Slowing the Revolving Door: Community Reentry of Offenders With Mental Illness

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The war on drugs and the mandatory minimum sentences of the 1990s dramatically increased the population of persons incarcerated in the United States. As a result, with many inmates' sentences now expiring, offenders are leaving correctional facilities at unprecedented rates. Nearly 650,000 adults return to communities each year from state and federal prisons after serving time for major offenses (1). Even more persons are released from local jails, facilities that hold persons who are serving relatively short sentences or awaiting disposition of their charges. As is all too well known, most persons leaving prisons and jails are later returned to confinement. This column will discuss existing programs that help offenders with mental illness reenter the community and the importance of effective collaborations between criminal justice agencies and behavioral health providers.

Community reentry

Individually planned community reentry, a federal initiative that has continued through the 2000 administration change, seeks to reduce recidivism in a growing population with complex needs. Renamed the Serious and Violent Offender Reentry Initiative, formerly known as Going Home, the $100 million project led by the U.S. Department of Justice involves the Departments of Health and Human Services, Education, Housing and Urban Development, Veterans Affairs, and Labor (2). The initiative is designed to curb recidivism through collaboration among criminal justice and human service agencies at federal, state, and local levels. Related efforts have been undertaken by the National Institute of Corrections and such groups as the National Governors' Association and the Council of State Governments. Reentry is also the subject of unprecedented empirical and policy analysis by the Urban Institute and other highly regarded research organizations. Recently, the needs of reentering offenders with mental illness have received increasing attention and have been extensively discussed in the Council of State Governments' Criminal Justice/Mental Health Project Consensus Project Report, a groundbreaking effort of major stakeholders from both systems (3).

The U.S. Department of Justice estimates that approximately 16 percent of the population in prisons and jails have a serious mental illness (3). Most of these persons have little access to effective mental health services, a systemic issue with obvious relevance to community reentry. Discharge generally occurs without adequate arrangements to meet their needs, including treatment, supervision, and housing. In many cases, offenders are denied parole—that is, early release under law enforcement supervision—because the community mental health services that they need do not exist, resulting in their being discharged at the end of their sentence without any services or supervision. Whatever the circumstances, released offenders with mental illness often quickly experience the homelessness and behavioral problems that lead to reincarceration. Some of the released offenders return to prison on technical parole violations, such as having missed an appointment with a parole officer or failing to find employment, and others are incarcerated for committing new offences. All in all, unsuccessful reentry significantly compounds the offender's problems and is extremely costly to the community.

Offenders with mental illness who reenter the community, particularly those with co-occurring substance use disorders, obviously have complex needs. At the same time, public safety issues are a concern to all involved. Community mental health providers frequently feel ill equipped to serve this population. Staff of community mental health providers may be intimidated by dealing with parole agencies as well as with the numerous service agencies with which offenders may be involved; perplexed by confidentiality, treatment consent, and commitment laws; and concerned about their own safety. Reluctance to serve this population is common but seems to be decreasing. In addition, innovative programs do exist that help offenders with mental illness reenter the community.

In New York, for example, the State Office of Mental Health and the Division of Parole negotiated a workable memorandum of understanding. The memorandum delineates the shared responsibility for enhancing the coordination of mental health evaluations for parole decisions, increasing discharge planning for inmates with serious mental illness, and providing mental health training for all parole officers. Specialized parole officers, with maximum caseloads of 25, receive additional training to work with offenders with serious mental illness and with community mental health agencies.

In Massachusetts the Departments

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of Mental Health and Corrections have established a forensic transition program that provides inmates who have serious mental illness with individualized planning and support services three months before and three months after their release from prison. The program appears to be effective and, interestingly, a study of the program has found that almost one-fourth of the offenders had no contact with the mental health system before incarceration (4). This lack of contact suggests that prison's "case-finding" role, its propensity to precipitate mental illness, and other matters warrant research.

Among a number of initiatives undertaken in Texas, an agreement was reached between prison administrators and regional Social Security Administration offices. As a result, staff of the Texas Council on Offenders With Mental Illness assist inmates in filing for benefits—including Supplemental Security Income, Social Security Disability Insurance, and food stamps—three months before their anticipated release date (5).

Elsewhere, collaborations assist in providing transitional programming for women, specialized housing, assistance in accessing Section 8 apartments, and independent clinical assessments of individuals who are eligible for parole, including assessing the risk of medication noncompliance. Clearly, much is being accomplished through collaboration.

Discharge planning and services issues are also reaching the courtroom. In New York City a class action suit decrying the abrupt release of jail inmates with mental illness was resolved in 2003 by a settlement agreement. These individuals now receive medication, community service referrals, and assistance in obtaining Medicaid and housing (6). Soon after this settlement, a class action was filed against the Cook County Jail in Chicago raising claims of inadequate discharge planning, among others; that case is pending (7). In addition to litigating, advocates have published an excellent guide for criminal justice and mental health staff that explains offenders' eligibility for federal health care, income supplements, and veterans' benefits (8).

Successful individual reentry

The experiences of the programs that are listed above appear consistent with those of programs that provide assertive community treatment and integrated treatment for co-occurring mental and substance use disorders. Coordinated, comprehensive services can genuinely improve individual outcomes when key elements are addressed.

