



THE TEMPLE UNIVERSITY COLLABORATIVE ON
COMMUNITY INCLUSION
of Individuals with Psychiatric Disabilities

Returning to the Community: Reentry Barriers following Incarceration among Individuals with Serious Mental Illnesses

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Introduction.

Reintegration of individuals with mental illnesses into everyday community life following incarceration is a major issue affecting every municipality and state around the country. The Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities was asked to provide technical assistance to Philadelphia City councilman Dennis O'Brien to develop suggestions for how this complex and urgent issue could best be addressed. Key stakeholders in the field were identified, including individuals with mental health conditions who had left jails and prisons, and asked to offer their opinions about the most significant barriers during the reentry transition. Information from these conversations informed a Resolution that was introduced to Philadelphia's City Council and ultimately led to an investigatory hearing on the issue. These activities resulted in thirteen recommendations that are briefly described in this document. The intention of this document is to share these recommendations with others as well as describe a process that could be used in other cities and states to identify similar recommendations that meet local circumstances and that raise the importance of community reentry and inclusion in the eyes of local governments.

The Problem.

The past decade has seen rising public concern and a bi-partisan political focus on the problems of the U.S. criminal justice system. Those concerns have primarily focused not only on the growth of the prison population but also on the unavailability of strong programs to prepare prisoners for re-entry into community life and to support them in building effective and law abiding lives in the community following incarceration. All of these problems are heightened for the substantial numbers of individuals in prisons with mental illnesses, and no appropriate solutions to the prison crisis will be effective without taking into consideration the needs of those with mental illnesses who are returning to community life following their experiences as inmates in jails or prisons.

In the United States, jail and prison are very different. Jails, operated by local or county governments, typically hold individuals who are either serving short sentences or awaiting trial. Prisons, on the other hand, hold individuals convicted of crimes that carry longer sentences and are operated by state or federal governments. While both involve different and complex issues, this document will focus on jail and prison issues overall: returning to the community from any institutional setting presents similar barriers that will be addressed here.

Nationally, approximately 2.5 million people are incarcerated in jails and prisons (Koschmann & Peterson, 2013). Studies about the presence of mental illnesses among inmates have consistently found elevated rates of serious mental health issues in prisons relative to the general population: for instance, based on one systematic review of published surveys, the estimated rates of psychotic disorders and major depression are two- to four times higher among U.S. prison inmates than among the general adult population (Baillergeon et al., 2010). Those diagnosed with a serious mental health issue range from 15-31% of the combined jail and prison population (Fries et al., 2013; Lamb & Weinberger, 2005). However, these statistics do not take into consideration substance abuse issues: when substance abuse is defined as a mental illness, the total prevalence of mental illnesses among prisoners increase dramatically, and

can reach upwards of 90% (Fries et al., 2013). The reasons for the greater prevalence of such individuals in jails and prisons is complex and beyond the scope of this document, but likely goes beyond simple explanations such as the criminalization of mental illness.

Ninety-five percent of jail and prison inmates will be released after serving less than 12 months behind bars (Koshmann & Peterson, 2013; Angell et al., 2014). However, two-thirds of those released will be re-incarcerated within three years (Koshmann & Peterson, 2013). Because insufficient budgets typically mean that comprehensive behavioral health treatment is not an option in most jails and prisons, individuals who are released from incarceration often have exacerbated mental health symptoms, and inadequate discharge plans frequently fail to make strong linkages to community mental health resources (Constantine et al., 2010).

Additionally, many individuals with mental health conditions who are returning to the community lack the social capital to help them successfully reintegrate back into their communities, particularly with regard to employment: they often lack high school diplomas, employable skills, or even the social supports to steady themselves for work. Gainful and legal work is a particular problem (Morani et al., 2011; Baron et al., 2013). Some of those leaving jails and prisons find that the jobs they want, the jobs that offer the income, stability and benefits needed for a successful life post-incarceration - require a two-year or four-year college degree, which is often out of reach for these individuals and leaves them choosing only among low-skilled or part-time work that may not cover the costs of basic living needs.

For others, the unavailability of the social supports that family and friends and previous co-workers could provide prevent them from having a cushion until they are able to be in a position to financially support themselves. It is not surprising, then, that successful community reentry has proven so difficult. High recidivism rates, among those with and without mental illnesses, point to the challenges that prison reform initiatives will need to address in the years ahead to facilitate effective community reentry.

What is Community Reentry?

Community reentry describes the process of leaving a correctional facility and transitioning back into community life. Although a 1980 class action lawsuit in Texas, *Ruiz v. Estelle*, charged jails with the responsibility of screening and identifying inmates with mental illnesses, and of providing crisis intervention and psychiatric stabilization while the individual is incarcerated, there is no clear definition of what constitutes adequate care and many inmates' mental health needs are not met either while in prison or following release (Osher et al., 2003). For anyone leaving incarceration behind, the challenges of this transition - including securing housing, finding legal employment, obtaining identification documents, locating and continuing physical, substance abuse and/or mental health treatment, and even reconnecting with family and friends - is particularly difficult if the individual also faces mental health challenges.

There are several elements that comprise an effective community reentry transition: 1) a discharge plan should be individualized; 2) making community connections while the person is

incarcerated has been shown to have good results, and a continuation of those services when reentering into the community will ensure that needs are met during a critical time point; 3) services that address housing needs provide a critical element of post-incarceration stability, for research has shown that affordable and stable housing improves the likelihood of an individual successfully integrating back into their community; 4) people also benefit from access to education and employment training; 5) tailored mental health and/or substance abuse services provide support while going through such a disruptive transition; and 6) having access to resources that assist in connecting with friends and family, classes such as parenting or life skills, and other community engagement activities will also improve stability during community reentry (Brucker, 2006; Morani et al., 2011; Baron et al., 2013; Angell et al., 2014). These services and programs also tend to be more successful when they are integrated and coordinated.

