

**MEMORANDUM**

October 6, 2009

TO: Public Safety Committee  
Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst 

SUBJECT: **Briefing and Discussion** – Mental Health and the Jail System – Discussion with Dr. Fred Osher, Director of Health Systems and Services Policy, Council of State Governments Justice Center

Dr. Fred Osher from the Council of State Governments Justice Center will brief the joint Committee on issues regarding the prevalence of serious mental illness among jail inmates. Dr. Osher will be joined at the table by Art Wallenstein, Director of the Department of Correction and Rehabilitation, and Uma Ahluwalia, Director of the Department of Health and Human Services. The Health and Human Services Committee requested this joint session at its June 29<sup>th</sup> follow-up worksession on the 2002 Report from the Blue Ribbon Task Force on Mental Health. In 2002, the Blue Ribbon Task Force noted:

- *When a mental health system fails to provide access to effective treatments, some individuals “fall between the cracks,” only to re-emerge in jails, prisons, juvenile detention facilities, homeless shelters, wandering the streets, or dead...*
- *The Department of Corrections Director estimates that the total mentally ill population in the Montgomery County Detention Center increased from 15% of all inmates in FY99 to 21% of all inmates in FY01, and that in FY01, 17% of mentally ill individuals admitted to the Montgomery County Detention Center were repeat admissions...*
- *Data collected by the Montgomery County Coalition for the Homeless (2000) indicate that 54% (425) of 786 single homeless individuals in Montgomery County have serious mental illness...*

**Prevalence of Serious Mental Illness Among Jail Inmates**

Attached at © 1-5, is the article, “Prevalence of Serious Mental Illness Among Jail Inmates,” authored by Steadman, Osher, Robbins, Case, and Samuels, which appeared in the June 2009 edition of *Psychiatric Services*. Montgomery County served as a research site for this

study which estimates the current prevalence of serious mental illness among adult male and female inmates. Two screening tools were used, the Brief Jail Mental Health Screen (BJMHS) and the Structured Clinical Interview for DSM-IV (SCID). In addition to looking at the prevalence of serious mental illness, the data was also used to validate the BJMHS as a screening tool.

**This study discusses the prevalence of serious mental illness such as major depressive disorder, bipolar disorder, schizophrenia, and psychotic disorder. The study found that the rate of current serious mental illness for male inmates across all five study sites was 14.5% and for females 31%. In the first phase of the study (2002-2003), 18% of male inmates and 28% of female inmates in Montgomery County were found to have serious mental illness. In the second phase of the study (2005-2006), 8% of male inmates and 21% of female inmates were found to have serious mental illness. (©4)**

Other studies have shown that the prevalence of mental health problems (which include a much broader range of mental health issues) among inmates is widespread. Attached at © 6-9 is a summary prepared by the Ohio Office of Criminal Justice Services of Federal data that reported that 63% of male jail inmates and 75% of female jail inmates reported mental health problems. Many times these co-occur with substance abuse problems.

While there are clearly implications from the prevalence of mental health problems among inmates, the implications of prevalence of serious mental illness are substantial as these disorders generally require long-term supportive treatment. Council staff was particularly struck by the implications of 30% of females in the jail system having a serious mental illness and how the female population might be reduced through better community-based measures that would treat serious mental illness before a crime is committed and the need for long-term community based supports after release from jail in order to prevent re-offending.

Dr. Osher will also be providing comments to the joint Committee on the relationship between homelessness and incarceration. The Federal data (© 9) indicates that 17% of persons in local jails with mental health problems were homeless in the year before their incarceration compared to 9% without mental health problems. As funding options for long-term supportive housing for persons with mental illness can be impacted by a person's criminal record, preventing persons with mental illness from entering the criminal justice system or from re-offending with a more serious crime is important for retaining long-term options for providing community based treatment and stable housing.

### **Best Practices Model for Re-Entry**

Attached at ©10-30 is "A Best Practices Approach to Community Re-Entry from Jail for Inmates with Co-Occurring Disorders: The APIC Model," authored by Osher, Steadman, and Barr, in 2002 and sponsored by the GAINS Center. The APIC model is for use by jails (as opposed to prisons) and provides "a set of critical elements that, if implemented, are likely to improve outcomes for persons with co-occurring disorders who are released from jail." APIC abbreviates: (1) **Assess** the inmate's clinical and social needs, and public safety risks, (2) **Plan**

for the treatment and services required to address the inmate's needs, (3) **Identify** required community and correctional programs responsible for post-release services, and (4) **Coordinate** the transition plan to ensure implementation and avoid gaps in care with community-based services. The model calls for a coordinating committee of local stakeholders. A transition person or team should involve the inmate in the transition planning process and both gather information and listen to the inmate's perceptions of what he or she needs. The planning should work to address short-term (including the hour, day, and week after leaving jail) and long-term needs.

As the joint Committee is aware from previous discussions, the Montgomery County Department of Correction and Rehabilitation in partnership with the Department of Health and Human Services have both a Criminal Justice Behavioral Health Initiative and a regular re-entry and transition work group reviews the needs of and develops plans for individual inmates. Council staff has asked DOCR Director Wallenstein and DHHS Director Ahluwalia to provide comments on how the county's efforts incorporate the APIC best practices elements in providing transition planning for jail inmates.

# Prevalence of Serious Mental Illness Among Jail Inmates

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**Objective:** This study estimated current prevalence rates of serious mental illness among adult male and female inmates in five jails during two time periods (four jails in each period). **Methods:** During two data collection phases (2002–2003 and 2005–2006), recently admitted inmates at two jails in Maryland and three jails in New York were selected to receive the Structured Clinical Interview for DSM-IV (SCID). Selection was based on systematic sampling of data from a brief screen for symptoms of mental illness that was used at admission for all inmates. The SCID was administered to a total of 822 inmates—358 during phase I and 464 during phase II. To determine the current (past-month) prevalence of serious mental illness (defined as major depressive disorder; depressive disorder not otherwise specified; bipolar disorder I, II, and not otherwise specified; schizophrenia spectrum disorder; schizoaffective disorder; schizophreniform disorder; brief psychotic disorder; delusional disorder; and psychotic disorder not otherwise specified), interview data were weighted against strata constructed from the screening samples for male and female inmates by jail and study phase. **Results:** Across jails and study phases the rate of current serious mental illness for male inmates was 14.5% (asymmetric 95% confidence interval [CI]=11.0%–18.9%) and for female inmates it was 31.0% (asymmetric CI=21.7%–42.1%). **Conclusions:** The estimates in this study have profound implications in terms of resource allocation for treatment in jails and in community-based settings for individuals with mental illness who are involved in the justice system. *Psychiatric Services* 60:761–765, 2009)

According to the Bureau of Justice Statistics, during the 12 months ending at midyear 2007, there were 13 million admissions to local jails in the United States (1). At midyear 2007, local jails held 673,697 adult males and 100,047 adult females—figures that represent increases of 24.0% and 42.1%, respectively, since midyear 2000. The majority of these jail inmates were pretrial detainees (1).

Prisoners have a constitutional right to adequate health care, including mental health treatment (2–4), and the growth of local correctional populations has strained the limited capacity of jails to respond to the health needs of inmates (5). The situation is particularly challenging in the case of inmates with serious mental illnesses, who require specialized treatment and services (6). There has been consistent evidence that per-

sons with mental illnesses are over-represented in jails, and determining the extent of these higher rates is a first step to improved jail management and the development of alternatives to incarceration.

