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From Correctional Custody to Community: The Massachusetts Forensic Transition Program

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The Massachusetts Forensic Transition Program

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Offenders with mental illness who are serving correctional sentences are released to the community. Without support systems linking their transition to community-based programs following release from prison, the services necessary for their community reintegration are often fragmented and attenuated. Nearly two-thirds of all inmates return to prison, and offenders with mental illness face major challenges during reintegration and have an even more difficult time living in the community without specialized, informed services. This article describes a Massachusetts program designed to bridge the transition of offenders with mental illness from incarceration to the community. The authors review historical and recent trends that support the need for such a program along with a description of the demographics of the population served and the challenges faced during program implementation. They also offer recommendations for enhancing public safety and providing efficient service to offenders with mental illness.

Since the mid-1950s and through advances in psychotropic medication, an increasing number of people with mental illness have been moved from psychiatric hospitals to the community.[1] While the trend to deinstitutionalize continues in response to changes in commitment statutes and health care financing, hope for community integration is illusive, and the displacement or "trans-institutionalization" of those with mental illness is evident.[2] A fivefold increase in the arrest rate of those with mental illness followed the original changes in policy and commitment laws.[3] Over time, sentencing alternatives and public tolerance for offenders with mental illness in the community and the number of psychiatric beds dwindled.[4] The nation's current prison population includes four to five times the rate of mental

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illness found in the community and twice the rate of mental illness reported in prisons a little more than a decade ago.[5] Recent estimates suggest that 16 percent of all incarcerated males and 24 percent of all incarcerated females are afflicted with mental illness.[6]

A 1999 White House conference focused national attention on supporting Americans with mental illness. Members outlined numerous community mental health initiatives and priorities, including innovative community mental health programs. This article highlights one such program, which bridges correctional and community mental health services for people with severe and persistent mental illness. Attention to this population has been reinforced in light of the potential impact on public safety, resource allocation strategies, and human rights issues, including the appropriateness of releasing a person with major mental illness to the community without support.

Local Context

Between 1991 and 1993, three Massachusetts state mental hospitals closed on the heels of an economic recession based on the premise that they were costly, inefficient, and ineffective. Rather than reflecting the original goals of deinstitutionalization, this move projected a trend toward managed care and efforts to contain costs. Concern over the displacement of Department of Mental Health (DMH) clients from these hospital closures was tempered by the reallocation of resources from hospital maintenance to community-based programs. Additionally, a rising vacancy rate made landlords increasingly amenable to supporting DMH housing initiatives and clients.[7]

Nevertheless, managing a decentralized community-based system of mental health care has posed its own set of challenges in Massachusetts as elsewhere. Department of Mental Health clients who transfer across systems, particularly those who shuttle between criminal justice and mental health systems, are difficult to track, monitor, and engage in appropriate services. Whether in corrections, the community, or another mediating system, when they are not receiving adequate services, they may pose a risk to themselves and others. These same clients are often the highest users of emergency health, housing, and criminal justice services. It was this disproportionate and often inefficient use of services that the DMH wished to ameliorate through the implementation of specialized programming.

The Massachusetts county houses of correction and state prisons manage approximately 22,850 inmates.[8] An estimated 5 to 20 percent of inmates suffer from schizophrenia, bipolar disorder, or other major mental illness.[9] Although inmates with mental illness are expected to reside in the community after release, securing a place to stay, accessing insurance and entitlements, managing medications and money, and coping with the adjustment from prison to the open community is daunting for those with a major mental illness and criminal history.[10]

Attempting to ease the community reintegration of offenders with mental illness who are completing prison sentences, the Department of Mental Health's Division of Forensic Services established the Forensic Transition Program in 1998. This assertive model of continuing care was designed to pay special attention to the unique vulnerabilities of offenders with mental illness; it was viewed by stakeholders as an essential service to enhance public safety and future correctional diversion program-

ming for the state's offenders with mental illness. Their potential for inflicting danger on themselves or on others increases when noncompliance with treatment is coupled with social isolation and substance abuse.[11] The Forensic Transition staff provides monitoring and support to offenders with mental illness, alleviating barriers to community reintegration and extreme social isolation.[12] Without preventative service interventions such as the Forensic Transition program, there is an increased likelihood that offenders with mental illness will continue to cycle through social service agencies, courts, jails, and prisons.[13]

