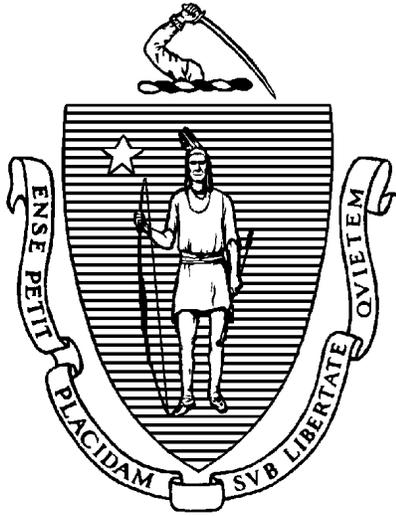


THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE FOR ADMINISTRATION AND FINANCE



Policy Report Excerpts

Moving Beyond Serving the Homeless to Preventing Homelessness

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THE COMMONWEALTH OF MASSACHUSETTS
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EXECUTIVE SUMMARY

Despite the significant levels of state investment made by the Cellucci-Swift Administration for services provided to the Commonwealth's homeless citizens, the State's emergency shelter system continues to feel strained. As part of the Administration's overall efforts to implement initiatives that will improve the ability of all of its citizens to have safe, decent, and affordable housing, the Executive Office for Administration and Finance (EOAF) launched an examination of the State's efforts to prevent homelessness by appointing two working groups on homelessness, each of which were part of the Task Force on Housing and Homelessness, established at the direction of Governor Cellucci and Lieutenant Governor Swift. Both groups included representatives from state agencies, advocacy organizations, and service providers (listed in Appendix A).¹ One group, the Working Group on Housing Search and Retention, examined and assessed the Commonwealth's housing search and retention services available to families and individuals who are homeless or at risk of homelessness. The other group, the Working Group on Discharge Planning, examined and analyzed discharge planning policies and procedures within a number of correctional facilities as well as human service agencies that provide custodial, residential, or inpatient services to single adults.

Working Group on Housing Search and Retention

After a report submitted by the Massachusetts Fiscal Affairs Division in December of 1999 concluded that the effective design and delivery of housing search and retention services could make a significant difference in preventing homelessness,² Governor Cellucci and Lieutenant Governor Swift directed EOAF to convene a Working Group on Housing Search and Retention to examine the Commonwealth's current delivery system for these services.

First, the Group examined the Commonwealth's statewide system of housing search and retention services for families. These services are provided, for the most part, to homeless families and families at risk of homelessness through the Commonwealth's Emergency Assistance program. Specifically, the Department of Transitional Assistance (DTA) provides housing search services to homeless families in DTA's family shelter system; and the Department of Housing and Community Development provides housing search and retention services, through community-based contracted agencies, to families who are at risk of losing their housing.

Second, the Group conducted discussions about the current delivery of housing search services to homeless individuals and single adults at risk of homelessness. Specifically, various levels of housing search efforts for single homeless individuals are built into the work of numerous parties

¹ In addition, the Executive Office for Administration and Finance (EOAF) appointed a Working Group on Single Person Housing to address the risk of homelessness among single individuals. The findings and initiatives of this Group are summarized in EOAF's recently released Policy Report No. 4.

² Massachusetts Executive Office for Administration and Finance, Fiscal Affairs Division, "Homelessness in Massachusetts. Are State-Funded Resources and Services Allocated and Coordinated Effectively?" December 20, 1999.

such as street outreach and veterans outreach workers, health care for the homeless workers, and discharge planners for persons in residential, inpatient, or custodial settings. The State also utilizes the statewide Mobile Resource Team (MRT) program, which is designed exclusively for homeless individuals in need of housing search and stabilization services. MRT is funded with a grant awarded to the Commonwealth from the U.S. Department of Housing and Urban Development's (HUD) Continuum of Care program.

Lastly, the Group examined other housing search and retention programs in place throughout the Commonwealth that are not statewide in nature. Specifically, there are regional and community-based organizations that provide housing search, retention, and stabilization services to families and/or individuals. Many of these programs are supported with a combination of federal, state, and local resources. Strategies applied by these organizations range from those that target interventions to specific individuals based on certain characteristics or sets of characteristics; to certain groups of people considered at risk; or to an entire population. The Group found that, in practice, many programs mix these strategies. Examples include three programs reviewed by the Working Group: Springfield Tenancy Preservation Program, Housing Counseling Program in Central Massachusetts, and Project Prevention in Hyannis.

Following its review of programs in place throughout the Commonwealth, the Group determined that it is essential that housing search and retention policies and practices facilitate clear communication across all systems and among numerous stakeholders, such as landlords, tenants, homeless persons, housing courts, state agencies, and community-based organizations. Group members expressed a view that state-sponsored efforts at housing search and retention can function as catalysts in getting all stakeholders involved and in increasing the chances that early identification of housing problems will be accomplished before individuals or families become homeless. This coordinated and comprehensive approach facilitates the effective leveraging of available resources and increases the likelihood that assistance programs will be flexible and tailored to meet the needs of an individual or family. Flexible programs, in turn, help decision-makers achieve the appropriate balance between their obligation to address emergency needs and strategies that would effectively promote the goal of long-term housing stability.

Another key finding of the Working Group was the determination that practical and consistent data collection standards and procedures are essential for effectively measuring the sustainable impact that housing search and retention programs have on reducing the incidence of homelessness. This led the Group to propose that the Commonwealth continue to take steps to improve its data collection strategies. In addition, the Group proposed that any new state-sponsored housing search and retention program include performance objectives and a data collection effort so that the success of the program can be effectively evaluated.

The following is a brief summary of the Working Group's initiatives, which are designed to effectively move homeless persons into permanent housing, accomplish early identification of those at risk of homelessness, and promote long-term housing stability among the Commonwealth's families and single adult population.

1. A new Housing Assistance Program (HAP) will replace and consolidate two programs currently administered separately by the Department of Housing and Community Development and the Department of Transitional Assistance, both of which provide housing

search and retention services to families. HAP will be a single, more integrated and comprehensive service approach that builds on the strengths of each former program with a focus on accomplishing early identification of housing problems and effective interventions to prevent families from losing their housing; and helping those families who do become homeless to regain and then retain stable, permanent housing.

2. A task force will assess the feasibility of a potential program designed to complement HAP by providing flexible residential assistance (such as first and last month's rent, utilities, security deposits, and rental payments) to homeless and at-risk families.
3. A statewide regional network of Housing Consumer Education Centers will provide new educational opportunities for all types of housing consumers, including homeowners, homebuyers, tenants, and landlords.
4. Consistent with the needs identified by the Working Group, the Commonwealth gained expanded support in Fiscal Year 2001 for the Individual Self-Sufficiency Initiative to assist homeless single persons who need a helping hand for up to twelve months in obtaining permanent housing.
5. The Commonwealth will support broad-based state agency participation in a "best practices" summit to be convened by the Massachusetts Housing and Shelter Alliance to identify key, field-tested practices in the field of housing search and retention for homeless single adults.
6. A task force will assess and implement policies to effectively evaluate housing search and retention programs and ensure that measurable and appropriate performance objectives are in place.
7. A proposed state-sponsored conference on housing search and retention strategies will include presentations of eviction prevention programs and best practices by and for a wide array of stakeholder organizations, including the Commonwealth's Housing Court system.

Working Group on Discharge Planning

During the fall of 1999, while the Massachusetts Fiscal Affairs Division was preparing its report on homelessness,³ emergency shelter providers suggested to the report's authors that many of the single adults in the Commonwealth's emergency shelter system have, at some time, been in state-funded residential treatment, correctional facilities, or youth programs. This suggestion by shelter providers was further supported by a survey of individuals and families in Boston shelters, conducted by the McCormack Institute of Public Affairs. This "snapshot" survey of people who spent the night in Boston shelters in March 1997 revealed that 57% had lived in at least one institutional setting within the prior 12 months, such as a hospital, mental health

³ Ibid.

facility, jail, detoxification center, or halfway house; and 22% had recently lived in a criminal justice setting.⁴

In January 2000, Governor Cellucci and Lieutenant Governor Swift directed the Executive Office for Administration and Finance to establish the Working Group on Discharge Planning. The Group was charged with examining the discharge planning policies and systems within correctional facilities and the Commonwealth's human service agencies and identifying initiatives to improve those systems. In its review, the Working Group found a wide range of discharge planning activities among the state agencies and county correctional institutions represented in the Group. In some instances, the Group found well-developed protocols of long-standing practice. In others, the Group found agencies developing new policies and procedures that had not yet been formally adopted.

During discussions among members of the Working Group, representatives from correctional facilities expressed the view that the recent emphasis on discharge planning constitutes a significant change in expectations for their institutions. Unlike correctional facilities, however, most of the human service agencies represented expressed the view that their organizations have long understood themselves as being somewhat responsible for arranging service provision for their clientele during the post-discharge period. For some of these human service agencies, however, the focus on the potential of discharge planning efforts represents a new perspective on their overall and ongoing efforts to promote successful community reintegration among their clients.

In fulfillment of its charge to recommend improvements to discharge planning policies and systems, the Working Group offered a list of "best practices" and agency-specific initiatives to improve discharge planning. A consolidated list of agency-specific initiatives can be found in Appendix B of this report. In addition, the Group identified five "cross-cutting" initiatives to improve policies and practices across multiple state agencies. Both sets of initiatives largely reflect agency efforts to bring existing policies and systems into accord with a list of "Characteristics of an Effective Discharge Planning Policy and System," produced by the Working Group and included in this report.

There are many similarities among the agency-specific initiatives to be implemented by the organizations represented in the Working Group. Many focus on agency efforts to incorporate the goal of effective discharge planning into the overall missions of the agencies, for example. Other common points of focus include:

- enhanced assessment tools to evaluate client or inmate needs;
- expanded involvement of community-based service providers in service delivery prior to discharge;
- enhanced training in the post-discharge availability of community-based resources;
- identification of potential opportunities for interagency collaborations;

⁴ Friedman, et al, "A Snapshot of Individuals and Families Accessing Boston's Emergency Homeless Shelters, 1997" John W. McCormack Institute of Public Affairs at University of Massachusetts, Boston, (Boston: August 15, 1997)

- enhanced ability to assess the available supply of housing resources being utilized by discharged individuals and how that supply corresponds with the demand for those resources; and
- improved data collection regarding the post-discharge disposition of former clients or inmates.

In addition, the Working Group identified five “cross-cutting” collaborative initiatives that will improve the Commonwealth’s discharge planning policies and systems. Individually, these initiatives seek to:

1. ensure consistency in discharge planning among the Commonwealth’s vendors;
2. pilot and institute a program to allow inmates to apply for MassHealth eligibility while still in correctional facilities for coverage during the post-incarceration period;
3. promote the successful transition of youth to independence from state custody and/or care through improved access to health care, educational support, and job development;
4. build upon the work of current collaborative efforts to improve discharge planning for mentally ill inmates; and
5. enhance data collection processes and promote the evaluation of discharge planning systems and outcomes.

By describing existing discharge planning policies and systems and identifying initiatives for their improvement, the Working Group has sought to improve the circumstances faced by individuals leaving the residential, custodial, or inpatient programs operated by its member agencies. While the Group recognizes the inherent limits of discharge planning efforts in reducing the incidence of homelessness, it offers its work as an attempt to fully utilize the potential that such efforts do represent. Recognizing the unique opportunity its agencies have to improve the prospects of individuals formerly in its care or custody, the Commonwealth will continue its efforts to seize that opportunity.

INTRODUCTION

Although the number of homeless persons in Massachusetts is difficult to determine in a definitive manner, the John W. McCormack Institute of Public Affairs estimates that 25,000 individuals and 10,500 families were homeless in Massachusetts at some time during 1999.⁵ The Cellucci-Swift Administration has responded to this persistent problem by investing over \$100 million in Fiscal Year 2000 for services provided to the Commonwealth's homeless citizens. State spending on homelessness services has steadily increased over the last several years; and, as recently as September 2000, Governor Cellucci and Lieutenant Governor Swift asked the legislature for a supplemental budget appropriation of \$4.5 million to increase the capacity of the Department of Transitional Assistance's family shelter system.

Despite economic prosperity, the number of homeless persons in Massachusetts continues to grow. A growing homeless population can create pressure on the Commonwealth to continually increase the number of available emergency shelter beds; however, this approach carries with it a significant economic and social cost. State officials and advocates for the homeless were concerned that as the State focused its efforts on meeting the emergency shelter needs of its citizens, it would lose sight of potential opportunities to promote homelessness prevention.

As one piece of the Cellucci-Swift Administration's overarching efforts to make permanent housing available, accessible, and sustainable for the Commonwealth's citizens, the Executive Office for Administration and Finance began examining homelessness prevention issues by appointing two working groups on homelessness with representatives from state agencies, advocacy organizations, and service providers (listed in Appendix A).⁶ Both groups were part of the Task Force on Housing and Homelessness, established at the direction of Governor Cellucci and Lieutenant Governor Swift. Specifically, the Working Group on Housing Search and Retention examined and assessed the Commonwealth's housing search and retention services available for persons that are homeless or at risk of homelessness; and the Working Group on Discharge Planning examined discharge planning policies within correctional facilities and a number of human service agencies that administer state-funded custodial, residential, and inpatient programs.

The efforts of the Working Group on Housing Search and Retention were stimulated by a report issued by the Massachusetts Fiscal Affairs Division in December 1999, in which the authors concluded that the effective design and delivery of housing search and retention services could make a significant difference in preventing homelessness.⁷ This Working Group was charged with identifying opportunities to improve the Commonwealth's current delivery system for

⁵ Center for Social Policy, John W. McCormack Institute of Public Affairs, University of Massachusetts, (Boston: August 2000) Appendix C contains information on the Center's methodology for estimating the number of homeless individuals and families in Massachusetts.

⁶ In addition, the Executive Office for Administration and Finance (EOAF) appointed a Working Group on Single Person Housing to address the risk of homelessness among single individuals. The findings and initiatives of this Group are summarized in EOAF's recently released Policy Report No. 4.