However, such comprehensive programs are few and far between. Most financial support for post-incarceration services tends to go into parole and probation supervision (Koshmann & Peterson, 2013). Indeed, eighty percent of all state prisoners being released from prison will be released into parole supervision, thus retaining some connection to the criminal justice system (Brucker, 2006). This disproportionate focus on parole rather than rehabilitation can be problematic for multiple reasons. Firstly, individuals typically recidivate based on technical parole violations rather than criminal activity (Koshmann & Peterson, 2013): mandatory appointments with counselors and parole and probation officers are challenging when paying for transportation is difficult, family obligations have increased, and the need to look for work is urgent. Second, when reentry programs do exist, they are still referred through the criminal justice system which means that care is typically fragmented and the most important factor for individuals becomes meeting parole and probation stipulations rather than locating, scheduling and attending mental health treatment and rehabilitation services (Koshmann & Peterson, 2013). And lastly, research has typically shown that surveillance programs are generally ineffective at reducing recidivism (Koshmann & Peterson, 2013).

The limited number of prisoner reentry programs designed to help individuals with mental health conditions successfully adjust to community life following incarceration have been united by a single theme: the reduction of recidivism by providing individuals with mental health services (Wolff et al., 2012). However, individuals returning to community life tend to believe that securing and maintaining affordable housing and employment are the most immediate challenges they face, rather than more clinically-oriented assistance (Baillargeon et al., 2010). These results demonstrate that economic and survival needs must be addressed as part of an effective community mental health reentry program.

Addressing Community Reentry Barriers.

Recognizing that community reentry is a critical point-in-time for individuals with mental illnesses who are leaving jails and prisons, the Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities (The TU Collaborative) was asked to highlight these issues and develop recommendations that could be used in Philadelphia and possibly elsewhere. The TU Collaborative is a federally funded research and training center focusing on the community inclusion needs of individuals with mental illnesses, including how building effective connections to mainstream

community life can positively impact post-incarceration experiences for those with serious mental illnesses. In a partnership with former Philadelphia City Councilman Dennis O'Brien, who has a long-standing interest in disability issues and a growing concern with prison reform issues, key stakeholders in the field were identified, including individuals with mental health conditions who had left jails and prisons, and asked to offer their opinions about the most significant barriers during the reentry transition. Their comments were the impetus for Councilman O'Brien to develop a proclamation that addressed reentry barriers with support from TU Collaborative staff. On February 19, 2015, Councilman O'Brien introduced Resolution No. 150131, co-sponsored by Councilman Curtis Jones (see Appendix A). The Resolution called for Council's Committees on the Disabled and Special Needs and Public Safety to hold a public hearing to examine the state of community reentry after incarceration in Philadelphia for people with mental health issues. The hearing took place on Friday, March 20, 2015. Joining Councilman O'Brien in attendance were Councilmen David Oh and Darryl Clarke, and Councilwoman Jannie Blackwell.

Each witness spoke about some aspect of community reentry, such as barriers that they themselves had faced or barriers that they have seen others face when transitioning back into their communities, the current state of reentry supports in the city of Philadelphia, and some of the successful reentry programs that are currently being carried out. The witness list was comprised of six key stakeholders on this topic, including Certified Peer Specialists (individuals with their own history of mental illnesses who are working in the mental health system), academics, current and past City mental health officials, parole personnel, and community reentry program providers:

Ray Ziegler, Certified Peer Specialist and identifies has having an SMI, Greater Philadelphian Asian Social Service Center;

Jeff Draine, Professor, Department of Social Work, Temple University;

Sandy Vasko, Director, Office of Mental Health, Department of Behavioral Health and Intellectual Disability Services;

Eric Stryd, Assistant Chief, Diversion Courts Unit, District Attorney's Office;

Jeannette Palmer, Supervisor, Mental Health Unit, Adult Probation & Parole; and

Matt Tice, Director of Clinical Services, Pathways to Housing.

The testimony from these witnesses can be found in Appendix B. Key recommendations coming out of the testimony and other sources, such as conversations with key stakeholders, were as follows:

Recommendations.

Legislative entities, like City Councils, should hold their local criminal justice and mental health public agencies responsible for reframing services to achieve:

1. **Better coordination between mental health and criminal justice systems:**

Several presenters noted the lack of coordination at discharge between the criminal justice and mental health systems, arguing for more coordinated care that emphasized data sharing

between all providers. Communication is key in providing support, keeping everyone on the same page while individuals get back on their feet.

2. Improved discharge planning:

Inmates are often released with no clear plan for what should happen once they are back in their communities. Whenever possible, discharge planning should begin while an individual is still incarcerated: continuity of care has been shown to be effective at reducing recidivism and integrating individuals back into their communities. Having established relationships between the criminal justice system and mental health providers, such as community mental health centers, will improve the likelihood that needs are met upon release. This would also make it more likely that discharge planning would be more individualized, recognizing that everyone entering the community will have highly individualized needs.

3. Expansion of educational resources and supports:

Individuals with mental illnesses leaving jails and prisons often lack the employment opportunities, attitudes and/or skills needed for remunerative jobs in the competitive labor market. Educational resources should be in place to help overcome that barrier, including GED classes, and in particular those targeted to non-English speaking populations in the criminal justice system. GED and college courses that are offered during confinement would further the social capital of individuals to avoid time lost. An emerging 'best practice' in the rehabilitation field - Supported Education -links people to community college four-year programs, and other training opportunities and provides supports throughout their educational engagement - would also be beneficial in providing support to ensure completion of a program.

4. Heightened employment resources and supports:

Individuals may have difficulties finding employment for a number of reasons. They tend not to have regular or reliable internet access with which to respond to the increasing percentage of job applications online. Supported employment programs, offering individual's assistance in determining their competitive employment goals, finding and stabilizing their performance on the job, and offering long-term employment supports, are rarely available to improve the individual's likelihood of success. There are also state policies that ban individuals from working certain categories of jobs if they have a criminal background, and these policies should be changed/modified in order not to prevent someone from obtaining gainful employment.