The DMH-Forensic Transition Program and Clients

The Massachusetts transition program is a statewide initiative that assists DMH-eligible preadjudicated and convicted inmates. The program provides *tracking* — information gathering and sharing services — for the preadjudicated group awaiting criminal justice disposition and transitional *release planning* services for those whose release from correctional custody is pending — approximately 1,150 persons in the Massachusetts correctional system at any given time. Program staff members assist transitioning groups in accessing the support they need to adjust to community living prior to and after release from correctional facilities.

Release from incarceration requires that individuals with mental illness transfer between systems, from the Department of Corrections to the Department of Mental Health, and roles, from inmate to client. The identity and system shifts involve multiple service agencies, including, but not limited to, the parole and probation departments and the vendors of health and entitlement services. The Forensic Transition program staff collaborate with relevant departments, agencies, and vendors to facilitate the transition of ex-offenders with mental illness across the six regions of the state. They work with inmates with mental illness in correctional facilities at least three months before release to coordinate relevant psychosocial and criminal information for the transition and treatment planning process after release. Staff also provide case coordination and consultation to community providers for up to three months after release to address any immediate obstacles to client community adjustment.

The Forensic Transition program includes the following *objectives:*

- To coordinate services for Department of Mental Health clients during the transition from correctional custody to the community;
- To maximize treatment outcomes for offenders with mental illness through identification, early engagement, consistent support, and a well-monitored transition;
- To enhance community safety by collaborating with state and public safety agencies and community service providers;
- To develop a database on this special population that will inform program development and ongoing research.

The services provided by the Forensic Transition program are time-limited and informed by classic and recent innovations in social service collaboration.[14] Appropriate inmates are identified to the transition staff when a referral is made to the Department of Mental Health. Once clients are identified, the staff meet with in-

mates during incarceration to complete an assessment of the client's needs on release. The goal of the program is that by the time they are released from custody, housing, mental health services, and economic supports are in place.

At the end of the program's second year of operation, the database maintained on all client contacts since the program start-up included information on 682 offenders with mental illness. Of the 433 found eligible for DMH services, 77 percent (N=333) had a history with the department. This figure indicates that Department of Correction staff are identifying a population of individuals for Forensic Transition coordination and DMH services and treatment who were not connected to state mental health services prior to incarceration.

A composite of all DMH-eligible clients who completed the *transitional* service provided by the program during the first two years of operation (N=170) reveals that the majority of clients released from correctional custody are males (77 percent or 131) between the ages of 27 and 45 (59 percent, N=100) with an Axis I major thought (47 percent, N=80) or mood disorder (44 percent, N=74). Sixty percent (59 percent, N=101) are white, 21 percent are black/African-American (N=35), 15 percent are Latino (N=26), and the remainder are Native American. These numbers are consistent with the race demographic of this state's inmate population.[15] To date, more than half of all clients completing their transition (57 percent, N=97) served time in county houses of correction with sentences of less than two and a half years. A smaller percentage (43 percent, N=73) completed sentences at state correctional institutions for major felonies, including violent offenses — assault, robbery, sexual assault, and murder. Nearly 40 percent of all transitional clients (N=67) anticipated homelessness following their release, 69 percent (N=117) had a history of substance abuse, and 13 percent (N=22) committed sex offenses. While nearly a quarter (24 percent, N=40) served split sentences, with the second half served on probation, fewer than 10 percent (N=16) were released on parole or under another form of correctional supervision. Data on most recent criminal charge are presented in Table 1 below.