Prevalence estimates of mental illnesses in U.S. jails have varied widely depending on methodology and setting. Using survey methodology, a 1999 report from the Bureau of Justice Statistics (BJS) estimated that 16.3% of jail inmates reported either a “mental condition” or an overnight stay in a mental hospital during their lifetime (7). In 2006 BJS reported that 64% of jail inmates had a recent “mental health problem” (8). The 2006 findings were based on personal interviews conducted in the 2002 Survey of Inmates in Local Jails, and the rate of 64% included all inmates who reported one or more symptoms of any mental illness. Data on functional impairment and duration of illness were not collected, and inmates were not excluded if their symptoms were a result of general medical conditions, bereavement, or substance use (8). Although the methods used in this study are not consistent with other efforts to establish the prevalence of mental illnesses in jails, the findings are often, and mistakenly, cited as evidence of an escalating problem. More recently, Trestman and colleagues (9) evaluated a cohort of inmates who were not identified at intake as having a mental illness and found that over two-thirds met criteria for a lifetime psychiatric disorder, including anxiety disorders and anti-social personality disorder.

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The most rigorous data on the prevalence of mental disorders among both male and female jail inmates were collected by Teplin, Abram, and McClelland (10–14) in the 1980s and 1990s in Cook County (Chicago), Illinois. The data were collected for the purpose of measuring severe mental disorders, which are not comparable to broader estimates of serious mental illness. These researchers used the National Institute of Mental Health Diagnostic Interview Schedule with stratified random samples of inmates awaiting trial in the Cook County Department of Corrections and estimated rates of current (two-week) severe mental disorders to be 6.4% for male inmates (12) and 12.2% for female inmates (11).

The study reported here sought to estimate current prevalence rates of serious mental illness at two jails in Maryland and three jails in New York during two time periods. These inmates would constitute the group that meets constitutional requirements for jail mental health services and for whom aggressive discharge planning would be a priority (15). Data from a screen for mental illness were collected for all inmates who were booked into the jails during the data collection phases, and a portion of those screened were selected through systematic sampling for administration of the Structured Clinical Interview for DSM-IV (SCID). Prevalence rates were estimated through a weighting procedure whereby the data were organized into strata by gender, phase, and jail. The original purpose of gathering the data used in this study was to validate and refine a mental health screen for correctional officers to administer to jail inmates at intake (16,17).

## Methods

From large samples of recently admitted jail inmates who were screened with the Brief Jail Mental Health Screen (BJMHS), subgroups were selected and the SCID was administered to them. Results for the subsamples were weighted back to the larger screened samples in order to estimate current prevalence rates of serious mental illness. Because the original purpose of data collection was to validate the BJMHS, systematic sampling

methods were used to select individuals for the SCID subsamples in order to obtain an adequate sample of inmates who screened positive and a sufficient number of female inmates to enable a separate gender analysis.

### Data collection

The BJMHS was developed as a jail intake screen to determine whether an inmate should be referred for further mental health evaluation. The BJMHS was validated during two phases of data collection. During phase I (May 2002 through January 2003) the original eight-item screen was validated at two county jails in Maryland (Montgomery County and Prince George's County) and two county jails in New York (Albany County and Rensselaer County). For phase II (November 2005 through June 2006) a revised 12-item version of the screen was tested at the same jails in Maryland and at the Rensselaer County jail, but the Monroe County jail in New York was substituted as the fourth site. During both phases, the screen was administered to inmates during intake, except for Monroe County in phase II, where screens were administered within 24 hours of intake after the initial court appearance (17).

### SCID

The SCID is a semistructured clinical interview designed to assess the presence of selected *DSM-IV* axis I diagnoses (18). The instrument is administered by a trained clinical interviewer or mental health professional and uses a modular format with skip patterns within diagnostic sections. When criteria for a given diagnosis are met, the diagnosis is scored in terms of its lifetime prevalence and its presence in the past month. For the phase I and phase II data collections, a subset of modules were administered.

For this study, serious mental illness was defined as the presence of one or more of the following diagnoses in the past month: major depressive disorder; depressive disorder not otherwise specified; bipolar disorder I, II, and not otherwise specified; schizophrenia spectrum disorder; schizoaffective disorder; schizophreniform disorder; brief psychotic disorder; delusional disorder; and psychotic disorder not

otherwise specified. There were no measures of functional impairment.

As soon as inmates were classified into those who screened positive and those who screened negative, clinical research interviewers who were blind to the inmates' sampling group status approached the inmates on their list of potential participants. Participation in both phases was voluntary. Informed consent forms approved by the institutional review board of Policy Research Associates, Inc., were required and obtained for all SCID subsample participants. Participants were informed that the decision to participate would not affect their stay in the jail, and a brief quiz was administered to assess competency to consent. All SCID interviews occurred within 72 hours of an inmate's admission to the jail but typically not within the first eight hours.

In both phases the overall refusal rate of inmates approached for the SCID interview was 31% (16,17). In phase I women were more likely than men ( $p < .05$ ) to refuse when approached for an interview, and in phase II the refusal rate was particularly high in the Prince George's County jail—126 of 228 inmates (55%) who were approached refused to participate. The refusal rate was likely due to the fact that compensation was not offered to SCID sample participants at this jail and to the constraints imposed by the jail on scheduling and conducting interviews. However, because the results of all analyses are presented by gender and by jail and because no significant differences were found between those who refused and those who consented in Prince George's County, there are no biases on these two factors.

### Interviewer training

Nine clinical research interviewers were trained for phase I, and 16 were trained for phase II. Many of the phase I interviewers also participated in phase II. During each phase, interviewers participated in a two-day on-site training in administration of the SCID by a certified SCID instructor. Interviewers practiced with acquaintances and volunteer psychiatric patients. Interrater reliability ( $\alpha = .964$ ) was ensured by having each interviewer complete two reliability tapes,

which were scored. Interviewers were also observed while conducting interviews in the jails.

**Data analysis**

All data management and analyses were conducted in SPSS (version 12) or Stata (release 10). Weighted prevalence estimates and confidence intervals were computed with the survey procedures in Stata (release 10).

**Weighting**

Persons who were screened by the BJMHS (a "population") were grouped into strata defined by study phase, jail, gender, and BJMHS result (positive or negative). Those who also were administered the SCID (the "sample") were classified into the same strata. Each person in the SCID subsample received a selection weight  $W=(N/n)$ , where N was the number of population members in the person's population stratum and n was the

number in the person's SCID sample stratum. If a certain number—represented by "a"—of those who also were administered the SCID are classified as having serious mental illness, then the estimated prevalence in the stratum is  $p=a/n$  and the estimated number of population members with serious mental illness in the stratum is  $A=(N/n)a=Np$ . These stratum numbers were added to form the numerators and were divided by the known population totals to get estimated prevalence rates. Confidence intervals for specific rates for jail, phase, and gender were based on the assumption that within strata individuals were selected for the SCID by systematic sampling. This was at best an approximation. The pooled gender-specific rates compute confidence intervals by treating jails as sampled clusters. The intervals were computed on the logit scale and transformed to the probability scale (19) and were asymmetric.

**Screening samples**

*Phase I.* Screening data were collected from 11,438 male and female jail inmates admitted to one of four county jails from May 2002 through January 2003. Valid data were obtained for 11,168 inmates. The percentage with positive scores on the eight-item BJMHS ranged from an overall high of 14% (N=399) in Prince George's County to an overall low of 9% (N=287) in Albany County.

