

**AFTERCARE PLANNING FOR INMATES WITH SEVERE AND PERSISTENT  
MENTAL ILLNESSES RELEASED TO THE COMMUNITY  
FROM STATE CORRECTIONAL INSTITUTIONS**

**A Report in Response to a Request by  
The Honorable Stephen R. Wise, Florida State Senator, 5<sup>th</sup> District  
The Florida Legislature**

**December 23, 2004**

**EXECUTIVE SUMMARY**

At the request of Senator Wise, a workgroup was convened by the Department of Corrections and the Department of Children and Families to address aftercare planning for inmates with severe and persistent mental illnesses released to the community from state correctional institutions.

The workgroup found that there is a fragmented aftercare planning system for inmates with severe and persistent mental illnesses being released to the community, resulting primarily from a lack of ongoing collaboration between the Department of Corrections (DC) and the Department of Children and Families (DCF). This fragmentation largely stems from insufficient coordination of the aftercare planning processes utilized within each of the two agencies. Consequently, the aftercare plans of many inmates with severe and persistent mental illnesses who are released to the community are marginally effective in ensuring continuity of requisite mental health aftercare. The workgroup identified the following major gaps in the current aftercare planning process:

1. There is no current interagency agreement or memorandum of understanding between the two departments that specifies roles for each department in aftercare planning for inmates with severe and persistent mental illnesses.
2. There is a lack of role delineation between the DCF districts/region and their contracted community mental health providers for aftercare services to inmates with severe and persistent mental illnesses released to the community.
3. There is a history of failed first appointments by inmates with severe and persistent mental illnesses, with no identifiable mechanism for follow-up prescribed in mental health statutes, rules or contracts.

The Department of Corrections and the Department of Children and Families recommend the following to address the above referenced gaps in the current aftercare planning process:<sup>1</sup>

1. Develop an Interagency Agreement between the Department of Children and Families and the Department of Corrections with the purpose(s) of:
  - a. Strengthening the linkages between the two systems of care;
  - b. Incorporating the DCF Target Populations and Priority Clients in the agreement and achieving mutual agreement regarding identifying and addressing inmate service needs before release;
  - c. Sharing information and data through the identification of state-level contact liaisons;
  - d. Developing stronger linkages with the Social Security Administration;
  - e. Arranging in-service training on applying for Social Security benefits, using for example, representatives from the Social Security Administration and/or the University of South Florida Louis de la Parte Florida Mental Health Institute; and
  - f. Conducting ongoing review of aftercare planning for inmates with severe and persistent mental illnesses released to the community; and taking additional actions in the future as needed to ensure adequate mental health aftercare planning for such persons. Such actions will include but not be limited to an assessment regarding any additional resources that may be required to address the needs of this population.
2. Initiate a process of joint planned in-service training events and ongoing technical assistance to DCF districts/regions staff and providers, and pertinent DC staff;
3. Educate the courts to use split sentences for individuals with severe and persistent mental illnesses to ensure post-release community supervision and continuance of necessary treatment;
4. Update and revise both departments' release planning procedures to ensure alignment with the proposed interagency agreement;
5. Establish and maintain a current directory of community-based providers on the DCF internet, so that it is consistently available to DC staff during mental health aftercare planning; and

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<sup>1</sup> These recommendations are repeated beginning on page 9 of this report.

6. Where indicated and practical, assign a DCF case manager provider to inmates with severe and persistent mental illnesses prior to release.

The first recommendation will be acted upon and completed by June 30, 2005. The remaining recommendations will be acted upon and completed by December 31, 2005.

## **REQUEST SUMMARY**

In a letter dated November 6, 2003, the Honorable Stephen R. Wise, State Senator, requested that the Department of Corrections (DC) and the Department of Children and Families (DCF) convene a workgroup to study and report on the relative adequacy of aftercare planning for inmates with severe and persistent mental illnesses who are released to the community from state prison.

Senator Wise raised five specific issues for discussion:

1. What steps need to be taken for inmates discharged to be included in the priority population to receive mental health funding? Is such designation advisable?
2. What can be done to seek Medicaid eligibility for inmates, preferably prior to their release, so that it may be accessed as quickly as possible upon their release?
3. What are the gaps in the current mental health referral system and what are the mechanisms to close these gaps?
4. How can a system of referral for mental health services be developed that includes "follow-up" mechanisms to help ensure that clients attend their appointments?
5. Are there reasonable steps that can be taken to ensure that mentally ill inmates complete travel to their intended destination after being released from prison?

The original due date for the report of October 1, 2004, was extended to December 31, 2004.