⁷ Massachusetts Executive Office for Administration and Finance, Fiscal Affairs Division, "*Homelessness in Massachusetts. Are State-Funded Resources and Services Allocated and Coordinated Effectively?*" (December 20, 1999)

housing search and retention services available for homeless or at-risk individuals and families. It assessed the extent to which such services are offered on a statewide basis and examined various regional service delivery models. The Group then proposed ways to effectively move homeless families and individuals out of homelessness, accomplish earlier identification of those at risk of becoming homeless, and promote long-term housing stability among the Commonwealth's citizens who are homeless or at risk of losing their housing.

Similar to the Working Group on Housing Search and Retention, the activities of the Working Group on Discharge Planning were motivated by the homelessness study conducted by the Massachusetts Fiscal Affairs Division. Emergency shelter providers suggested to the report's authors that many of the single adults in the Commonwealth's emergency shelter system have, at some time, been in state-funded residential treatment, corrections facilities, or youth programs. The Working Group on Discharge Planning was charged with examining ways that the Commonwealth could improve upon its agencies' discharge planning policies and systems so that people in state-funded care or custody would be less likely to fall into homelessness after discharge.

Following a brief profile of homelessness in Massachusetts (below), this report is organized into two parts. Each part reflects the work of one working group, beginning with Housing Search and Retention and concluding with Discharge Planning. This report provides a comprehensive review of the Commonwealth's current policies, systems, and practices in both of these areas and includes a detailed account of the key findings and initiatives of both Working Groups.

**WORKING GROUP ON DISCHARGE PLANNING
REVIEW, FINDINGS, AND INITIATIVES**

I. CHARACTERISTICS OF AN EFFECTIVE DISCHARGE PLANNING POLICY AND SYSTEM

In order to facilitate its examination of discharge planning policies and procedures, the Working Group developed the following list of “Characteristics of an Effective Discharge Planning Policy and System” during its discussions and used it as a guide in evaluating each organization’s policies.

PRINCIPLES

Effective discharge planning:

1. is a priority of the agency and institution;
2. supports the goals of public safety, social and economic self-sufficiency, and homelessness prevention;
3. begins at intake;
4. involves the consumer or inmate in the design, delivery, and evaluation of discharge plans and post-discharge arrangements;
5. focuses on strengthening an individual’s assets as well as reducing the risk of adverse behavior, dependency, homelessness, and recidivism;
6. reflects a high level of coordination and collaboration between, among, and within government agencies;
7. recognizes the importance of establishing strong community links pre- and post-discharge for successful community re-integration;
8. considers culturally specific issues; and
9. matches individuals’ needs with post-discharge housing options, programs, and resources.

FRAMEWORK

1) Comprehensive Needs Assessments

The discharge planner conducts a comprehensive needs assessment for each individual.

- a) Each candidate for discharge is coupled with an individual or team with the institutional responsibility for overseeing his/her discharge (e.g., Team leader, Case Manager, Discharge Planner).

- b) The discharge planner works in partnership with the consumer to prepare individualized discharge plans tailored to the unique needs, strengths, and preferences of each individual.
- c) The discharge planner acts as the coordinator of all information pertinent to discharge and aftercare, soliciting input from all appropriate internal and external parties when assessing the needs of the consumer or inmate and aftercare options.
- d) Appropriate parties may include:
 - the consumer or inmate;
 - the family of the consumer or inmate;
 - clinical staff;
 - supportive service experts with a knowledge of local housing options; and
 - service providers from the outside community that have made contact with the consumer prior to discharge.
- e) The discharge planning process includes consideration of a full range of post-discharge needs, including, but not limited to:
 - housing;
 - employment;
 - health care; and
 - substance abuse, mental health, and other supportive services.
- f) The discharge planner has the authority to resolve disputes among various staff within his/her government agency regarding proper discharge placement.

2) Effective Matching of Needs with Post-Discharge Options

The discharge planner effectively matches the needs of the consumer or inmate with available post-discharge housing options, programs, and resources.

- a) The discharge planning system is designed to support the goal of community re-integration and homelessness prevention.
- b) Each candidate for discharge has an ongoing working relationship with a person(s) responsible for providing and gathering information pertinent to his/her discharge.
- c) The discharge planner works with other government agencies to secure all services for each individual prior to discharge.
- d) The discharge planner is properly trained in identifying and gaining access to a full range of housing options available to the individuals being discharged.

- e) The government agency, institution, or program staff is knowledgeable of all transitional residential beds, permanent supportive beds, and other supportive services generally available or specifically designated for those discharged from its facilities.
- f) Pertinent information about available discharge options is catalogued, frequently updated, and readily accessible to all relevant staff. Such information includes eligibility criteria of residential discharge options, relevant aftercare programs, and entitlements.
- g) The discharge planner effectively matches the needs of the individual with available post-discharge housing, programs, and appropriate and necessary transitional and supportive services.
- h) The discharge planning system includes the participation of community-based resources during the pre-discharge period to the extent permissible and feasible under existing statutes.
- i) The discharge planning process enables discharged individuals to gain initial access to housing and necessary and appropriate community services.
- j) The discharge planning system anticipates individual setbacks and possible recidivism as part of the recovery process for some individuals.
- k) The discharge planner implements contingency plans when discharge candidates choose not to actively participate in the planning process and the planner has exhausted all efforts to secure such participation.
- l) Discharging entities have procedures in place to identify, calculate, and communicate the relationship between the supply and demand of community resources available to those being discharged.
- m) Where appropriate and feasible, discharging entities have a system in place that allows for ongoing collection and reporting of data regarding the status of discharged individuals.
- n) A mechanism is in place to gather or receive feedback from aftercare and housing providers as to the sufficiency of discharge services rendered or appropriateness of placement in their facilities or programs.

3) Government Agency Coordination

A high level of coordination and collaboration exists between and among government agencies.

- a) The discharge planning system includes the utilization of service delivery programs and staff from other government agencies and /or joint service delivery programs.
- b) The discharge planning system includes training for planners with participation that cuts across government agencies.

- c) The discharge planning process includes an official liaison to government and community programs. Government programs include, but are not limited to:
 - housing;
 - employment;
 - health care; and
 - substance abuse, mental health, and other supportive services.
- d) Written agreements exist between government entities. The agreements delineate appropriate roles and responsibilities (e.g., intergovernmental service agreements – ISA, or memorandums of understanding – MOU).
- e) Such agreements establish official liaisons between agencies to serve as contact points on collaborative efforts.
- f) Procedures exist to determine whether available or designated resources are utilized and sufficient.
- g) Appropriate purchasers of human and social services include effective discharge planning within the performance specifications of each contract.

In light of the characteristics listed above, the Group conducted an examination of the Commonwealth’s discharge planning policies and systems. For each agency represented, the Group identified “best practices” and specific initiatives designed to improve discharge planning within each participating organization (described in Section II). In addition, the Group identified five collaborative or “cross-cutting” initiatives that will be implemented across multiple state agencies (described in Section III).

II. DISCHARGE PLANNING POLICIES AND PROCEDURES

A review of the policies and procedures in place at various state agencies revealed a wide range of activities related to discharge planning. In some instances the Working Group found well-developed protocols of long-standing practice. In others, the Working Group found agencies developing new policies and procedures that had not yet been formally adopted.

This range of practices is attributable to a variety of factors and does not necessarily reflect a resistance to, or rejection of, the development of appropriate discharge planning practices. Different institutional histories, shifting mission expectations, and changes in the balance between in-house versus vendor-provided services, for example, have all contributed to the wide range of practices identified by the Working Group.

In this section of the report, the policies and procedures relating to discharge planning are described for each of the participating agencies or departments, as is the role that discharge planning plays, and has played, in the overall mission of each organization.

The section is organized into the two broad categories of correctional and human service organizations. While there are various differences within these broad categories, there are sufficient similarities in mission and client populations to warrant such an organization.

CORRECTIONAL FACILITIES

The Massachusetts Department of Correction and the county correctional facilities that were represented on the Working Group have all recently intensified their efforts in the area of discharge planning. While the Department of Correction and county correctional facilities have recently experienced a considerable expansion of discharge planning services, however, most have not entirely integrated those services into their overall mission. Defining the proper role of discharge planning within the overall mission of correctional facilities would involve fundamental questions about the nature and scope of that mission and has not been systematically undertaken by most of the agencies discussed here. Nevertheless, all members of the Working Group representing the criminal justice community expressed their sense that recent changes have occurred in the expectations for their institutions regarding community reintegration, and they displayed a professional commitment to respond to those changing expectations.

As expressed by the participants, the traditional role of correctional facilities ended at the prison wall. The institutions did not extend their period of concern beyond the date of release. More recently, however, all correctional facilities are concerning themselves with the transitional needs that inmates face upon release from their institutions. Consistent with this reported perception and account, the facilities represented in the Working Group with the most developed discharge planning protocols and procedures have only had such procedures in place for a few years.

The challenge of reintegrating released inmates back into the community is likely to be one of growing importance for the Commonwealth, as it will be for many other states and the federal

correctional system. While examining the discharge planning procedures in place at state and county correctional facilities in the Commonwealth, the Working Group on Discharge Planning discovered trends that demand the continuation of efforts to promote the successful community reintegration of inmates leaving secure facilities. If successful, such efforts will reduce the number of releases into homelessness and help preserve the significant gains in public safety that have been achieved over the past decade.

As a result of changes made to promote public safety over the past decade, inmates have been serving longer sentences and serving those sentences at higher levels of security than was previously the case. Because longer sentences are now being served, the custody population has continued to expand significantly despite recent declines in the rate of commitment to correctional facilities. Longer sentences have also resulted in a decline in the number of releases from Department of Correction facilities over the three-year period between 1996 and 1998. However, according to the Department, 1999 will likely mark the first year of what is likely to be a sustained, multi-year expansion in the number inmates released from the Department's custody. This expansion will result from the gradual release of offenders committed to the Department's custody under stricter sentencing provisions adopted during the 1990's.

The building of prison beds that accompanied the growth of the custody population focused on the medium and maximum level facilities. Combined with changes in sentencing laws and the classification process that were adopted to promote greater public safety, the result has been that a smaller percentage of inmates are now assigned to minimum-security beds. Inmates are now being released from prison having served longer sentences, at higher levels of security, than did their predecessors. While these changes have restored the integrity and truthfulness of sentencing and increased public safety, they have also transformed the traditional system of community reintegration that occurred at the end of sentences served. That is, a smaller percentage of inmates now end their sentences at Pre-Release Centers in which they had formerly been able to begin employment search and make arrangements for housing during daytime hours, while remaining under direct supervision overnight. Discharge planners now commonly assist inmates in making such arrangements while they remain under direct supervision around the clock.

Like that of the Department of Correction (DOC), the county custody population has expanded significantly during the 1990's. Traditionally smaller than the DOC population, the county population now exceeds that of DOC. Since the counties have traditionally utilized fewer Pre-Release Centers than DOC has, this shift in assignments towards the county system may be contributing to changes in the level of security from which inmates are released and, as such, may constitute a broader change in how inmates in the Commonwealth are typically transitioned back into their communities.

Inmates released at this time from all facilities are also much less likely to be let out of prison on parole than they once were. This change has been the result of the Commonwealth's strategy to restore integrity to the criminal justice system and to promote public safety. With a greater emphasis on public safety, the Parole Board has significantly reduced the percentage of parole applications that they are granting. Over the past decade, the percentage of DOC inmates being released on parole has declined from roughly 57% in 1990 to 34% in 1999. Even when a parole

request is granted, the lack of a residential setting suitable to meet the conditions of parole, such as treatment or recovery centers, can preclude or delay a release. This overall decline in the use of parole, like many of the trends identified, has meant a significant change in the way former inmates are reintegrated into the community. As a result of these changes, the need for effective discharge planning has grown considerably and the burden of meeting that need has fallen on correctional authorities.

It is in the context of these broad changes and in an attempt to address the identified need that correctional facilities have expanded discharge planning services designed to transition inmates back into the community, promote public safety, and prevent releases into homelessness. However, only with a clear understanding of the role of discharge planning within the overall mission of an institution, including its potential benefits and limitations, can such services be properly designed, administered, and evaluated over time.

Among the many objectives to be achieved by discharge planning, the goal of preventing releases into homelessness should appropriately be identified as one priority. This should include a discussion of discharge planning as both a public safety issue, as it relates to the potential reduction of recidivism, and a cost containment opportunity. In evaluating the success of discharge planning conducted by both Commonwealth employees and contracted vendors, prevention of releases into homelessness should be included as a performance standard. This is not to argue that discharge planning in the context of correctional facilities can, or should, be understood as guaranteeing stable housing arrangements or supportive services for every released inmate. Consistent with their mission to promote public safety, however, these institutions can be expected to act on behalf of the general public in assisting inmates who are in their custody and are preparing to transition back into the general public.

In sum, changes made to the criminal justice system over the past decade to promote public safety have significantly altered the correctional system of the Commonwealth. In order to preserve and extend the significant advances that have been made in public safety as a result of those changes, the correctional system and the entire criminal justice system are adapting to the new environment in which they operate. In terms of community reintegration, this means developing a new system that is consistent with the spirit and objectives embodied in earlier reforms while recognizing the challenge represented by the new environment.

The ongoing efforts related to discharge planning described below will undoubtedly be an important part of the new system of community reintegration. Defining the potential and limitation of discharge planning within an overall system of reintegration is one of the more significant challenges confronting correctional systems. It is hoped that the participants in the Working Group and their professional peers will continue to lend their expertise and experience to the ongoing effort to develop a successful and integrated system of community reintegration for ex-offenders.

MASSACHUSETTS DEPARTMENT OF CORRECTION

Under the auspices of the Massachusetts Executive Office of Public Safety, with the protection of the public as its primary objective, the Department of Correction oversees the operation of the

state's prison system. The Department currently employs nearly 5,000 Correction Officers, Correctional Program Officers, and other security, support, and training staff who are collectively responsible for more than 10,000 inmates incarcerated in the state's prison system.