*Phase II.* Between November 2005 and June 2006 a total of 10,562 inmates admitted to one of the four county jails were screened with the 12-item BJMHS. Valid data were obtained for 10,240 inmates. The percentage of screened inmates classified as positive on the basis of scoring for the eight-item BJMHS ranged from 24% (N=296) in Monroe County to 9% (N=880) in Montgomery County. The high positive rate in Monroe County is due to the large

**Table 1**

Inmates at four jails who screened positive or negative on the Brief Mental Health Jail Screen (BJMHS) and rates of serious mental illness among those selected for assessment with the Structured Clinical Interview for DSM-IV (SCID), by gender and study phase

Gender, phase, and county jail	BJMHS						SCID-diagnosed serious mental illness			
	Positive			Negative			BJMHS			
	Total N	Selected for SCID		Total N	Selected for SCID		Positive		Negative	
	N	N	%	N	N	%	N	%	N	%
<b>Male inmates</b>										
<b>Phase I</b>										
Montgomery	275	18	7	3,092	31	1	7	39	5	16
Prince George's	323	14	4	2,268	35	2	6	43	3	9
Rensselaer	87	15	17	987	30	3	7	47	5	17
Albany	201	27	13	2,484	41	2	18	67	7	17
<b>Phase II</b>										
Montgomery	271	16	6	3,345	42	1	7	44	2	5
Prince George's	689	10	1	2,886	44	2	5	50	2	5
Rensselaer	65	6	9	543	27	5	3	50	2	7
Monroe	103	17	17	723	44	6	6	35	6	14
All	2,014	123	6	16,328	294	2	59	48	32	11
<b>Female inmates</b>										
<b>Phase I</b>										
Montgomery	113	14	12	326	24	7	7	50	5	21
Prince George's	76	4	5	256	12	5	2	50	4	33
Rensselaer	35	9	26	156	26	17	8	89	10	39
Albany	86	24	28	403	34	8	11	46	15	44
<b>Phase II</b>										
Montgomery	100	21	21	442	75	17	10	48	11	15
Prince George's	191	15	8	375	30	8	6	40	5	17
Rensselaer	50	13	26	71	18	25	6	46	4	22
Monroe	193	37	19	193	49	25	16	43	5	10
All	844	137	16	2,222	268	12	66	48	59	22



**Table 2**

Weighted prevalence rates of serious mental illness among inmates at four jails, by gender and study phase<sup>a</sup>

Gender, phase, and county jail	%	95% CI
Male inmates		
Phase I		
Montgomery	18.0	8.8–33.4
Prince George's	12.8	6.1–25.2
Rensselaer	19.1	9.4–35.0
Albany	20.8	10.3–37.5
Total	17.5	12.5–24.0
Phase II		
Montgomery	7.7	3.5–16.0
Prince George's	13.3	6.3–26.0
Rensselaer	12.0	5.6–23.7
Monroe	16.3	7.9–30.9
Total	11.1	6.1–19.5
Both phases (pooled data)	14.5	11.0–18.9
Female inmates		
Phase I		
Montgomery	28.3	14.7–47.5
Prince George's	37.1	20.5–57.5
Rensselaer	47.7	28.5–67.6
Albany	44.4	25.9–64.6
Total	38.3	25.4–53.1
Phase II		
Montgomery	20.7	10.3–37.4
Prince George's	24.5	12.5–42.6
Rensselaer	32.1	17.1–52.0
Monroe	26.7	13.8–45.5
Total	24.4	19.4–30.1
Both phases (pooled data)	31.0	21.7–42.1

<sup>a</sup> Rates are based on the number of inmates given a diagnosis of a serious mental illness on assessment with the Structured Clinical Interview for DSM-IV. The percentages are weighted to reflect the total population at each jail. Confidence intervals are asymmetric.

proportion of female inmates and the consistently higher number of positive scores for women.

#### SCID samples

The SCID was administered to a total of 822 inmates—358 during phase I and 464 during phase II. In both phases, women and inmates who screened positive were approached in larger numbers for an interview. Across the four jails, a total of 147 (41%) women were interviewed in phase I, and 258 (56%) women were interviewed in phase II. Of the inmates in the SCID subsample, 125 (35%) at phase I and 135 (29%) at phase II had screened positive on the basis of the eight-item BJMHS. Among both men and women, consistently higher rates of se-

rious mental illness were observed for those who screened positive, which was expected given the predictive accuracy of the BJMHS (16,17).

## Results

### Prevalence of mental illness

Table 1 shows the results of screening at the four jails by phase and by gender as well as the SCID results for the subsamples.

Table 2 presents the weighted prevalence and asymmetric 95% confidence intervals (CIs) of current serious mental illness in the jails by gender and phase. The weighted estimates adjust for oversampling in the SCID subsample of women and of inmates who screened positive and provide accurate estimates of the prevalence of serious mental illness. Data from all four jails were used for analysis in each phase. The same analysis using just the three jails that participated in both phases yielded results that were not significantly different.

**Male inmates.** Prevalence of serious mental illness among male inmates in phase I ranged from 12.8% in Prince George's County to 20.8% in Albany County, with an overall rate of 17.5%. In phase II prevalence of serious mental illness for men ranged from 7.7% in Montgomery County to 16.3% in Monroe County, with an overall rate of 11.1%. Analysis of pooled data from the two phases yielded an estimated 14.5% prevalence rate of serious mental illness among male jail inmates. The addition of posttraumatic stress disorder (PTSD) as a serious mental illness increased the estimate to 17.1% (asymmetric CI=3.2%–21.8%).

**Female inmates.** Estimated rates of serious mental illness among female inmates in phase I ranged from 28.3% in Montgomery County to 47.7% in Rensselaer County, with an overall rate of 38.3%. Phase II results for women were slightly lower, with prevalence rates ranging from 20.7% in Montgomery County to 32.1% in Rensselaer County and an overall rate of 24.4%. Analysis of pooled data from the two phases yielded a prevalence rate of 31% among female jail inmates. As with the male inmates, the addition of PTSD as a serious mental illness raised the prevalence rate among fe-

male inmates only modestly to 34.3% (asymmetric CI=24.4%–45.7%).

## Discussion

The final, weighted prevalence rates of current serious mental illness for recently booked jail inmates were 14.5% for men and 31.0% for women across the jails and study phases. When these estimates are applied to the 13 million annual jail admissions in 2007, assuming that the proportion of female admissions was 12.9%, there were about two million (2,161,705) annual bookings of persons with serious mental illnesses into jails. If a primary SCID diagnosis of PTSD was included as a serious mental illness, the weighted estimates increased to 17.1% for men and 34.3% for women.

The estimated prevalence rates among female inmates found in this study were double those for male inmates. This gender difference is particularly important given the rising number and proportion of female inmates in U.S. jails (1). The estimated prevalence among female inmates is higher whether or not current PTSD is included as a serious mental illness.

These prevalence estimates provide evidence for what jail staff already know to be true: the volume of inmates entering jails with serious mental illnesses is substantial. One possible explanation for the high estimates is limited access to community behavioral health services (20). We believe that rates for male and female inmates could be applied to a particular jail to yield a reasonable estimate for planning purposes. Using these estimates, jail administrators can likely anticipate that the prevalence of serious mental illness will be between 11.0% and 18.9% among men and between 21.7% and 42.1% among women, with a 14.5% average among men and a 31.0% average among women.

Several limitations of this study are noteworthy. Because no measure of functional impairment was used, it is unclear whether these individuals met federal and state definitions of serious or severe mental illness (21). In addition, the definition of serious mental illness did not include some axis I disorders that can be very severe, such as anxiety disorder. Similarly, some axis II

disorders, such as borderline personality disorder, can also be severe, and none were included. On the other hand, only a small proportion of the overall SCID subsample who were deemed to have a serious mental illness received a primary diagnosis of depressive disorder not otherwise specified (four inmates, or 1.9%)

Although some variation was noted across the jails and study phases, the estimates were consistent. The reason for the variation is unclear because the same screening and diagnostic interview, and in many cases the same interviewers, were employed during both phases. We examined other factors, such as differences or changes in racial composition, as possible reasons for the differences among jails or phases, but none were found.