## **PROCEDURE**

The following activities were conducted in support of this effort:

- A glossary of terms was established for the workgroup's use in addressing issues (See Appendix 1);

- A workgroup was established that included representatives from the Department of Corrections, Department of Children and Families, Agency for Health Care Administration's (AHCA) Medicaid Program, Florida Mental Health Institute (FMHI), Florida Council for Community Mental Health (FCCMH), and staff of the Florida Senate (See Appendix 2);
- A series of workgroup meetings were held;
- Two surveys were taken, one of DCF staff and one of DC staff, to determine the relative adequacy of aftercare planning for inmates with severe and persistent mental illnesses who are released to the community (See Appendix 3);
- An April 30, 2004, FMHI study on mental health service utilization by prison inmates who were released to the community was reviewed;
- A computer search of relevant literature was completed (See Appendix 4);
- Data from both departments was reviewed (See Appendix 5); and
- A list of suggested strategies and recommendations from the Florida Council for Community Mental Health was reviewed (See Appendix 6).

## **FINDINGS**

### **Overview of Current Aftercare Planning Efforts**

Both departments have aftercare planning procedures to follow when inmates with severe and persistent mental illnesses are preparing for release to the community. Those procedures delineate guidelines to ensure aftercare services are available to inmates with severe and persistent mental illnesses whose release to the community is imminent. As currently written, the two separate procedures are not sufficiently integrated to consistently ensure development of effective aftercare plans for inmates who need them.

### **Gaps/Problems Associated with Current Aftercare Planning Efforts**

The workgroup identified several procedural and administrative issues that contribute to the gaps in the current aftercare planning efforts. These gaps, in order of priority, are as follows:

1. There is no current interagency agreement or memorandum of understanding between the two departments that specifies roles and responsibilities for each department in aftercare planning;

2. There is a lack of role delineation between the DCF districts/region and their contracted community mental health providers for coordinating aftercare services; and
3. There is a history of failed first appointments by inmates with severe and persistent mental illnesses with no identifiable mechanism for follow-up prescribed in statutes, rules or contracts.

**Issue 1:** What steps need to be taken for inmates discharged to be included in the priority population to receive mental health funding? Is such designation advisable?

**Background:**

- No special designation exists in the community mental health system for former inmates with severe and persistent mental illnesses.
- Of the 2,690 inmates with severe and persistent mental illnesses released in fiscal year 2003-2004, 25 percent (668) of those individuals accessed community mental health services. Only 17 percent, or 474, of the inmates were released with community supervision such as probation or conditional release. This data reflects greater penetration than originally anticipated.
- All released inmates with severe and persistent mental illnesses are included in the Department of Children and Families Target Populations, but only those inmates with severe and persistent mental illnesses who meet the criteria specified in Chapter 65E-15, Florida Administrative Code, are included as Priority Clients and thus eligible for case management services.
- A Target Population, as cited in s. 394.9082(7)(b), Florida Statutes, refers to persons in need of substance abuse or mental health services who fit the profile of one of the legislatively-mandated Target Populations.
- A Priority Client is an individual who meets the criteria for Continuity of Care Case Management services as defined in Chapter 65E-15, Florida Administrative Code.
- As currently defined in Chapter 65E-15, Florida Administrative Code, Priority Client status includes most, if not all, soon-to-be released inmates with severe and persistent mental illnesses in need of mental health aftercare planning.
- Although the Department of Corrections has no authority to establish the priority of mental health services for post-release offenders, they support the designation as a Priority Client and would work with DCF to establish criteria for inmates with severe and persistent mental illnesses.

- There is a limited understanding between the two departments of how each other's system of care operates, and the Target Populations of each system.
- It is very likely that a significant percentage of inmates with severe and persistent mental illnesses already meet the criteria for one of the several DCF Target Populations but are not receiving services because they did not meet, or were not evaluated to determine, their eligibility as a Priority Client.
- There are no current interagency agreements or memoranda of understanding between the two departments.
- Additional training is needed for all district/region adult mental health/forensic coordinators on the full range of inmates with severe and persistent mental illnesses, and for affected DC staff to ensure that they are aware of DCF's Target Populations, and the Priority Client status requirements for adult community mental health.
- There is a lack of data sharing between the two departments.

**Conclusion:**

Better coordination and integration of the mental health aftercare planning process between the two departments will ensure that soon-to-be released inmates with severe and persistent mental illnesses will be identified and referred for mental health aftercare services as Priority Clients when indicated. Recommendations 1, 2, 4, and 6 on page 9 of this report are applicable to this issue.

**Issue 2:** What can be done to seek Medicaid eligibility for inmates, preferably prior to their release, so that it may be accessed as quickly as possible upon their release?

**Background:**

- It is possible that inmates are enrolled in Medicaid but the district/region is not aware of the enrollment. It is also possible that Medicaid eligibility may be retroactive once it is granted so enrollment actually trails first service.
- It was suggested that the Department of Children and Families' economic determination representatives coordinate with institutional staff to assist inmates in obtaining Supplemental Security Income (SSI) and Medicaid eligibility prior to their release.
- The lack of Social Security and Medicaid benefits serve as major barriers to successful community placements and hinder access to primary health care.