During the period from 1990 to 1998, the custody population of the Department of Correction grew from 7,553 to 10,218.¹⁴ During the same period, releases to the street dropped from 3,835 to 2,829.¹⁵ Recent statutory changes that have promoted public safety through mandatory minimum sentencing and truth-in-sentencing have contributed to these seemingly inconsistent trends. Over time, however, one should expect to see an increase in release numbers. Preliminary estimates for 1999 suggest that this increase in releases has begun and will likely continue for some time.¹⁶ This expansion will result from the eventual release of inmates committed during the 1990's under the new sentencing provisions. As the number of inmates eligible for release begins to rise, planning for their eventual reintegration into the community becomes increasingly important.

Recognizing the importance of discharge planning in this context, the Department of Correction has adopted a release preparation program entitled the *Public Safety Transition Program*. The program consists of two main components: a risk reduction plan and transition workshops. The risk reduction plan is based on an initial assessment, done at the time of intake, which is designed to identify each inmate's risk of recidivism and overall programmatic needs. Based on this initial assessment, the inmate is then directed towards an appropriate sequence of programming aimed at enhancing public safety (examples include substance abuse treatment, sex offender treatment, or literacy education). These programs all seek to increase skills that reduce the likelihood of recidivism and thus promote public safety. Similarly, the transition workshops seek to promote public safety and minimize social and financial costs to the Commonwealth by promoting a successful transition of released inmates back into their communities.

Five-Day Workshops and Transition Plans

The five-day transition workshops constitute one element of the overall programming and represent the second part of the overall transition program. The workshop programming begins when the inmate is within one year of his/her earliest possible release date and constitutes the most widely applied form of discharge planning at the Department of Correction. Since December 1998, the program has been coordinated in each facility by the Director of Treatment (or his/her equivalent) who, while also responsible for other activities within the facilities, serves as the Transition Planning Coordinator in this capacity.

As the Transition Planning Coordinator, this individual is responsible for managing program referrals as well as coordinating, planning, implementing, and monitoring the *Public Safety Transition Program*. Currently, five-day workshops, which are an important component of the *Public Safety Transition Program*, are conducted by employees of a private vendor that has been

¹⁴ Massachusetts Department of Correction. *January 1, 1999 Inmate Statistics* (November 1999) p.16

¹⁵ Massachusetts Department of Correction. *A Statistical Description of Releases From Institutions and the Jurisdiction of the Massachusetts Department of Correction During 1998*. (November 1999) p. 21.

¹⁶ Preliminary estimates for 1999 were provided by the Massachusetts Department of Correction.

contracted by the Department to perform these and other services. During the five 2.5-hour workshops, inmates receive assistance in developing a Transition Plan. These plans call on inmates to identify extensive details of their intended post-release arrangements and expectations regarding employment, transportation, housing, treatment programming, medical needs, and household budgeting. Approximately two-thirds of all released inmates attend the workshops and complete a Transition Plan. After completion of the workshops, workshop staff members are available during regularly held office hours to all participants who choose to meet individually. Once this process is completed, workshop staff are responsible for forwarding the plans to the Department's representatives, coordinating post-release referrals, and, in some instances, attending the "Triage" meetings described below.

On a monthly basis, beginning in January 2000, the Transition Planning Coordinator is expected to convene a meeting of appropriate personnel to complete Transition Planning Tracking Forms with which the team (often referred to as the Triage Team) identifies special transition needs of individual inmates. The group often includes medical personnel, workshop staff, the Institution Parole Officer, members of the Mental Health Forensic Transition Team, and other appropriate personnel familiar with the inmate's needs. The information compiled by this group then serves as the basis upon which efforts to secure services are based. The responsibility to secure such services is left largely to the inmate whenever possible. However, the Transition Planning Coordinator and other staff may become involved in assisting inmates who have special needs gain placement with community service providers when the group determines that the individual is not likely to secure proper services without its assistance.

Special Populations

Inmates at High Risk of Recidivism

Some of the most extensive discharge planning services are included within the Department's "intensive treatment programming." These services are targeted to inmates at high risk of recidivating and include treatment for criminal behavior, criminal thinking, anger management, and substance abuse relapse. With substance abuse often identified as the single most common challenge facing the inmate population, and given that it is also a common affliction of the homeless population, it is not surprising that the Department's intensive treatment programming includes substance abuse relapse prevention.¹⁷

The Department of Correction has a contract with a private provider of intensive treatment for inmates at high risk of recidivism. This program is called the Correctional Recovery Academy (CRA), which operates in ten facilities. One component of the treatment program under CRA is Reintegration Services. This aspect of the program offers inmates individual and group instruction on the preparation of discharge/aftercare plans. These more customized services are available to CRA participants that have also completed the eight-week, reinforcing curriculum

¹⁷ A 1997 survey of state and federal inmates nationally, states that, "(A)bout three-quarters of all prisoners reported some type of involvement with alcohol or drug abuse in the time leading up to their current offense." Even removing individuals who reported that they were not using drugs regularly in the month before their offense, "the percentage of alcohol- or drug-involved State inmates drops (only) slightly to 69%". U.S. Department of Justice, Bureau of Justice Statistics. *Substance Abuse and Treatment, State and Federal Prisoners, 1997*. (January 1999) p.8.

known as Graduate Maintenance Programming (GMP). In addition, these individuals are then offered post-release tracking services. Although they do not meet with released prisoners in person, a CRA Reintegration Counselor tracks the former inmate's adherence to his/her discharge plan by phone and offers him/herself as an informational resource to the former inmate regarding community-based services.

The relatively extensive discharge planning assistance that the Commonwealth provides to participants in the Correctional Recovery Academy (CRA) is the result of the Commonwealth's successful grant application, which secured funding from the federal government's Residential Substance Abuse Treatment (RSAT) program. This program pays the salary of the Reintegration Counselors associated with the CRA. These counselors typically work with caseloads of 18-45 people, and they can specialize in the types of programming and services required by this population. Furthermore, the existence of community-based residential facilities specifically serving the recovering substance abuse population makes the placement of substance-abusing inmates easier than it is for other inmates being released.

Mentally Ill Inmates

The Department of Correction seeks to identify and offer special program services to inmates suffering from mental illness, including discharge planning services. According to the Department, 17% of inmates are classified as open mental health cases and 11% are on some form of psychotropic medication.¹⁸ These figures represent a significant challenge to staff trying to transition inmates back into the community. This population, for a variety of reasons, is a particularly difficult one for discharge planners.

The most severe mental health cases are housed in separate facilities at the Bridgewater State Hospital or, in the case of females, at state hospital facilities run by the Department of Mental Health (DMH). Less severe cases are housed in treatment units within Old Colony Correctional Center and MCI-Framingham. Those housed in the general prison population most often find themselves receiving discharge planning services from an on-site mental health clinician contracted by the Department. This clinician works as part of the Triage Team to arrange for the appropriate placement of such inmates. As part of the Transition Workshops or Triage Team process, others, such as staff from the five-day workshops or the Transition Planning Coordinator, are also likely to be involved with providing discharge planning services to this population. The contracted provider of mental health services also has one formal discharge planner who serves the entire system. This person assists Transition Planning Coordinators in discharge planning for the most difficult placement cases.

The Department also partners with the Department of Mental Health, the Massachusetts Parole Board, and County Correctional Facilities to support the Forensic Transition Team (FTT) operating out of the Department of Mental Health (DMH). The members of this team are called in to facilitate the transition of inmates approaching their release date who have been identified as future recipients of DMH services. If the inmate is determined to be a candidate for DMH services by eligibility specialists in the district office of DMH, the FTT member will assist the

¹⁸ Massachusetts Department of Correction. *Department of Correction Health Services Division*. (Medfield, MA: 1999)

inmate in securing a proper community placement upon release. Often this involves coordination of the application process for DMH eligibility, coordination between various district offices of DMH, and determination of the community-based resources appropriate to the inmate. FTT members often participate in the Triage meetings with the Department of Correction and parole staff and, in this manner, facilitate an effective collaboration among the state agencies offering a continuity of care to those who are mentally ill. Upon release, client progress is then monitored by the FTT for a three-month period. Approximately 60% of all applications submitted to DMH on behalf of state inmates have been accepted for DMH services since the FTT program was instituted in April 1998 (further discussion of the DMH Forensic Transition Team is included in Section III below).

AIDS/HIV Positive Inmates

Representatives of the Department of Correction and officials representing county facilities both reported a much easier time securing services, resources, and residential facilities for individuals testing positive for HIV/AIDS than for those discussed above. These individuals often require special discharge planning services from the Department of Correction and many resources have been provided by the Commonwealth to promote successful community reintegration of AIDS/HIV positive inmates. The Commonwealth is a leader in providing care to individuals living with HIV/AIDS and is now establishing itself as a leader in providing discharge planning assistance to them as well. In addition to the medical services that the staff makes available to the general inmate population, there are several healthcare professionals hired under a separate contract, funded by the Massachusetts Department of Public Health (DPH), that provide specialized medical services for the HIV/AIDS population. There are also several HIV caseworkers that are jointly funded by the Departments of Correction and Public Health that are extensively involved in planning post-release services for the HIV-positive population. Through the Triage Team Process, all of these individuals also participate in the broader transition planning process of the Department of Correction.

With regard to the continuance of prescription drug insurance (identified as a significant problem for many other released prisoners), these individuals benefit from a program managed by the Department of Public Health (DPH) that covers the cost of prescription drugs related to their illness. The HIV Drug Assistance Program (H.D.A.P.) distributes these drugs through participating area drugstores. By facilitating the easy continuance of these expensive medications, the Commonwealth is protecting the sizable investment it is making in the public health by providing specialized care within its correctional facilities.

The transition planning and post-release services available to the HIV/AIDS population will be further enhanced by another program recently initiated by the Massachusetts Department of Public Health and the Commonwealth's correctional facilities. The Transitional Intervention Program (TIP), jointly funded by the U.S. Centers for Disease Control and the U.S. Health Resources and Services Administration, will be administered by the Department of Public Health (DPH). DPH will contract with a variety of private vendors to staff this reintegration program. The Transitional Intervention Program will provide \$1,000,000 annually for three years to support transition planning services for state and county inmates. These services will range from providing transportation services upon the day of release to helping former inmates enroll in programs for the treatment of mental illness and substance abuse. The grant will support

reintegration teams in each of the six regions of the Department of Public Health. The objective of the TIP program is to build on the strong discharge planning program available to AIDS/HIV positive inmates prior to their release by providing a link to reintegration specialists working “beyond the walls.” In this way, the program seeks to support and complement the work of discharge planners. It will also serve as a mechanism for providing feedback to institutional discharge planners on the appropriateness and success of their release plans. There are also earmarked housing resources available to this population that make residential placement relatively easier for the AIDS/HIV positive inmates and their discharge planners.

Transitional and Supportive Housing

There are a variety of transitional and supportive housing facilities that serve inmates released by the Department. A lack of statistics related to the utilization of these facilities by released inmates, however, precludes a high level of precision in identifying them. If available, such an inventory would surely include facilities such as recovery homes, substance-abuse treatment centers, sober houses, halfway houses, and a variety of supportive housing settings available to clients of the Department of Mental Health. Identifying a specific stock of transitional and supportive housing available to individuals released from DOC facilities would certainly require an extensive commitment of time and effort since the Department discharges inmates to all geographic areas of the Commonwealth.

Among the important resources available to the Department of Correction are facilities offering residential services to recovering substance abusers. Because of the high concentration of substance abusers within the prison population, discharge planners place released inmates into all varieties of residential substance abuse treatment programs. The majority of these facilities are non-profits or privately operated facilities offering one or more of a wide range of programs. The programming can be as simple as a sober house environment which offers the released inmate the opportunity to live in otherwise typical, multifamily housing with others recovering from substance abuse. At the other extreme, inmates can be referred to highly structured and restrictive settings that place the ex-offender in a more intensive therapeutic environment.

While the Department’s discharge planners have apparently established a working relationship with organizations offering these types of transitional housing to the substance abuse population, the inventory of such resources is not well documented and it is impossible to quantify the relationship between supply and demand.

Under the McKinney Emergency Shelter Grant (ESG) program, the Executive Office of Health and Human Services has contracted with a vendor to provide case management services to a limited number of inmates within 90 days of release. Under the program, reintegration support is provided to inmates in order to divert them from emergency shelters. This support ranges from referrals to community-based, non-residential programs to the direct provision of transitional rental assistance. The program utilizes a broad range of community resources in order to prevent homelessness among recently released ex-offenders. Over the past two years the program has experienced a period of rapid programmatic expansion and, yet, the demand for its services continue to outrun its service capacity.

Access to other McKinney-funded housing resources has been limited by some confusion regarding the eligibility of inmates being released to utilize them. While far from an ideal residential placement of inmates, transitional shelters funded by McKinney programs are certainly preferable to the use of emergency shelters by those inmates.

It is the understanding of the Working Group that those being released are, in fact, eligible for such housing when there have been exhaustive, well-documented, and unsuccessful efforts made to secure alternative placements for these individuals. Given the recent expansion of discharge planning services being offered by the Commonwealth's correctional facilities, they are now in a position to offer such documentation in many instances.

Therefore, the Department of Correction should formally seek definitive word from the Headquarters Office of the U.S. Department of Housing and Urban Development (HUD) on what constitutes due diligence in searching for alternative housing arrangements. Having done so, the Department should then ask the Executive Office of Public Safety to circulate this information to all those involved with discharge planning from correctional facilities in order to make sure there is universal understanding of the eligibility requirements. Given the limited alternatives available to discharge planners working with this population, they need to have all legitimate alternatives at their disposal. Making sure that is the case with regard to McKinney housing should be a high priority for the Department of Correction.

In addition to utilizing existing community resources, the Department of Correction (DOC) has also collaborated with the Department of Public Health (DPH) to designate 135 recovery home beds for the continuing treatment of substance abusers after their release from the custody of a correctional facility. Under this innovative program, DPH has been able to offer DOC and county discharge planners earmarked beds in which released inmates can be placed. The Department also utilizes beds funded by DPH that are earmarked for AIDS/HIV positive inmates upon their release.

