Correctional Discharge Planning & the Missing Linkages

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Abstract

This research project explores correctional rehabilitation and disconnects between correctional facilities and linkage to follow up mental health treatment. One of the components to releasing inmates is providing them with services that help reintroduce them into society. For the mentally ill, linkage to mental health services after spending any amount of time in a correctional facility is heavily dependent on follow through by the former inmate and the expediency and capacity of the mental health departments’ outpatient facilities within the community the former inmate is released into.
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Entry into the correctional system is arguably understood by both individuals who have never been incarcerated and individuals who have. The offender commits a crime, a court hearing determining guilt or innocence takes place, and, if found guilty, the offender is ordered to spend time in a county jail or state prison facility. The reasons for how long a prisoner is to spend time in jail vary. Once inside, a prisoner will find that jails and prisons have programs available to them to help them adjust to the environment. Some even offer programs that allow them further their education. Towards the end of any given sentence, inmates are offered an opportunity to participate in programs that will help them transition back into the community. The challenges associated with transitioning back into the community are diverse and difficult for some depending on their status prior to entering the correctional system. One might assume that if a prisoner applies oneself, the transition should be fairly easy. If released under conditions of parole or probation, former inmates appear for appointments, take court ordered classes, and attend counseling.

But what about community transition for mentally ill inmates? Navigating the mental health system after leaving the supervision of a correctional facility can be extremely difficult, even for the most proactive prisoner. While they may be determined to keep their mental illness under control, gaps within the mental health system presents challenges. Lack of funding, staffing, and easily accessible facilities make it so that understanding why local and state correctional agencies are unable to guarantee adequate support takes a complete understanding of how many departments of mental health operate.
According to a study published in 2006 by the U.S. Department of Justice titled ‘Mental Health Problems of Prison and Jail Inmates’, the Bureau of Justice statistics reported 56 percent of state prison inmates, 44 percent of federal prison inmates, and 64 percent of jail inmates have documented mental health conditions. The sample groups included individuals who were either told they had a mental health disordered by a licensed mental health professional, were previously admitted to a psychiatric facility for observation, used psychiatric medications or received mental health therapy. The same study also looked at the percentage of inmates who were documented as having a dependency on drugs or alcohol or both. According to the same study, 41 percent of state prison inmates, 28 percent of federal prison inmates, and 48 percent of jail inmates have both mental health conditions and dependence or abuse of a controlled substance. The term used to describe individuals diagnosed as having some form of mental illness and drug dependency is referred to as ‘dual diagnosis.’

Addressing behavioral issues associated with mental illness in jails and prisons is a challenge in itself. Mentally ill inmates range from low level offenders to some of the most violent members of society. For the most violent offenders, jail seems to be the only option to receive treatment. According to a publication in the Psychiatric Services journal titled, Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program, the authors found that the use of mental health services by misdemeanants increased significantly when they were prosecuted by way of the Mental Health Court. (Henrickx, Swart, Dolezal, & King, 2005). Misdemeanants contact with the Mental Health Court had been initiated after arrest by Broward County law enforcement.
The Los Angeles County Sheriff’s Department Jail, the nation’s largest de facto mental health treatment facility (Gideon, p. 158), has sections of the jail dedicated to the segregation of mentally ill inmates. Inmates who report having a mental illness during the classification process would be screened and sent to a housing pod where they are interviewed by a nurse and psychologist. After their diagnosis is confirmed the psychologist will prescribe mood stabilizers and make recommendations for confinement in the jail system. Unfortunately, attempting to address potential behavioral issues at the onset of confinement and sending an inmate through the process also means delays in scheduling court appearances and release from custody or both.

