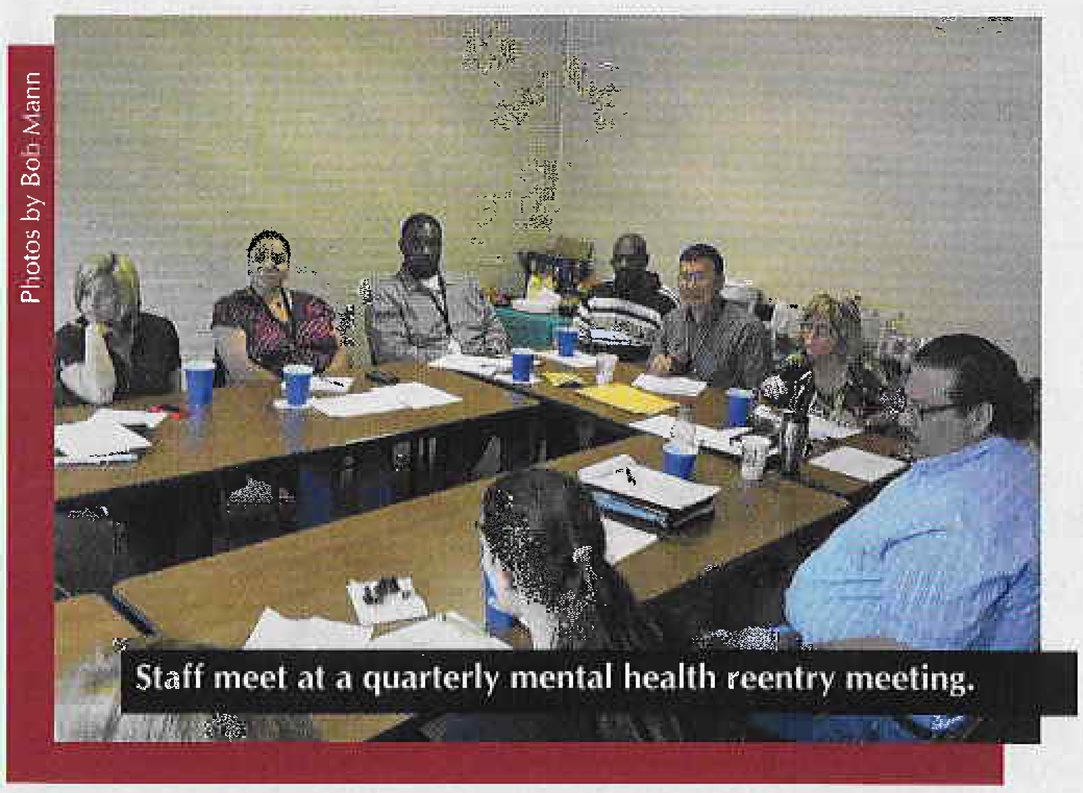
Collaborating for SUC in Inte Correctional

By Bob Mann, Donna Bond and Robert J. Powitzky

"Walter" was 8 years old when he started injecting heroin. By age 11, he was living in a boys ranch, and then was placed in a long-term boys home until he was 18. After a short period on the street, Walter said he "hooked up with my best friend, heroin" and shortly began his first prison term. After his release, Walter was again incarcerated after a brief period of time on the street. Prior to his last incarceration (that began at the age of 35), Walter was sent for a psychiatric evaluation and was diagnosed with schizophrenia, paranoid type. "I remember my kindergarten teacher telling my mother that there's something wrong with me; if she only knew how right she really was," he said.

Walter's last incarceration was different. During that time, he started taking medications for his mental illness and began to think more clearly. Walter also made the decision to stop using drugs. "I just snapped and realized that dope wasn't my friend after all and that if I ever did get out of prison again I was going to have to leave the dope alone, or I'd be back and never get out again," he said.

From the age of 11 until he was 53, Walter only lived outside of correctional institutions for 5.5 years. As Walter approached his discharge from prison in 2009, his case manager asked him if he would like to participate in a new mental health reentry program that would provide continuity of mental health services and much needed recovery support in the community. Walter told the case manager that he had never heard of a reentry intensive care coordination team (RICCT) before, but that "No one has ever helped me before, and if they will help me get my psych meds, then I'm willing to give them a try." Walter admits that he was scared and leery of meeting the team members prior to their meetings to develop a comprehensive reentry plan before he was discharged from prison.