One key element is a written individual discharge plan that is collaboratively developed by the community and institutional staff, the inmate with mental illness, and, if possible, his or her relatives. It should provide for the inmate to have continuity of medication, appointments with community clinicians known to the inmate, income benefits, and health care after release from incarceration. Attention should be paid to personal identification, transportation, and other issues that arise in the first days after release. Housing is a difficult but not insurmountable problem. The Nathaniel Project in New York City, which successfully serves offenders with mental illness and serious charges, works diligently to establish close relationships with housing providers and to secure funding to develop its own specialized housing stock (9).

Integrated treatment for mental illness and co-occurring substance use disorders is clearly needed by many individuals who are leaving incarceration. Hopefully, the efforts of the federal Substance Abuse and Mental Health Services Administration in this area will soon increase service availability. Connections to one-stop employment offices are also important. Communication among all agencies must begin long before the inmate's release date and must produce discharge plans with explicit expectations for each agency.

The second key element is clarity among corrections and mental health staff about their respective duties in monitoring the person in the community after reentry. Parole and service providers must know who is responsible for what—for example, case management, medication compliance, and monitoring drug and alcohol use—and how each will be handled—for example, through home visits, day reporting, phone contact, and checking that appointments were kept, and checking that urinalyses were scheduled and given. Roles must be defined as to who will respond to clinical deterioration, treatment noncompliance, and new offenses. Additionally, response options—such as reassessment, plan modifications, more frequent meetings, parole revocation, and civil commitment—should be reviewed in advance. Corrections staff and mental health staff should also address positive reinforcements, including stepped-down supervision, and incentives, such as small gift certificates for clothes donated by business associations concerned about homelessness, religious organizations, or other community groups. Barriers to collaboration among agencies, including past problems between agencies, should be acknowledged and addressed.

Intersystem collaboration

Strained relations between criminal justice agencies and behavioral health providers are not surprising. Because of differences in mission and culture, funding mechanisms, and incentives, tension is inherent. However, the recognition that daily interaction is unavoidable prompts cooperation when it produces even partial solutions to concrete problems. Strategies to facilitate collaboration include:

- Examining databases and expenditures to identify shared clientele, duplicative activities, and service gaps.
- Offering cross training that provides criminal justice staff with concrete information about mental illness, recovery, and the use of clinical information. In addition, mental health staff can learn relevant legal procedures, agency responsibilities, and how to write reports that are useful to criminal justice staff. In addition, joint training can help staff members from different "worlds" understand each other better and establish relationships.
- Negotiating clear, written agreements among agencies about clinical information sharing, management information systems, staff liaisons, and dispute resolution, as well as agreements that deal with how to assist

persons who were released with housing, substance use problems, and public benefits.

♦ Determining each agency's contributions to reentry—for example, staff time, space, changes in operating practices, shifting funds, and responsibility.

♦ Creating joint efforts between agencies—for example, working together to apply for funding and seeking changes in state implementation of federal benefit rules.

The approval of state and agency chief executives is often required for operating entities to integrate their divergent priorities. Selection of an "honest broker" known by the stakeholders, including advocates, to lead the collaboration is a critical decision.

In addition, the determination of outcome measures requires collaboration in order to evaluate effectiveness in terms that are meaningful to very different organizations. Rates of parole revocation, new arrests, drug and alcohol use, and clinical service use are significant measures of the effectiveness of the collaboration. Also important are symptom reduction, family integration, housing stability, job training, individual satisfaction, and other measures associated with community tenure. Moreover, given the complex web of issues involved, the goal should be slowing rather than eliminating the revolving door of incarceration—unrealistic expectations need to be challenged.

Looking ahead

Although mental illness has long perplexed the criminal justice system, the diversion and reentry initiatives suggest that such issues as the insanity defense are no longer the primary focus of the criminal justice system in the area of mental illness. Reentry programs are related to diversion projects, which seek to provide this population with community services as an alternative to incarceration. Programs at both the front and back doors of the criminal justice system are needed to maximize the treatment engagement and community tenure of many individuals with mental illness. The current initiatives will require lengthy commitments of funds and personnel, and they should complement improvements in crisis intervention services and treatment during incarceration. A positive sign is passage by the U.S. Senate of the Mentally Ill Offender Treatment and Crime Reduction Act of 2003 by unanimous consent (10). If enacted, the act will create a five-year grant program and will authorize $100 million in each of the next two years to foster collaborative efforts between criminal justice and mental health partners at state and local levels. However, as coordination increases, so does the need to guard against mental health services' drifting toward social control functions.

The initial successes of reentry programs suggest that the revolving door of reincarceration can be slowed, although how much and in what ways remain to be determined. Developing individualized plans and delivering coordinated services require major changes in the often contentious relationships between criminal justice and mental health agencies as well as new partnerships with substance abuse treatment system and public benefits agencies. Nonetheless, if the misery, social disruption, and public costs of homelessness and recidivism are to be reduced, collaboration is essential. ♦

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Submissions for Datapoints Invited

Submissions to the journal's Datapoints column are invited. Areas of interest include diagnosis and practice patterns, treatment modalities, treatment sites, patient characteristics, and payment sources. National data are preferred. The text ranges from 350 to 500 words, depending on the size and number of figures used. The text should include a short description of the research question, the database and methods, and any limitations of the study.

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