5. Better policies to improve housing options:

Individuals with mental illnesses leaving jails or prisons are more likely than others to experience homelessness during reentry. Depending on the criminal charges of which they have been convicted, some individuals are banned from receiving housing benefits due to policy restrictions: these policies should be altered to allow individuals improved access to housing. Numerous research studies have shown that most individuals can and do have a more successful community reentry when placed in stable housing. Further, the limited number of assisted housing options makes it difficult for many to secure stable housing. At the same time, many

individuals released into halfway houses and supervised housing find that restrictive house rules are not conducive to job searching and other employment hours. Housing policies should not be tied to punitive measures, such as a violation of parole or probation.

6. Changes in Medicaid termination policies:

A significant portion of individuals with mental illnesses who are incarcerated were receiving Medicaid benefits prior to being arrested, but most states terminate these benefits after 30 days of incarceration. This is problematic for continuity of care, as it prevents individuals from accessing healthcare upon release. All states should opt for a Medicaid 'suspension' rather than termination, and should offer assistance in restoring benefits before people are released. Local governments can play a role in pressuring state and federal policy changes in this area.

7. Increased funding for programs that support community reentry:

Local governments should take advantage of already-existing programs that support the community reentry population by directing funds for program expansion. Many individuals face waitlists and programs that are already over capacity. This prevents continuity of care upon release and has the potential to be a major barrier to community engagement. At the same time, local governments should be aggressive in allocating local budgets or seeking out philanthropic or grant resources to expand community reentry services.

8. Parole/Probation policy changes:

The criminal justice system tends to focus on surveillance and control. A vast majority of prisoners are released into probation and parole supervision. While there is an obligation to uphold some of these policies with regard to public safety, local governments can play a role in arguing for parole and probation policy shifts that focus more on community engagement.

9. Expanded anti-stigma initiatives:

Those returning to community life from jails and prisons face the possibility of dual discrimination: they may be discriminated against – in finding housing, jobs, and social opportunities – because of their history of incarceration and/or face the same difficulties because of their history of mental health issues. More should be done – through both broad public education campaigns and programs that offer opportunities for community members to get to know those returning to their communities following incarceration in order to challenge prevailing public attitudes and to lessen the impact of this discrimination.

10. Development of A Guidebook to Community Re-entry:

A guidebook that builds on these recommendations and lists services and resources that people can access when they are reentering the community would be a useful addition to the resources of community providers. An initial guidebook can be targeted to the Philadelphia community, but others could be developed, on the same model that incorporate information on policies, programs and practices specific to the community. Former inmates can also play a key role in the development of such a guidebook.

11. A greater general focus on community inclusion:

Parole and probation as well as community mental health programs should be expected to devote more resources to provide opportunities for individuals to participate in their communities as active and equal members, linking former inmates not only to decent housing and good jobs, but also to opportunity for civic engagement, leisure and recreation activities, and connection to mainstream religious congregations, etc.

12. Expansion of the community adjustment role of peer specialists:

People leaving jails and prisons often lack dedicated supports to help guide them through this transition. The use of 'peer specialists' – those with their own histories of both incarceration and mental illnesses who are hired to support others like themselves - has proven effective. Not only would an addition of this role to agencies increase the workforce for this population, it would address the lack of support barrier.

Conclusion.

This hearing held by Philadelphia City Council provides a model for other city and state legislators as a means to highlight key issues and focus local government action on addressing the community reentry and inclusion needs of individuals with serious mental illnesses. The aforementioned recommendations can lead to effective strategies to address the barriers that prevent people with serious mental illnesses who are returning to the community following incarceration from living lawful, productive, engaged and satisfying lives, and facilitate long-term positive impacts on both the individuals involved and the families, employers, and communities to which they return.

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Appendix A.

City of Philadelphia



Council of the City of Philadelphia
Office of the Chief Clerk Room 402, City Hall
Philadelphia

(Resolution No. 150131)

RESOLUTION

Authorizing Council's Committees on the Disabled and Special Needs and Public Safety to hold joint public hearings investigating the barriers faced by people with serious mental health issues who are transitioning from incarceration to the Philadelphia community.

WHEREAS, United States jails and prisons house approximately 2.5 million people. Of those in the system, 95 % will be released after mostly serving 12 months or less behind bars and with significant reentry challenges. Additionally, two-thirds of the population will end up getting re-incarcerated within three years after their release; and

WHEREAS, People with psychiatric disabilities are at a disproportionately greater risk for involvement in the criminal justice system compared to the general population. While 6% of U.S. adults have a psychiatric disability, 15% of men, and 31% of women entering jails are believed to have a psychiatric disability, with illegal substance use playing a major factor in arrests; and

WHEREAS, The sudden, unpredictable nature of incarceration interferes with the maintenance of family and social relationships and the development of consistent community participation (e.g., work, school, church attendance, etc.) and ties to the community. Diminished family and social ties, and the structure provided by stable community participation, could further increase the risk of new arrests and illegal substance use, creating a vicious cycle. Innovative preventative interventions based on connecting or re-connecting people to community, including meaningful participation and family and social relationships, may not only enhance community living and participation outcomes, but also prevent further involvement in the criminal justice system; and

WHEREAS, Social supports have been identified as improving health outcomes, treatment compliance, quality of life, and community tenure. Individuals with mental health issues tend to have smaller and less diversified social networks. Incarceration can disrupt these bonds and create instability and weakened support systems that are crucial for successful reentry; and

WHEREAS, Stable employment has been shown to have positive economic and health outcomes. However, the labor force participation rate for persons with psychiatric disabilities has remained around 25%, the lowest rate among all disability groups. Finding employment is difficult for this population due to low educational attainment, drug addiction and social stigma. When someone is involved in the criminal justice system, they also face legal barriers and restrictions that prevent stable employment; and

