaningful reentry initiative must revolve around one core concept—integration: integration of the returning individual to the community, integration of corrections-based mental health care with community treatment, and the inter- (not "merely" multidisciplinary) approach that follows. The nature of this book reflects the broad approach that is needed, from scholarly research to consideration of the very specific personal reactions and experiences of individuals. That is why the reader will find book chapters contributed by judges, lawyers, economists, advocates, consumers, social workers, psychologists, and psychiatrists.

The book is divided into three parts. The first five chapters in Part 1 deal broadly with policy issues whether they be the role of the courts and a sentencing judge, the legal mandates related to reentry, the specifics of obtaining needed benefits, or the role of advocacy in improving society's response to this problem. The five chapters in Part 2

explore model approaches to reentry with this population. Whether it be Critical Time Intervention, forensic assertive community treatment, or consideration of an approach that takes the correctional environment and its effects into consideration, the insights discussed in the chapters on substance abuse and the consumer's perspective are relevant to them all. Finally, the chapters in Part 3, which describe an approach taken in one reentry prison in Australia and recent, relevant research, point again to the importance of a broad approach culling useful ideas from not only disparate disciplines, but also from different countries, always guided by scientific research. While I have emphasized a particular outlook in this introduction, ultimately, it is evidence-based approaches that should be employed.

The distinguished authors of the chapters in this book have made important contributions not just to this project, but to their respective fields—and they took the time to do so out of schedules already packed with pressing commitments. Their dedication speaks for itself, as does their scholarly work. Thank you to them all.

—Henry A. Dlugacz
October 2009

# About the Editor and Contributors

**Henry Dlugacz, M.S.W., J.D.,** is an attorney and social worker who has devoted most of his career of almost thirty years to correctional mental health and reentry issues. He is a clinical assistant professor of psychiatry and behavioral sciences at New York Medical College and an adjunct professor of law at New York Law School and St. John's University School of Law. Cofounder and former cochair of the New York State Bar Association's Health Law Section's Committee on Mental Health Issues, he is the former director of mental health of the St. Vincent's Hospital Prison Health Services in New York City. Prior to these experiences, Mr. Dlugacz provided direct clinical treatment and assessment services on both an inpatient and ambulatory care level to people with mental disabilities confined in the New York City correctional system.

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**Herman Joseph, Ph.D.,** currently retired, was employed since the 1960s in drug research and program planning within the New York City Department of Probation, the Rockefeller University, and the New York State Office of Alcoholism and Substance Abuse Services (OASAS). Among his many accomplishments, Dr. Joseph organized the first methadone maintenance program in probation, which treated about 1,000 addicted probationers, and in the south Bronx the first Vocational Guidance and Employment Service for probationers with the Federation Employment and Guidance Service. At Rockefeller University, Dr. Joseph organized and directed the first major follow-up study of methadone patients who were discharged from treatment. His work in the substance abuse field has included major program development within the New York City jail system, including the Key Extended Entry Program (KEEP) program. With Pathways to Housing and OASAS staff, Dr. Joseph helped to initiate the first housing program for homeless methadone patients with serious mental problems known to the NYC jails. Dr. Joseph is the author of numerous articles about heroin addiction, methadone treatment, pain management, the homeless population, the HIV/AIDS epidemic, and the criminal justice system, along with books on related topics. He has lectured extensively in the field. Dr. Joseph has received various awards and grants related to his work in this area, including Aaron Diamond Grants and the Nyswander-Dole Award for his work in methadone maintenance treatment. In 1999, Dr. Joseph received a proclamation from Michael A. White, the Mayor of Cleveland, for his overall work in addiction treatment and criminal justice.

**Sarah Kerr, J.D.,** has been a staff attorney at the Prisoners' Rights Project (PRP) of the Legal Aid Society in New York City since 1994, litigating federal court civil and disability rights impact litigation cases that challenge human rights abuses experienced by persons confined in jail and prison. Her work currently focuses on the treatment of prisoners with mental illnesses in the New York State prison system including the statewide litigation, *Disability Advocates, Inc. v. New York State Office of Mental Health, et al.,* 02 Civ. 4002 (S.D.N.Y.) (GEL).

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**C. Terence McCormick, M.S.W., M.P.A.,** has been involved in jail diversion, reentry planning, and community services for persons with mental illnesses in the justice system for twenty-five years. He implemented the first mental health court in New York and was the lead consultant in the New York State (NYS) Medication Grant Program as well as numerous consumer and family initiatives to promote consumer integration into the community. He has worked with the National Institute of Justice (NIJ), the

Council of State Governments (CSG), the Technical Assistance and Policy Analysis (TAPA) Center, and currently works with the Justice Mental Health Collaboration Project, the Howie the Harp Forensic Peer Specialist program, and the National Alliance on Mental Illness-New York State Criminal Justice Family Advocacy Program.

**LaVerne D. Miller, J.D.,** is a lifelong New Yorker who believes that recovery from mental illness is possible. She currently works as a senior project associate with Policy Research Associates in Delmar, New York, providing technical assistance and support to the nine states that received federal mental health transformation state incentive grants. Ms. Miller is a graduate of Stuyvesant High School and the University of Pennsylvania. In 1986, she received her Juris Doctor degree from Northeastern University School of Law in Boston Massachusetts. Since 1997, she has been involved on policy-making levels in efforts to develop comprehensive alternatives to incarceration and to create employment opportunities in human services for individuals with a history of mental illnesses and incarceration in jails or prisons. She believes that trauma informed care and peer support are critical to successful reentry. She believes strongly that consumers must be included in all efforts to transform the mental health and criminal justice system.

**Yvonne M. Perret, M.A., M.S.W., L.C.S.W.-C,** is a psychiatric social worker who has specialized in homelessness, serious and persistent mental illness, and co-occurring disorders for the past twenty-five years. She has worked in social work for the past thirty-three years and is a national expert in public benefits, especially Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). She ran an outreach project to adults who are homeless for ten years that has become a national model for assisting such adults with accessing Social Security benefits and using these benefits as a tool in beginning recovery. Ms. Perret is a partner in the federal SOAR initiative described in Chapter 3 in this book. Ms. Perret coauthored *Children with Disabilities: A Medical Primer,* with Mark Batshaw, M.D., and has presented frequently at national mental health and homelessness conferences.

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**Honorable Jack B. Weinstein,** is a senior U.S. district court judge of the Eastern District of New York, where he has served since 1967. He was a member of the Columbia Law School faculty. He has authored casebooks, multivolume treatises, and numerous articles, books, and legislative reports, most recently publishing *The Role of Judges in a Government Of, By, and For the People: Notes for the Fifty-Eighth Cardozo Lecture* (2008).

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