Photos by Bob Mann

Staff meet at a quarterly mental health reentry meeting.

Immediately after Walter was released from prison, the RICCT staff worked to connect him to federal benefits and to address his immediate needs. Walter was enrolled in a mental health recovery group designed to help individuals with a serious mental illness develop skills for managing their recovery. At first, Walter had difficulty working in a group. "I still didn't like being around people and walked out of group at first, but I kept coming back," he said. Walter's story is not unique.

Background

The closing of state long-term mental health facilities followed by the lack of well-planned and well-funded community mental health services infrastructure has created a mental health services vacuum, both nationally and in Oklahoma. The recent dramatic increase in the number of individuals with serious mental illness who come into conflict with the criminal justice system is well-publicized. In Oklahoma, the general population of state prisons has increased 19 percent since 1998, while the number of offenders on psychotropic medications has increased 289 percent. Many times, prison is now seen by judges as the safest and most compassionate mental health care they can mandate for individuals with serious mental illness who have come into conflict with the law.

A study conducted by the Oklahoma Department of Corrections (DOC) in 2010 revealed that approximately 12,600 (50 percent) out of 25,200 offenders have a history of, or

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are currently exhibiting some form of mental health problem. A total of 2,130 (79 percent) female offenders and 10,350 (46 percent) male offenders fall in that category. Approximately 6,500 (26 percent) of the total population — 1,400 (52 percent) females and 5,175 (23 percent) males — currently exhibit symptoms of a serious mental illness, given the most conservative definition.

In fiscal year 2010, about 8,300 DOC offenders discharged from custody to either probation/parole supervision or directly to the street without supervision. Approximately 2,000 of these offenders had a mental illness. Figure 1 shows the percentages of offenders with a serious mental illness who were released between July 1, 2005, and June 30, 2006 (the year prior to implementation of the Interagency Mental Health Reentry Program), and who were again incarcerated in the Oklahoma DOC by July 1, 2009, compared with recidivism of the general population.

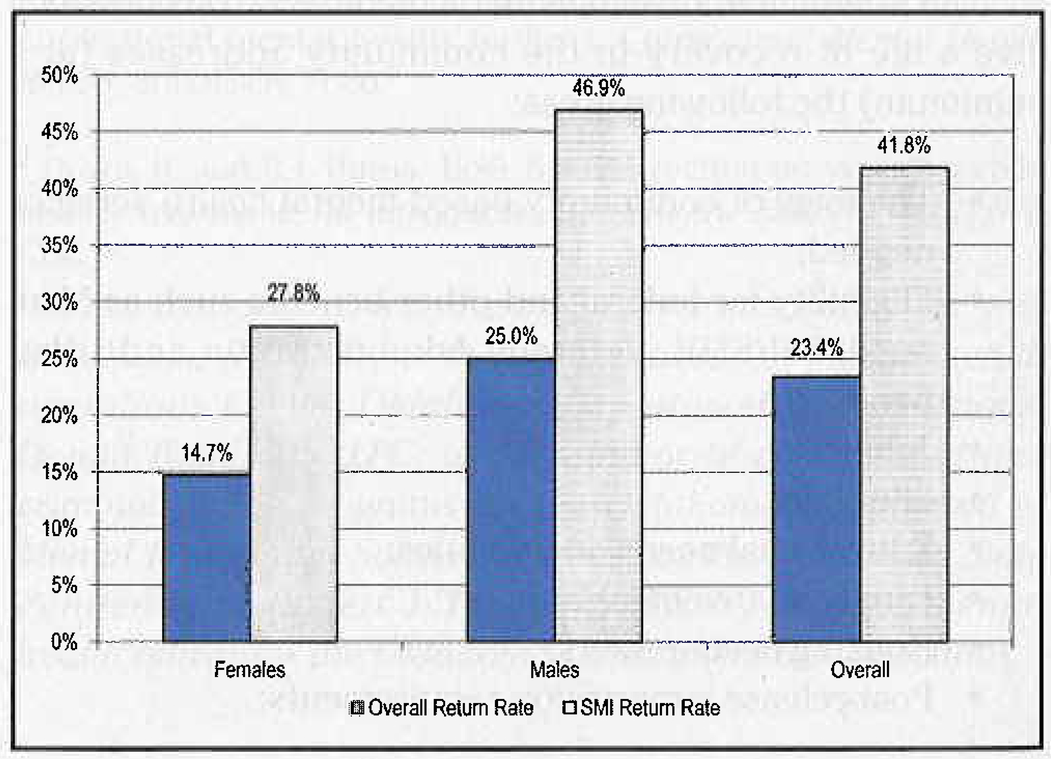
Collaborative Mental Health Reentry Program