WHEREAS, Approximately 80% of individuals released from prison are uninsured. Once incarcerated, most states, including Pennsylvania, terminate inmate's Medicaid benefits. While research shows that the first few weeks after release are the most critical in terms of connecting people to treatment, benefits are not always restored upon release and is a process that can take upwards of several months. It has the potential to disrupt continuity of care and delay needed treatment and resources; and

WHEREAS, The transitional process from incarceration to community is multidimensional and requires collaboration from many systems. Individuals returning to the community may have multiple immediate needs, such as housing, food, clothing, substance abuse treatment and child custody issues. An inability to address all of these challenges can lead to a return to criminal activity; and

WHEREAS, Total correctional expenditures are continuing to expand, with the total annual per-inmate cost averaging more than \$31,000. With budgets already strained, it is more cost effective to help returning citizens become more productive members of society as opposed to paying for institutional care; and

WHEREAS, The Mayor's Office of Reintegration Services is looking to address these problems in the City by introducing a reentry pilot. This initiative seeks to overcome many of the significant barriers that prevent returning citizens with serious mental health issues from successfully reintegrating back into their communities; and

RESOLVED, BY THE COUNCIL OF THE CITY OF PHILADELPHIA, That the Committee on the Disabled and Special Needs is hereby authorized to hold public hearings reviewing the significant barriers that prevent successful reentry into the community of returning citizens with serious mental health issues.

FURTHER RESOLVED, That in furtherance of such investigation, the Committee is hereby authorized to issue subpoenas as may be necessary or appropriate to compel the attendance of witnesses and the production of documents to the full extent authorized under Section 2-401 of the Philadelphia Home Rule Charter.

CERTIFICATION: This is a true and correct copy of the original Resolution, adopted by the Council of the City of Philadelphia on the nineteenth day of February, 2015.

Darrell L. Clarke
PRESIDENT OF THE COUNCIL

Michael A. Decker
CHIEF CLERK OF THE COUNCIL

Introduced by: Councilmembers O'Brien and Jones

Sponsored by: Councilmembers O'Brien, Jones, Bass, Reynolds Brown, Tasco, Council President Clarke, Councilmembers Greenlee, Blackwell, Henon, Neilson, Johnson, Quiñones Sánchez and Oh

Appendix B.

Raymond Ziegler

My name is Raymond Zeigler and I have been in and out of prison since I was eight years old. I was released from SCI-Graterford prison in 2010 after serving 20 years for a crime I committed while under the influence of crack cocaine. I have been using drugs and alcohol for close to forty years and every time I used, the end results would be prison.

In 1981, I was sent to SCI-CampHill prison for voluntary manslaughter. While there, I learned that I could not read or write, not even at a third grade level. I learned this when I took the GED testing which I flunked twice and only earning it by two points the third time.

While serving the 20 year sentence, I enrolled in a Business Management course with Montgomery County Community College which lead to achieving an associate's degree. I was informed by other men in prison that Villanova University was giving out scholarships, so I took the test with them and earned one of the scholarships. In 2010, I received my Bachelor Degree and I am now working on a Dual Master's Degree with Eastern Mennonite University. The degrees are a Master of Divinity and MA in Conflict Transformation. In addition, I have received two Journeyman's in Electrical and Electronics.

Upon my release prison in 2010, my mother suggested I should talk to someone in mental health, I took her advice and learned that I am BI-Polar and have trauma that stemmed from my youth and prison experiences. I am in treatment for both. With the help from The Department of Behavior and Health Intellectual Disability Services, I received training as a Certified Peer & Forensic Specialist (CPS-CFS), amongst other trainings to better help me in supporting other men & women who want to live a life of recovery. Today, I am employed at Greater Philadelphia Asian Social Services, working as a Certified Peer Specialist (CPS). My responsibilities include weekly drug & alcohol outpatient group Sessions (OP), writing drug & alcohol progress notes (DAP), helping men and woman with employment and peer support. As needed, I also do intensive outpatient (IOP) sessions.

Many of the times that I was released, I tried to apply myself in job training from many agencies that stated they supported Reentry. As a result of being denied employment due to my criminal record I went back into the streets - just as most men and women do who are denied another chance by employers. This is the number one barrier that we face and then your addiction kicks in. If not for the support of Gpass and their commitment to reentry - where would I be at today. I will also talk more about my addiction - this point must be stressed.

Jeff Draine

Professor, School of Social Work
College of Public Health, Temple University.

Reentry or Removal? Comments on the State of our knowledge regarding “reentry” “restoration” or “rehabilitation” of people with mental illnesses.

For nearly 25 years, I have engaged in research on the involvement of people with mental illness in the criminal justice system. My work has been funded by the NIMH, NIDA, SAMHSA and HRSA. I have over 70 peer reviewed publications in this area, and would have more if that were the thing that got people’s attention on this issue. What gets most people’s real attention on this issue is telling the human story.

My interest began during my earlier days as a full time volunteer for a religious community working to address homelessness in my home town of Richmond, Virginia. The state prison (now demolished) sat across the street from the place we worked, and men (it was a men’s prison) would use our street address, 308 West Canal, as their discharge address, and would walk across the interstate bridge and into our front door. The one time I’ve ever been physically hit in this business was when one of those men walked in the front door and had to hit someone to vent his anger over time lost to prison. True to our way at the time, we logically made him our cook, a role he filled for years following. We had built a coalition that provided physical comforts, mental health care, and advocacy for the welfare of the people who came to us. We were not naïve about our guests. Many were tough characters hardened by life on the street. A third to a half of those who came through our doors were living with serious mental illnesses. We gave them things to do and things to aim for—school, jobs, relationships. I begin with this to paint for you the perspective I have about this issue that is treated as a clinical issue. It is first and foremost an issue of human dignity.