Table 1

Charges of 170 Offenders with Mental Illness
Who Completed the Transition Program

Charge	N	Percentage[a]
Public order	46	27
Property crime	25	15
Arson	8	5
Assault and battery	56	33
Sexual assault, adult	5	3
Sexual assault, minor	11	7
Murder	3	2
Violation of Probation	16	9

[a]Owing to a rounding error, percentages do not add up to 100.

At the end of the first two years of data collection, 62 percent or 106 of the 170 transitioned clients were living in the community and engaged in mental health services. The remainder were hospitalized immediately after prison release (20 percent

or 34); reincarcerated (3 percent or 5) or hospitalized (5 percent or 8) after a brief stay in the community; 10 percent or 17 clients disengaged from services during that time.

Challenges and Lessons Learned

Challenges in program implementation occur at both client and system levels. Perhaps one of the most worrisome challenges involves managing clients who tend to disengage from services after release. The Department of Mental Health cannot enforce treatment compliance for clients in the community. Partnerships with public safety agencies like parole and probation can be formed to provide a mechanism to manage a high-risk client safely during reintegration. Even when clients are released after completing a sentence without public safety oversight, they are still fortified for community reentry by the program services (from one-on-one counseling to entitlement assessments) received prior to release from correctional custody.

At the system level, the Forensic Transition staff experience barriers endemic to the role of all "boundary spanners."[16] To begin, the program spans two large public service systems that have traditionally diverging missions. The Department of Correction manages care and custody of individuals by restricting individual self-determination while the Department of Mental Health strives to enhance independent community living. Issues related to sharing information, division of responsibility, service duplication, and cross training have been identified as needs that involved agencies must negotiate. The program also traverses other service systems and agencies with divergent goals and greater to lesser capacities to accommodate offenders with mental illness. For example, linkages with the Departments of Probation and Parole and contacts with the courts, treatment programs, emergency shelters, and emergency rooms are common. Working both within and across systems with a population that shuttles between many social services can be difficult because agencies must "share" the burden of creating and managing continuity.

Correctional mental health services in prison and offenders with mental illness's preparation for release are significantly improved by (1) shared client records via client "releases of information" across systems; (2) documented memorandums of procedural agreements across agencies; and (3) joint after-care release planning meetings. The goal of release planning meetings should be to share information within a group of constituents from related social services. Constituents involved with this endeavor should include public and private agencies serving inmates with special needs in correctional settings and the community, including, but not limited to, vendors, state departments, and social service agencies.

Service level information compiled from a longer-term follow-up of former Forensic Transition program clients reveals trends toward community reintegration. DMH clients who continue to engage in community services are adjusting to community living and avoiding reinstitutionalization. These clients receive intensive case management and psychiatric services, attend outpatient treatment sessions, and are involved in substance abuse treatment. Their entitlements are in order and they are proficient in accessing their own medication in the community. Interestingly, day treatment or social club engagement, homeless or vocational services, and engagement in sex offender therapy are not associated with community commitment. Perhaps the need for housing and social skills programming is offset by the fact that

most of the clients who do well in the community are living with family and friends.

To date the program has seen thirty-two former clients return to prison.[17] A profile of recidivists is emerging. Female offenders with mental illness who also have substance abuse problems do poorly on probation or parole. Recidivists also have long histories with DMH and are more often mood disordered and a criminal history including assault and battery and a violation of probation or parole. Those who are reincarcerated lived on their own or in a residential placement while in their community.

Recommendations

We offer recommendations for transitioning offenders with mental illness from correctional custody to the community for consideration and development. They are organized in sections around three areas. The program development section addresses the issues of boundary spanning and program planning. The client reintegration section considers community reentry resources and supports, including sentencing guidelines, post-release housing, and treatment options. The final section examines the potential of information systems from shared data sets to future research on community reintegration and community follow-up.

