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| cleveland state university |
| POLICY BRIEF DRAFT |
| DISCHARGE PLANNING OF BENEFITS FOR INMATES BEING RELEASED FROM INCARCERATION |
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| **SWK 300- DR. DOVER** |
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1. SCOPE OF THE PROBLEM

When released from institutions, inmates are often released without necessary essentials to help them function effectively and make a successful transition back into society. When necessary benefits, such as medications, mental health supervision, medical care, and SSI/SSD, are not in place when re-entry into the community occurs, a lapse in services occurs which is a major contributing factor for recidivism. Discharge planning is necessary to provide continuity of care and services during transition from institutional life back into society. Past policy was basically to let offenders undergo the transition process alone, and these individuals were given virtually no support. Current policy is for inmates differ from state to state, and much of the discharge planning that occurs is not thorough enough to meet the client’s needs. Proposed policy will include to formation of a discharge planning system to meet all needs of the clients, and a change in benefit policies to insure benefits are in place the day of release.

According to the Bureau of Justice Statistics Special Report (2006), in 2005, 56% of all State prisoners, 45% of all Federal prisoners, and 64% of all jail inmates were estimated to have a mental health problem. Inmates with mental health issues being released from prisons and jails desperately need discharge planning services to reconnect with outside mental health services and achieve mental stability. Upon leaving a correctional facility, the mental health care needs of the individual will often become heightened due to the collateral consequences of incarceration, such as homelessness, and due to traumatic situations, such as victimization, abuse, and solitary confinement, experienced in the institution.

Incarceration leads to virtually every inmate receiving public assistance to lose benefits due to suspension or termination of them automatically upon incarceration. Without discharge planning, it is nearly impossible for inmates returning into society to obtain the treatment,

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benefits, and support immediately following release that they were relying on prior to incarceration. According to the Bureau of Justice Statistics Special Report (2006), 34% of adult correctional facilities in the United States do not help released prisoners obtain mental health services. For the 66% that do, the quality of assistance is unknown. Legally, mental health care patients have a right to discharge planning. Because the mental health care is occurring in an institution, the inmates are not receiving discharge planning to the extent that should be protected by the legal system. A relapse prevention strategy for mental health inmates is necessary in which a web of social and emotional support is provided from the network of forces, including treatment providers, friends and family, the institution, and the client coming together to meet the clients needs (Steadman, 1993, p. 143).

2. PAST POLICY

In the past, inmates being released from prison were basically just thrown out on to the streets, given a few dollars and a bus pass, and left to fend for themselves. They were not given any medication, referral to services, assistance obtaining benefits, or even a referral to a shelter for those who were homeless. Past policy for discharge planning is basically non-existent. In 1976, with the case of Estelle v. Gamble, the Federal Courts mandated mental health treatment for those incarcerated in prison and jails, but the issue of discharge planning was ignored (Barr, 2003, p 101). In 1999, the first class action suit in the U.S. regarding discharge planning was filed because virtually no discharge planning upon release was being offered. In the Brad H. suit against the City of New York, discharge planning and assistance was sought for each person, upon release from jail, for an adequate supply of medication, a shelter with a bed, access to mental health services, and assurance of immediate benefits such as Medicaid and food stamps

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(Slate, 2008, p. 179). Several organizations including The Bazelon Center, NAMI, and The American Orthopsychiatric Association, along with eleven other organizations had a brief made to document the importance of discharge planning and the best way of implementation for the jails (Judge David L. Bazelon Center for Mental Health Law, n.d., “Discharge Planning for Inmates”). Another federal ruling, in which the case originated out of California, came from Wakefield v. Thompson in which the court ruled:

“The state must provide an outgoing prisoner who is receiving and continues to require medication with a supply sufficient to ensure that he has that medication available during the period of time reasonable necessary to permit him to consult a doctor and obtain a new supply. A state's failure to provide medication sufficient to cover this transitional period amounts to an abdication of its responsibility to provide medical care to those, who by reason of incarceration, are unable to provide for their own medical needs” (Human Rights Watch Publications, 2003).

This law applies to the ninth circuit- including California, Nevada, Arizona, Oregon, Washington, Montana, Idaho, Alaska, and Hawaii (Judge David L. Bazelon Center for Mental Health Law, 2003, “Finding the Key”). Without discharge planning, approximately 2/3 of mentally ill individuals will re-offend and be returned to the system (Human Rights Watch Publications, 2003). Although these rulings attempted to make discharge planning available in prison systems, the problem is just now starting to be addressed with current policies.

3. CURRENT POLICY

Federal benefits, including SSI, SSDI, Medicaid, Medicare, Food Stamps, TANF, and Veterans, that a person may receive are all put in jeopardy if incarcerated in a prison or jail.

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Many times, they are terminated or suspended soon after the person becomes an inmate of a jail, prison, or other facility operated by a criminal justice agency. Generally, the length of time a person is in jail determines which benefits will cease.