- The two departments have not typically shared information regarding their approach to linking with the Social Security Administration.
- DC should have guidelines for linking with the Social Security Administration and should develop a process for initiating pre-release SSI/Medicaid applications.
- DC would benefit from training on Social Security application procedures.

### **Conclusion:**

A formal, organized approach to assisting inmates with severe and persistent mental illnesses to apply for Supplemental Security Income (SSI) and Medicaid while still incarcerated needs to be developed. Additionally, the development of an interagency agreement between the two departments and the provision of training on social security applications would help to address this issue. Recommendations 1, 2, 4 and 6 on page 9 of this report are applicable to this issue.

**Issue 3:** What are the gaps in the current mental health referral system and what are mechanisms to close these gaps?

### **Background:**

- There are three (3) major gaps (delineated on page 1 of this report) which can be eliminated or minimized through a designation of inmates with severe and persistent mental illnesses as Priority Clients.
- DC reports that inmates with severe and persistent mental illnesses who are released but not enrolled in Medicaid's targeted case management service or DCF's intensive case management or Florida Assertive Community Treatment (FACT) typically have a poor compliance rate for keeping appointments.
- DC also reports that many community mental health providers are reluctant to schedule an appointment with a released inmate with severe and persistent mental illness, and simply advise the inmate to "show up". DC attributes this reluctance to the historically high incidence of "no-shows" by released inmates.
- Scheduling appointments with community mental health providers is problematic because appointments are often at a premium.
- Scheduling of inmate appointments in the necessary timeframe (within 30 days, based on supply of medications the inmate receives upon release) is often very difficult.

- To forge stronger linkages between the two departments, it would be helpful for district/region adult mental health/forensic coordinators and community mental health center case managers to have a greater physical presence at DC institutions. Such visibility and availability would facilitate better and more productive coordination of the referral process between DCF, DC, and community mental health center (CMHC) staff.
- Unless a former inmate is under community supervision (e.g. through conditional release or probation), he/she may not be compelled to keep an aftercare or other mental health appointment.

**Conclusion:**

Insufficient coordination of aftercare planning between the two departments attenuates the effectiveness of aftercare plans that are established for inmates with severe and persistent mental illnesses. The several recommendations on page 9 of this report are applicable to this issue.

**Issue 4:** How can a system of referral for mental health services be developed that includes “follow-up” mechanisms to help ensure clients attend their first appointments?

**Background:**

- Of the 668 former inmates with severe and persistent mental illnesses served within the adult community mental health, 52 percent were seen within the first month of their release to the community.
- Stronger collaboration and coordination between the two departments would enhance better follow-up.
- An interagency agreement between DC and DCF will improve coordination.
- There is a general perception that an inmate’s first appointment is made prior to release.
- Districts are often unaware that a first appointment has been made.
- Follow-up could be improved if the community mental health provider had accurate contact information, including address and telephone number and the telephone number of the probation officer for conditional releases.
- Currently, DC policy requires institutional case managers to commence aftercare planning within 180 days of end-of-sentence for inmates with severe and persistent mental illnesses.

## **Conclusion:**

Stronger coordination through an interagency agreement, sharing of data, and educating pertinent judicial, correctional and DCF staff would ensure effective follow-up. The several recommendations on page 9 of this report are applicable to this issue.

**Issue 5:** Are there reasonable steps that can be taken to ensure that mentally ill inmates complete travel to their intended destination after being released from prison?

## **Background:**

- Effective mental health aftercare planning and follow-up is a shared responsibility of both departments that can be addressed by developing interagency protocols.
- Except for inmates who are released under community supervision (e.g. conditional release) or to an inpatient mental health facility, there is no jurisdictional authority for DC staff to ensure that mentally ill inmates complete travel to their intended destination upon release from prison.

## **Conclusion:**

Stronger coordination efforts between the departments, sharing of data and educating pertinent judicial, correctional and DCF staff would increase the likelihood of inmates reaching their intended destination. Recommendations 1, 2, 4, and 6 on page 9 of this report are applicable to this issue.

## **RECOMMENDATIONS**

1. Develop an Interagency Agreement between the Department of Children and Families and the Department of Corrections with the purpose(s) of:
  - a. Strengthening the linkages between the two systems of care;
  - b. Incorporating the DCF Target Populations and Priority Clients in the agreement and achieving mutual agreement regarding identifying and addressing inmate service needs before release;
  - c. Sharing information and data through the identification of state-level contact liaisons;
  - d. Developing stronger linkages with the Social Security Administration;

