NYS DCJS JMHCP Technical Assistance Bulletin

Intercept 4: Discharge Planning and Linkage to Community - Based Treatment

Introduction:

Almost all jail inmates with mental illness will leave correctional settings and return to the community. It is estimated that 14.5% of men and 31% of women in jails have a serious mental illness. Approximately 49% of individuals leaving jail have a co-occurring substance use disorder when a serious mental disorder is diagnosed. It is also estimated that 7-9% of persons on Probation and Parole have a serious mental illness. Transition planning, that ensures these individuals have access and are linked to appropriate services such as medical (medications), housing, peer supports, mental health and substance abuse services, benefits, etc. is very important. Without adequate transition planning these individuals are at risk in the community and could compromise public safety, as well as experience increased psychiatric symptoms, relapse to substance abuse, homelessness, suicide and hospitalization.

Cross – System Planning:

Effective transition planning to the community requires cooperation and collaboration among corrections, behavioral health, community corrections and state entities. The goals for collaboration are:

- Achieve better treatment outcomes for individuals with MI who are confined in and leaving local jails through:
    - Screening and assessment
    - Provision of services
    - Discharge planning
- Enhance collaboration between MH and local correctional systems
- Contribute to reduction in recidivism among this population

Collaboration across systems requires a structure that invites all necessary parties to join, share information and agree to address issues as a group. There may be planning groups within a county that could be expanded to take on the goal of transition planning from jail for individuals with mental health disorders or a new planning group will need to be created. The planning group should have the support of and direction from the county leadership. Through this collaborative process representatives of different systems will gain knowledge, appreciation and professional trust which will be necessary to work together. There are tools with common guidelines and frameworks that apply to all these entities and can assist in implementing sustained collaboration for transition planning. One such tool is the APIC (Assess, Plan, Identify, Coordinate) model for individuals re-entering the community from jail.

APIC Model:

The APIC Model was developed by corrections and behavioral health experts to guide evidenced - based transition planning. APIC stands for:

- **Assess** the individual's clinical and social needs, and public safety risks;
- **Plan** for the treatment and services required to address the individual's needs (while in custody and upon re-entry);
- **Identify** required community and correctional programs responsible for post-release services; and
- **Coordinate** the transition plan to ensure implementation and avoid gaps in care with community-based services.

Guidelines for the four parts of the APIC Model:

Assess

1. Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance used disorders, mental disorders, co-occurring substance use and mental disorders and criminogenic risk.
2. For individuals with positive screens, follow up with comprehensive assessments to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on: basic demographics, clinical needs, strengths and protective factors, social and community support needs, and public safety risk and needs.

Plan

1. Determine appropriate level of treatment and intensity of supervision; identify and target criminogenic needs; address disorders that affect function; develop strategies for integrating recovery support services and acknowledge dosage treatment as part of recidivism reduction.
2. Develop collaborative responses between behavioral health and criminal justice that match individual's levels of risk and behavioral health need with the appropriate levels of supervision and treatment.

Identify

1. Anticipate that the time after release is critical and identify appropriate interventions as part of transition planning practices for the individuals.
2. Develop policies and practices that facilitate continuity of care through the implementation of strategies that promote direct linkages for post-release treatment and supervision agencies.

Coordinate

1. Support adherence to treatment plans and supervision conditions through coordinated strategies with services and criminal justice; and employ problem-solving strategies to encourage compliance, promote public safety and improve treatment outcomes.
2. Develop ways to share information from assessments and treatment programs across different points in the criminal justice system for cross systems goals.
3. Encourage and support cross training between workforces and agencies to facilitate collaboration at all levels.
4. Collect and analyze date to evaluate program performance; identify gaps in performance and plan for long-term sustainability.

Resources:

Osher, F., Steadman, H.J., Barr, H. (2002) A best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: the APIC Model: Delmar, NY: The National GAINS Center.

Blandford, Alex M. and Fred C. Osher. Guidelines for the Successful Transition of Individuals with Behavioral Health Disorders from Jail and Prison. Delmar, NY: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, 2013.

National GAINS Center for People with Co-occurring Disorders in the Justice Systen (2001) The prevalence of Co-occurring mental illness and substance abuse disorders in jail. FACT SHEET SERIES. Delmar, NY: Author.

Steadman, H.J., Osher, F., Robbins, P., Case, B., Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. Psychiatric Services 60, 761-765.