Federal SSI and SSDI cash benefits are generally lost when an individual is incarcerated. SSI benefits can be suspended for up to 12 months. If the person is incarcerated for less than 30 days, the person’s benefits are not affected. After the 12 months, the SSI benefits are terminated, and the person must reapply. SSDI benefits are suspended 30 days after incarceration but are reinstated upon release. If benefits for either are suspended, reinstatement can take several weeks. If terminated, it may take several months to begin receiving benefits. SSA will accept and process inmates' applications several months before anticipated release to insure benefits are payable shortly after, even the day of, release. A pre-release agreement between the facility and SSA ensures this process. Local assistance from the Social Security offices, due to the pre-release agreement being place, help inmates qualify for SSI benefits immediately upon release (Judge David L. Bazelon Center for Mental Health Law, 2003, “A Better Life”).

Pre-release agreements are written, formal or informal agreements to commitments from a correctional institution and the SSA (Judge David L. Bazelon Center for Mental Health Law, n.d., “Discharge Planning for Inmates”). The correctional facility agrees to notify SSA of inmates who are likely to be eligible for SSA and will be released shortly, and have a liaison to handle all referrals and work with local SSA. The facility must also provide medical information to support the inmate's claim. The facility is also responsibly to provide an anticipated release date, and later the actual release date along with informing the local SSA of release date changes. SSA will train jail staff about SSI/SSDI rules, provide a contact person at SSA to assist jail staff

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with pre-release procedure, process applications as quickly as possible, and notify the jail, as promptly as possible, of the decision on eligibility for the inmate.

For Veterans disability benefits, service- connected and non-service connected are lost after 60 days for incarceration of a felony. For non-service connected disability, benefits are also lost for a misdemeanor charge after 60 days. The VA requires written proof that the individual is no longer incarcerated to restart benefits. TANF assistance and food stamps are unavailable to incarcerated individuals. TANF cash assistance is restored as soon as the parent has resumed a caregiver role. Food stamp applications can be filed along with SSI benefits or upon release. If filed with SSI benefits, no action is taken on the application until release but it can help speed up the process (Social Security Administration, 2007). Prohibitions, by federal law, exist regarding access to Veterans benefits, TANF, and food stamps for anyone convicted of a felony related to illegal drugs. States can specifically modify or eliminate this prohibition, and about half of the states have opted out or narrowed this prohibition (Judge David L. Bazelon Center for Mental Health Law, 2003, “Building Bridges”).

Medicaid benefits are not required to be terminated upon incarceration by the Federal rules, but all states terminate Medicaid upon incarceration because federal Medicaid funds are not allowed to be used for services provided while the individual is incarcerated (Bazelon brief). Upon release, reassessment and reinstatement is a fairly quick process. If the person qualifies for Medicaid through eligibility for SSI, restoration of SSI must first be restored before Medicaid can resume. This can cause significant delays, especially if SSI has been terminated as apposed to being suspended.

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In some states where inmates are not eligible for benefits until release, the correction departments help mentally ill inmates fill out their applications to prepare for release. Still, other states provide a very minimal amount of help for mentally ill offenders. The departments of corrections simply do not view transition assistance as part of their jobs. Apparently, a greater partnership between state agencies, private agencies, and community providers is needed to improve services for ex-offenders. Although some states are implementing programs that are on the way to providing a positive, helpful transition, they are still missing a follow-up component to make sure that care is actually being provided for individuals being released from institutions.

In a research study by National Institute of Justice (2007), three pre-release programs that help severely ill inmates prepare and file applications for Federal benefits were analyzed for the state of Texas, the state of New York, and the city of Philadelphia, Pennsylvania. All three programs provided benefit assistance to inmates prior to release; targeted inmates who were screened for medical or mental illness while in the institution; relied on inter-agency partnerships; and had several years of experience assisting inmates with benefits applications (NIJ research for practice). All three programs had positive results and a dramatic increase in the number of clients receiving medical and mental assistance was noted. Partnerships and a dedicated staff kept the process alive. Filling gaps until benefits commence was proven to be very essential, and a centralized operation cite reduced delays and improved communications.

Currently, the extent of discharge planning varies greatly, from state to state as well as county to county. In regards to mental health treatment, states give the individual a supply, between one week and one month, of medication. Some states schedule after-care appointments for the client, but most individuals leaving the correctional system are simply given the contact

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information for providers. Initial after-care appointments for individuals just released from institutions can hard to obtain due to the lack of county providers and some people may have to wait up to twelve weeks to see a mental health professional (Human Rights Watch, 2003).

The states in our nation are currently under fiscal distress and look to cut corners and costs by cutting programs they deem unnecessary. Unfortunately, the mentally ill incarcerated population is not very loudly spoken for and programs for the mentally ill are vulnerable to budget cuts. In the long run, spending more money on discharge planning programs and transition from institutions would save money due to the high risk of this population returning to prison. These programs could sever the ties between imprisonment and the mentally ill. Helping offenders obtain Helping offenders obtain Federal benefits can also reduce the financial burden on State and local governments that fund indigent health care systems (National Institute of Justice, 2007).