Jails and prisons deploy the same treatment modalities used for inmates who have not been identified as mentally ill on low level offenders who have been diagnosed. For example, low level offenders who face some kind of mental health condition are allowed to participate in group treatment. There are four group treatment modalities (Clear, Cole, & Reisig, 2013). Reality therapy emphasizes personal responsibility for actions and their consequences. Correctional staff leading the therapy makes it clear to prisoners that life becomes difficult when they refuse to follow rules of society. Rather than blame others for their troubles, inmates are encouraged to take responsibility for their actions. (p. 356). Confrontation therapy is a treatment technique, usually done in a group, which vividly brings the offender face to face with the crimes’ consequences for the victim and society. (p. 356). This type of therapy can cause inmates to become angry as other inmates in the group are encouraged to be vocal. An inmate may become defensive and argumentative which presents another challenge for the offender to control his or her anger. Transactional analysis is a form of treatment that focuses on patterns of interactions with others, especially patterns that indicate personal problems (p. 356). The
facilitator takes on the role of the teacher and points out personality traits of the prisoner that may be hindering them from being able to function fairly in society. Cognitive skill building is a form of behavior therapy that focuses on changing the thinking and reasoning patterns that accompany criminal behavior. (p. 356). The facilitator focuses on teaching the offender skills that assist them in day to day living. Some methods include role playing and recreation of emotionally stressful past occurrences. Ideally, these types of treatment modalities could possibly be used on inmates identified as being diagnosed with oppositional defiance disorders during adolescence.

As the American correctional system moves towards a system of rehabilitation, so do efforts to decriminalize mental illness. It is widely believed by theorist that criminal behavior can be corrected by addressing its cause. For prisoners having no mental illness, it is understood that people make choices to break the law and that those choices are not a matter of free will. But for the mentally ill, breaking the law may not be a matter of choice or free will. Many correctional institutions have developed programs to assist inmates with transitioning back into society. One example is the Los Angeles County Sheriff’s Department Community Reentry & Resource Center. Opened in May, 2014, the sheriff’s department held the grand opening of its first ever community reentry and resource center. The CRRC, which is overseen by the Education Based Incarceration Bureau’s (EBI) Community Transition Unit (CTU), provides a wrap-around service for newly released inmates (personal communication, May 22, 2014). The purpose of the center is to link inmates to housing, mental health, drug rehabilitation, employment, and life skills services to help them transition out of jail and into a stable lifestyle. It is a collaborative of the Los Angeles County Sheriff’s Department, Los Angeles County Department of Mental
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Health, Los Angeles County Probation Department, Los Angeles County Department of Public Health, Substance Abuse Prevention & Control, healthRIGHT 360, and Volunteers of America.

While the CRRC sounds like a worthwhile endeavor that ensure adequate support for the mentally ill upon release, the services are offered on a voluntary basis and rely on independent mechanisms to initiate services. For example, when an inmate identified as mentally ill is released, they are sent out in the same manner as any other inmate. They may be provided with one or two weeks-worth of medication and provided with resource material to receive follow up services. But one of the unforeseen challenges ahead of the release is the length of time it takes to receive a follow up appointment.

Theorists believe that criminal behavior is heavily influenced by ones surroundings, psychological background, upbringing, values, and lack of good moral judgement. Mental health professionals agree that linkage to services is the most important step toward treatment as each of these elements are challenged from the moment a mentally ill inmate is released from custody. In Los Angeles County, the average wait time for an intake appointment with a Department of Mental Health or Department of Health Services outpatient clinic is two weeks. An inmate who is released with only one or two week worth of medications can run out prior to the next appointment assuming the appointment is made on the day of release. And even if the released inmate makes it to the appointment with one day of medication to spare, the appointment does not guarantee a new prescription will be written. Typically, the first appointment with the outpatient clinic is for intake purposes only. A caseworker or social worker gathers information and assesses the needs of the client to be forwarded to the psychologist. There’s also the issue of
medical coverage. Depending on the type of medical coverage the released inmate has, they may be referred a second time to another facility or their primary care provider, extending the time it takes for them to get the services they need even further.