Another collaborative effort in transition planning involves the DOC and the Department of Mental Health (DMH). Through the services of the Forensic Transition Team and district offices of DMH, DOC inmates suffering from mental illness are being placed in transitional and supportive housing identified by DMH. Through this collaboration, this population, otherwise at risk of homelessness, is benefiting from many of the extensive resources available to DMH clients. This evolving program, recently integrated into the Triage Team process, is an important development in interagency collaboration and is discussed in more detail later in this report.

Within the Department of Correction itself, the lower security Pre-Release Centers can be understood as providing a form of transitional housing to inmates eligible to be classified at this level. At this security level, offenders continue to spend nights under direct supervision while leaving direct supervision during daytime hours. Under these conditions, inmates often continue to participate in programs and receive transitional planning services. In Boston and Springfield, inmates in Pre-Release Centers and ex-offenders participate in programs at Community Resource Centers. Additional funding has been made available to open additional Community Resource Centers in Lowell, Worcester, and Fall River in the next fiscal year. Inmates held at the pre-release level also have the opportunity to pursue employment opportunities and make housing arrangements for the period following their impending release from DOC custody.

Pre-Release Centers were not, and are not, principally intended as transitional housing. Nonetheless, this has been one of the secondary roles Pre-Release Centers have served for many inmates released from DOC custody over the years. As a greater emphasis on public safety objectives has transformed the criminal justice landscape, however, the percentage of inmates spending their last weeks and months of incarceration in Pre-Release Centers has declined significantly. As a result, this ancillary role that Pre-Release Centers have been playing, as transitional housing, is much less common than it once was.

In this context, the importance of identifying, evaluating, and making known the transitional housing resources available to released inmates becomes all the more important. The efforts to effectively identify alternative housing resources for offenders making the transition from prison to the community reflect a significant change in the overall process of community reintegration and represents a fundamental challenge to correctional authorities and other public safety officials.

Local Partnerships for Community Reintegration

Over the past several months, the Department of Correction has undertaken “reentry initiatives” with two separate Commonwealth communities. The initiatives involve working with local law enforcement and community representatives to support an inmate’s transition into the community.

The Lowell Reentry Partnership Project is a pilot initiative operating at the local level with the support of the U. S. Department of Justice. The project is a collaboration of the National Institute of Justice, the U.S. Department of Justice, Corrections Program Office, the U.S. Executive Office of Weed and Seed,¹⁹ and the U.S. Community Oriented Policing Services Office. Massachusetts is one of five states nationwide participating in this project. As part of this initiative, the Department of Correction is working in collaboration with the Lowell Police Department, Lowell community representatives, and a community-based non-profit to manage the reentry process for inmates returning to the City of Lowell. The Department provides assessment, programming, transition planning, and intelligence information (such as institutional adjustment and security-threat group involvement) to the Lowell Police Department and facilitates meetings between police officers and inmates prior to release. Inmates are encouraged to follow-up with police after their release should they have any difficulties during the transition process.

The Department is in the initial stages of a collaborative initiative with Hampden County. This collaborative initiative will enable the Department’s inmates who are from Hampden County to enter Hampden County Correctional facilities several months prior to release to complete their sentences and gain access to the transition planning services currently in place in those facilities. The Department will share assessment, programming, transition planning, and intelligence

¹⁹ The U.S. Executive Office of Weed and Seed of the Department of Justice is charged with advancing programs based on the “Weed and Seed” strategy, a community-based multi-disciplinary approach to combating crime. Weed and Seed involves both law enforcement and community-building activities including economic development and support services.

information with the Hampden County Correctional facility as well as with local law enforcement upon the inmate's release to the community.

Best Practices

In reviewing the policies and procedures related to discharge planning in place at the Department of Correction, the Working Group found many to be consistent with the *Characteristics of an Effective Discharge Planning Policy and System* listed earlier in this report. As such, they constitute *Best Practices* that can be built upon by the Department and serve as suggestive models for others.

- The discharge planning system appears particularly well conceived and structured in terms of conducting a needs assessment of inmates to be discharged. For both the general and special populations identified, the Department's programs seem well suited to identify the acute needs of soon-to-be-released inmates.
- Through the Triage Team system, the process brings together appropriate parties likely to possess vital information regarding post-release needs.
- The five-day workshops and the reintegration program for substance abusers associated with the Correctional Recovery Academy both involve the inmates extensively in the process of planning for their own post-release conditions. This can be expected to contribute to the eventual economic and social self-sufficiency of the released inmate. The Department may want to consider including inmates in the Triage Team process, as well, for the same reasons.
- The Department's recently established collaborative efforts with both the Department of Public Health and Department of Mental Health provide specialized discharge planning services for targeted populations.
- The Department, in collaboration with other agencies, appears to be in the process of expanding the involvement of community-based service providers within their facilities. By contracting for services with community-based providers who will continue interacting with the inmate in the post-release period, these efforts promise to offer some continuity of service to those passing through the transition period. This type of continuity is an important characteristic of effective discharge planning. Recent collaborations with the Executive Office of Health and Human Services (case management services) and the Department of Public Health (Transitional Intervention Plan – TIP) are promising developments in this regard.
- The Transitional Intervention Plan (TIP) also promises to provide feedback to discharge planners regarding the success and appropriateness of their discharge planning, which is another important characteristic of effective discharge planning systems.

INITIATIVES TO IMPROVE DISCHARGE PLANNING

To address the issues raised by the Working Group, the Department will work toward implementing the following initiatives throughout Fiscal Year 2001:

1. The Department of Correction (DOC) is in the early stages of implementation of a system-wide discharge planning process. As part of this process, the Department will clearly articulate the role of discharge planning in its overall mission. The Department will also establish a method to monitor the operational success of the new process and its various components. Such an evaluation will be designed to identify both the potential benefits and the limits of discharge planning as a means of promoting successful reintegration and, by extension, furthering the goal of protecting public safety.
2. As the Department of Correction makes housing referrals, it will compile an inventory list of transitional and supportive housing programs being utilized by inmates released from its facilities. Without such an inventory, it is nearly impossible to evaluate the needs that exist or the reallocation of resources that might be possible and desirable.
3. As discharge planning becomes a more prominent aspect of the Department's work, it will provide appropriate training for those staff carrying out these responsibilities. The Department will develop a systematic training process by which staff members learn to locate and identify the community resources available to released inmates. While specialized vendors do much of the discharge planning, Department staff members, through involvement in the Triage Teams, also participate in these efforts and will benefit from systematic training in support of these activities.
4. The Department will catalogue its collaborative efforts with other state agencies and departments and identify those that are regularly serving its released inmates. Such identification will serve as a first step in identifying potential areas of further collaboration to strengthen the safety net of services available to these vulnerable populations and thus reduce recidivism and higher long-run costs to the Commonwealth.
5. While utilizing community-based resources for services during the pre-discharge period poses a greater challenge for the Department's facilities than it does for the more geographically-specific, county correctional facilities, linkages will be actively pursued wherever possible. To date, the Department has experienced limited involvement of community-based resources providing services to inmates within its facilities. This type of continuity of care can provide important community links and help minimize the disruption of the transition period.
6. The Department will establish procedures to gather information on the appropriateness of its placement practices. As the Department increases its interaction with community-based service providers, it will have an ongoing system for monitoring its reliance on and utilization of those resources. Without compromising the privacy rights of ex-offenders, the Department will collect information from community-based providers about the general and ongoing suitability of its referrals and placements. The Transitional Intervention Plan (TIP) will be closely monitored as a model in this regard. Although TIP is designed to serve a

limited population (AIDS/HIV positive inmates), the lessons learned from its design and operation will be closely observed and shared with the Department's policy-makers.

7. The Department will adopt low-cost procedures to be followed for the one-third of its inmates who chose not to participate in discharge planning workshops. For example, the Department is preparing resource packets to provide certain inmates upon their release. There will always be non-participating or disengaged inmates who, nevertheless, have needs related to their reintegration. Contingency plans, such as the distribution of resource packets, are not in place at this time. While transition planning is ultimately the responsibility of the released inmate, the potential community costs of failed reintegration dictate that some minimal level of useful information should be provided to all inmates being released.
8. The Department will identify those inmates most likely to be at high risk of homelessness beyond those suffering from substance abuse and mental illness. The Working Group heard anecdotal evidence of the unique challenges facing some types of offenders in their attempt to secure housing in the post-incarceration period. The Department will attempt to quantify this problem and articulate the need for discharge planning and community reintegration programs appropriate to these types of special populations. Such an assessment should include a realistic evaluation of the potential and limits of pre-release discharge planning.
9. Over the past several months, the Department of Correction has undertaken "reentry initiatives" with two separate Commonwealth communities. The initiatives involve working with local law enforcement and community representatives to support an inmate's transition into the community. Specifically, the Department is working with the City of Lowell and Hampden County. These two programs will be closely monitored as pilots that can potentially be expanded statewide in the future.
10. The Department will formally seek definitive word from the Headquarters Office of the U.S. Department of Housing and Urban Development (HUD) on inmate eligibility for McKinney-funded transitional housing resources. Having done so, the Department will then ask the Executive Office of Public Safety (EOPS) to circulate this information to all those involved with discharge planning from correctional facilities in order to make sure there is universal understanding of the eligibility requirements. EOPS will then solicit the support of parties responsible for overseeing the funding and operation of such transitional resources to make them aware of the HUD regulations.

COUNTY CORRECTIONAL FACILITIES

Inverting the traditional rank order of their respective custody populations, the county correctional facilities now house a slightly higher number of inmates than the Department of Correction.²⁰ County facilities face many of the same challenges as those confronted by the Department of Correction (DOC). There are, however, several differences that are relevant to discharge planning. Most important among these are the shorter average terms being served by

²⁰ The average population during the first quarter of 2000 was 10,569 in DOC facilities and 11,764 in county facilities. *Quarterly Report on the Status of Prison Overcrowding, First Quarter of 2000*. Massachusetts Department of Correction. (May, 2000) pp.4,6

county inmates and the more limited geographic area from which the inmate population is typically drawn and to which it is typically discharged. The county system is made up of jails and houses of correction, which are most commonly located in the same facility. Jails hold prisoners awaiting trial while houses of correction house sentenced inmates serving terms of up to 2.5 years.

The county houses of correction hold inmates who are serving sentences of a shorter average duration than inmates being held at state correctional facilities, and their sentences tend to be for crimes of a less serious nature. Serving shorter sentences, these inmates are more likely to have remaining ties to the local communities from which they have been removed. Those remaining family ties and social contacts can potentially help facilitate reintegration. On the other hand, the brief length of incarceration can mean less extensive utilization of on-site rehabilitative services and, therefore, less opportunity to identify and secure appropriate placements upon release. Given the differences between DOC and county populations, it is important that the unique circumstances of the counties are recognized and that the programs offered there be designed to address those circumstances.

The inmates at county facilities are also much more likely to be from the geographic area surrounding the facility in which they are held than are those held by the DOC. In most cases, this presents the correctional facility with added opportunities with regard to discharge planning. One of the characteristics of an effective discharge planning system, as identified above, is the use of community-based resources during the pre-discharge period. Such community involvement can promote continuity of service and establish community links that promote overall stability during the reintegration period. Because the county prison population is most often returning to the immediate geographic area in which the prison is located, establishing and utilizing such links prior to release is quite feasible in the county setting. When utilized, such links serve as a firm foundation for successful discharge planning.

The Working Group expected to find a wide variety of programs and protocols in place at the county correctional facilities. This variation is a reflection of the unique governmental entity constituted by each of the counties. Each institution has a unique history and is under the direction of an autonomous County Sheriff. To begin a review of county practices, three Sheriff's Departments were asked to participate in the Working Group. Each readily agreed to help us. The cooperation of the three Sheriffs in sending representatives to the Working Group and inviting a review of the policies and protocols related to discharge planning in place at their facilities added enormously to the Working Group's understanding. The "Best Practices" listed at the end of each section below are evidence of the many efforts being made by the Sheriffs to promote public safety by promoting the successful reintegration of inmates into our communities. The "Initiatives" which end each section reflect a willingness on the part of the Sheriffs to exercise their authority in order to build even further upon those efforts.

THE HAMPDEN COUNTY CORRECTIONAL CENTER

The Hampden County Correctional Center (HCCC) is located in Ludlow and currently houses approximately 1,600 inmates spread over 20 housing units. Approximately 1,100 of these are

sentenced inmates and 500 are non-sentenced.²¹ Hampden County embraced the concept of community corrections earlier and more extensively than most Massachusetts correctional facilities and continues to be a leader in this area. The community correction model seeks to promote the responsible reintegration of offenders back into the community by utilizing a well-structured, gradual process of transition from prison life back into the community. The community corrections system of Hampden County includes a Community Corrections Center (CCC), a day-reporting center, and the After Incarceration Support Systems Program (AISS). The Western Massachusetts Correctional Alcohol Center (WMCAC), which is also operated by the Hampden County Sheriff's Department, also incorporates elements of a community corrections model. Through these programs as well as extensive ties established with community service agencies, the Hampden County Correctional Center actively involves itself with the process of reintegrating inmates into the community. This embrace of the community correction concept by the Hampden County Sheriff's Department, is key to understanding the discharge planning policies and practices that they have adopted.

An unusually large percentage of Hampden County inmates spend the last months of their sentences in either "day reporting" status or in the more restrictive pre-release program. In 1999, 6,922 inmates were released from the Hampden County Correctional Center and 2,364 of these were sentenced inmates. In 1999, approximately 29% of sentenced inmates released from HCCC custody were released from either "day reporting" or pre-release status and approximately 11% were released to parole. Both of these programs seek to make offender reintegration a gradual process and provide a variety of services to assist the inmate in transitioning back into the community. The discharge planning system of the Hampden County Correctional Center has been built upon this community corrections framework and utilizes many of the resources that have been developed to support it.