- e. Arranging in-service training on applying for Social Security benefits, using for example, representatives from the Social Security Administration, and/or the University of South Florida Louis de la Parte Florida Mental Health Institute; and
  - f. Conducting ongoing review of aftercare planning for inmates with severe and persistent mental illnesses released to the community; and taking additional actions in the future as needed to ensure adequate mental health aftercare planning for such persons. Such actions will include but not be limited to an assessment regarding any additional resources that may be required to address the needs of this population.
2. Initiate a process of joint planned in-service training events and ongoing technical assistance to DCF districts/regions staff and providers, and pertinent DC staff;
  3. Educate the courts to use split sentences for individuals with severe and persistent mental illnesses to ensure post-release community supervision and continuance of necessary treatment;
  4. Update and revise both departments' release planning procedures to ensure alignment with the proposed interagency agreement;
  5. Establish and maintain a current directory of community-based providers on the DCF internet, so that it is consistently available to DC staff during mental health aftercare planning; and
  6. Where indicated and practical, assign a DCF case manager provider to inmates with severe and persistent mental illnesses prior to release.

The first recommendation will be acted upon and completed by June 30, 2005. The remaining recommendations will be acted upon and completed by December 31, 2005.

## **APPENDICES**

## APPENDIX 1

### (Glossary of Terms Used in the Report)

**Aftercare services** means activities designed to prevent relapse and are a vital part of recovery in every treatment level. Activities include client participation in daily activity functions that were adversely affected by mental illness and/or substance abuse impairments. New directional goals such as vocational education or re-building relationships are often priorities. Relapse prevention issues are critical in assisting the client's recognition of triggers and warning signs of regression. Aftercare services help families and pro-social support systems reinforce a healthy living environment.

**Case Management Services** consist of activities aimed at identifying the recipient's needs, planning services, linking the service system with the person, coordinating the various system components, monitoring service delivery, and evaluating the effect of the services received.

**Community Mental Health Center (CMHC)** means a Community Mental Health Center contracted to provide specific services purchased by the Department of Children and Families.

**Community case managers** means individuals hired by Community Mental Health Centers to perform activities aimed at identifying the recipient's needs, planning services, linking the service system with the person, coordinating the various system components, monitoring service delivery, and evaluating the effect of the services received.

**District/region Adult Mental Health/forensic Coordinator** means an individual hired by the District Mental Health Program Office to coordinate aftercare services for inmates with severe and persistent mental illnesses being released from prison.

**Institutional Case Managers** means Department of Corrections Psychological Specialists that actively monitors inmate day-to-day progress through the system for the receipt of mental health care.

**Medication management** means the review of relevant laboratory test results, prior pharmacy interventions (i.e., medication dosages, blood levels if available, and treatment duration), and current medication usage. Medication management includes the discussion of indications and contraindications for treatment, risks, and management strategies with the recipient or other responsible persons.

**Outreach services** mean a formal program to both individuals and the community. Community services include education, identification, and linkage with high-risk groups. Outreach services for individuals are designed to

encourage, educate, and engage prospective clients who show an indication of substance abuse and mental health problems or needs.

**Priority client** mean persons of all ages with one of the following characteristics:

- a) Being admitted to a state facility or are awaiting admission to a state treatment facility;
- b) In a state treatment facility regardless of admission date;
- c) Moved into the district from a district where they had been receiving case management;
- d) At risk of institutionalization or incarceration for mental health reasons;
- e) Discharged from a state treatment facility;
- f) Had one or more admissions to a crisis stabilization unit (CSU), short-term residential facility (SRT), or inpatient unit;
- g) Reside or have been discharged from a mental health residential treatment facility; or
- h) Are experiencing long-term or serious acute episodes of mental impairment that may put them at risk of requiring more intensive services.

**Receiving facility** means any public or private facility designated by the Department of Children and Families to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. The term does not include a county jail.

**Severe and Persistent Mental Illnesses** means, for purposes of this report, conditions involving an Axis I or Axis II mental disorder (as defined in the current Diagnostic and Statistical Manual of Mental Disorders), and co-existence of any of the following:

- Documented evidence of long-term psychiatric disability;
- Current or past eligibility for public financial assistance (e.g. SSI, SSDI, Veterans or other);
- Age 60 or older and unable to perform independently in day-to-day living (e.g. personal hygiene, dressing appropriately, obtaining regular nutrition and housekeeping); and
- At risk of institutionalization or incarceration for mental health reasons.

**Target populations** mean a grouping of individuals sharing similar characteristics that the Department of Children and Families is authorized by the legislature to serve.