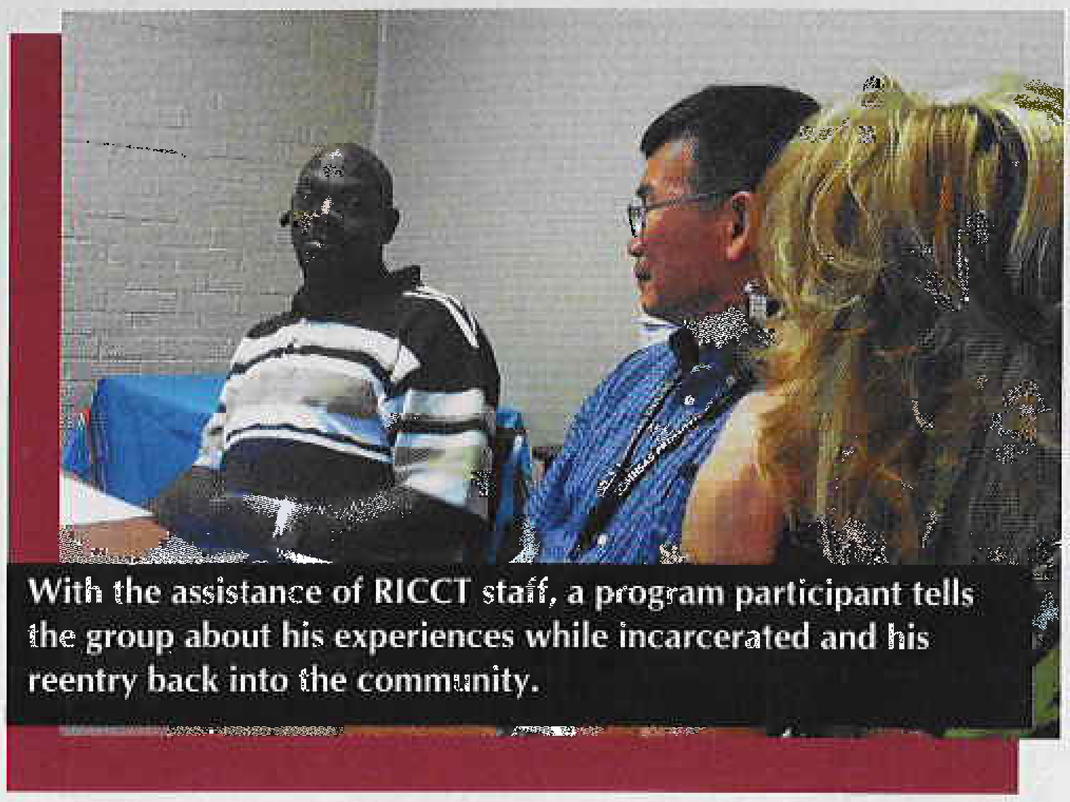
In 2005, the Substance Abuse and Mental Health Administration contracted with Mathematica Policy Research to work with key stakeholders in Oklahoma to design, implement and evaluate a model program to ensure that individuals with a mental illness were enrolled in Medicaid upon discharge from state mental and correctional institutions.[1] The interagency workgroup that was developed served as the core group that helped to identify the needs and design a program for collaborative correctional mental health reentry services. For the first time in state history, during the 2006 legislative session, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and the DOC together requested and received funding for new ODMHSAS staff positions to be located in the correctional facilities that housed offenders with the most serious mental illnesses.