### Conclusions

There is broad consensus that jails are not the optimal settings to provide acute psychiatric treatment. In line with the recommendations of the Criminal Justice/Mental Health Consensus Project report (22) and the President's New Freedom Commission on Mental Health (23), many communities have instituted mechanisms to divert individuals with serious mental illnesses from the front door of the jail to community-based services or have established linkages to services by way of transition planning at the back door. Since a 1992 survey estimated that only 52 jail diversion programs operated in the United States (24), there has been a rapid expansion of specialized law enforcement-based responses (25), problem-solving mental health courts (26), and specialized probation models (27) aimed at reducing the prevalence of individuals with mental illnesses in jail settings. Such expansion has been supported by an array of state and federal grant programs, including the Criminal Justice, Mental Health and Substance Abuse Reinvestment Act in Florida; the Mental Health Courts Program and the Justice and Mental Health Collaboration Program of the Bureau of Justice Assistance; and the Targeted Capacity Expansion for Jail Diversion Programs and the Jail Diversion and Trauma Recovery—Priority to Veterans initiatives of the Substance Abuse and

Mental Health Services Administration. Nonetheless, the substantial presence of individuals with serious mental illnesses in our country's jails, as estimated in this study, calls for a clearer explication of the contributing factors and discussion of appropriate responses.

### Acknowledgments and disclosures

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The authors report no competing interests.

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## MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES

### **Ohio Office of Criminal Justice Services**

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## MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES

On September 6, 2006, the Bureau of Justice Statistics released the special report *Mental Health Problems of Prison and Jail Inmates*. The following data come from this report. A link to the full report can be found on the Bureau of Justice Statistics web site:  
<http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf>.

Interviews with state and federal prisoners and jail inmates indicated that at midyear 2005, more than half of all prison and jail inmates had a mental health problem. Mental health problems were defined to include either a recent history of mental illness (clinical diagnosis or treatment by a mental health professional) or symptoms of a mental health problem (based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition) within 12 months prior to being interviewed. Fifty-six percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates had a mental health problem.

### Characteristics of prison and jail inmates with mental health problems

- Female prison and jail inmates had much higher rates of mental health problems than did male prison and jail inmates.
- White prison and jail inmates were more likely than black or Hispanic prison and jail inmates to have a mental health problem.
- Prison and jail inmates age 24 or younger had the highest rate of mental health problems. Those 55 or older had the lowest rate of mental health problems.
- Those prison and jail inmates who had a mental health problem were twice as likely as prisoners and inmates without a mental health problem to have been homeless in the year before their incarceration.
- Compared to those prison and jail inmates who did not have a mental health problem, almost twice as many of those who did have a mental health problem said that they lived in a foster home, agency, or institution growing up.
- A smaller percentage of those prison and jail inmates who had a mental health problem reported having been employed in the month before their arrest than those who did not have a mental health problem.
- Prison and jail inmates who had a mental health problem were much more likely to report being physically or mentally abused in the past.
- Prison and jail inmates with a mental health problem were more likely than those without to have a caregiver who was a substance abuser.
- Prison and jail inmates with mental health problems were also shown to have higher rates of substance dependence or abuse than those without a mental health problem. Those with a mental health problem were more likely to report dependence or abuse of drugs than of alcohol.
- Approximately one-third of state prison and jail inmates said they used drugs at the time of their arrest. Marijuana or hashish was the drug most commonly used in the month before the offense.

- Among state prisoners, a slightly higher percentage of individuals with mental health problems had as their most serious offense a violent crime. Across all offenses committed by state prisoners with mental health problems, robbery was the most common serious offense (14 percent), followed by drug trafficking (13 percent) and homicide (12 percent).
- Convicted violent offenders with mental health problems were just as likely as those without to have used a weapon during the offense.
- State prisoners with a mental health problem had a mean maximum sentence that was five months longer than those without a mental health problem. In contrast, jailed inmates with a mental health problem had a mean sentence five months shorter than that for jail inmates without a mental health problem.
- Prison and jail inmates with a mental health problem had a larger number of prior probation or incarceration sentences than those without a mental health problem.
- State prisoners with a mental health problem had the highest rate of mental health treatment, followed by federal prisoners and jail inmates. Medication for the mental health problem was the most common type of treatment inmates received upon admission to prison or jail.
- Prison and jail inmates with a mental health problem were more likely than those without to have been charged with breaking facility rules.

Characteristic	State Prison		Federal Prison		Local Jail	
	With MH problem	Without MH problem	With MH problem	Without MH problem	With MH problem	Without MH problem
Males	55%		44%		63%	
Females	73%		61%		75%	
White non-Hispanic	62%		50%		71%	
Black non-Hispanic	55%		46%		63%	
Hispanic	46%		37%		51%	
24 or younger	63%		58%		70%	
55 or older	40%		36%		52%	
Homeless in year before incarceration	13%	6%	7%	3%	17%	9%
Ever lived in foster home, agency, or institution	18%	10%	10%	6%	14%	6%
Employed a month before arrest	70%	76%	68%	76%	69%	76%
Experienced physical or sexual abuse in past	27%	10%	17%	6%	24%	8%
Have parent/guardian with substance abuse	39%	25%	33%	20%	37%	19%
Have substance dependence or abuse	74%	56%	64%	50%	76%	53%
Used drugs during offense	38%	26%	31%	23%	34%	20%
Had violent crime as most serious offense	49%	46%	16%	13%	26%	24%
Used weapon in offense	37%	37%			21%	21%
Mean maximum sentence length	146 months	141 months	128 months	135 months	40 months	45 months
Had 3 or more prior sentences	47%	39%	35%	30%	42%	33%
Received treatment after admission to facility	34%		24%		18%	
Charged with rule violations in facility	58%	43%	40%	28%	19%	9%

# A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model

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## Abstract

Almost all jail inmates with co-occurring mental illness and substance use disorders will leave correctional settings and return to the community. Inadequate transition planning puts people with co-occurring disorders who enter jail in a state of crisis back on the streets in the middle of the same crisis. The outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, relapse to substance abuse, hospitalization, suicide, homelessness, and re-arrest. While there are no outcome studies to guide evidence-based transition planning practices, there is enough guidance from the multi-site studies of the organization of jail mental health programs to propose a best practice model. This manuscript presents one such model—APIC. The APIC Model is a set of critical elements that, if implemented, are likely to improve outcomes for persons with co-occurring disorders who are released from jail.

## Introduction

Approximately 11.4 million adults are booked into U.S. jails each year (Stephan, 2001), and at midyear 2000, 621,000 people were detained on any given day (BJS, 2000). Current estimates suggest that as many as 700,000 of adults entering jails each year have active symptoms of serious mental illness and three-quarters of these individuals meet criteria for a co-occurring addictive disorder (GAINS, 2001).

While jails have a constitutional obligation to provide minimum psychiatric care, there is no clear definition of what constitutes adequate care (APA, 2000). In a review of jail services, Steadman and Veysey (1997) identified discharge planning as the least frequently provided mental health service within jail settings. In fact, the larger the jail, the less likely inmates with mental illness were to receive discharge planning. This occurs in spite of the fact that discharge planning has long been viewed as an essential part of psychiatric care in the community, and one of the country's largest jail systems, New York City, was recently required by court order to provide discharge planning services to inmates with mental illness. (Brad H. v. City of New York).