## APPENDIX 2

### DOC/DCF Workgroup Members

<b>CHAIR:</b>	Cynthia Holland, Department of Children and Families
Dean Aufderheide, Ph.D.:	Department of Corrections
Tim Boaz, Ph.D.:	Florida Mental Health Institute
Neal Carter, Ph.D.:	Department of Corrections
Sheila Collins:	Florida Senate
Pat Curtis	Florida Council for Behavioral Healthcare
Rick Donk:	Department of Children and Families
Roderick L. Hall, Ph.D.:	Department of Children and Families
Suzanne Harrell:	Department of Children and Families
Cynthia Holland:	Department of Children and Families
Ron Kizirian:	Department of Children and Families
Karen Koch	Florida Council for Community Mental Health
Deborah McNamara:	Agency for Health Care Administration
Sen Yoni Musingo, Ph.D.:	Department of Children and Families
Stephen Poole:	Department of Children and Families
David Randall:	Department of Corrections
Linda Rollins	Advocacy Center for Persons with Disabilities
Wendy Scott:	Department of Children and Families

## Appendix 3

### Summary of Survey Results

- Two of the seven districts/providers responding believed 100 percent of the DC referrals met the DCF criteria as a Priority Client while another two districts estimated that approximately 50 percent of referrals met the criteria. One district estimated approximately 10 -15 percent met the criteria and one district reported that it did not maintain data on DC-referred inmates.
- Inmates with severe and persistent mental illnesses being referred by DC for adult community mental health services who did not meet the criteria for Priority Client status typically were placed on a waiting list for services. Services typically provided to non-priority individuals are medication management rather than case management services.
- Three districts report that 100 percent of all released inmates come to the community without SSI/Medicaid benefits; one district estimates 96 percent are released without SSI/Medicaid benefits; one district reports 80 percent or more; one district states very few have benefits and one says the data is not available at the district level.
- District/region adult mental health/forensic coordinators believe that the application or reinstatement of benefits process is the responsibility of DC.
- Responses from the DCF/DC survey process identified the following gaps:
  1. Funding is not adequate to support case management issues;
  2. Data is not shared;
  3. Improved coordination between DC/DCF/CMHC is needed to improve linkages at the system and individual level.
- The number of inmates actually keeping their first appointment ranges from 0 percent to as high as 65 percent. Typically, unless a person was previously known to a mental health provider, there is no way to follow up in cases where an appointment is missed. Some mental health providers may send a follow-up letter but the effectiveness of this approach is unknown.
- Of the 8 respondents, only 1 district reports NOT scheduling a mental health appointment prior to the inmate's release; 5 reported they do and 2 reported appointments are only sometimes scheduled prior to release.
- For the percentages of inmates that attend their first appointment, responses ranged from 0 percent to 65 percent. All were estimates and 3 reported they did not know.

- With regard to follow-up on missed appointments, 3 reported follow-up with a letter or phone call; 2 reported follow-up sometimes if the inmate was previously known by the CMHC or if the inmate had an assigned case manager; 2 reported no follow-up; and 1 reported not knowing.
- The following were recommended to ensure follow-up: accurate contact information (phone number, address); flexible funding; mandatory probation; pay inmates to attend their first appointment; assigning a case manager or specially trained mental health probation counselor prior to the inmate's release – someone accountable for follow-up; funding of outreach services to locate released inmates and follow-up with them.
- Four districts report that 100 percent of inmates released from prison were committed under chapter 394 to a receiving facility, 1 district estimated only a small percentage were committed, and 3 districts did not know the percentage.
- One district reported less than 10 percent of inmates released from prison were committed under chapter 394 to a state hospital, 1 district estimated a small percentage were committed, 3 districts reported 0 percent were committed, and 3 districts did not know the percentage.
- Seven districts reported not knowing the percentage of inmates who make it to their intended destination upon release, 1 district estimated a high percentage made it to their destination and kept their first appointment, but 3 districts reported that it was the responsibility of DC to ensure that inmates arrive, and 2 reported that it is a shared responsibility of DC and DCF, while 2 districts offered no response.
- Recommendations to ensure arrival included: transport all inmates requiring mental health follow-up to a receiving facility in the community; DC to designate resources to track inmates to their designation; mandate compliance and follow-up by probation officer; needs to be a priority issue for DC; a case manager/specially trained mental health probation counselor assigned prior to release and responsible to transport the inmate if necessary; DC should transport and notify DCF upon arrival.

## Appendix 4

### Summary of National Literature Review

- It is clear that persons with severe mental illnesses are overrepresented in jails and prisons. Studies suggest that the prevalence of severe mental disorders in correctional facilities ranges between 6 percent and 16 percent. That is significantly higher than the rate of 2.8 percent in the general population.
- Nationally, several contributing factors have been identified as probable causes for the increased number of inmates in the nation's prisons with severe mental illness. Chief among those identified are:
  1. Lack of consistent community services;
  2. Mandatory sentencing: the removal of judicial discretion;
  3. Lack of treatment in jails and prisons;
  4. Inflexible legal standards relating to legal insanity and incompetence to stand trial; and
  5. No diversion under court monitoring of nonviolent, mentally disordered offenders who are willing to accept treatment.
- Some of the national factors contributing to offenders recycling through the criminal justice system include:
  1. Lack of Supplemental Security Income (SSI) or loss of eligibility while institutionalized;
  2. Lack of discharge planning in the jails and prisons;
  3. The failure of mental health agencies and the courts to properly execute the jurisdiction's mental health laws;
  4. Lack of case management;
  5. The exclusion from drug treatment of mentally disordered substance abusers;
  6. Lack of effective discharge planning
  7. Lack of probation supervision; and
  8. Failure to establish specialized mental health courts or, alternatively, assigning specially trained judges and lawyers to cases involving mental disorders and co-occurring diagnoses (Broward Mental Health Court and similar efforts in Florida are notable exceptions).
- Particularly relevant to issues of DC/DCF coordination is Part I, Chapter IV, of the *Criminal Justice/Mental Health Consensus Project*, entitled, Incarceration and Reentry. Recommendations from this document are contained in the workgroup's recommendations.