Program Development

Members of the Forensic Transition program link numerous service systems in response to needs of offenders with mental illness and in the interest of public safety and public health. Given that nearly 25 percent of the individuals identified by Corrections for program services are new Department of Mental Health clients, there is potential to forecast the needs of this emerging population. Early identification of a previously unknown client pool enables tailored service delivery accompanying community reentry from correctional settings. The program staff members contact approximately twenty new clients with mental illness, criminal histories, and a myriad of other health and social problems, for example, homelessness and substance abuse, each month. Coordinators essentially acquire caseloads of new DMH clients at three times the rate at which clients complete their transition to communities.

Forensic Transition clients fall along a continuum of persons with greater to lesser service needs and costs. Each day an ex-offender with mental illness remains in the community, as opposed to returning to prison, approximately $56.70 is saved by those who have a residence.[18] The savings should be considered when tailoring service provision around the essential needs of safety and security for the population and the communities with structured treatment and housing options.

Client Reintegration

The individuals served by the program are unique in their combined criminal justice and mental health histories. For the most part, they are males with major mental illness who are completing sentences for crimes against persons. When they return to the community, the vast majority are no longer under the jurisdiction of the criminal justice system, having completed their sentences rather than being released on parole or probation. One-third are homeless and two-thirds have a history of

substance abuse. Given the clients' collected data, necessary treatment cannot be mandated. It is important for the sentencing commission to be made aware of (1) the emerging population and (2) the benefits of their receiving mandated treatment.[19] In many cases, extenuating criminal justice jurisdiction in the community — enforced by the courts and the departments of Probation and Parole in collaboration with DMH — provides the necessary leverage to engage ex-offenders with mental illness in appropriate community treatment. However, cross training in cooperation with public safety agencies is necessary for an understanding of both the special behaviors of the offenders with mental illness and the available social services that can address, understand, and mitigate these actions prior to the levying of criminal justice sanctions.

Additionally, offering formal support to the family members and friends of transitioning clients is crucial because most offenders with mental illness who do well in their community live with family and friends. For those who lack family, friends, and stable housing, community integration is more difficult. This is where social skills programming might become significant. Life skills or mentoring programs can be a start in improving functioning, and securing housing is far easier when landlords, family, and program directors can reinforce or sanction behavior. In essence, the leverage and accountability the criminal justice jurisdiction provides offers more opportunities for ex-offenders with mental illness to live comfortably in the community. However, expanding criminal justice jurisdiction must occur in the framework of understanding each client's individual needs — clinical diagnosis, criminal history, housing, and substance abuse history — and the goal of independent community living.

Information Systems

From a systems standpoint, social service, mental health, and criminal justice leaders and experts should, at the very least, be informed of such programs as Forensic Transition. While the staff prepares Department of Mental Health clients for release from correctional custody into communities, other means of tracking and engaging offenders with mental illness or those with extreme service needs include coordinated social service management information systems. Ideally, a centralized database on those who shuttle between and across social service systems would be invaluable in immediately assessing client needs and resources such as housing and entitlements. The creation of such a database is feasible when issues of client confidentiality and consent are thoroughly reviewed and considered.[20] Continued efforts to ensure appropriate services for those with mental illness involved with the criminal justice system should include broad-based systemwide initiatives such as the current county level sheriff's offering each incoming inmate the opportunity to sign a release of information for DMH services.

Finally, ongoing research and information dissemination is necessary. In the Forensic Transition program, research facilitated the creation of a secondary database from which the demographic and service need descriptions of persons with mental illness returning from correctional custody to communities was compiled. In addition, an initial follow-up of clients receiving this service suggests that the majority receive the support necessary to engage in community mental health treatment — an essential first step to community reintegration. Based on the data already collected and these findings, resources should continue to be sought for longer-term commu-

nity-based follow-up of people with mental illness returning to communities from prisons and houses of correction to ensure that state-of-the-art programming continues. Research, coupled with an ongoing evaluation of the Forensic Transition program, can offer Massachusetts policymakers and service providers necessary information about offenders with mental illness and how best to serve their needs and those of each community.

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