There are important differences in how transition planning can and should be provided for inmates with mental illnesses completing longer-term prison stays versus short-term jail stays (Griffin, 1990, Hartwell and Orr, 2000, Hammett, et al., 2001, Solomon, 2001). Jails, unlike prisons, hold detained individuals who are awaiting appearance in court, and unsentenced people who were denied or unable to make bail, as well as people serving short-term sentences of less than a year (although as prisons become more crowded, jails increasingly are holding people for extended periods of time). Short episodes of incarceration in jails (often less than 72 hours) require rapid assessment and planning activity, and while this challenge may be offset by the fact that jail inmates are less likely than prisoners to have lost contact with treatment providers in the community, short stays and the frequently unpredictable nature of jail discharges can make transition planning from jails particularly challenging (Griffin, 1990).

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Nowhere is transition planning more valuable and essential than in jails. Jails have, in many parts of the country, become psychiatric crisis centers of last resort. Many homeless people with co-occurring disorders receive behavioral health services only in jail, because they have been unable to successfully access behavioral health services in the community, and lack of connection to behavioral health services in the community may lead some people to cycle through jails dozens or even hundreds of times. Inadequate transition planning puts people with co-occurring disorders who entered the jail in a state of crisis back on the streets in the middle of the same crisis. The outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, hospitalization, relapse to substance abuse, suicide, homelessness, and re-arrest.

While there are no outcome studies to guide evidence-based transition planning practices, there is enough guidance from the multi-site studies of the organization of jail mental health programs by Steadman, McCarty, and Morrissey (1989); the American Association of Community Psychiatrists continuity of care guidelines (2001); and the American Psychiatric Association's task force report on psychiatric services in jails and prisons (2000), to create a best practice model that has strong conceptual and empirical underpinnings and can be expeditiously implemented and empirically evaluated. The APIC Model presented in Table 1 is that best practice model.

#### Jail Size As a Factor

Just as critical differences exist between jail and prison practice, almost every facet of jail practice is influenced directly by the size of the jail. What is necessary and feasible in the mega jails of New York City or Los Angeles is quite different from what can or should be done in the five- or ten-person jails in rural Wyoming or even the 50-person jails in the small towns of the Midwest. We have designed the APIC Model to provide a model of transition planning that contains core concepts equally applicable to jails and communities of all sizes. The specifics of how the model is implemented and on what scale will vary widely. Nonetheless, we believe that the basic guidance the model offers can be useful to all U.S. jails.

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## Tilling the Soil for Re-entry: System Integration

Efforts in the past to help people with co-occurring disorders in the criminal justice system have taught us that the results of these efforts will only be as good as the correctional-behavioral health partnership in the community. Transition planning can only work if justice, mental health, and substance abuse systems have a capacity and a commitment to work together. As a result, the APIC model depends on, and could perhaps drive, active system integration processes among relevant criminal justice, mental health and substance abuse treatment systems. In order to mobilize a transition planning system, key people in all of these systems must believe that some new response to jail inmates with mental illness is necessary and that they can be more effective in addressing the needs of this population by combining their efforts with other agencies in a complementary fashion (GAINS Center, 1999).

Good transition planning for jail inmates with co-occurring disorders requires a division of responsibility among jails, jail-based mental health and substance abuse treatment providers, and community-based treatment providers. Jails should be charged with the screening and identification of inmates with co-occurring disorders, crisis intervention and psychiatric stabilization; such functions are not only constitutionally mandated, but also facilitate better management of jails and supply enough information to alert discharge planners to inmates needing transition planning services. After those functions, a jail's principle discharge planning responsibility should be to establish linkages between the inmates and community services. The goal of these linkages is to reduce disruptive behavior in the community after release and to decrease the chances that the person will re-offend and reappear in the jail.

### The APIC Model

<b>Assess</b>	<i>A</i> ssess the inmate's clinical and social needs, and public safety risks
<b>Plan</b>	<i>P</i> lan for the treatment and services required to address the inmate's needs
<b>Identify</b>	<i>I</i> dentify required community and correctional programs responsible for post-release services
<b>Coordinate</b>	<i>C</i> oordinate the transition plan to ensure implementation and avoid gaps in care with community-based services

Table 1.

In general, integration of criminal justice, mental health and substance abuse systems can reduce duplication of services and administrative functions, freeing up scarce resources that can be used to provide transition planning and assist inmates with co-occurring disorders in their re-entry to community from jail. Mechanisms for creating this interconnected network will include the following: new relationships among service organizations to coordinate the provision of services, the accurate recording of service provision, management information systems (with information sharing as permitted by confidentiality requirements), and staff training. Working partnerships among probation, neighborhood businesses, and service providers can also develop opportunities for the ex-inmate to participate in restorative and therapeutic activities and community service projects.

A coordinating committee comprising all stakeholders at the local level can be a key element in systems integration. This coordinating committee will work with staff providing transition planning to identify and remove barriers to successful re-entry. System integration is not an event, a document, or position. It is an ongoing process of communicating, goal setting, assigning accountability, evaluating, and reforming.

Throughout this article, we follow the suggestion of the American Association of Community Psychiatrists (AACCP) by using the term “transition planning,” rather than “discharge planning” or “re-entry planning.” (AACCP, 2001). The AACCP recommends “transition planning” as the preferred term because *transition* both implies bi-directional responsibilities and requires collaboration among providers. It is understood that some ex-inmates will return to custody, and, thus re-entry can be seen as part of a cycle of care.

The APIC model for jail transition to community is described in the following pages. The critical elements have been organized to allow for a hierarchical approach that prioritizes elements for “fast-track” (i.e., less than 72 hours) inmates. Earlier elements in each section apply to all inmates; the latter elements should be conducted as allowed by time, the court, and the division of resources between correctional staff and community providers.

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*Transition planning can only work if justice, mental health, and substance abuse systems have a capacity and a commitment to work together ... [T]he results ... will only be as good as the ... partnership in the community.*

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## The APIC MODEL

### 1. **Assess** the clinical and social needs, and public safety risks of the inmate

Assessment catalogs the inmate's psychosocial, medical, and behavioral needs and strengths. The nature of behavioral health problems is described, their impact on level of functioning is reviewed, and the inmate's motivation for treatment and capacity for change is evaluated (Peters and Bartoi, 1997). The time for assessment is dependent on the time the individual spends in jail. "Fast-track" strategies will be required for inmates spending less than 72 hours. A hierarchy of assessment strategies should be employed to ensure, even for short-stay inmates, basic needs are identified and linkage to resources is achieved. For longer stay inmates, longitudinal assessment strategies can be developed that are informed by continual observation and the collection of relevant records and opinions.

Transition planning is an essential component of the treatment plan and should begin as soon as any behavioral disorder is identified after incarceration (Jemelka et al., 1989). While uniform methods should be developed for screening and identification of people with behavioral disorders, a valid, reliable, and efficient screening tool is yet to be available (Veysey et al., 1998). Standardized screening tools with follow-up assessment strategies should be employed. Because of the high rates of co-occurring disorders among jail inmates, the detection of either a substance use disorder or a mental illness should trigger an evaluation for co-occurring conditions.

A specific person or team responsible for collecting all relevant information—from law enforcement, court, corrections, correctional health, and community provider systems—must be clearly identified. If the inmate has been previously incarcerated at the detention center, previous treatment records and transition planning documents should be obtained. This person or team will be responsible for utilizing all available information to create a fully informed transition plan. Mechanisms for getting all relevant information to the person/team must be established.