I’ll now focus on the four works that start with “re” in the title for this talk. First: Rehabilitation. This is often seen as the “soft” aim of correctional policy. However, “rehabilitation” in the context of prisons and correctional institutions has critical limitations. This is not due to the lack of effort or experience of prison staff. Rehabilitation as a term refers to the process of helping a person adjust to their living circumstances with new skills and accommodations. Correctional settings do not offer naturalistic environments for Rehabilitation. Evidence in psychiatric rehabilitation have consistently shown that interventions provided in natural environments, those experienced like everyone else, are more effective than those conducted in workshops or institutional settings. Our aim should be moving people with mental illnesses toward supported education, supported employment and supported housing as quickly as possible to the extent possible in correctional settings. I would suggest a move from CJ oriented rehab with a focus on “criminogenic” factors, to the psychiatric rehab interventions that are focused on inclusion in the most natural environments—specifically those interventions linked to inclusion in the aspects of community life associated with lessened risk of criminal recidivism, employment, housing and education. Let these evidence based interventions do their work while their participants are under any required supervision of corrections.

“Removal” is a term popularized by influential criminologist Todd Clear. He promoted this term as an alternative to the definition of our problem focus as reentry. The term “removal” highlights the extent to which the returning prisoner is principally held back by his or her separation from friends and family, and the maintenance of those relationships, as well as the removal of key people from communities into jails and prisons, changing the structure of neighborhoods and their capacity to support households in the community. This also frames the issue as attributed to incarceration policy as well as individual culpability.

“Reentry” is a vaguely defined term. Interestingly, when I discuss this issue with people unfamiliar with this issue, their most common question is “reentry to what”? Amongst ourselves, we’re often not completely clear on this element of what we mean—and it’s very similar to the diversion issue of “diversion to what”. Once we think though this question is becomes clear that this element of reentry needs more work. Most reentry interventions I’ve seen lack either impact or capacity, or both. By impact we mean a theoretical and empirical basis for it being effective, i.e. “evidence based”. By capacity—I mean the extent to which the intervention can be “scaled up” to the level that it addresses the scope of the problem of helping people return to the community from prison or jail. Thus, we need to consider the extent to which we can respond to the expected continuing rise of people leaving jails and prisons with sufficient staff and resources. One of the main issues is that of professional personnel for implementation of any programs.

Most reentry programs do not offer the impact of intervention on an effectiveness nor humane level that is called for by the experience of incarceration. We know, for instance, that the mortality rate for the two week period following prison release can be as high as 24 times the general mortality rate—primarily attributable to violence, substance use, inadequately treated preexisting disease and suicide. Clearly this is a time of tremendous suffering and stress. I think an essential question is this: Do we address this suffering as compassionately as we aim to address criminogenic factors? In my view, a frank recognition of suffering is the most important element we have yet to adequately address in intervention models. Doing this would allow a frank discussion of the incarceration experience and the uncertainty involved in the community after release. It will also allow us to directly address the reality of trauma as part of incarceration.

“Restoration” is the word that I believe best explains our aims. Restoration can encompass housing in a neighborhood as well as community relationships, and engagement with tasks associated with employment, education, and family. Restoration places the goal as a full integration in the community—a restoration to life outside of prison or jail. We all share in the aims of restoration. It also ups the ante in what our goals are. In reentry, the goal is basically to leave jail without coming back. In “restoration” we can actively use the incarceration experience as a springboard to learning lessons and moving forward. This is consistent with a criminological literature that is called the “good lives model.” This model examines the ways that people make sense of lives that includes criminal behavior and incarceration. How can a person cope with the losses inherent to the experience of incarceration? How does a person generate a new identity as a former prisoner that is positive and leading to growth? Basically, how do we bring people home to our communities in a way that they become part of a community that includes both “them” and “us” together?

Sandy Vasko

CITY OF PHILADELPHIA

Department of Behavioral Health and Intellectual disAbility Services Promoting Recovery, Resilience & Self Determination

TESTIMONY OF

Sandy Vasko

DEPARTMENT OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY SERVICES

BEFORE THE CITY COUNCIL COMMITTEES ON: PUBLIC SAFETY AND THE DISABLED AND SPECIAL NEEDS

RE: RESOLUTION NUMBER 150131 March 20, 2015

Barriers to Reentry for Individuals with Serious Mental Illness

Good Morning Chairman O'Brien, Chairman Jones, and members of the Public Safety and The Disabled and Special Needs Committees. My name is Sandy Vasko, Director of Mental Health at the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). I appear on behalf of Dr. Arthur C. Evans, Commissioner, DBHIDS, and Dr. H. Jean Wright II, Director, Behavioral Health and Justice Related Services. Dr. Wright is unable to be here today, and asked me to represent our efforts in this extremely important area.

Individuals reentering society from custody who suffer with a Serious Mental Illness (SMI) face formidable challenges. Individuals diagnosed with an SMI (Schizophrenia, Bi-Polar Disorder, Major Depressive Disorder, Psychotic Disorder) suffer from impaired mental, emotional or behavioral functioning to the extent that they require supportive treatment services if they are to successfully remain in the community. The national average for incarcerated individuals diagnosed with an SMI is 9-18%. Recent data from the Philadelphia Prison System (PPS) is on the lower end of this estimate. As of January 2015, the PPS census had an average daily population of 8,158. 959. Of those individuals only 11.8% had been diagnosed with an SMI. Additionally, it was noted that between 30% and 40% of incarcerated individuals have received Behavioral Health Services. In total, according to PPS admission/release data, the yearly average is 37,000 admissions (33,000 unduplicated). Of those, SMI admissions at PPS average 4,200 per year, or 81 per week. Individuals released from PPS with an SMI diagnosis average 12 per day, or 84 per week.

For individuals diagnosed with an SMI, emphasis must be placed on substance use/dependence and mental health treatment. Those individuals with co-occurring behavioral health challenges are four times more likely to violate parole, and/or, return to jail within the first year after reentry than persons with no SMI or substance use/dependence history (Skeem, 2014).

Given the significant number of persons with SMI reentering the community every week, the challenge to remove barriers that impede successful reentry requires a collaborative effort on the part of all city agencies that serve in this role. Collaboration across disciplines and jurisdictional boundaries is at the core of jail reentry. Recent years have seen a national explosion of creative and productive partnerships among jails and law enforcement, probation/parole, faith-based organizations, mental

health clinics, victim advocacy groups, the business community, and a variety of other social service and community providers.