- A recent national study listed the following issues as barriers to successful community reentry<sup>2</sup>:
  1. Lack of adequate arrangements to meet inmates' needs including treatment, supervision, and housing;
  2. Released inmates often experience homelessness and behavioral problems that lead to re-incarceration;
  3. Community mental health providers frequently feel ill-equipped to serve this population; and
  4. There are not enough innovative reentry programs for offenders with mental illness to reenter the community.
  
- The same study made the following strategic recommendations to achieve successful individual community reentry:
  1. An individual discharge plan that is *collaboratively* developed by the community and institutional staff, the inmate with mental illness, and, if possible, his or her relatives;
  2. The discharge plan should include continuity of medication, appointments with community clinicians known to the inmate, income benefits, and health care after release;
  3. Attention should be paid to personal identification, transportation, and other issues that arise in the first days after release;
  4. Integrated treatment for mental illness and co-occurring substance abuse disorders are clearly needed;
  5. Communication among all agencies must begin long before the inmate's release date;
  6. Clarity among corrections and mental health staff about their respective duties in monitoring the person in the community after reentry;
  7. Differences in mission, culture and funding must be overcome because strained relationships between two distinct entities compromises successful reentry;
  8. Strategies to facilitate collaboration include:
    - a). Examining databases and expenditures to identify shared clientele, duplicative activities, and service gaps;
    - b). Offering cross training that provides criminal justice staff with concrete information about mental illness, recovery, and the use of clinical information;
    - c). Training mental health staff on relevant legal procedures, agency responsibilities, and how to write reports that are useful to criminal justice staff;
    - d). Joint training of staff on the different "worlds" of corrections and health care and how to establish better relationships;
    - e). Negotiating clear, written agreements among agencies about clinical information sharing, management information systems, staff liaisons, and dispute resolution as well as agreements that deal with how to assist

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<sup>2</sup> Slowing the Revolving Door: Community Reentry of Offenders with Mental Illness, Haimowitz, Stephan, J.D., Psychiatric Services, Vol. 55, No. 4, April 2004.

- persons who were released with housing, substance use problems, and public benefits;
- f). Determining each agency's contribution to reentry – for example, staff time, space, changes in operating practices, shifting funds, and responsibilities; and
  - g). Creating joint efforts between agencies – for example, working together to apply for funding and seeking changes in state implementation of federal benefit rules.
- The United States Senate gave final approval on October 12, 2004, to a bill (S. 1194) to address the growing number of people with mental illnesses in the criminal justice system. The Mentally Ill Offender Treatment and Crime Reduction Act would authorize \$50 million in federal funding for grants to states to support pre- and post-booking interventions, including crisis intervention teams and law enforcement training, mental health courts and other court-based approaches, re-entry and transitional programs. The bill establishes one-year planning grants and five-year implementation grants that would require states to increase their share of funding for the program in later grant years.

## Appendix 5

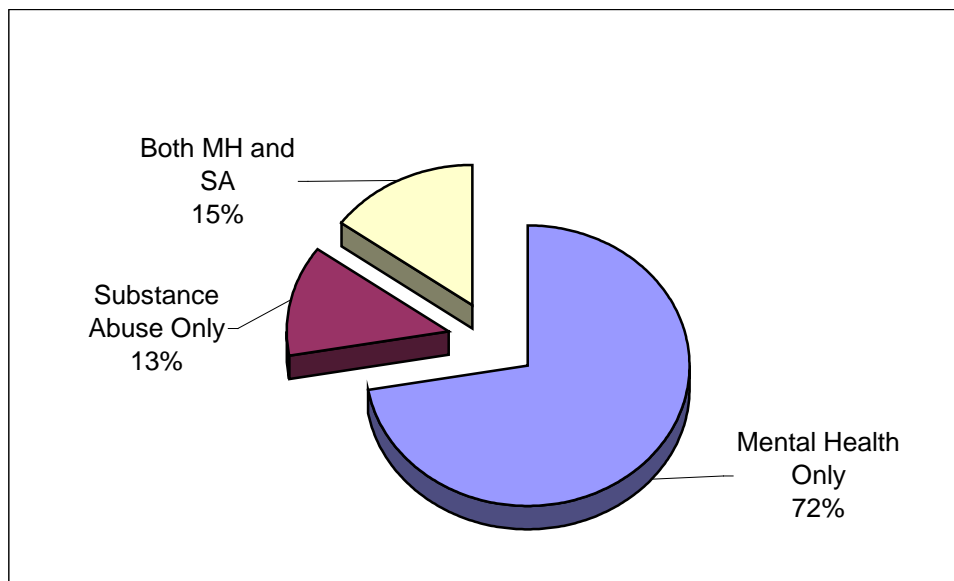
### Summary of Data Relevant to Issues Breakdown of Inmates Released – Approximate Numbers (Historical data; not based on a specific fiscal year)