In January 2007, both state agencies created a collaborative reentry program to improve the transition of incarcerated offenders with serious mental illness to ensure entry into appropriate community-based mental health services upon release. Integrated services discharge managers, employed through ODMHSAS, function out of offices located on the mental health units at Mabel Bassett Correctional Center, Joseph Harp Correctional Center and the Oklahoma State Penitentiary. The discharge managers, as part of the DOC treatment team, coordinate the mental health discharge planning. In addition, four RICCTs (two in Tulsa and two in the Oklahoma City area) are under ODMHSAS contracts to provide assertive community treatment by engaging with the offenders/consumers prior to discharge and then working with them in the community until they are fully participating in the appropriate community-based mental health and substance abuse services. The RICCTs are comprised of two staff members; one is certified mental health case manager and the other a peer recovery support specialist. This specialist is an individual with a history of recovery with a mental illness and/or a substance abuse disorder who has completed ODMHSAS training to provide peer support.

Many of the incarcerated individuals with a serious mental illness who return to prison have a co-occurring substance abuse disorder. Therefore, ODMHSAS further

Figure 1. Return Rates to Prison, Fiscal Year 2006 Releases





With the assistance of RICCT staff, a program participant tells the group about his experiences while incarcerated and his reentry back into the community.

funded three co-occurring treatment specialists who have training and experience in delivering integrated substance abuse and mental health services. These specialists provide services to offenders near release to promote integrated mental health and substance abuse recovery skills.

Core Program Elements

Identification of the target population. The Oklahoma DOC has developed a unique mental health classification system[2] that identifies those offenders with mental illness who are preparing for reentry and who are at highest risk of relapse and are in need of the most intensive mental health services in prison. Through collaboration and teamwork, the DOC case manager, discharge manager, qualified mental health professional and offender begin the process of determining the appropriate referral resources that will best meet the unique goals and needs of the offender. Discharge managers work with the facility case management staff to monitor when an identified offender approaches a projected release date of 12 months.

Assessment. The DOC begins assessment upon receipt of offenders to an assessment and reception facility and continues the assessment process for the duration of the offenders' incarceration. When an eligible offender at Mabel Bassett Correctional Center, Joseph Harp Correctional Center or the Oklahoma State Penitentiary approaches 12 months of a projected release, the discharge managers begin the process of assessing the reentry readiness of the offender.

The assessment of an offender's readiness to successfully live a life of recovery in the community addresses (at a minimum) the following areas:

- The level of community-based mental health services needed;
- Eligibility for federal and other benefits such as Medicaid, SSI/SSDI, Veterans Administration and tribal benefits;
- Job skills;
- Life skills;
- Educational needs and abilities;
- Family involvement/support;
- Housing needs/assets;
- Post-release supervision requirements;
- Basic needs (e.g., clothing and toiletries); and
- Criminogenic factors.

Preparation for successful reentry planning. Information obtained during the assessment process drives the mental health reentry plan. The discharge managers (in conjunction with the facility's qualified mental health professional staff and DOC case management staff) will meet with each offender to collaborate on developing an individualized, strength-based, offender-driven mental health reentry plan.

DOC case managers begin to prepare the offender by insuring that the individual has a copy of his or her birth certificate and Social Security card. A birth certificate and Social Security card are necessary for discharge services such as photo identification, Social Security benefits, job applications and driver's license. DOC case managers also contact family members or individuals identified by the offender to ascertain if he or she will have a residence to go to upon discharge. Family support is encouraged as a natural support for the offender.

Discharge planning. Although reentry planning begins at reception, the formal discharge planning process begins 12 months from the offender's projected discharge date. DOC case managers and ODMHSAS discharge managers monitor the discharge projections to identify offenders meeting criteria for mental health reentry services.

Discharge managers meet with the offender to explain and offer services. These services are voluntary and the offender may decline. If the offender is interested in services, the discharge manager will begin gathering information about any potential housing options available within the area or state the offender wishes to live, and some of the offender's goals and interests following release. The offender is the driving force in the discharge planning process, with ODMHSAS and DOC providing support, suggestions and linkage for continued care. The level of community-based mental health care will be determined collaboratively by the offender and the treatment team.