Another unforeseen challenge is the consequence of the inmate being released with psychiatric medication that works for only a few days and then stops as it does not adequately address all, if not any, of the social behaviors. For example, as mentioned previously, alcohol and drug abuse are very common among people with bipolar disorder. The likelihood of self-medicating with drugs and alcohol increases tremendously in the non-controlled environment. This is especially true for individuals who are homeless and lack support groups that are able to monitor their behavior pending the appointment. For the homeless mentally ill community, street narcotics such as cocaine, heroin, and methamphetamine are easily accessible. As their mood deteriorates, they are easily influenced to ingest narcotic or alcohol. The homeless may decide to sell the medication as a street drug so that they’ll have money for temporary housing or food. There’s also the possibility that inmates choose not to take the prescribed medication they were released with because of the adverse side effects that come along with their use.

Perhaps the best approach to improving how mentally ill inmates are discharged is to look at the best practices of non-correctional institutions, examining the needs of the inmate from a clinical standpoint prior to release, and bringing outpatient resources into the custody environment. The first step to reintegrating mentally ill inmates into society is to integrate the services needed to adequately treat the inmate. Creating an initiating the discharge plan prior to the inmates release creates a continuum of care that leaves little room for deviation.
The first approach is to integrate licensed clinical social workers to the custody environment. The social workers can develop a standardized protocol for inmates who are pending release. Prior to release, the social worker can be responsible for scheduling appointments, advocating for the mentally ill inmate and stressing the need for visiting an outpatient clinic on a priority basis. Prior to release, the social worker will meet with the inmate and explain the plan. They can also insure that an emergency contact is notified that the inmate is being released, removing the burden of feeling responsible for releasing a mentally inmate into a community they may not be familiar with. Should the social worker be unable to notify an emergency contact, they can provide information to homeless outreach services in the area that are familiar with the needs of the mentally ill.

The second approach to discharge planning is authorizing mental health and health services departments to give priority to inmates within the first five to ten days of their release from the jail or prison. Within the timeframe, mental health professionals can assess short-term solutions for ensuring the inmate’s successful reintegration into the community, the need for follow up treatment, and reinforcement of group treatment modalities.

The last approach to discharge planning is an honest assessment of mental health and health services departments to determine whether they are capable of meeting the needs of the growing mentally ill population. Law enforcement has for quite some time been blamed for contributing to the worsening conditions of individuals identified by the mentally ill. Reforms to address the criticism has led to law enforcement agencies breaking away from their primary responsibility
which is to enforce the law and protect the constitutional rights of every citizen. Because of their shifting focus, correctional officials and law enforcement officers alike are put in positions that are in direct conflict. One example is delaying a person’s right to a speedy trial because their mental illness is such that they are unable to safely transport them to court. A second example is risking lawsuit or federal probes for over-detention because the inmate’s dual diagnosis is causing them to take longer to sober up after being arrested for being under the influence of a controlled substance prior to the mental illness becoming apparent. Alternatively, law enforcement agencies release the inmate after the allotted time despite the bizarre behavior, which could threaten the safety of the general public or the inmate himself. It is equally arguable that mental health and health service departments lack adequate funding to take on the influx of inmates referred to their outpatient facilities as they attempt to fulfill the needs of individuals already in the community. However, much like medical treatment, preventive care has the potential to reduce recidivism as time passes.

We know there is a nexus between mental illness and the likelihood of unintentional criminal activity. We also know that people who are mentally ill are not exempt from the law and therefore must be submitted to the motions of the criminal justice system. However, a lack of comprehensive discharge planning for mentally ill inmates fosters a revolving door between rehabilitation and incarceration. Greater collaboration between mental health agencies, health service agencies, law enforcement agencies, and homeless services could be done prior to an inmate’s release. It is important that mentally ill inmates follow through with recommendations for continuous treatment after release, however, it is equally important that all departments
involved in the plan work together to make it possible for the inmate to receive treatment in a timely manner.
References

