The Douglas County Department of Corrections (DCDC) is a 1,453-bed adult jail facility located in the downtown area of Omaha, Neb. The jail is responsible for housing pretrial, sentenced and federal inmates, both male and female. During the previous two years, while the inmate population has been decreasing, the number of inmates coming into the jail with a diagnosed mental illness has increased. Moreover, the acuity level of the mentally ill population is also increasing. Several reasons can account for this phenomenon.

Nebraska recently passed legislation that made the assault of a medical care worker a felony. Several individuals housed in mental health facilities have been charged under this new statute and jailed. Some mental health providers are reluctant to accept the mentally ill who have some types of criminal history or exhibit aggressive behavior. The availability of long-term residential beds for the mentally ill is extremely limited. Short-term acute beds for the mentally ill are also in very short supply. For example, in Nebraska, the number of individuals who received mental health services at state hospitals declined from 1,946 in 2007 to 539 in 2009. This decrease represents a decline of 72 percent. Moreover, the number of individuals who received mental health services provided by the state of Nebraska fell from 37,163 in 2007 to 28,321 in 2009 — representing a 24 percent decline.

As the mentally ill become a growing, underserved population due to shrinking fiscal resources, the likelihood of these individuals having adversarial contacts with law enforcement rises — as does the potential for going to jail. In 2010, The National Psychologist reported that New York City’s Riker’s Island, Chicago’s Cook County Jail and the Los Angeles County Jail were the largest inpatient psychiatric facilities in the nation.

DCDC is not immune to what appears to be taking place on a national level, as it too is quickly becoming the largest mental health facility in the state of Nebraska.

Seven years ago, inmate mental health issues were the responsibility of one full-time licensed mental health practitioner (LMHP) and a part-time psychiatrist. The percentage of inmates diagnosed as having mental health conditions and who received psychotropic medication was less than five percent. The LMHP conducted individual and group therapy.
sessions. Mental health staff did what they could to keep up with crisis intervention and management of high-risk inmates, but very little time was spent connecting soon-to-be released inmates with mental health services in the community. Jail chaplains provided some ad hoc assistance to the mentally ill in the way of providing resource lists for housing and treatment centers to soon-to-be released inmates. However, recidivism was very likely for this population.

Addressing the Mentally Ill Population

Five years ago, in an attempt to better meet the needs of the mentally ill population, one additional full-time LMHP was hired along with a part-time LMHP. The additional LMHP hours provided an opportunity to develop a discharge planning program for the inmates. Twenty percent of the new full-time LMHP’s time was dedicated to that effort. Those services included providing soon-to-be released inmates with an updated list of mental health resources available in the community. The new full-time LMHP also scheduled initial appointments with providers so that an inmate’s mental health appointment closely coincided with his or her release date. To further facilitate the transition from the mental health services an inmate received in jail to those provided in the community, the discharge planner also provided 10-ride bus tickets. These bus tickets helped to reduce some of the transportation barriers and reduced the “no-show” rate for scheduled appointments. As an additional attempt to help bridge the continuum of care, newly released inmates were also provided with a seven-day supply of discharge medication.

The initial discharge planning effort at the jail was well-received by participating inmates. However, only 30 inmates each month received some type of discharge planning assistance. There needed to be a more effective outreach to the inmate population. A decision was made by DCDC staff to advertise the discharge planning services that were available through the medical department. The outreach included posting memos describing the available services inside each of the housing units. Within three to six months, the part-time LMHP, who was the discharge planner, was averaging 125 contacts every month.

In March 2013, DCDC’s medical contract was awarded to Correct Care Solutions. The part-time LMHP position was increased to a full-time position. An additional LMHP was hired and charged with part-time substance abuse programming responsibilities to include treatment programs and a discharge component of placing released inmates in various levels of treatment in the community. The medical unit now has three full-time LMHPs and one part-time LMHP.

The LMHP currently averages 366 new contacts each month. These numbers do not reflect those already engaged in discharge planning services or who have attended a discharge planning orientation class. Inmate requests include employment assistance, locating housing, recovering identification and receiving practice college entrance examinations to refresh their educational knowledge while they are incarcerated. Other requests include:

Orientation classes help develop plans for reentry to the community.
Financial assistance (general assistance, employment resources, credit reports, food stamp application, clothing pantry, etc.);

- Assistance getting into treatment programs, including facilities that treat both mental health and substance abuse disorders, or co-occurring facilities;
- Shelter referral/placement;
- Medical referrals/appointments;
- Networking with Douglas County Mental Health Diversion, Young Adult Court and the Re-Entry Assistance Program, Drug Court, Vocational Rehabilitation, and Probation’s Specialized Substance Abuse Supervision Program;
- Referrals/appointments made to community counseling agencies;
- Legal referrals (attorney contacts, workforce development, Child Protective Services assistance, disability claims consultants);
- College/trade school information; and
- Networking with advocates for detainees being deported to their country of birth.

Attorneys are also consulted so that a realistic discharge plan can begin, which may entail services such as presentence release for substance abuse treatment. Inmates are usually able to communicate with the admitting treatment providers prior to leaving incarceration. This is to ensure a clear understanding of program guidelines, length of service/treatment and participant expectations.

Critical to the success of the discharge planning program are the relationships developed with the inmates and the follow-through of the LMHPs. Inmates believe that they can change when their specific individual needs are being heard and addressed. Increasing the hours dedicated to discharge planning services provides staff an opportunity to develop individualized plans of care. These services are available regardless of the time an inmate has left to serve — whether he or she is to be transferred to another correctional facility or released to the another community.