### **Assessment involves...**

- √ *cataloging the inmate's psychosocial, medical, and behavioral needs and strengths*
- √ *gathering information—from law enforcement, court, corrections, correctional health, families and community provider systems—necessary to create a fully informed transition plan*
- √ *incorporating a cultural formulation in the transition plan to ensure a culturally sensitive response*
- √ *engaging the inmate in assessing his or her own needs*
- √ *ensuring that the inmate has access to and means to pay for treatment and services in the community*

Pre-trial services and the court system should provide adequate time to the releasing facility to develop a comprehensive community-based disposition plan or assign responsibility for comprehensive assessment to community providers; courts should coordinate with transition planners to ensure that plans can be completed and implemented without delaying release of inmates. Action protocols should be developed for correctional staff to identify and respond to potential behavioral health and medical emergencies. While the responsibility for assessing risks to public safety is traditionally the role of the court, communication between behavioral health providers and an inmate's defense attorney may provide useful information that the attorney can use in advocating for appropriate community treatment and court sanctions (Barr, 2002).

Special needs of the inmate must also be considered; with very high percentages of jail inmates in many jurisdictions being people of color, it is critical to incorporate a cultural formulation in the transition plan to ensure a culturally sensitive response. If the inmate does not speak English as their primary language, the transition plan must also determine and accommodate any need for language interpretation. Attention must also be paid to gender and age to ensure that the transition plan links the inmate with services that not only will accept the person but will connect him or her with a compatible peer group.

The most important part of the assessment process is engaging the inmate in assessing his or her own needs. The person or team responsible for transition planning must involve the inmate in every stage of the transition planning process, not only to gather information from the inmate that will lead to a plan that meets the inmate's own perceptions of what s/he needs, but also to build trust between the staff member and the inmate. One of the barriers to even the best transition plan being implemented can be an inmate's perception that transition planning is an effort by the jail to restrict his or her freedom after release from the jail or even an on-going punishment. The primary way this barrier can be overcome is by engaging the inmate, from the earliest stage possible, in considering and identifying his or her own transition needs, and then building a transition plan that meets those needs.

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*The transition plan must consider special needs related to*

- *cultural identity*
- *primary language*
- *gender*
- *and age*

*to ensure that the inmate is linked with services that will accept the person and connect him or her with a compatible peer group*

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Another critical aspect of re-entry planning is ensuring that the inmate has access to and a means to pay for treatment and services in the community. An essential step in transition planning is assessing insurance and benefit status (including Medicaid, SSI, SSDI, veterans benefits, and other government entitlement programs) and eligibility. Very few communities have policies and procedures for assisting inmates in maintaining benefits while incarcerated or obtaining benefits upon release. Assessment for eligibility should be performed as early after admission as possible. People who were receiving SSI or SSDI payments when arrested have these benefits suspended if they are incarcerated for more than 30 days, but some jails have agreements with the local Social Security Administration field offices that facilitate swift reactivation of these benefits (Bazelon, 2001); creation of such agreements should be encouraged and transition planning staff should be trained to make use of such agreements. If the inmate is likely to be eligible for public benefits and insurance or private insurance then application for benefits should be incorporated into the planning phase. If the inmate is likely to have limited access to care because of inability to pay for services upon release, this should be documented and an alternative mechanism for the person to obtain treatment found.

## 2. **Plan** for the treatment and services required to address the inmate's needs

Transition planning must address both the inmate's short-term and long-term needs. Special consideration must be given to the critical period *immediately* following release to the community—the first hour, day and week after leaving jail. High intensity, time-limited interventions that provide support as the inmate leaves the jail should be developed. The intensive nature of these interventions can be rapidly tapered as the individual establishes connections to appropriate community providers. Again, the most important task of the transition planner is to listen to the inmate. Many inmates have been to jail before, and some have passed through the same jail and the same transition back to the community dozens of times; the single most important thing a transition planner can do during the planning process is learn from the inmate what has worked or, more likely, not worked during past transitions, and plan accordingly.

## **Planning involves...**

- √ *addressing the critical period immediately following release—the first hour, day and week after leaving jail—as well as the long-term needs*
- √ *learning from the inmate what has worked or not worked during past transitions*
- √ *seeking family input*
- √ *addressing housing needs*
- √ *arranging an integrated treatment approach for the inmate with co-occurring disorders—an approach that meets his or her multiple needs*
- √ *ensuring that the inmate...*
  - *is on an optimal medication regimen*
  - *has sufficient medication to last at least until follow-up appointment*
- √ *connecting inmates who have acute and chronic medical conditions with community medical providers*

Inmate input into the release plan must occur from the beginning, and should not be limited to sharing information with the planner. For example, the inmate can be enlisted, with supervision, in making phone calls to set up aftercare appointments. As the inmate's psychiatric condition improves during the course of treatment, s/he should be encouraged to assume an increasingly greater share of the responsibility for the plan that will assure ongoing and continuing care following release.

#### *Family*

Family input into the release plan should occur to the extent the inmate identifies and wishes for a family member(s) to be involved. All potential sources of community-based support should be enlisted to help the transition back to the community. The family or other primary support system should be notified of the inmate's release in advance, with inmate consent.

#### *Housing*

When faced with a behavioral health consumer in crisis in a community with inadequate supports, police often resort to incarceration for both public safety and humane concerns. Teplin and Pruett (1992) have noted that arrest is often the only disposition available to police in situations where people are not sufficiently ill to gain admission to a hospital, but too ill to be ignored. According to the National Coalition for the Homeless, "In a country where there is no jurisdiction where minimum wage earners can afford the lowest Fair Market Rent, and where rates of homelessness are rapidly growing, it is increasingly difficult to avoid jail as a substitute for housing." (National Coalition for the Homeless, 2002)

Inmates with co-occurring disorders who are homeless or at risk of homelessness should be prioritized for community low-income and supportive housing resources because the stability of these individuals is both a clinical and a public safety concern. For inmates who are homeless, referral to a shelter following release does not constitute an adequate plan. Barriers to housing, such as discriminatory housing policies, should be communicated to and resolved by a criminal justice/behavioral health oversight group (see *Coordinate*). People arrested for drug related offenses with inadequate housing should be prioritized for substance abuse treatment so that public housing restrictions can be avoided.

## ***Planning involves***

*continued...*

- √ *initiating benefit applications/reinstatements for eligible inmates—for Medicaid, SSI/SSDI, Veterans, food stamp, and TANF—during incarceration*
- √ *ensuring that the inmate has...*
  - *adequate clothing*
  - *resources to obtain adequate nutrition*
  - *transportation from jail to place of residence and from residence to appointments*
  - *a plan for childcare if needed that will allow him or her to keep appointments*

Housing providers are understandably reluctant to take in tenants with histories of violence. Conviction for arson or sex offenses makes it nearly impossible to find an individual housing upon release. Mechanisms for sharing the liability of housing high-risk ex-inmates should be developed among housing providers, public behavioral health agencies, and correctional authorities, because it is in no one's interest for these individuals to be homeless and isolated from services and treatment.