Fortunately, in Philadelphia, cross-system collaboration among justice partners and the behavioral health system has been a healthy reality for much of the past decade. The behavioral health system actively participates on the Criminal Justice Advisory Board, and meets regularly with the Courts, Philadelphia Prison System, District Attorney's Office, Philadelphia Defender Association, and Probation/Parole, focusing on implementing evidence-based practice for planning and implementation of reentry strategies and programs. Two current behavioral health partnership initiatives specifically address reentry, while the third example addresses both diversion and reentry.

1. DBHIDS has been an active participant in the First Judicial District Mental Health Court (FJDMHC) since its inception in July 2009. This is the first reentry mental health court in Pennsylvania, in which sentenced individuals who are diagnosed with an SMI are released from custody into the community to court ordered housing, treatment, case management and other supportive services. DBHIDS is currently working with the FJDMHC through a U.S. Department of Justice Office of Justice Programs grant for Comprehensive Assessment for Placement and Services. The scope of this grant is to implement a comprehensive assessment which encompasses the clinical needs of the court participants and addresses the risk of reoffending. This grant period runs from October 1, 2014 to September 30, 2016.
2. DBHIDS is working with Philadelphia's Veterans Court through two Substance Abuse and Mental Health Services Administration (SAMHSA) grants, one of which we will focus on today. This four-year grant (through June 2015) project diverts U.S. Military Veterans with traumarelated disorders from the criminal justice system and incarceration in local jails to programs that address their behavioral health and recovery needs. The veterans diverted from the criminal justice system receive trauma-specific treatment and support services within a trauma informed integrated service system. This project's goal is to facilitate the healing process for men and women who have suffered from the acute stress and trauma of war and to assist them with reintegration into our community. This project is a pilot here in Philadelphia and in Allegheny County, and will then be replicated throughout the Commonwealth.
3. Over the past 22 years the Office of Addiction Services, under DBHIDS, has worked in partnership with criminal justice agencies including: the First Judicial District, Court of Common Pleas, Municipal Court, Adult Probation and Parole and Pretrial Services, the District Attorney's Office, Defender's Association, Philadelphia Prison System and seventy addiction treatment providers, to develop a network of justice/behavioral health projects. These projects work to divert non-violent substance abusers from jail as well as promote community re-entry activities to link inmates to services when they return to the community.

Justice and Addiction Treatment Initiatives include:

- Forensic Intensive Recovery (FIR)
- Drug and Alcohol Restrictive Intermediate Punishment Program
- Philadelphia Treatment Court
- Driving Under the Influence (DUI) Court
- Accelerated Misdemeanor Program (AMP)
- Domestic Violence Court
- DAWN Court
- Family Court Adult Evaluation
- Juvenile Treatment Court
- Youth Violence Reduction Program (YVRP)

During Fiscal Year 2014 a total of 7,000 individuals were served by these initiatives. The problem solving courts – Treatment, DUI, Domestic Violence, DAWN and Juvenile – are all programs designed to divert or prevent individuals from entering the Philadelphia Prison System (PPS). FIR and Intermediate Punishment programs are early release/parole programs that offer reentry support and alternatives to local incarceration. Approximately 3,200 individuals are in licensed treatment programs in lieu of incarceration annually.

This is by no means an exhaustive list of collaborative efforts between justice partners and behavioral health to mitigate the effect of risk factors, and promote protective factors, for returning citizens with SMI and co-occurring challenges. Successful reentry is a shared challenge, and requires creative, shared collaborative solutions. There is much work to do.

I appreciate the opportunity to present my testimony here today. I would be happy to answer any questions that the Committee may have.

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Eric Stryd



**Testimony of Eric Stryd
Assistant Chief, Diversion Courts Unit
Philadelphia District Attorney's Office**

**Before the Joint Committees on the Disabled & Special Needs and Public Safety
Philadelphia City Council**

Regarding Resolution No. 150131

March 20, 2015

Good Morning Chairman O'Brien, Chairman Jones, and members of the Joint Committee. Thank you for inviting me to testify.

My name is Eric Stryd, and I am the Assistant Chief of the Diversion Courts Unit at the District Attorney's Office. As Assistant Chief, I am responsible for running a number of re-entry and diversionary programs, including County Intermediate Punishment, State Re-entry Court, MENTOR and Mental Health Court. Prior to becoming assistant chief, I was in the trial division for over 6 years handling many cases, including non-fatal shootings and other violent felonies in South Philadelphia. Many of these non-fatal shootings and violent felonies involved defendants from the Focused Deterrence Program. Prior to joining the District Attorney's office, I worked for a year and half as an assistant public defender in Missouri.

First Judicial District Mental Health Court (MHC) was Pennsylvania's First Re-entry Mental Health Court and was started in 2009 under the leadership of Judge Sheila Woods Skipper and has processed over 3000 cases since its inception. Mental Health Court is a post-sentence reentry program designed to

provide specialized services to those who struggle with mental illness. It provides an alternative to incarceration for non-violent offenders with mental illness and co-occurring disorders by preparing individuals for re-entry into supervised communities. The goal of Mental Health Court aims to reduce the jail population and criminal justice costs by balancing justice, treatment, and public safety.

Defendants can be referred to Mental Health Court through a variety of avenues. Cases can be identified by Judges, defense attorneys, probation officers, or the assistant district attorney. Once a defendant is identified as a possible candidate for Mental Health Court, a formal referral is submitted to the program coordinator, Patricia Wilson. Ms. Wilson reviews the application and the defendant's mental health history to determine whether the defendant is a good fit for the program. I also review the defendant's application, his mental health history, and also the facts of the case to determine whether he or she is eligible for the program. If both the District Attorney's Office and Ms. Wilson agree that the applicant is an appropriate candidate, the defendant is accepted to Mental Health Court. When the defendant enters the program, President Judge Woods Skipper explains the program in detail and also explains what our expectations are for the participant.

