



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

Fred Osher, M.D., Henry J. Steadman, Ph.D., Heather Barr, J.D., M.A.

Published by the National GAINS Center

September 2002



Funded by the Center for Mental Health Services and  
the Center for Substance Abuse Treatment



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

Fred Osher, M.D.<sup>1</sup>, Henry J. Steadman, Ph.D.,<sup>2</sup> Heather Barr, J.D., M.A.<sup>3</sup>

September, 2002

<sup>1</sup>Associate Professor and Director  
Center for Behavioral Health, Justice, and Public Policy  
Baltimore, MD  
3700 Koppers Street, Suite 402  
Baltimore, MD 21227  
(410) 646-3511  
Fax (410) 646-5324  
Email: foshier@psych.umaryland.edu

<sup>2</sup>Policy Research Associates, Inc.  
345 Delaware Avenue  
Delmar, NY 12054  
(518) 439-7415  
Fax (518) 439-7612  
Email: hsteadman@prainc.com

<sup>3</sup>Urban Justice Center/Mental Health Project  
666 Broadway, 10th Floor  
New York, NY 10012  
(646) 602-5671  
Fax (212) 533-4598  
Email: hbarr@urbanjustice.org

---

---

This work was conducted under support to the SAMHSA-funded National GAINS Center for People with Co-occurring Disorders in the Justice System. The input of Susan Davidson, M.A., and Michelle Naples, M.A., both of the GAINS Center, and attendees of the GAINS Center's Re-entry Roundtable on September 5–6, 2001 is gratefully acknowledged.

---

The suggested citation for this monograph is 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.

---

## 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).

---

*Current estimates suggest that as many as 700,000 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).*

---

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.

---

*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; lack of connection to behavioral health services in the community may lead some individuals to cycle through jails dozens or even hundreds of times.*

---

## 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.

---

*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.*

---

## 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.

---

*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*

---

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

---

*Many inmates ... have passed through the same jail dozens of times ... the single most important thing a transition planner can do ... is learn from the inmate what has worked or ... not worked during past transitions and plan accordingly.*

---



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 comorbidities. 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.

---

*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.*

---



### 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.

---

*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.*

---

## 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.

---

*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).*

---



## REFERENCES

- American Association of Community Psychiatrists (2001). AACP continuity of care guidelines: *Best practices for managing transitions between levels of care*. Pittsburgh, PA: AACP.
- American Psychiatric Association (2000). Psychiatric services in jails and prisons: A task force report of the American Psychiatric Association. Washington, DC: APA.
- Andrew, D. (1995). The psychology of criminal conduct and effective treatment. In *What Works: Reducing Reoffending – Guidelines from Research and Practice*, McGuire J. (ed.). John Wiley & Sons Ltd., 35–62.
- Barr, H. (2001). Social workers as advocates for mentally ill criminal defendants/inmates. In *Serving Mentally Ill Offenders*. Landsberg, G., Rock, M., Berg, L.K.W., Smiley, A. (eds.). Springer Publishing, 229–245.
- Bazon Center for Mental Health Law (2001). *Finding the Key to Successful Transition from Jail to Community*. Washington, DC: Bazon Center.
- Becker, D.R., Smith, J., Tanzman, B., Drake, R.E., Tremblay, T. (2001). Supported employment program fidelity and employment outcomes. *Psychiatric Services*, 52: 834–836.
- Brad H. v. City of New York (2000). 712 N.Y.S.2d 336, N.Y. Misc. LEXIS 305.
- Bureau of Justice Statistics (2000). Prison and jail inmates at midyear 2000. U.S. Department of Justice Statistics, NCJ-185989.
- Dennis D.L. and Steadman H.J. (1991). The Criminal Justice System and Severely Mentally Ill Homeless Persons: An Overview. Report prepared for the Task Force on Homelessness and Severe Mental Illness. Delmar, NY: Policy Research Associates.
- Dvoskin J.A. and Steadman H.J. (1994). Using intensive case management to reduce violence by mentally ill persons in the community. *Hospital and Community Psychiatry*, 45(7): 679–684.
- Griffin, P.A. (1990). The backdoor of the jail: Linking mentally ill offenders to community mental health services. In *Jail Diversion for the Mentally Ill: Breaking Through the Barriers*. Colorado: United States Department of Justice, Federal Bureau of Prisons, National Institute of Corrections, 91–107.
- Hammett, T.M., Gaiter, J.L., Crawford, C. (1998). Reaching seriously at-risk populations: Health interventions in criminal justice settings. *Health Education and Behavior*, 25: 99–120.
- Hammett, T.M., Roberts, C., Kennedy, S. (2001). Health-related issues in prisoner re-entry. *Crime and Delinquency*, 47( 3): 390–409.
- Hartwell, S.W. and Orr, K. (2000). Release planning. *American Jails*, Nov/Dec, 9–13.
- Jemelka, R., Trupin, E., Chiles, J.A. (1989). The mentally ill in prisons: A review. *Hospital and Community Psychiatry*, 40: 481–491.
- Lamberti J.S., Weisman R.L., Schwarzkopf, S.B., Price, N. Ashton, R.M., Trompeter, J. (2001). The mentally ill in jails and prisons: Towards an integrated model of prevention. *Psychiatric Quarterly*, 72 (1): 63–77.
- The National Coalition for the Homeless and the National Law Center on Homelessness & Poverty (2002). *Illegal to be Homeless: The Criminalization of Homelessness in the United States*. Washington, DC: NCH, NLCHP.
- The National Coalition for Mental and Substance Abuse Health Care in the Justice System (1996). *Community Corrections in America: New Directions and Sounder Investments for Persons with Mental Illness and Co-Occurring Disorders*. Lurigio, A.J. (ed.). Seattle, WA: NCMSAHC.
- The National GAINS Center for People with Co-Occurring Disorders in the Justice System (1999). *The Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System*. Delmar, NY: Policy Research Associates.
- The National GAINS Center for People with Co-Occurring Disorders in the Justice System (1999). *Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders*. Delmar, NY: Policy Research Associates.
- Osher, F.C. (2000). Co-occurring addictive and mental disorders. In *Mental Health, United States*, Manderscheid, R.W., and Henderson, M.J., (eds.). Washington, DC: Center for Mental Health Services, 91–98.
- Peters, R.H. and Bartoi, M.G. (1997). *Screening and Assessment of Co-occurring Disorders in the Justice System*. Delmar, NY: Policy Research Associates.
- Substance Abuse and Mental Health Services Administration, DHHS (2000). Cooperative Agreement for a National Center for Mentally Ill and Substance Abusing Youth and Adults Involved with the Justice System: Programmatic Guidance. Catalog of Federal Domestic Assistance No. 93.230.
- Steadman, H.J., McCarty, D.W., Morrissey, J.P. (1989). *The Mentally Ill in Jail: Planning for Essential Services*. New York: Guilford Press.
- Steadman, H.J. and Veysey, B. (1997). *Providing Services for Jail Inmates with Mental Disorders*. National Institute of Justice: Research in Brief.
- Stephan, J.J. (2001). Census of Jails, 1999. Washington, DC, United States Department of Justice Programs, Bureau of Justice Statistics.
- Teplin, L.A. and Pruett, N.S. (1992). Police as streetcorner psychiatrist: Managing the mentally ill. *International Journal of Law and Psychiatry*, 15: 139–156.
- U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Mental Health.
- Veysey, B.M., Steadman, H.J., Morrissey, J.P., Johnsen, M., Beckstead, J.W. (1998). Using the referral decision scale to screen mentally ill jail detainees: Validity and implementation issues. *Law and Human Behavior*, 22(2): 205-215.