#### *Integrated treatment for co-occurring disorders*

Given the high prevalence rates of co-occurring disorders within jails, and the high morbidity and mortality associated with these disorders, the identification of effective interventions has gained great attention and a growing body of knowledge adequate to guide evidence-based practices. For the past 15 years, extensive efforts have been made to develop integrated models of care that bring together mental health and substance abuse treatment. Recent evidence from more than a dozen studies shows that comprehensive integrated efforts help people with dual disorders reduce substance use and attain remission. Integrated approaches are also associated with a reduction in hospital utilization, psychiatric symptomatology, and other problematic negative outcomes, including re-arrest (Osher, 2001). Unfortunately, in spite of these findings, access to integrated programs across the country remains limited. Nonetheless, judicial awareness of the utility of integrated care can be a stimulus for its development. Developing a transition planning system can demonstrate to judges, on both a case-by-case and system-wide level, how treatment programs that fail to meet the multiple needs of inmates with co-occurring disorders significantly reduce the likelihood of successful re-entry.

#### *Medication*

The evidence for the effectiveness of pharmacological treatment of mental illness is overwhelming (U.S. Department of Health and Human Services, 1999). Previous medication history should be accessed to assure continuity of care during incarceration, and clinicians within the jail should work with the inmate to ensure that by the time of release s/he is on an optimal medication regimen from the perspectives of improving functioning and minimizing side effects. Medication adherence is critical to successful community integration, and mechanisms should be developed to encourage and

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monitor medication compliance. A plan to assure access to a continuous supply of prescribed medications must be in place prior to the inmate's release. Packaged medications should be provided for an adequate period of time (depending on where and when the follow-up is scheduled). Prescriptions can be provided as well, assuming a payment mechanism has been established.

*Other behavioral health services*

Depending on the individualized assessment, a range of other support services may be required upon release. Treatment providers must be familiar with the unique needs of ex-inmates with co-occurring disorders. Specialized cognitive and behavioral approaches may be required. Established criminology research findings suggest that an understanding of situational, personal, interpersonal, familial, and social factors is necessary to prevent re-arrest (Andrew, 1995). Outreach and case management services are frequently useful in the engagement of people with serious mental disorders. Psychiatric rehabilitation services, including behavioral or cognitive therapy, illness management training, peer advocacy and support, and vocational training, can help ex-inmates move toward recovery.

The importance of work as both an ingredient of self-esteem and a way to obtain critical resources cannot be overestimated. Newer models of supported employment and vocational rehabilitation have provided higher percentages of people with serious mental illness the opportunity to work than previously thought possible (Becker, et al., 2001). Family psycho-educational interventions may also be appropriate when family members can be incorporated into an ex-inmate's recovery.

*Medical care*

People released from jail often have significant medical co-morbidities. Because, unlike the rest of society, inmates have a constitutional right to health care, jails for many inmates may be a place where illnesses and medical conditions are first diagnosed and treated. Linkage to ongoing community-based care following release from jail is essential if these inmates are to achieve control over or eradicate their medical conditions. Transition planning should connect inmates with specific providers for acute and chronic medical needs, as necessary.

*Recent evidence from more than a dozen studies shows that comprehensive integrated efforts help people with co-occurring disorders reduce substance abuse and attain remission. Integrated approaches are also associated with a reduction in hospital utilization, psychiatric symptomatology, and ... re-arrest (Osher, 2001).*

### *Income supports and entitlements*

As noted above, access to behavioral health and addiction treatment and to the income support that can pay for housing and other essential services is, for most jail inmates with serious psychiatric disabilities, available only through public benefits. For inmates who are eligible but not enrolled, Medicaid, SSI/SSDI, veterans, food stamp, and TANF benefit applications should be initiated during incarceration. The courts, probation department and jail behavioral health providers should work with local departments of social services and other agencies that manage indigent health benefits to avoid termination of benefits when an individual enters jail. Instead, a suspension of benefits should occur, with immediate reinstatement upon release. State policy can and should be amended to prevent people who are briefly incarcerated from being removed from state-run health and benefit plans (GAINS, 1999). Jails should enter into pre-release agreements with local Social Security offices to permit jail staff to submit benefit applications for inmates and help inmates obtain SSI and SSDI benefits as soon as possible after release.

### *Food and clothing*

No one should be released from a jail without adequate clothing and a plan to have adequate nutrition. Inadequate food and clothing is an obvious, frequent and easily preventable cause of immediate recidivism among released jail inmates. Inmates should be assessed for eligibility for food benefits, linked with those benefits, and provided a means to obtain food until those benefits become available.

### *Transportation*

A plan for transportation that will allow the individual to travel from the jail to the place s/he will live, and from the residence to any scheduled appointments, should be in place prior to release. This is a critical and often overlooked need, especially in non-metropolitan areas with spotty or nonexistent public transportation. Ex-inmates whose psychiatric symptoms make it difficult for them to travel may need to be escorted.

### *Child care*

A plan for childcare (as needed) that will allow the ex-inmate to keep appointments should be in place prior to release. This is an especially acute need for women, who are much more likely than men to be responsible for children.

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*Psychiatric rehabilitation services, including behavioral or cognitive therapy, illness management training, peer advocacy and support and vocational training, can help ex-inmates move toward recovery.*

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### 3. *Identify* required community and correctional programs responsible for post-release services

A transition plan must identify specific community referrals that are appropriate to the inmate based on the underlying clinical diagnosis, cultural and demographic factors, financial arrangements, geographic location, and his or her legal circumstances. If jail behavioral health staff do not double as community providers, they should participate in the development of service contracts with community providers to assure appropriateness of community-based care (APA, 2000).

Cultural issues, including the inmate's ethnicity, beliefs, customs, language, and social context, are all factors in determining the appropriateness of community services. Other factors in identifying appropriate services are the preferences of the inmate, including what type of treatment s/he is motivated to participate in and any positive or negative experiences s/he has had in the past with specific providers.

The appropriateness of specific placements should be determined in consultation with the community team. A complete discharge summary, including diagnosis, medications and dosages, legal status, transition plan, and any other relevant information should be faxed to the community provider prior or close to the time of release. Jails should ensure that everyone who has entered jail with a Medicaid card or other public benefit cards or identification receives these items and the rest of their property back when released. Special efforts should be made to engage the Veterans Benefits Administration in determining eligibility and providing services to qualified veterans. Every ex-inmate should have a photo ID; those who did not have one prior to arrest should be assisted in obtaining one while in jail.

Conditions of release and intensity of community corrections supervision should be matched to the severity of the inmate's criminal behavior. Intensity of treatment and support services should be matched to the inmate's level of disability, criminal history, motivation for change, and the availability of community resources. Inmates with co-occurring disorders should not be held in jail longer than warranted by their offense simply because community resources are unavailable, and people who have committed minor offenses

### *Identifying involves...*

- √ *naming in the transition plan specific community referrals that are appropriate to the inmate based on*
  - *clinical diagnosis*
  - *demographic factors*
  - *financial arrangements*
  - *geographic location*
  - *legal circumstances*
- √ *forwarding a complete discharge summary to the community provider*
- √ *ensuring that every inmate's belongings—including benefit card(s)—are returned upon release and that the inmate has a photo ID*
- √ *ensuring that treatment and supportive services match the ex-inmate's level of disability, motivation for change, and availability of community resources*

should not be threatened with disproportionately long sentences to induce them to accept treatment. Ex-inmates with low public safety risk should not be intensively monitored by the criminal justice system. Ex-inmates who need services but are not subject to substantial criminal justice sanctions should have voluntary access to intensive case management services or other services designed to engage them voluntarily. The differences between inmates with court ordered sanctions and those without must be incorporated into transition planning. Probation and parole officers working with ex-inmates with co-occurring disorders should have relatively small caseloads.