Type of Release	Number
Number of inmates released	29,000
Average number of inmates released with a mental disorder	2,700
Number of inmates released with conditions	948
Number of inmates released with conditions preset by court that DC cannot change	474
Number of inmates released with conditions that can be impacted by the Parole Commission via DC recommendations	474

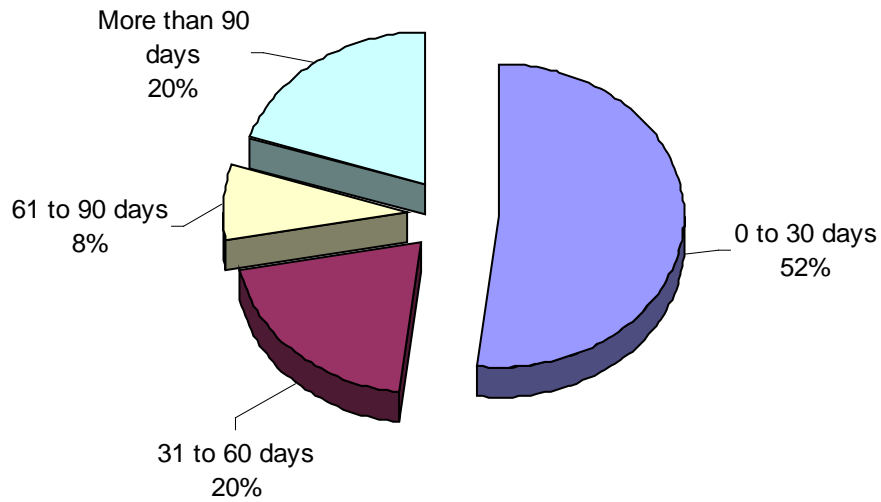
Number Released from DC and Served by DCF		
	FY 02-03	FY 03-04
Unduplicated SSN in file	2,482	2,690
Total SSN found in ADM community data system*	779	668
Percent found	31%	25%

\*Service date must have occurred after release date

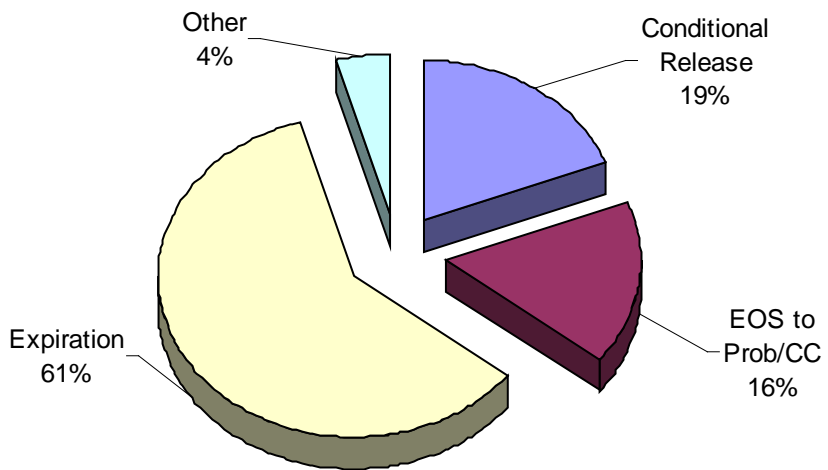
### Types of DCF Services Received by Released Inmates in FY 03-04