Once the defendant enters Mental Health Court, he or she will be required to follow all the conditions of the program, which include attending mental health treatment, remaining medicine compliant, and meeting all other conditions set forth by the Mental Health Court Probation Officer. Mental Health Court has a number of built-in rewards and sanctions for the participants. If the participant is doing well, he or she will receive applause in the courtroom, see a decrease to the probation reporting requirements or a lowering of the probation supervision level and ultimately a reduction in the sentence. If the defendant does poorly or violates the rules of the program, sanctions include writing an essay, having to sit in the jury box, increased probation supervision, jail time, or expulsion from the program.

When I review applications for Mental Health Court, I usually focus on three things. First, does the defendant have a serious mental illness? The program is designed for the defendants who are suffering from Bipolar, Major Depressive Disorder, Schizoaffective Disorder or Schizophrenia. Second, what are the facts of the current case? We are targeting individuals with non-violent offenses, so defendants with sexual assault cases and other violent cases will be rejected. Third, what is the defendant's prior criminal history? If the defendant has a history of violent behavior, he will be rejected from the program. We are not bound by these three areas, as every defendant is always looked at on a case-by-case basis; however, they provide guidance for us to try and seek consistency in our referrals and approvals.

Serious mental illness affects a large segment of general prison population and remains a problem for our society and our prison system. Our prisons often do not have the ability to provide the necessary services to a defendant who suffers from a serious mental illness. When a defendant does not receive treatment for his underlying problems, it often leads to rearrests for new charges. This harms not only the defendant, but the victim of the crimes and the community at large. Mental Health Court makes a difference in these defendants' lives by providing intensive supervision, case management, and treatment in order to help the defendant re-enter society. When a defendant does not re-offend, he saves taxpayers money, reduces risks of harm to his community, and also helps himself.

While providing services and treatment to participants in Mental Health Court is much more cost efficient than incarcerating them, it is very time consuming and labor intensive. Mental Health Court requires many groups and agencies to work together for the betterment of the individual and society. In order for Mental Health Court to continue to be successful going forward, I see two immediate concerns:

- 1. Bed Space.** While we have many wonderful partners in Mental Health Court, we often run into the problem of not having enough beds for our participants. Our city needs to increase the amount of beds for people who need in-patient treatment for their mental illness. This includes more beds at secure facilities and also more beds at non-secure facilities. To give an example, Norristown State Hospital currently has a waiting list of 99 individuals for the male population and an approximate wait time of one year. This is unacceptable.
- 2. Resources Required to Keep the Program Running.** Mental Health Court requires much more staff time than merely trying a case. That is, in fact, one of the primary purposes of Mental Health Court – to ensure that the offenders in the program receive the time, programs, and follow-up necessary to help them avoid committing new crimes and to help treat their underlying conditions. As you know, the savings associated with Mental Health Court, such as reduced prison costs, are significant. Unfortunately, the caseloads are often unmanageable. With more investment, the system will yield even better results.

We believe that we have the tools and knowledge to better deal with a growing mental health population in the criminal justice system. Mental Health Court is an effective alternative to the revolving door of custody for mentally ill offenders. This is a special population that requires a specialized approach.

I thank the council for its interest in this subject and I am happy to answer any of your questions.



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Friday, February 26, 2016

Testimony to the Committee of Disabled and Special Needs and Public Safety

Good Morning Councilman Jones, Councilman O'Brien esteemed guest. I would like to thank you for this opportunity to speak with you regarding a very important issue.

My name is Jeannette Palmer I can attest that I have worked for the First judicial District of Pennsylvania, specifically the Probation and parole Department, proudly for over (27) years. I am currently the supervisor of the Mental Health Unit for the Philadelphia Adult Probation and Parole Department. This is one of two units specifically designated to supervise offenders with mental illness. The other unit, the Specialized Court Unit, (Mental Health Treatment Court) is supervised by Christine Carassai who is present with me today. I personally supervise (11) probation officers and oversee (1,450) probation and parole offenders who have been court ordered to have a specialized probation officer assist them with successfully completing the period of supervision.

I was transferred to the Mental Health Unit on February 10, 2014 and immediately began the process of communicating with as many Mental Health partners that I could to assist our population. I may add that, prior to supervising the Mental Health Unit; I supervised the Forensic Intensive Recovery Unit of the Probation and Parole Department whereby I gained experience and knowledge in the funding process for offenders who have drug and alcohol addictions as well as mental health issues related to the use of drug and alcohol.

From 1999 through 2002, I was also employed with Horizon House, Inc. This organization specifically assisted people with mental health disabilities. While working with this organization, I gained the love, respect and admiration of people in general who suffer with mental illness.

In December 2014, the Mental Health Unit of the Probation Department supervised (1,481) active offenders with a total of (2,423) active cases. (316), or (21 %) of our offender population are incarcerated. The Mental health Unit received (40) new offenders in this month, with a total of (103) new cases. The average case load size of a Mental Health Probation Officer is (135) offenders. The Probation officers had face to face contact with (1,189) offenders during this month which equals a (77%) face to face contact rate. The total number of phone contacts made by the Officers to the

offenders or related parties to the offenders was (1,404) calls. I have provided you just a few of our end of the year statistics, but I must state, this is by far the least busy months of the year.

The Probation Officers are responsible for ensuring that the offender complies with the rules, regulations and direct of the Court. Essentially, we follow the direction of the Judge's Court Order. The Mental Health Units of the Probation and Parole are very unique in that they request and want to work with this very challenging population. We are stern, but compassionate. We wear the hat of counselor, law enforcement office, mediator, therapist and yes...confidant. We meet with the Judge, the attorneys, the family, the therapist, and the treatment providers in general. Many times we are all things to our offenders.

I am here to make a passionate plea for your assistance.