Issues of confidentiality and information sharing need to be addressed as part of any re-entry process. Responsibility to discuss and clarify issues of confidentiality and information sharing should be jointly assumed by staff within the jail and the treatment provider/ case manager in the community. The community provider's role (with regard to limits of confidentiality) vis-à-vis other social service agencies, parole and probation, and the court system also needs to be addressed and clarified with the inmate. If probation or parole is involved, specific parameters need to be set about what information the officer will and will not receive, and these parameters should be explained to the inmate. The treatment provider should discuss the potential benefits and problems for the individual in signing the "Release of Information" form, and should negotiate with probation or parole to agree upon a release that will permit enough information to be exchanged to involve the officer in treatment without compromising the therapeutic alliance. For people at risk of acute decompensation, advanced directives specifying information to be shared, treatment preferences, and possible alternatives to incarceration or hospitalization, or healthcare proxies naming an alternate individual to make treatment decisions, may be advisable.

The transition treatment plan must be included in the chart of the jail behavioral health service as well as the chart at the community behavioral health agency. Documentation should include the site of the behavioral health referral and time of the first appointment; the plan to ensure that the ex-inmate has continuous access to medication and a means to pay for services, food and shelter; precisely where the ex-inmate will live and with whom; the nature of family involvement in post-release planning or at least efforts that

## *Identifying involves*

*continued...*

- √ *supporting conditions of release and community corrections supervision that match the severity of the inmate's criminal behavior*
  
- √ *addressing the community treatment provider's role (with regard to limits of confidentiality) vis-à-vis other social service agencies, parole and probation, and the court system*

have been made to include them; direct or telephone contacts with follow-up personnel; and the “transition summary.”

#### 4. **Coordinate** the transition plan to ensure implementation and avoid gaps in care

Due to the complex and multiple needs of many inmates with co-occurring disorders, the use of case managers is strongly encouraged (Dvoskin and Steadman, 1994). In spite of the face validity of this concept, few jails provide case management services for inmates with co-occurring disorders on release (Steadman et al., 1989). The form of case management may vary between sites, but the goals remain the same: to communicate the inmate’s needs to in-jail planning agents; to coordinate the timing and delivery of services; and to help the client span the jail-community boundary after release. For inmates needing case management services, a specific entity that will provide those services should be clearly identified in the transition plan. A clinician, team or individual at the community treatment agency should be identified as responsible for the coordination/provision of community care following release. They should be contacted, kept informed, and actively involved in the transition plan. Alternatively, the community treatment agency, probation, the courts and the jail could establish a jointly funded team of caseworkers to carry out this transitional service. The development of Assertive Community Treatment (ACT) teams focused on people with serious mental illness coming out of jail has demonstrated effectiveness in reducing recidivism (Lamberti, 2001)

Case assignment to a community treatment agency must be made cooperatively by the inmate, the jail providers and the agency itself. Responsibility to assume care of the individual between the time of release and the first follow-up appointment must be explicit and clearly communicated to the individual, to the family, and to both the releasing facility and the community agency. This responsibility includes ensuring the individual

- knows where, when, and with whom the first visit is scheduled
- has adequate supplies of medications to last, *at the very least*, until the first visit
- knows whom to contact if there are problems with the prescribed medication and/or the pharmacist has a question about the prescription

### **Coordinating involves...**

- √ *supporting the case manager entity—in coordinating the timing and delivery of services and in helping the client span the jail-community boundary after release*
- √ *case assignment to a community treatment agency must be made cooperatively—by the inmate, the jail providers and the community agency itself*
- √ *explicitly communicating—to the individual, the family, the releasing facility and the community treatment agency—the name(s) and contact information of the person(s) who will be responsible for care of the ex-inmate between the time of release and the first follow-up appointment*

- knows whom to contact if there are problems (medical or social-service related) between discharge and their first follow-up appointment
- knows whom to call if it is necessary to change the appointment because of problems with transportation, daycare, or work schedule.

Incentives should be created for community providers to do “inreach” to the jails and begin the engagement process prior to release. The inmate should, prior to release, know a person from the community treatment agency that accepts responsibility for community-based treatment and care, preferably via face-to-face contact. Ideally, caseworkers from the community’s core service agencies should accompany the individual to housing or shelter and conduct assertive follow-up to insure continuity of care. Efforts should be made to make it as easy as possible for community providers to enter the jail in their efforts to maximize continuity of care. Wait time at the jail prior to seeing inmates should be reduced to a minimum; hours for their visits should be extended as much as possible; and, to the extent consistent with effective security, the search procedure upon their entering the jail should be streamlined.

At the same time, community behavioral health providers must understand and respect the need to maintain jail security. The jail staff should be willing to train community providers on how their security policies and practices work in order to facilitate the providers’ adherence to jail procedures and expedite admission to the facility.

A mechanism to track ex-inmates who do not keep the first follow-up appointment should be in place (i.e., responsibility needs to be assigned to a specific person or agency such as the releasing facility, community treatment agency, or case manager entity). The ex-inmate should be contacted, the reason for failure to appear should be determined, and the appointment should either be rescheduled or the plan for follow-up should be renegotiated with the ex-inmate.

## *Coordinating involves*

*continued...*

- √ *confirming that the inmate...*
  - *knows details regarding the first follow-up visit*
  - *has adequate medications*
  - *knows whom to contact if*
    - *there are problems with medication*
    - *there are medical or social service-related problems*
    - *it is necessary to change the follow-up appointment*
- √ *establishing a mechanism to track ex-inmates who do not keep the first follow-up appointment (appointment should be rescheduled or the plan renegotiated with the ex-inmate)*

The court system, with the participation of probation and parole officers and community providers, should utilize graduated sanctions and relapse prevention techniques, including hospitalization, in lieu of incarceration for the ex-inmate with co-occurring disorder who has violated conditions of release. Probation and parole officers should be encouraged to work with behavioral health providers to develop clinical rather than criminal justice interventions in the event of future psychiatric episodes. Probation and parole agencies should have specialized officers with behavioral health expertise; these officers should be cross-trained with behavioral health clinicians to facilitate collaboration between the clinicians and law enforcement. Law enforcement officials should have easy access to clinical consultations with behavioral health professionals. "No refusal" policies should be incorporated into contracts with community providers to ensure that ex-inmates with co-occurring disorders are not denied services that are otherwise available within the community.

An oversight group with appropriate judicial, law enforcement, social services and behavioral health provider representation should be established to monitor the implementation of release policies. Collaborative efforts bringing together correctional systems and community-based organizations are particularly promising (Griffin, 1990, Hammett, 1998). A mechanism for rigorous quality assurance must be established. The jail and community providers should collaborate in establishing standards for post-release treatment planning and documentation and a mechanism to monitor implementation of the plan. A joint committee of representative jail providers and community behavioral health providers should meet regularly to monitor the process, resolve problems, and hold staff to the standards established by the committee.

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*The jail and community providers should collaborate in establishing **standards** for post-release treatment planning and documentation and a mechanism to **monitor** implementation of the plan. A **joint committee** of representative jail providers and community behavioral health providers should meet regularly to monitor the process, resolve problems, and hold staff to the standards established by the committee.*

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## Conclusion

The APIC model is a set of critical elements that, if implemented in whole or part, are likely to improve outcomes for people with co-occurring disorders who are released from jail. Which of these elements are most predictive of improved outcomes awaits empirical investigation. The National Coalition for Mental and Substance Abuse Health Care in the Justice System noted that any comprehensive vision of care for people with co-occurring disorders re-entering community must “build lasting bridges between mental health and criminal justice systems, leading to coordinated and continual health care for clients in both systems” (Lurigio, 1996). Successful development of these “bridges,” jurisdiction by jurisdiction, will ultimately create an environment where ex-inmates with co-occurring disorders have a real opportunity for successful transition.

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