The discharge manager or social services specialist (these social services specialists are located at Joseph Harp Correctional Center and the Oklahoma State Penitentiary only) begins collecting information for the offender's Social Security disability application. The psychologist begins the necessary psychological evaluation and required testing. Sixty to 90 days prior to release, the discharge manager or social services specialists will arrange and moderate telephone interviews with the Social Security Administration. Discharge managers facilitate the benefit application process by receiving correspondence, filling out additional forms requested and acting as a liaison between the Social Security Administration and the offender throughout the process, as suggested in the SSI/SSDI Outreach and Recovery Program. The discharge manager serves as the contact person on all pending applications for local and state programs and benefits. The Medicaid application is submitted by the discharge manager 30 days prior to discharge date.

Post-release services. The discharge manager coordinates, plans and supervises all RICCT outreach visits prior to release. The majority of these visits are conducted in

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person by the RICCT staff, although some engagement visits may be conducted via teleconference.

The RICCTs provide reentry support services for the offender prior to and after discharge similar to the well-established model of assertive community teams.[3] RICCT staff meet the offender on the day of discharge to provide ongoing 24-hour availability and assistance with day-to-day needs, with access to flex funds that can be used for temporary housing and purchasing incidental items such as clothing, bus passes and small houseware items. Offenders on probation/parole supervision work with a probation/parole officer who participates as part of the reentry team. Mentally ill offenders who have been convicted of sex offenses often require assistance making contact with their probation/parole officers to ensure compliance with sex offender registration requirements.

If the offender has debts such as fines, fees, restitution or court costs, RICCT staff will help with developing a payment plan. RICCT staff aid the offender with engagement in community-based mental health/substance abuse services. RICCT services normally end within a year of discharge, but may end earlier if the offender is fully engaged in community-based services and able to live independent of RICCT services.

Program Outcomes

A recent outcome analysis of the program that was performed by ODMHSAS showed promising results. Outcomes of offenders served during the first 24 months of the program were compared with a baseline group comprised of similar individuals. Here are the results:

- Inpatient hospitalizations decreased from 8.7 to 2.4 percent;
- Outpatient service utilization increased from 55.1 to 89.1 percent;
- The median days from release to first day of service decreased from 15 days to three days;
- The rate of service engagement (receiving at least four services in 44 days from release from DOC) increased from 11.7 to 64.8 percent;
- Enrollment in Medicaid within 90 days of release from DOC increased from 12 to 53 percent;
- Social Security benefit allowance rate increased from the Oklahoma average of 39 to 92 percent; and
- Return to the DOC decreased from 32.1 to 16.5 percent.

Future Challenges

The program has not been fully implemented in all state correctional facilities due to budgetary constraints. Although the ODMHSAS discharge managers work at the three DOC facilities that have mental health units (and therefore work with those individuals with the highest level of need for continuity of mental health and substance abuse treatment), there is a large number of eligible offenders throughout the state who are not receiving these intensive services. Furthermore, RICCT staff only cover two major metropolitan areas in the state (Tulsa and Oklahoma City). For the past three years, ODMHSAS has requested additional funds from the Oklahoma Legislature to augment this program, but no additional funds have been available.

The Oklahoma DOC and the ODMHSAS have partnered to create a dynamic collaborative reentry program to improve the transition of incarcerated offenders with serious mental illness into appropriate community-based mental health services. Outcome data indicate this collaborative effort has significantly reduced recidivism, increased approval rates for federal benefits and increased utilization of mental health services post-release for those offenders who had the highest risk of returning to prison due to unmet mental health needs.

Walter was discharged from prison in 2009. In April 2011, he told his story of recovery at the ODMHSAS board meeting. "I know in my heart that had it not been for the RICCT staff I would be back in prison," he said, "but instead I'm doing better than I've ever done in my life."

ENDNOTES

[1] Wenzlow, Audra T., Henry T. Ireys, Bob Mann, Carol Irving and Judith L. Teich. 2011. Effects of a discharge planning program on Medicaid coverage of state prisoners with serious mental illness. *Psychiatric Services*, 62(1):73-78.

[2] Powitzky, R. 2003. A useful management tool for understanding correctional mental health services. *Correctional Mental Health Report*, 4(5):65-66, 77-80.

[3] Drake, R. and B.J. Burns. 1995. Special section on assertive community treatment; An introduction. *Psychiatric Services*, 46(7):667-678.

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