The Probation and Parole Department needs housing programs, inpatient programs, and more intensive case managers for the mentally ill offender. Have you ever gone to work and happen to seen a man or woman talking to themselves? Or perhaps you have seen a person swinging at the air? Or maybe you watched a man lying on the church steps eating out of a paper bag. Chances are that individual may be one of the offenders assigned to the mental health Unit of the Probation and Parole Department. The lack of resources for this population is growing every day.

Our offenders are being released from custody, (jail or prison), with nothing. In most cases, if they have not been court ordered to a specific program and transported by the Philadelphia County Sheriff's Department, they are sent to the city's Shelter system. This more times than not leaves the offender vulnerable, as the Shelter system is not always the most suitable location for this population. Because the offender often has no proper identification, no medication, and sometimes no family contact information or family to assist them, they are forced to live on the street. We will ALWAYS attempt to have an offender 302'd, but in most cases this is not an option for the Probation Department. Secondly, when medication is not available for an offender, and this could be for any number of reasons. They have lost their benefits due to not completing necessary paperwork for the Department of Welfare, they have lost the identification. Sometimes, our offenders lose their medications and cannot get more medications because it is not time for a refill. They have no one to assist them and too often they are left alone to spiral out of control. Due to the arrest record, and often violent offenses the individual is not appropriate or will not be accepted to many of the mental health housing programs. When the offender reports to the Probation Department, we are often left with no choice but to remand this individual into custody. While in jail, they can have a warm bed, medications, and some stability. We will request a Court Ordered Mental Health Evaluation for the purpose of an updated diagnosis, and competency. This solution as you can envision, is never...ever a solution.

Earlier in my testimonial, I provided statistics to give you an idea of how many offenders we supervise and the high number issues that we are confronted with daily. If we had programs, case managers, beds, nurses and staff that would willingly accept mentally ill offenders, we could reduce the number of offenders who are incarcerated. While incarceration is "better than being on the street", mental health therapeutic treatment unavailable. Statistics have proven that all recovery and mental stability works best when combined with treatment and medications. This begins with stable housing, food and clothing.

In closing, yes...we supervise offenders. They are people who have broken the law, often unstable, often without family, however, they are people who are in need. The Probation Department cares. We care about the City of Philadelphia and its citizens. We care about ensuring the Court order is honored and obeyed. But, we also care about our offenders. They ARE in need of our assistance, our care, and our expertise. Availing affordable housing to this population would save our city from housing offenders in custody, wondering the streets of the city, or not being properly supervised in general. This issue is so important.

I thank you for this opportunity and your consideration in this very important matter.

Respectfully,

N. Jeannette Palmer

Matt Tice



Testimony to the Committee on Disabilities and Individuals with Special Needs/Public Safety

Good Morning Chairman O'Brien, Vice-Chairman Henon and Committee members. Thank you for the opportunity to testify.

My name is Matt Tice and I am the Clinical Director of Pathways to Housing PA, a non-profit organization here in Philadelphia. I'm here as a licensed social worker who has been in the field for the last 10 years. Over this time I've worked with many men and women who have struggled to land on their feet after reentering communities from circumstances like incarceration. Since coming to Pathways to Housing I've gotten to know and serve an incredibly resilient group of individuals living with severe mental illness who have lived with chronic homelessness due to a wide variety of complications in their lives including re-entry. People come to us with difficult histories and through a "housing-first" model we offer them their own apartment in locations spread across the city with no other preconditions.

The people my agency serves do not generally come directly from prisons. Often instead they are the people who find themselves leaving institutions like prison and not knowing where to turn, how to properly access care, deal with addiction, or find adequate housing. Our program participants describe confusing or unsympathetic systems with long waits that do not seem to thoroughly consider mental illness when they return.

Because of a combination of individualized behavioral challenges and outside institutional barriers they find themselves homeless, and not just for short stints. We exclusively serve chronically homeless individuals so they need to have been on the street or in and out of shelters for at least a year to qualify for our program. Our job is to help pick up the pieces when it all goes wrong. Many have been "outside" for dozens of years. We've also seen homelessness and other the resulting nuisance crimes contribute to incarceration. These concerns become deeply ingrained issues that our staff later need to work with participants to resolve.

We come to you today to ask for your continued support for person-centered holistic care that offers easy and open access to all individuals passing through our jails and prison systems. Foster an environment where re-entry is supported by more productive discharges. Often individuals leave jails in the middle of the night and their only option if they don't have family to take them in is to go to the street or shelter. This is the first step in a cascade of problems where many feel like they are set up to fail. We need an environment where people are valued both inside and outside of prison walls and transitions between are made as smooth as possible.

The exciting thing about this group of people is that we know they can get better. I've helped individuals who have spent upwards of 30 years either on the street or in prison move into their own apartment. Through our supported housing program we serve the whole person including medical, therapeutic, and behavioral interventions. We routinely watch them maintain that housing at an

unheard of rate of 89% retention. They reintegrate with neighbors and communities and reconnect with family members. For those who want to access drug and alcohol treatment we help open that door and for those who are not ready, we continually offer access. We make sure healthcare is easily accessible, user friendly, and are happily amazed when people's health improves even in light of chronic conditions. We also offer support as our participants reconnect with faith communities and other spiritual endeavors.

Right now Pathways to Housing PA and Horizon House are the only programs in the city that utilize full adherence to the Housing First model. Other programs are starting to follow suite but it is a slow hard climb from graduated models that expect behavioral and psychiatric concerns be settled before housing is offered. We ask you to support developing initiatives that foster this kind of a movement. Philadelphia needs more housing first services.

We also fully support the Mayor's Office of Reintegration Services and see it as a great example of how the city is turning toward preventing re-entering individuals from ending up in situations like chronic homelessness but we need more. With the amount of people who pass through the prison system every year with serious mental illness we need the voices of our leaders, such as yourselves, to champion interventions that are geared toward wholeness, informed by the trauma so many have experienced, and welcome them right where they are. The flow of individuals into homelessness can be staved off but it won't happen with quick fixes. It will take the dedication of caring individuals informed by the voices of those of the streets. We thank you for listening to those voices.