The discharge planning system of Hampden County Correctional Center is incorporated into, or otherwise closely linked to, the After Incarceration Support Systems Program (AISS). The program was established in May 1996 to provide a continuum of service and support to inmates being released back to their communities. As recounted by the staff, this program arose from the recognition that, despite the use of pre-release centers and other programs, over 68% of inmates were being released into the community directly from medium-security facilities. The stated goals of the After Incarceration Support Systems Program are to: "educate, prepare, and assist the releasing inmate in transitioning to their communities. The process shall provide a clear method of assessing needs and providing knowledge of community-based services with the intent of continuing with services provided while incarcerated." The Hampden County Correctional Center pursues these goals with a combination of both in-house and community-based resources and programs.

In-House Programming

Within thirty days of incarceration, all Hampden County inmates are eligible to attend an Orientation to Aftercare group, which is facilitated by an After Incarceration Support Systems Program staff member. At these group meetings, Hampden's sentenced inmates are introduced

²¹ Massachusetts Department of Correction. *Daily Count Sheet – County Facilities* (April 3, 2000)

to the goals and objectives of the program, its key terms and concepts, and the importance of getting an early start in planning for their eventual release.

Within ninety days of release, all inmates are eligible to attend a Release Planning Group, which is also staffed by the After Incarceration Support Systems Program. During 1999, 1,530 individuals participated in Release Planning Group sessions. In order to promote attendance, the Hampden County Correctional Center (HCCC) reduces the time an inmate will serve by 2.5 days for all who participate in the Release Planning Groups. HCCC also has a policy of releasing Group participants earlier in the day, on their ultimate release date, than those who chose not to participate in the Groups. The low-cost incentive of releasing participants in the morning as opposed to in the late afternoon is reported to be an effective enticement to participate. The Release Planning Groups meet twice, over two weeks, for a total of three hours. During these sessions, the inmates are assisted in reviewing their needs and instructed in how to gain access to community agencies appropriate to those needs. Inmates fill out an assessment form which ties these two together and, based on these forms, the After Incarceration Support System (AISS) staff make appropriate agency recommendations to the inmate's case manager. The institutional case-management staff from each unit is relied upon to cooperate with the Program staff to develop individual release plans for each offender. During 1999, 1,386 release plans were completed by case-managers and AISS staff.

The After Incarceration Support System Program (AISS) has taken steps to train case-management staff in understanding the community resources available to released inmates. On a rotating basis, case-management staff are offered the opportunity to tour local facilities and meet staff from area service providers who are working with released inmates. Such training is credited towards the annual training hours required of each case-manager as part of their professional duties. During these tours, the AISS Program staff discuss the importance of distinguishing between appropriate and inappropriate referrals, identifying inmate characteristics that disqualify them from program acceptance, and learning the specifics of agency programming.

In order to further assist both inmates and case-management staff in their attempts to identify and make connections with community resources, the Program has developed its own resource manual and an accompanying electronic database. Using zip codes and program descriptions as cross references, the manual and database assist staff and inmates in developing appropriate post-release service plans for the inmates. The manual and database give a description of services available, staffing, hours of operation, contact person, fees, appropriate referral, referral process, and a brief program summary. These descriptive materials are also made available during regularly scheduled hours in a facility resource room. The resource room is staffed during office hours by AISS personnel who assist inmates and case-managers in navigating the system and choosing appropriate placements.

A particularly noteworthy program of Hampden County Correctional Center is the public health program operating within its walls. What makes the program unique, beyond its extensiveness, is the extent to which it utilizes community health centers from the surrounding area to provide medical care to inmates. Using zip codes from the home or intended destination of inmates, the program seeks to match offenders with one of four community health centers in the greater

Springfield / Holyoke area. The goal of this matching is to establish a continuity of care for inmates that facilitates a smooth transition back into the community upon release. The community health centers, working collaboratively with HCCC's clinic, provide medical services for the inmates while they are detained in the correctional facility and then continue providing those services as the inmates are reintegrated into the community. In this way, the establishment of provider / client relationship can be regarded as a form of discharge planning. The HCCC medical clinic also employs a discharge planning nurse and an outreach worker to assist inmates with chronic health problems secure medical services after their release.

Community-Based Programming

A key component of the discharge planning process at Hampden County Correctional Center is making the inmate aware of the continuing support services available to them upon release from the institution. Inmates are encouraged to participate, upon release, in ongoing support groups organized by the After Incarceration Support System Program. These ongoing groups, repeating on twelve-week cycles, provide community referral services, including: health services, employment assistance, educational opportunities, housing assistance, support groups, substance abuse prevention, and others. Representatives from local community agencies assist in the facilitation of these groups and give specific information pertaining to the services provided by their agencies. These "aftercare" groups are run separately for men and women, are conducted in both English and Spanish, and take place at four different locations across the County.

Individual case management services are also available to support group participants through the Aftercare Support Coordinator of the AISS Program. There are two Aftercare Support Coordinators responsible for running these programs; one each for the male and female populations. During 1999, 270 male ex-offenders and 195 female ex-offenders participated in groups or received case-management services. The Coordinators are assisted in their efforts by a cadre of 4 part-time "mentors", who are all former inmates, who work with the ex-offenders in securing a wide variety of services. These former inmates work one day per week answering requests for support services from recently released offenders. The two full-time Aftercare Support Coordinator positions are funded from the general budget of the County Sheriff. The four part-time "mentors" are funded from the facility commissary fund.

With such a strong community-based presence, the Hampden County Sheriff's Department is well positioned to continue the efforts of discharge planners in the post-release period. In a manner similar to that envisioned by the recently created Transitional Intervention Plan (TIP) of the state Department of Public Health, the After Incarceration Support System staff is well positioned to assist inmates in securing services envisioned in the Release Plans drafted during the Release Planning Groups. The AISS staff is also well positioned to provide feedback to case-managers operating within the walls on the appropriateness of their placements and the degree of inmate adherence to Release Plans.

Employment

The Hampden County Correctional Center offers relatively extensive employment assistance to both its custody and recently released population. Through its Community Correction Program, the County employs three Job Developers that develop business contacts and assist offenders in

both job placement and job development, e.g., resume writing, and interview skills. The Day Reporting Center, the Pre-Release (work release) Program, and the Community Corrections Center (probation) each have one of these Job Developers.

Annually, almost three hundred offenders also get employment assistance through the Lifeskills and Employment Program. This program is financed from a three-year, \$1.2 million grant from the U.S. Office of Correctional Education. The program offers 21-day, 6-hour per day, workshops designed to offer job development training, as well as cognitive and vocational skills training. It services both recently released inmates and those who remain in the custody of the Hampden County Correctional Center.

In addition to these resources, the Hampden County Correctional Center makes referrals to the one-stop service centers operated by the Department of Labor and Workforce Development. It also refers ex-offenders to a vendor provided service that offers job development services. This vendor is contracted by the Department of Correction to offer services to the released offender population.

Education

The Hampden County Correctional Center contracts the services of a full-time Educational Release Planner. The funding for this position is provided by a grant from a private foundation. The Educational Release Planner assists inmates in accessing post-release educational resources appropriate to their educational level. The objective of this program is to encourage offenders to continue or resume their education during the post incarceration period. Building on the in-house educational programming it offers, this position is a particularly specialized form of discharge planning.

Special Populations

One of the most striking aspects of the Hampden County Correctional Facility is the extent to which its discharge planning for special populations, such as recovering substance abusers and those suffering from mental illness, is incorporated into the overall discharge planning effort of the institution. While the special-needs aspects of their discharge planning are done by specialized staff, the more general needs of these inmates continue to be addressed by the overall After Incarceration Support System program.

Substance Abuse

The Hampden County Correctional Center does both in-house and off-site substance abuse treatment programming. In-house, they run a 28-day program as part of a Residential Substance Abuse Treatment Program (RSAT). The program is spread over two units of the facility and is segregated into intensive and follow-up programming. This federally supported program includes the services of a Reintegration Counselor who assists in the development of release plans for participating inmates. Assistance in this case, includes help in program placement and the identification of appropriate recovery-related services.

The off-site programming is conducted at the Western Massachusetts Correctional Alcohol Center. This program is funded by the Department of Correction, is administered and operated by the Hampden County Sheriff's Department, and serves inmates from five counties.

Although offenders participating in these programs get some need-specific discharge planning assistance from specialized program staff, their primary planning assistance comes from participation in the Release Planning Groups, case-management staff, and other resources available to the general inmate population. Rather than being tracked through a separate discharge planning system, this population's discharge planning is largely done as part of the overall program offered to the general inmate population.

Mental Illness

A recent head count showed that approximately 21% of all inmates of the Hampden County Correctional Center were open mental health cases. Of those, approximately 12% were eligible for Department of Mental Health (DMH) services upon release. Inmates suffering from mental illness are cared for in-house by mental health clinicians contracted by the Department of Mental Health. Under the same contract, the vendor is responsible for assisting inmates in their discharge planning.

Discharge planning for DMH eligible inmates includes providing assistance in securing eligibility status and coordinating efforts with DMH to secure a proper treatment setting for the post-release period. In these efforts, the mental health provider has established a strong working relationship directly with the local office of DMH. The Forensic Transition Team (FTT) of the Department of Mental Health is only relied upon in instances when the necessity of an out-of-county placement requires the cross-boundary vantage point that the FTT can offer. Otherwise, the local expertise accumulated by both the in-house vendor and the local DMH office put them in a better position to collaborate on behalf of the inmate being released.

Mental Health patients who are not DMH eligible also receive discharge planning services from the mental health provider. An important aspect of securing post-release services for these individuals involves establishing their MassHealth eligibility as soon as possible. Under a working agreement between the vendor's discharge planner and Department of Medical Assistance, applications are submitted for inmates prior to release, and, when denied solely based on the custody status of the inmate, they are earmarked for speedy approval upon the release of the inmate. The advantage of this early submission is the assurance that discharge planners are able to offer potential service providers out in the community. Assured of an expedited application process for MassHealth eligibility, community-based service providers are much more likely to accept the potential client. Through the Community Advisory Board of the After Incarceration Support System program, the facility has established a mechanism for these community-based mental health providers to come into the facility in order to conduct intake evaluations of offenders who will be utilizing their services upon release.

These types of efforts to smooth the transition back into the community are particularly important for this population. Breakdowns in the continuity of care offered to those suffering from mental illness can result in unnecessary relapses that are not only harmful to the health and well-being of the ex-offender but can also result in costly demands for medical services and

potential threats to public safety. Those offering mental health services to Hampden County inmates also report a positive relationship with the Homeless Outreach Team (HOT) of the Department of Mental Health. In the event that a successful transition to community-based services does not occur, once the Homeless Outreach Team is brought into the case by local authorities, HOT is able to contact the Correctional Center directly in order to ascertain a case history and, if applicable, current medical prescription information.

AIDS/HIV Positive

Discharge planning services for the AIDS/HIV positive population is shared by a variety of entities. As with other correctional facilities, Hampden County Correctional Center reported that Massachusetts has a well developed system for the care and reintegration of HIV /AIDS positive inmates. The medical aspect of their post-release care is coordinated by one of the four community health centers operating within the facility. Caseworkers from these providers are responsible for coordinating the various health services of the inmate being released and serve as discharge planners in matters related to their illness. As the Department of Public Health's Transitional Integration Program (TIP) is made operational, it is expected that the reintegration services offered under the new program will be incorporated into the Hampden system.

Transitional and Supportive Housing

Discharge planners for the Hampden County Correctional Center, like discharge planners in all correctional facilities, utilize a wide variety of transitional and supportive housing. In addition to the typical reliance on Department of Public Health recovery beds, other substance-abuse service providers, and McKinney supportive housing resources, however, Hampden County has developed a particularly strong relationship with a local, non-profit transitional housing program with multiple sites.

This non-profit program operates sober living / recovery facilities for ex-offenders and has a long-standing working relationship with the Hampden County Correctional Center (HCCC). This relationship has recently been strengthened by the addition of a HCCC case-manager on-site at one facility in Springfield. This position is designed to provide transition / aftercare planning service for recently released prisoners while they continue their recovery from substance abuse at the facility. All 18 beds at the Springfield location are earmarked for Hampden offenders, some of whom remain in County custody and are enrolled in the Day Reporting Center. While HCCC continues to utilize other program facilities, as well as other residential substance recovery programs, this relationship with the Springfield facility represents a new level of community-based reintegration service for former Hampden prisoners.

The extensive use of pre-release classification by Hampden County Correctional Center also can be understood as a form of transitional housing. Approximately 15% of sentenced inmates released annually from HCCC are released from pre-release status. Most of the 14% released from day-reporting status have also been at pre-release status prior to being assigned to day-reporting. While requiring inmates to return to the facility nightly, the pre-release program allows them to begin the process of securing housing, gaining employment, and accessing community-based services. Combined with the extensive resources of the Community Correction Center, pre-release status provides a stable housing environment from which the ex-offender can begin the reintegration process under close supervision of correctional authorities.

Best Practices

In reviewing the policies and procedures related to discharge planning in place at the Hampden County Correctional Center (HCCC), the Working Group found many to be consistent with the *Characteristics of an Effective Discharge Planning Policy and System* listed earlier in this report. As such, they constitute *Best Practices* that can be built upon by HCCC and serve as suggestive models for others.