4. PROPOSED POLICY

 NAMI, National Alliance on Mental Health (2000), in a conceptual paper, suggests that adequate discharge planning should include a written discharge plan in which the patient receives a copy, a temporary supply of medication and a prescription to refill the supply for the patient, referrals and links to mental health providers within the community, and assistance for the patient in obtaining federal medical and financial benefits and housing placement. Proposed policy options are suggested by two key organizations that advocate for mental health issues- The Bazelon Center for Mental Health Law and The Council of State Governments.

 The Bazelon Center for Mental Health Law (2003), proposed model law in a publishing called, Building Bridges: An Act to Reduce Recidivism by Improving Access to Benefits for

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Individuals with Psychiatric Disabilities upon Release from Incarceration. The act directs state and local agencies to adopt many key policies and procedures to assist individuals with psychiatric disabilities. With the model law, participation in federal income assistance and medical benefits should be speedily reinstated; and temporary health care coverage and income support should be provided while federal benefits are pending. The individual should also receive mental health services immediately upon release, including case management, medications, and substance abuse services if needed.

 The Council of State Governments (2002), coordinated a Criminal Justice Mental Health Consensus Project included a Development of Transition Plan. This plan recommends that transition planners should coordinate a case management process which focuses on involving all relevant community agencies along with family members in the development. The inmate should be provided secure, safe, reliable housing upon release in an attempt to ensure a gradual, successful release into the community. The inmate should be assigned to a community-based provider in which resources match the needs and strengths of the inmate. Dates, times and locations for follow- up appointments regarding supervision and care should be clear to the individual. At least a one week’s supply of medication along with refillable prescriptions should be provided upon release from incarceration. A process should exist to ensure that inmates receive public benefits upon release. Inmates should also be monitored closely approaching release and modify the discharge plan when appropriate.

 I feel that the Bazelon Model law being proposed is the most feasible. Funding would occur from both state and federal, in which Federal costs would match state costs to implement. For temporary assistance, initially the state would be responsible for the costs, but once the

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eligibility is confirmed, the state could seek reimbursement from the federal government. For individuals in prison or jail, the state mental health agency would be responsible for case management services. The cost to implementing this policy option would be outweighed by the long term savings. Tax dollars are wasted when people with psychiatric disabilities leave the institution without the resources or services they need to have a successful re-entry into the community. It becomes extremely inefficient and expensive to provide repeated care when the individuals end up back in jail, the emergency room, and psychiatric hospitals. Because existing staff could be used, I would estimate that the cost of implementing this program is relatively low because extensive training would be the most important aspect. I would estimate the states cost around $150,000 a year if the federal government would agree to match costs. The pros to implement this policy outweigh the cons due to the ethical responsibility to provide adequate follow-up care for individuals with psychiatric disabilities. The outlook for this policy includes lower recidivism rates for individuals with psychiatric disabilities and less hassle, stress, and delay in receiving benefits.

5. KEY ORGANIZATIONS/INDIVIDUALS

**Center for Effective Public Policy**

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<http://www.cepp.com>

**Community Shelter Board**

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Community Oriented Reentry Project

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**National Alliance on Mental Illness**

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6. GLOSSARY

**Case Management-** at minimum, helping access programs, services, and supports, as well as advocacy on individual clients’ behalf to establish and maintain eligibility for benefits and other programs, and to uphold clients’ rights. (Judge David L. Bazelon Center for Mental Health Law, 2003, “Building Bridges”)

**Discharge Planning-** determining what the inmate’s needs are, and providing services to meet the inmate’s needs in anticipation of the transition process back into society

**Federal benefit programs-** Medicaid, SSI, SSDI

**Food Stamps-** program supported by Food and Nutrition Service, help low income families buy the food they need for good health

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**Institution (of Corrections) -** a jail or prison operated by state or local correctional agency

**Incarcerated-** confinement in a correctional institution

**Individuals with psychiatric disabilities-** adults with serious mental illnesses

**Inmates**- incarcerated individuals

**Medicaid-** federal health insurance, provides access provided to health and mental health treatment for low income families

**Medicare-** federal health insurance for most people ages 65 and older

**NAMI (**National Alliance on Mental Illness) – nonprofit organization that advocates on behalf of people with mental illness and their families (National Alliance on Mental Health, 2000)

**Pre-release agreements-** formal or informal, written agreements between institutions and Social security offices (Social Security Administration, 2007)

**Recidivism-** re-offending, or committing another crime, after being let out of an institution

**SSA (**Social Security Administration)- administers social insurance programs

**SSDI (**Social Security Disability Insurance) - which is income support to people with disabilities who have sufficient prior work history (Judge David L. Bazelon Center for Mental Health Law, 2003, “Building Bridges”)

**SSI (**Supplemental Security Income) - which provides income support to low-income individuals who are aged, blind or disabled (Judge David L. Bazelon Center for Mental Health Law, 2003, “Building Bridges”)

**TANF (**Temporary Aid for Needy Families) - cash assistance and services for low income individuals who are caretakers

**Veterans Administration-** income and health benefits for veterans with a physical or psychiatric disability

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