The future goals of the discharge planning program are to have more immediate housing placements available for inmates upon their release from incarceration. The program also plans to implement ex-offender-only vocational training in the jail that will extend to the community and include ex-offender-only job fairs. Finally, reducing recidivism is virtually impossible without the buy-in of community businesses willing to hire ex-offenders. Educating community businesses about the benefits of hiring ex-offenders is an emerging priority in the evolution of the discharge planning program.

Partnering for Solutions

In May 2006, the Douglas County Community Mental Health Center (CMHC), the Douglas County Attorney’s Office and DCDC entered into a unique partnership to address the needs of the mentally ill who were arrested and booked into the facility. CMHC officials briefed the jail administration on the details of a newly formulated Mental Health Diversion (MHD) program. The MHD program works with some qualifying individuals on a voluntary basis, engaging them in the development of individualized treatment plans to divert them from jail into appropriate community programming/supports. Prerlease planning and following up in the community after release is provided for as long as the participant needs. CMHC administrators asked for office space in the jail for a supervisor and two case workers, as well as access to mental health screening data.

Each person booked into the jail is asked questions regarding his or her mental health history. This information is documented on a mental health screening form, which is delivered to MHD staff. The form is reviewed for affirmative responses to any of the following three questions: “Have you ever been hospitalized for a mental illness?” “Are you now, or have you ever received mental health outpatient treatment?” and, “Are you now taking, or have you in the past, taken prescribed medication for mental illness?” Individuals who meet the criteria are then scheduled for a face-to-face assessment. If the case worker determines that the inmate is eligible for the program, a recommendation is made to the prosecutor’s office.

Individuals who are accepted into the program engage in the development of an individualized treatment plan and are assigned to an intensive case manager. MHD utilizes a forensic intensive case management model. Each case manager has a caseload of approximately 20 participants. Case managers have frequent contact with participants to encourage participant involvement in their treatment plans and in community services and supports. Personal contact is made with each client at least once each week, or up to five times per week, depending on the need for services. Case managers provide extra support, education and encouragement as their participants move through the
treatment plan. Treatment plans include goals that increase independence and establish resources that can be maintained independently. These include but are not limited to: health and substance abuse assessment/treatment; housing; transportation; prevocational skills; obtaining employment; and/or education. Treatment plans also utilize evidence-based practices, Illness Management and Recovery, and engage the participants in pro-social and rehabilitative activities in the community.

Since the MHD program’s inception, 260 former inmates have been served. The success rate for completion of the program is 77 percent. There was a 60 percent reduction in homelessness among those who indicated they had no place to live. This cohort also experienced a 71 percent increase in access to benefits; a 72 percent increase in access to mental health services; a 53 percent increase in access to medical services; and a 62 percent increase in life satisfaction. In addition, CMHC also piloted a new intensive case management (ICM) program in 2010, and it is now a fully-funded program offered to young adults ages 18-24 who are leaving incarceration, are homeless and have mental health issues. Many of the young adults are transitional youths who have been involved in the foster care system and experienced a variety of social and environmental barriers. ICM provides the same level of pre- and post-release services, as outlined with MHD, but is not involved in the participant’s court case. To date, 95 young adults have been served by this program. There was an 85 percent reduction in homelessness among those young people who reported not having a place to live. Young adults involved in prevocational endeavors increased from seven percent to 33 percent; those able to access mental health services increased from 16 percent to 70 percent; and those accessing benefits increased from 20 percent to 31 percent.

CMHC programs also utilize peer support. Peer support professionals have personal experience with issues of mental illness, substance use, incarceration and homelessness, and are actively participating in recovery. Their unique social experiences and specific knowledge regarding recovery are integral to the success of the clients they work with. Peer support professionals work individually with each client to formulate a Wellness Recovery Action Plan and serve as mentors for clients who may have limited experience in utilizing mental health or substance abuse systems. This is accomplished through one-on-one as well as group education. Activities include, but are not limited to: rent wise training; National Alliance for Mental Illness connections; utilizing city transit; advocacy; wellness planning; and support group meeting attendance.

Conclusion

Traditionally, the mission and expertise of a jail facility is not in the provision of an array of services for those who experience mental illness in the community. However, as available mental health services dwindle in the community and the number of inmates experiencing mental illness continues to rise, there is an urgent need to respond and adapt to this growing concern. The discharge planning program arose out of concern for inmates who were being released with no links to services or providers. Untreated mental illness or a delay in accessing services can potentially lead to recidivism. But it is also important to partner with providers in the community who have the requisite skills and resources to work with the mentally ill. CMHC, the Omaha City Prosecutor’s Office, the Douglas County Attorney’s Office, the Douglas County Public Defender’s Office and the judiciary have been willing partners, as they are very aware of the challenges faced by the jail.

Discharge planning, MHD and ICM programs have all contributed to better outcomes for many of the mentally ill who were incarcerated. In fact, DCDC staff know that outcomes are changing when ex-offenders call the discharge planner at the jail on a regular basis to ask for additional resources. However, more work must be done. Long-term mental health assisted living facilities are virtually nonexistent. Many former inmates leaving treatment have to wait for long periods of time to receive state-funded vouchers for housing programs. Those with no health insurance have a difficult time accessing and maintaining medication management for mental health problems, which significantly contribute to criminal involvement. While resolution of these particular issues may be beyond the reach of jail administrators, that does not negate our responsibility to provide for the manifold needs of the mentally ill who are arrested and incarcerated. The task is daunting, and not likely to abate anytime soon. However, jail administrators have had some modicum of success, and are well-positioned to build upon a strong foundation with the help of mental health experts in the community.

ENDNOTES


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