- The discharge planning process of the Hampden County Correctional Center (HCCC) is understood as being critical to the overall mission of HCCC. It is, in fact, intricately interwoven with many other aspects of HCCC's overall mission. Hampden County has had the same sheriff for over a quarter century and its correctional system displays an unusual level of programmatic integration and coordination, which is most likely a function of this stability. The Sheriff's embrace of the community correction concept informs many aspects of the discharge planning process and gives the institution a high level of programmatic cohesion.
- The discharge planning process is designed to promote community reintegration and prevent homelessness.
- The process is very well conceived in terms of promoting community links prior to and after release. The public health model and the Aftercare Group Meetings are two particularly strong examples of enlisting community resources to serve offender needs and establishing strong links to community-based programming.
- While the program offers inmates extensive informational resources and personal assistance in gaining access to community-based programs, it includes extensive inmate involvement in the planning process.
- The planning process begins during the early stages of incarceration.
- Each inmate's case-manager, in collaboration with After Incarceration Support Systems staff, is responsible for preparing individualized discharge plans.
- The release plan drafted for individuals includes consideration of a full range of post-release needs including health care, employment, and supportive services, in addition to the inmates' housing needs.
- While relying on case-management staff to play a critical role in discharge planning, the After Incarceration Support System (AISS) program has taken steps to provide a systematic training program for case-management staff. This program seeks to make case-management staff aware of the full range of housing and program options available to inmates upon release.
- Information about community-based resources has been catalogued, is frequently updated, and is made readily available to both inmates and staff. The database, available in the resource room, includes information about eligibility criteria and disqualifying characteristics of a wide range of programs and resources.
- The community-based portion of the After Incarceration Support System provides a mechanism for the institution to gather or receive feedback regarding the sufficiency of discharge planning services rendered.

INITIATIVES TO IMPROVE DISCHARGE PLANNING

1. The Hampden County Sheriff's Department has an extensive discharge planning / After Incarceration Support System program. The strong community-based presence of this program offers many opportunities regarding program development and evaluation. Perhaps more than any other correctional facility in the Commonwealth, the Hampden County Correctional Center (HCCC) has the opportunity to evaluate the efficacy of its discharge planning efforts. Therefore, HCCC will take advantage of that opportunity by documenting the results of those efforts, including the housing resources being utilized by its released inmates.
2. Data will be compiled in order to facilitate an evaluation of the relationship between HCCC's need for transitional / supportive housing and the supply of such housing available to its released offender population.
3. The discharge planning process and the After Incarceration Support System will have as an explicit goal the elimination of releases into homelessness. Building on its efforts related to employment, healthcare, and educational opportunity, HCCC will increase its focus on securing housing for its released inmates.
4. The Hampden County Sheriff's Department will seek to establish a cooperative relationship with the Department of Labor and Workforce Development (DLWD). Hampden's extensive collaboration with community-based programming makes it a likely candidate to experiment with joint efforts with DLWD that might later be extended to other correctional programs and facilities. Rather than developing an extensive parallel set of employment services for ex-offenders, which coexists along side those for the general public, efforts will be made to take advantage of, modify, and develop existing resources.

THE PLYMOUTH COUNTY CORRECTIONAL FACILITY

The Plymouth County Correctional Facility (PCCF) opened in July of 1994. This \$110 million multi-jurisdictional prison was built with 1,140 beds. Double bunking in most single cells has since pushed the inmate count to more than 1,450 at its peak. With additional double bunking, the prison could handle up to 1,600 inmates if needed. The facility currently houses 1421 inmates between its jail and house of correction. Releases of sentenced inmates from the house of correction have grown from approximately 800 in 1990 to approximately 1,600 in 1999. All inmates are held in, and subsequently released from, the medium security level. In 1999, 6% of inmates released were released to parole supervision. The facility does not operate a pre-release center. There are no female inmates.

Within the inmate population, some are awaiting trial, while others have been sentenced. Among sentenced county inmates held in the house of correction, most are serving relatively short prison sentences, usually 2.5 years or less. The average length of stay for these inmates is approximately one year. State inmates are often housed here for longer sentences. One of the 23 separate housing units holds young offenders (under age 18) who have been committed to the care and custody of the Commonwealth's Department of Youth Services. Other units hold federal prisoners who are on trial in U.S. District Court in Boston or Providence. There are units

dedicated to re-integration and substance abuse treatment programs. There are also literacy and life-skills programs, Alcoholics Anonymous, and other opportunities for those who are willing to commit to self-improvement.

Discharge Planning

Similar to the Department of Correction, the Plymouth County Correctional Facility (PCCF) has recently begun to increase its activities related to discharge planning. Plymouth County began to focus on community reintegration in 1996. A targeted program for intensive counseling and post-release case management began in 1997. Given the relatively recent advent, and continuing development of broad-based discharge planning at PCCF, it is difficult to define precisely the protocols and procedures governing the process. Another limitation arising from the recent advent of the program is the lack of current and historical data relating to the utilization of governmental and community-based programs to service the needs of the released offender population. Despite these limitations, the following picture arose from the materials submitted by and conversations with PCCF personnel.

In January 2000, PCCF hired its first full-time Discharge Planning Coordinator to serve the general prison population and to work with the private vendors involved in discharge planning for special populations. During an orientation session conducted during the intake process, all 1,200 inmates sentenced annually to the PCCF are introduced to the discharge planning services available to them when they begin to approach their release dates. Every three months a projected release list is run in order to identify inmates whose release date is approaching. Once so identified, PCCF caseworkers meet with these inmates in order to assist them in filling out a discharge planning form. The form is designed to help staff and inmates assess the likely needs of an individual inmate upon release. Once completed, the form becomes part of the inmate's institutional file and is also forwarded to the Discharge Planning Coordinator. The Discharge Planning Coordinator then works to make linkages between the identified needs and community-based resources where possible.

All inmates are free to request assistance in planning for their post-release arrangements when their release dates approach. There is a staff of 14 caseworkers who, along with the Discharge Planning Coordinator, do case management for the 875 sentenced inmates. Casework staff are trained to provide discharge planning services by the Discharge Planning Coordinator as well as by the Facility's Classification Captain and Treatment Manager. Inmates who participate in programming for special populations (see below) receive discharge planning services as part of those programs. Among inmates not participating in specialized treatment programs who were released between January and March 2000 and received discharge planning assistance, 31 required housing referrals, 48 required program referrals, and 30 required mental health follow-ups.

PCCF staff estimates that approximately 25% of released inmates require special assistance with regard to discharge planning. This 25% includes inmates who are either self-identified or flagged by a caseworker or other staff. The remaining inmates are understood to be returning to relatively stable support networks after comparatively brief periods of incarceration, and therefore are not believed to warrant specific discharge planning assistance. Perhaps reflecting

this perspective, discharge planning services at the Plymouth County Correctional Facility have tended to be particularly concentrated on special populations.

In the summer of 2000, however, the Plymouth County Correctional Facility's Discharge Planning Coordinator began conducting discharge planning groups on all units that house sentenced inmates. The objectives of these groups are: to review and discuss in detail all inmate needs related to their impending return to the community; to assist inmates in prioritizing their needs; to assist inmates in gaining access to community-based service agencies; to relieve the stress experienced by inmates in facing community reintegration; and, to enable the Discharge Planning Coordinator to assist caseworkers in their efforts related to discharge planning. The group sessions are being offered once per week on each of the units holding sentenced prisoners. Attendance is voluntary and offered to all inmates on the unit who are within three months of release.

Employment

The Plymouth County Correctional Facility reported the recent development of a "work force development initiative". Established during the summer of 2000, this program is designed to assist inmates in work skill development. Inmates are designated for involvement in the program during the initial classification process. Having been so designated, inmates are enrolled in the program when they are three months away from release. The curriculum is designed to prepare inmates to apply for, secure, and maintain employment after release. The Facility plans to establish a "community advisory panel" to help guide the ongoing development of the program. Facility staff also reported having applied for a grant from the Bureau of Justice Assistance to further support efforts related to work force development. Beyond these efforts, PCCF is scheduling a job fair for inmates in October 2000. The program will be run by existing staff and is expected to be a bi-annual event in the future.

Special Populations

Substance Abuse

Plymouth County Correctional Facility deploys its most extensive discharge planning assistance towards the segment of the inmate population facing substance abuse problems. Of the approximately 1,200 sentenced county inmates serviced by PCCF during a recent interval, 744 were self-identified as having "substance issues" at the time of booking. These figures, consistent with national statistics, support the perception of Plymouth County staff that problems related to substance abuse represent the most common obstacle to successful community reintegration for released inmates. Reflecting this perception, Plymouth County has devoted much of its early effort in the area of discharge planning to this special population. The availability of both State and federal resources for programs related to the treatment of substance abuse, including discharge planning services, is another likely reason for the relatively extensive services available to this population.

Three special units have been established within the prison to offer programming to prisoners suffering from substance abuse problems. Once an inmate is assigned to one of these "theme program units," the primary responsibility for his discharge planning is transferred to the staff on

that particular unit. In each of the units, inmates are provided some measure of assistance in designing and fulfilling individualized discharge plans. Plymouth County Correctional Facility is taking an active role in looking beyond the release dates of these inmates and concerning themselves with their continuing needs in the post-release period. According to statistics provided by PCCF, each of these three units discharges approximately 130 inmates annually.

The Reintegration Unit is a program, funded by the Plymouth County Sheriff's Department, for inmates at high risk of re-offending. The program has as its goal to "educate, motivate, and support individuals who are willing to or want to achieve a more positive way of dealing with the difficulties and stresses of life, thus reducing the chances of coming back to jail." The program serves 56 inmates at any given time and is designed to include a minimum of six phone contacts and one community contact during the post-release period. Until recently, PCCF had contracted with an outside vendor to operate both the in-house and aftercare components of this program. As of July 1, 2000, however, Plymouth County began operating this program itself and has established a community presence of its own to support the community-based aspects of the program. As it is now structured, the community-based portion of the program includes three reintegration counselors who will offer referral services to former inmates. The reintegration counselors now work under the direction of the Facility's Treatment Manager.

In the second such unit, known as the DS1 Unit, PCCF is engaged in a joint effort with the Department of Public Health (DPH) to run a Substance Abuse Treatment Program. This is a four-stage, three-month program that is designed to "intervene in the lives of those inmates afflicted with substance abuse problems." Upon successful completion of the three-month program, the inmate is expected to complete a Discharge Plan. The vendor contracted by PCCF to run this program also provides community-based service in the County. As such, the vendor can offer continuing services to inmates during the post-release period when necessary. Of 52 inmates discharged from PCCF custody during a recent twelve-month period after having participated in the program, 12 were placed in community-based residential programs. The remainder reportedly returned to private homes.

The Aftercare / Reintegration Unit, opened in September of 1998 and operated on the BN2 unit, constitutes Plymouth County's third unit dedicated to substance abuse treatment programming. This program is supported with funds secured by the state from the federal Residential Substance Abuse Treatment (RSAT) program. The Reintegration Program at PCCF includes among its goals the development of "individualized plans for community treatment / reintegration (to) begin when the inmate enters the program." Another of its stated goals is to "coordinate aftercare planning with Parole, Classification, Probation, the Courts and community agencies for each inmate to meet all required stipulations and to assist the inmate with reintegration into the community." Upon completion of this program, almost a third of the inmates were known to have entered halfway houses or sober houses.

Mental Illness

Approximately 8% of all inmates at the Plymouth County Correctional Facility (PCCF) are open mental health cases. Currently the Facility provides mental health care to these inmates with staff funded jointly by the Plymouth County Sheriff's Department and the Department of Mental Health. Discharge planning for these individuals is conducted by a combination of these mental

health clinicians, casework staff, and the Facility's Discharge Planning Coordinator. Currently, there is no discharge planner who specializes in serving the inmate population suffering from mental illness. PCCF staff did indicate plans to expand utilization of the Forensic Transition Team of the Department of Mental Health for this purpose.

In order to continue improving both mental health care and discharge planning to its inmates suffering from mental illness, PCCF has recently established a Mental Health Advisory Committee. The initial meeting of the Advisory Committee is scheduled for September 8, 2000. Participants will include representatives of PCCF, advocates for the mentally ill, and service providers.

AIDS/HIV Positive

Those inmates testing positive for HIV/AIDS also receive special discharge planning services. Through a partnership with the Department of Public Health (DPH), Plymouth County Correctional Facility has a full-time medical service provider serving this population. DPH also supports a part-time position that assists AIDS/HIV positive inmates exclusively with their discharge planning regarding both medical and housing needs.

In addition to these services, Plymouth County has a program for inmates identified as being at high risk of contracting HIV. The program derives its funding from a combination of DPH, the Sheriff's Department, and a mixture of private sources. It serves 100 inmates annually in groups of 14 during the last 60 days of their incarceration. Participants are drawn from the general population, and they attend daily classes and workshops on a wide variety of topics designed to end high-risk and "self-defeating" behavior. The program offers participants referrals to a wide variety of community-based services such as employment counseling, substance abuse, G.E.D. programs, and a variety of residential programs. Program participants agree to have contact with program staff for a period of six months after release. In order to facilitate such contacts and to provide further referral services to participants, program staff hold office hours in a community-based field office three mornings per week.

Transitional and Supportive Housing

The Plymouth County Correctional Facility was unable to offer a current inventory of transitional and supportive housing beds being utilized by inmates released from its various programs. It is clear, however, that a variety of such resources are being utilized by the Facility in its discharge planning efforts. Those who attempt to place prisoners being released from the Facility utilize a wide variety of halfway houses, sober houses, and transitional housing units. Some of these are state funded programs overseen by the Department of Public Health, while others are strictly private enterprises that are available within the community. Through the services of the Forensic Transition Team of the Department of Mental Health, PCCF is also utilizing a variety of supportive housing options available to mental health patients.

A significant problem identified by PCCF staff is the limited number of appropriate residential settings available for parolees who, as a condition of parole, await placement in recovery homes / halfway houses, or other supportive housing settings. Local parole officers often impose restrictions on the number of parolees allowed to reside in a particular facility in order to reduce the risk of recidivism. The limited supply of such facilities generally, coupled with these

restrictions, can pose a significant challenge for discharge planners. PCCF staff estimated that many potential parolees are unable to find suitable placements to qualify for release on parole because of the rules regarding multiple placements.

Best Practices

In reviewing the policies and procedures related to discharge planning that are in place at the Plymouth County Correctional Facility (PCCF), the Working Group found many to be consistent with the *Characteristics of an Effective Discharge Planning Policy and System* listed earlier in this report. As such, they constitute *Best Practices* that can be built upon by the Facility and serve as suggestive models for others.