**Percent of People Served in DCF Within Specified Time Frames From DOC Date of Release FY 03-04**

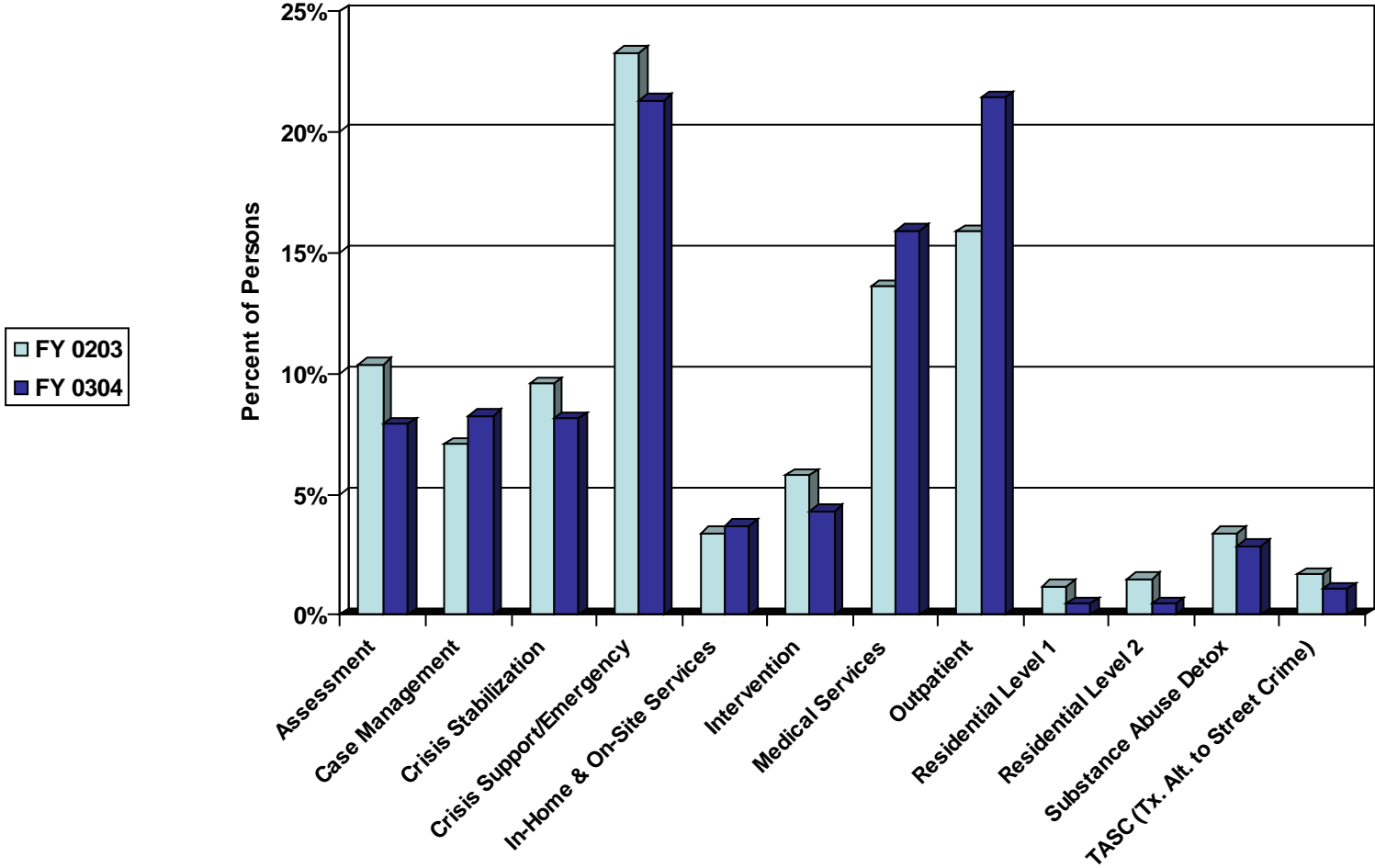


**DOC Release Type for Persons Served in DCF FY 03-04**



Expiration = Expiration of Sentence and no community supervision  
 EOS to Prob/CC = End of Sentence; Released on Probation

Percent of Persons by First Service After-Release Date By Fiscal Year  
 Persons may be included in more than one service.  
 Services with less than 1% were excluded.



## Appendix 6

### Summary of the Florida Council for Community Mental Health's Recommendations<sup>3</sup>

1. Increase funding to assure expanded priority population has services available to meet their needs such as access to low cost or free medication, outpatient services, ACT (Assertive Community Treatment).
2. Fund specialized ACT programs for released prisoners or expand Forensic FACT teams and forensic transition teams such as the Massachusetts Model.
3. Establish a program for community behavioral health agency "in-reach" to prisons to assist in treatment, transition planning, and community reintegration.
4. Establish a hotline for crisis response and assistance to released inmates and connect released individuals to 24/7 mobile crisis services.
5. Establish specialized re-entry units in large urban behavioral health agencies.
6. Ensure release of prisoner health records to appropriate community facilities.
7. Establish a Mentally Ill Crime Reduction Grant Program for community reentry demonstration programs such as the California model.
8. To the extent possible, require community behavioral health care and compliance with medication regimen as a condition of release.
9. Require DC and DCF to conduct joint-planning with designated receiving community behavioral health agency.
10. Assign community behavioral health staff to prisons to assist in transition planning.
11. Coordinate release to inpatient/residential treatment when necessary.

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<sup>3</sup> These recommendations, while not endorsed by the workgroup, may receive further consideration during ongoing review of the aftercare planning process.