- The Facility has recently hired a full-time Discharge Planning Coordinator. This should raise the profile of discharge planning in the institution.
- The discharge planning system has some community links upon which to build. The facility has contracted with a community-based service provider to provide substance abuse treatment programming in the Facility. This vendor was, in part, selected because of its ability to offer continuing out patient services to inmates upon release. Such links between service providers inside and outside of the facility offer inmates being released the opportunity for continuous care and links to the community.
- PCCF is in the ongoing process of evaluating its reintegration needs and practices. The institution appears to be in an experimentation phase and is considering various ways to improve discharge planning and community links.
- The orientation process includes information regarding discharge planning and early efforts are made to identify individuals likely to require discharge planning assistance at the time of release.
- Discharge planning services available to those on the “theme units” include a comprehensive need assessment process. This process includes the inmate in the process of evaluating housing, employment, substance abuse treatment, mental health care, and educational needs.
- Inmates released from one of the “theme units” have their post-release reintegration process monitored by reintegration counselors who offer referral assistance where appropriate. Such monitoring by reintegration counselors affords discharge planners the opportunity to monitor the success and appropriateness of their placements.

INITIATIVES TO IMPROVE DISCHARGE PLANNING

To address the issues raised by the Working Group, the Plymouth County Correctional Facility will work toward implementing the following initiatives throughout Fiscal Year 2001.

1. The role of discharge planning in the overall mission of the Facility will be clearly defined and articulated. By doing so, PCCF can establish realistic expectations and evaluative criteria for its discharge planning efforts.

2. A system for routinely determining the discharge planning needs of all inmates has been established during the summer of 2000. This process will reduce the likelihood of overlooking or overstating need and will assist the staff to properly allocate limited resources only to those with established need.
3. The Facility will catalogue, frequently update, and make readily available to all appropriate staff, a listing of all community-based resources available to released inmates.
4. Preventing releases to homelessness will be a stated goal of the discharge planning process, and the housing component of that process will be given increased prominence.
5. To the fullest extent possible, the institution will utilize community-based resources during the pre-release period. At the county level, in particular, these community connections can facilitate a continuity of care and establish community links for released offenders. The vendor currently providing substance abuse treatment services at the Facility can serve as a model of this type of utilization.
6. The Facility has recently established a Mental Health Advisory Committee to evaluate on an ongoing basis, and make recommendations for improving, the care and discharge planning services offered to inmates suffering from mental illness.
7. A workforce development initiative was begun during the summer of 2000 and will continue to be developed. The curriculum of the program is designed to prepare inmates to apply for, secure, and maintain employment after release. PCCF also plans to begin job fairs for inmates during the fall of 2000. The Facility should track program outcomes in order to facilitate evaluation and potential improvements.
8. As the Facility develops its discharge planning system, it will establish a mechanism to monitor the success and appropriateness of its placements. It will also work to identify the relationship between the supply and demand for transitional and supportive housing, as well as other community-based resources being utilized by its released inmates.

THE SUFFOLK COUNTY HOUSE OF CORRECTION

The Suffolk County Sheriff's Department operates its jail facility and house of correction at separate facilities in different locations. The House of Correction is comprised of 28 separate housing units spread over seven buildings. The facility currently houses approximately 1,650 inmates. Most are held at what is technically medium security level, although there are gradations of security and oversight that exist within that level. Another group of approximately 60 inmates is held in contracted pre-release centers. The facility typically has about a dozen inmates in day reporting status. These inmates remain in the County's custody and continue to be supervised but are not housed in County facilities.

Upon entering the Suffolk County House of Correction (SCHC), inmates are evaluated, placed in appropriate units and programs, and assigned caseworkers. The average length of stay for inmates is approximately 14 months. Approximately 500 of the facility's beds are devoted to units that provide special programming, including a re-integration unit and a substance abuse

treatment unit. Also included is the Life-skills Initiative and Non-Violent Choices (LINC) program, which is a 90-day program run on a 150-bed unit that is devoted to helping inmates overcome violent tendencies. Graduates from this program, as well as those who came from substance abuse treatment programs, are eligible to move on to the Reintegration Unit where they receive special discharge planning assistance. In addition to these unit-based residential programs, the facility also has classroom programming devoted to the promotion of literacy and life-skills.

The Suffolk County House of Correction (SCHC) is in the process of constructing a community correction center on property that is adjacent to its current facility. In addition to housing up to 50 pre-release beds, this facility is envisioned as both a day reporting center and a facility to provide post-release referral services to recently released inmates from the House of Correction. As envisioned by the program staff, this referral service will be staffed with peer mentors who have successfully made the transition back to community living.

The discharge planning activities of the Suffolk County House of Correction (SCHC) are likely to be significantly influenced by this movement towards the community correction model. The discharge planning staff of SCHC report that their activities are developing as one part of this overall trend. The discharge planning system is moving to include more community-based programs within the prison walls and to extend institutional concerns beyond those walls. The discharge planning staff expressed the view that such inclusion, while not formally part of the discharge planning process, has the effect of supporting and complementing discharge planning efforts by facilitating the continuation of facility-based programming after release.

Discharge Planning

The Suffolk County House of Correction (SCHC) has recently begun to increase its activities related to discharge planning. SCHC has been developing discharge planning policies and protocols since 1994 and there are now four budgeted positions devoted to discharge planning. Approximately one-third of all released inmates currently seek and receive discharge planning assistance from SCHC staff. Participation in discharge planning sessions and the utilization of these services is completely voluntary. With the exception of the Reintegration Unit, Suffolk County House of Correction offers no “carrots” such as earned good time to promote utilization of discharge planning services. All inmates, however, are free to request assistance in planning their post-release arrangements when their release dates approach. In fact, the House of Correction actively recruits inmate participation from within the units.

Discharge planning staff of the Suffolk County House of Correction (SCHC) run workshops approximately once every six weeks on each unit. During those workshops, staff outline the services offered to inmates as they approach their release dates. Any inmate within 90 days of release, in possession of an affirmative parole decision, or possessing evidence of an impending “revise and revoke” order by the courts,²² is allowed to attend these workshops or otherwise seek assistance in discharge planning. During the workshops, each inmate is expected to complete a long evaluative form that covers many of the needs likely to be encountered during the transition

²² “Revise and revoke order” refers to an order issued by the courts which alters or withdraws the standing order under which the custody relationship between the correctional authority and the inmate has been established.

period. These include housing, employment, medical and mental health services, educational and vocational programming, and continuing substance abuse treatment programming. From these completed forms and from interaction with the inmates and their caseworkers, the discharge planning staff complete individualized discharge plans for program participants at least two weeks prior to their release dates. SCHC reported that 30-35% of released inmates have had such a plan completed for them prior to release.

Discharge planning staff for the Suffolk County House of Correction reported that those seeking their assistance most commonly fell into two broad categories: potential parolees, seeking assistance in fulfilling programmatic requirements imposed as a condition of parole, and non-parolees, seeking more general discharge planning assistance. The program has, in fact, compiled two separate manuals that list residential programs available to each population upon release. Inmates seeking recovery home placement as a condition of parole are advised to gain access to the discharge planning staff through their caseworkers. Once assistance is requested, the staff will assist inmates in contacting recovery homes and arranging interviews, when necessary. The inmates are also provided with sample letters of introduction and follow-up letters in order to assist them in gaining admittance to programs.

SCHC staff identified inmates with affirmative parole decisions that are conditioned on program placement as the inmates most likely to seek their assistance. Eager to fulfill their parole requirements, these potential parolees often seek placement in a recovery home program or sober house. The Suffolk County staff, like that at other correctional facilities, reported a waiting list for beds available to potential parolees in such facilities. While the Commonwealth's Parole Board accepts placement in all programs approved by the Department of Public Health (DPH), not all such programs accept parolees for admittance. Further restricting the availability of such beds, some programs limit the number of beds available to former inmates. Individual parole officers can also reject a proposed placement based on the high number of former offenders residing there.

The discharge planning system of the Suffolk County House of Correction (SCHC) has no formal mechanism to evaluate the success of its placements or referrals. As with other correctional facilities, SCHC staff articulated the view that their authority to track former inmates upon release was very limited, at best. They did, however, express hope that the creation of a community correction center might soon give them some informal feedback regarding the success and appropriateness of their placements and referrals. The hope is that those staffing the facility, who will have ongoing contact with recently released offenders, will be able to provide feedback on which efforts are most effective in facilitating successful community reintegration.

In order to facilitate the continuation of medical and mental health services that are provided in the House of Correction, the facility has arranged for a part-time person to come into the facility one day per week from a nearby medical facility to assist inmates applying for MassHealth eligibility. The completed applications are held by the facility until the release date and submitted for approval at that time. The aim of this preparatory process is to reduce the amount of time between release and enrollment and thereby minimize any potential suspension of care or programming.

Employment

The Demanding Inmate Accountability (DIA-Lifeskills) program is a three-year pilot program designed to bridge the gap between incarceration and the return to the community. In exchange for educational, employment, and transitional support, all program participants are expected to work, both before and after their release, to earn a high school diploma, develop work skills, and find employment. Having secured a grant from the U.S. Department of Education to support this program, the facility uses the DIA-Lifeskills program to provide academic, vocational, and post-release support services that are designed to lead the inmate towards a productive job and career. Participants are given support in job readiness and have their work histories assessed to identify potential areas of opportunity.

Beginning in May 2000, the Suffolk County House of Correction (SCHC) began running job fairs for soon-to-be released inmates as part of the DIA-Lifeskills pilot program. These job fairs are a collaborative effort with the Commonwealth's Department of Labor and Workforce Development (DLWD). Inmates are eligible to participate in the job fairs when they are within 90 days of discharge. During the May 2000 job fair, 71 inmates participated along with 11 potential employers. The DLWD vendor prepared both inmates and employers for the event in order to increase the likelihood of its success. The goal was to match potential employers with an underutilized labor pool and to facilitate the smooth transition to work without delay, upon release. If successful, the expansion of this program beyond the pilot stage could play an important role in the reintegration process.

Special Populations

Substance Abuse

The Suffolk County House of Correction (SCHC) operates both a 180-bed men's unit and a 38-bed women's unit dedicated to substance abuse treatment. These recovery and treatment units are supported with a variety of funds from the County, the Massachusetts Department of Public Health (DPH), and from a Residential Substance Abuse Treatment (RSAT) grant secured by the Commonwealth from the federal government. The men's unit is a 90-day program, while the women's unit is a 6-month program. Inmates participating in these programs who do not move on to the Reintegration Unit described below get their primary discharge planning assistance from the general discharge planning staff of the facility. Approximately fifty percent of inmates completing substance abuse treatment programming, however, ultimately move on to the Reintegration Unit, in which they will get more extensive assistance in discharge planning.

The Reintegration Unit

The Reintegration Unit is a 100-bed unit dedicated to preparing inmates for their impending release from the Suffolk County House of Correction (SCHC). Assignment to the Reintegration Unit is limited to those who have completed the programming in either a substance abuse treatment unit or in the unit devoted to the Life-skills Initiative and Non-Violent Choices (LINC) program. On the Reintegration Unit, reintegration counselors assist inmates in planning for their release, and they conduct programming designed to promote a continuation of the self improvement efforts inmates have made during earlier programming. As part of this effort, counselors offer referral and placement assistance to program participants.

The facility is currently making plans to expand the level of participation by community-based service providers on this unit. The goal of this expansion will be to connect inmates with community programming that they can continue after their release from the Suffolk County House of Correction. Community-based service providers and residential programs will be expected to make presentations, conduct interviews, and, in some instances, begin programming during the last phase of incarceration. In this way, program planners hope to promote the kind of community linkages that make a successful transition into the community more likely.

Mental Illness

Currently, SCHC provides mental health care to inmates through a vendor supported with financial resources provided by the Suffolk County Sheriff's budget. Discharge planning for mentally ill inmates is generally done by the discharge planning staff of SCHC. If the vendor believes the inmate is likely to meet eligibility criteria of the Department of Mental Health, however, they will enlist the support of the Forensic Transition Team (FTT) of the Department of Mental Health. If DMH determines that an inmate is eligible for their services, FTT will take the lead in providing discharge planning assistance to the inmate.

In the case of non-DMH eligible inmates, the discharge planning burden falls exclusively on SCHC staff. One of the challenges facing SCHC staff in their attempt to assist inmates suffering from mental illness is the prohibition in place at many community-based substance abuse treatment programs against accepting patients who use medications for mental illness. According to SCHC staff, some of these programs cite community agreements entered into as a condition of placement of a facility into neighborhood acceptance as the reason for their prohibition on the use of these medications by program participants. Others reportedly cite their lack of competent medical staff to oversee the dispersal of such medications. In both instances, these common prohibitions further limit the supply of available placement opportunities for the mentally ill offender who also is in need of continuing substance abuse treatment, a bed in a recovery facility, or simply a placement in a sober house setting.

AIDS/HIV Positive

Inmates testing positive for HIV/AIDS receive both medical and discharge planning assistance from a vendor supported with money from both the Department of Public Health and the Suffolk County Sheriff's Office. Unlike other identified special populations, the discharge planning staff of the Suffolk County House of Correction (SCHC) does not oversee discharge planning for these inmates. The contracted vendor is responsible for arranging discharge plans for these individuals. The newly created Transitional Intervention Program (TIP), administered by the Department of Public Health, is expected to enhance community reintegration efforts on behalf of this population. As with other correctional facilities, SCHC reported general satisfaction with resources available to this group.

Transitional and Supportive Housing

The Suffolk County House of Correction (SCHC) did not offer a current inventory of transitional and supportive housing beds being utilized by inmates released from its facility. Those who attempt to place released inmates utilize a wide variety of halfway houses, sober houses, and transitional housing units. While unable to quantify precisely where shortages exist in the supply

of such housing, SCHC staff did report waiting lists at a variety of residential treatment programs and in sober living facilities. The staff also reported a shortage of affordable transitional housing appropriate for inmates reentering the Boston community. In the absence of such a supply, it is likely that some inmates are utilizing homeless shelters upon release from the facility.

Like Plymouth County, the Suffolk County House of Correction reported a back-up of potential parolees in their facility. In their efforts to encourage appropriate residential placement of paroled offenders, parole field officers often place restrictions on which facilities can receive parolees as well as on the number of parolees that can be placed in those facilities. These restrictions have the effect of further limiting the already limited universe of placement options available to discharge planners.

Best Practices

In reviewing the policies and procedures related to discharge planning in place at the Suffolk County House of Correction (SCHC), the Working Group found many to be consistent with the *Characteristics of an Effective Discharge Planning Policy and System* listed earlier in this report. As such, they constitute *Best Practices* that can be built upon by SCHC and serve as suggestive models for others.

- As the Suffolk County House of Correction (SCHC) undergoes changes in its system of inmate classification and management, it is simultaneously reevaluating its discharge planning system. SCHC is increasing its focus on community reintegration, broadly defined. The discharge planning staff understands that their role is expanding and believes that its work is regarded as critical to the institution's changing mission.
- For those inmates utilizing discharge planning services, the system includes a comprehensive needs assessment and calls for the preparation of an individualized discharge plan.
- The discharge planning process includes consideration of many transitional needs such as housing, employment, medical needs, and supportive services.
- The discharge planning system includes the participating inmate extensively in the preparation of his/her own discharge plan.
- SCHC includes the participation of some community-based service providers inside the facility prior to release and has plans to expand such participation.
- SCHC has established a limited relationship with the Department of Labor and Workforce Development to provide employment assistance to inmates prior to their release.
- The facility has catalogued and made readily available to all participating inmates a list of some community-based resources available to them upon release.
- The facility's discharge planning staff plans to utilize its future community correction center to provide further referral and peer-support services to recently released inmates. The staff also plans to utilize this new resource as a means to gather feedback regarding their pre-release planning efforts.

INITIATIVES TO IMPROVE DISCHARGE PLANNING

To address the issues raised by the Working Group, the Suffolk County House of Correction will work toward implementing the following initiatives throughout Fiscal Year 2001.

1. The role of discharge planning in the overall mission of the facility will be clearly identified and stated and will receive careful attention from those planning the future mission of the facility.
2. Procedures will be established to solicit input from parties such as vendor staff and medical care providers with information related to the inmate's transitional needs, particularly those suffering from mental illness or with other special needs.
3. A system for routinely determining the discharge planning needs of all inmates will be established. While remaining voluntary, efforts to increase participation in discharge planning will be undertaken. Many of those currently not participating in discharge planning will likely need little or no planning assistance. Nevertheless, a more universally utilized evaluative process could help identify those most in need of available services.
4. The facility will catalogue, frequently update, and make readily available to all appropriate staff and inmates, a listing of community-based resources available to released inmates. This listing will build upon, but go beyond, that which is currently available, which identifies resources related to substance abuse treatment and recovery.
5. To the fullest extent possible, community-based resources will be utilized by the institution in the pre-release period. Involvement during this period by those likely to serve former inmates during the post-release period, in areas such as medical and mental health services, for example, can help ease the transition process and help avoid costly breaks in service. At the county level, in particular, establishing this continuity of care is often feasible and can help to establish community links that can serve as the foundation for successful community reintegration. SCHC will continue to expand utilization of such community-based service providers.
6. The facility will develop and provide a training program for those providing and supporting discharge planning services for inmates. The responsibility to both assess need and access community-based resources is a broad one and will be supported with appropriate training.
7. Anticipating non-participants, SCHC will adopt a set of contingency plans for released inmates who have not requested discharge planning assistance. Such steps might include the provision of an informational resource packet or other minimal assistance.
8. SCHC will establish mechanisms to monitor the success and appropriateness of its placements. It will also seek to determine the relationship between the supply and demand of community-based resources being utilized by its released inmates. Such an analysis will allow policy-makers to plan future resource allocations. Whenever feasible and appropriate, voluntary cooperation with such an effort will be enlisted from inmates.

CORRECTIONAL FACILITIES – SOME COMMON THEMES

As indicated in the preceding review of current policies and practices at correctional facilities, the correctional professionals of the Commonwealth share many common challenges. Most fundamentally, correctional systems are all in the process of defining the role of discharge planning within their overall missions. Changes made in the criminal justice system to promote public safety over the past decade have shifted the burden of reintegrating inmates back into the community towards correctional facilities themselves. This shift has meant an increasing involvement with inmates in planning for their post-release period. In the course of conducting its research, the Working Group on Discharge Planning discovered that all of the correctional agencies and institutions represented on it were in an expansionary stage with regard to their discharge planning efforts.

In addition to defining how these services fit into their overall mission, correctional entities are exploring ways to expand upon their data collection, client tracking, and program evaluation to the fullest extent possible. While statutory restrictions and the privacy rights of ex-offenders limit the potential scope of such efforts, there are, nevertheless, opportunities to gather such information in accordance with these restrictions. Some of those opportunities have been discussed above and others should be explored. Further development of institutionally-based discharge planning and after-incarceration programs requires such information to guide its direction.

In their efforts to provide effective discharge planning for their populations, discharge planners find their task influenced by trends and decisions beyond their immediate control. In addition to programmatic decisions made within their own agencies, legislative, regulatory, and judicial decisions all affect how correctional agencies manage their custody populations and the efficacy of their efforts to successfully reintegrate inmates into the community. Changes in sentencing provisions and the shortage of available housing in the Commonwealth, for example, are both well beyond the programmatic scope and control of state and county correctional agencies. As a result, correctional officials should work to identify what resources are needed and utilized by inmates during the process of community reintegration. Once so identified, such information should be shared with other agencies and service providers in order to inform their policy and program development decisions.

The preceding review of correctional facilities has sought to describe the many ways in which the facilities represented on the Working Group are responding to the discharge planning challenges laid before them. In a subsequent section, entitled Recommended Cross-Cutting Initiatives, this report will identify those areas in which the issues demand intergovernmental cooperation to be adequately addressed.

COMMONWEALTH SUPPORTED SERVICES FOR THE MENTALLY ILL

There are two state agencies primarily responsible for financing public mental health services in the Commonwealth. The responsible agencies are the Division of Medical Assistance/Medicaid (DMA) and the Department of Mental Health (DMH). As the State Mental Health Authority, DMH establishes the mental health policy that DMA uses to purchase mental health services under its managed care program. The service obligations of these agencies are generally divided into two broad categories. Acute care, which includes short-term inpatient, emergency, diversion, and an array of community-based outpatient services, is primarily purchased by DMA through its contractor, the Massachusetts Behavioral Health Partnership (the Partnership). Continuing care, which includes longer-term inpatient care and a continuum of residential, day, and support services for adults and children, is primarily purchased or provided by DMH.

Acute behavioral health care is primarily furnished through Medicaid funding and an interagency service agreement (ISA) between DMA and DMH. Through the ISA, DMH purchases from DMA emergency services for all populations and acute care, diversionary services, and short-term inpatient care for DMH clients without insurance. Under the agreement, DMA then contracts with the Massachusetts Behavioral Health Partnership, its managed care organization, to supply these services. In addition, DMA contracts with the Partnership to provide all other acute inpatient services and an array of outpatient services for its Medicaid recipients. The ISA also defines the relationship between DMH and DMA relative to the overall management and oversight of the Partnership.

Continuing or long-term care for those people who need and qualifying for such services is provided by DMH. The Department provides all adult and child/adolescent continuing or long-term care to eligible clients. This includes inpatient care in state hospitals and an array of community-based services that promote independence, rehabilitation, and recovery, and prevents unnecessary hospitalization.

While both of these organizations serve clients in need of inpatient mental health services and, in fact, many DMH clients receive their acute inpatient care through the Partnership, the anticipated duration and nature of their relationship with their inpatient clients is quite dissimilar and has important consequences for the type of discharge planning they typically provide to their respective clients. Partnership patients typically receive inpatient mental health care in a Partnership network hospital for 10-12 days until their acute symptoms are stabilized. After that time, patients are either referred to DMH for continuing care (if they meet DMH eligibility criteria) or are referred to other community-based service providers to service their continuing mental health needs. DMH remains proactively involved with its clients after discharge from an extended stay at one of its inpatient facilities, primarily through the case management system.

As will be seen in the descriptions that follow, these differences in service roles and anticipated duration of service provision lie behind the different scope of discharge planning services provided, particularly with regard to housing search.

DEPARTMENT OF MENTAL HEALTH

The mission of the Department of Mental Health (DMH) is to improve the quality of life for adults with serious and persistent mental illness and children with serious mental illness or severe emotional disturbance. This is accomplished by ensuring access to an integrated network of effective and efficient services that promotes consumer rights, responsibilities, rehabilitation, and recovery.

The critical components of a strong public mental health system have not changed, despite continued changes in the health care world. They include: flexible community-based programs, cost efficient state psychiatric hospitals and community mental health centers, high quality continuing care, and acute inpatient and diversionary services. These services must be accessible, clinically appropriate, and cost effective and are most effective overall when they are non-coercive and voluntary. As the state's public mental health authority, the Department provides a safety net for the most vulnerable citizens in the Commonwealth. Its goal is to provide appropriate clinical care and support, including a range of housing, educational, and employment programs for adults, interagency services, family support programs, and specialized residential care for children and adolescents.

DMH also has the regulatory responsibility to license private psychiatric hospitals and psychiatric units in general hospitals. The Department recently modified its licensing regulations to include language aimed at reducing the number of discharges to homelessness.

Over the past decade, the inpatient census of DMH has been reduced from an average daily census of 2,408 in 1990 to 1,151 in 1999. This reduction was accompanied by a large expansion of community-based residential care and as well as the transfer of funding for 186 acute (replacement) beds in the DMH system to DMA / the Partnership in 1996. The number of individuals discharged annually from DMH facilities also dropped over the decade from 8,131 in 1990 to 2,396 in 1999. Some of those discharged had only been referred to DMH by the courts for evaluation and were returned to court after a brief evaluation period. A smaller percentage of the inpatient population was discharged to other DMH facilities. Most of those discharged from

DMH inpatient facilities, however, returned either to private homes (with family, friends, or alone) or to DMH affiliated housing with supportive residential services delivered to them.

The long-term decline in the Department's inpatient population, the corresponding increase in community-based supportive services it provides, the concomitant increase in Medicaid financed inpatient services and the unique relationship the Department maintains with its client population after they are discharged from inpatient facilities have all played important roles in determining the discharge planning procedures of the Department. The de-institutionalization of the mentally ill over the past quarter century has moved the Department deeply into the business of community reintegration. Over the period, the Department has fine tuned its policies and procedures and focused extensively on transitioning its clients from institutionally based care to community-based care. Believing community-based care to be the clinically appropriate course of action to pursue for the vast majority of its clients, DMH has worked to create a service and housing infrastructure that allows them to offer this outcome as a viable alternative to long-term hospitalization.

For the Department of Mental Health, unlike all of the other state agencies represented on the Working Group, the moment of discharge is not understood as the defining moment of service termination in its core service area. While the other agencies may have limited ties to a small portion of their clients post discharge, DMH maintains its primary service obligation for between 80% and 90% of its clients during the post-discharge period. In order to fulfill that obligation, DMH has contracted with a variety of community-based mental health service providers to care for its clients in the community. Beyond this, however, the Department has commonly served as the gateway agency for its clients in terms of securing other services or resources from state and federal agencies. As they leave DMH inpatient facilities, or in some instances other state or county facilities, DMH clients must be assisted with transitioning to services they may require outside of the institutional setting, such as housing or medical services. In recognition of this, DMH has worked collaboratively with other state agencies to promote successful community reintegration for its clients.

Housing Supply and Development

Each of the six Area Offices of the Department of Mental Health (DMH) has an Area Housing Coordinator who is charged with developing and maintaining an inventory of varied affordable housing opportunities for local clients. A Central Office housing unit, in turn, supports the work of Area Housing Coordinators. Collectively, the Department's housing staff is involved with such matters as cultivating relationships with housing agencies, housing policy, housing planning, issue analysis, housing project development and finance, identification of state and federal funding opportunities, rental assistance, and siting problems. The staff also coordinates administration of several housing initiatives supported with DMH funds.

Most DMH clients have low income levels and usually require some sort of subsidized housing if they do not require a structured residential program and cannot live with their families. Striving to place very low-income clients that are ready to leave hospitals into housing through appropriate discharge planning has long been a major DMH objective. It has been an integral part of the Department's efforts to build and support a formal community-based residential services system. In recent years, DMH collaboration with partner agencies in the housing

community has mainly centered on identifying available housing resources and assisting with the submission of applications for federal and state housing grant funds. The system that has evolved includes a significant component for those clients experiencing homelessness as well as mental illness. Accordingly, the Department, its providers, and its partners have been active in pursuing McKinney homeless assistance funds from the U.S. Department of Housing and Urban Development (HUD).

The Department currently serves over 6,000 people in its community-based residential service system. Just under half of these are served in group home settings where clients receive up to 18-24 hour staff assistance. Most others are in more independent living situations with between one and three clients per living unit in which support services are sent into their living units. DMH refers to this second type of housing as supported housing, and the support services are much less intensive than for clients living in group homes. Each year, new clients enter the DMH system, so the need for expanded housing and services is constant.

Residential Services

DMH supports most of its housing placements with residential services. These are provided to clients living in: independent subsidized units, DMH contracted or arranged housing, housing provided by family or friends, or in their own home. Providers under contract to DMH deliver the services for the most part; however, DMH does have a few state operated housing programs as well. The level and intensity of services is based on each client's individual clinical need, which can change over time.

Residential services are, in effect, supportive housing services. These services can be rendered in 24-hour environments, such as some group homes, or in a client's apartment on a less than 24-hour basis. Residential service staff provide clients with support, supervision, and rehabilitation. They help clients gain access to other services or entitlements, maintain a stable residential setting, acquire social or recreation skills, perform activities of daily living, and pursue employment or educational opportunities. Staff members supervise clients to ensure they have a secure environment and provide safety instructions and training in self-sufficiency. In addition, staff monitor clients for symptoms and responses to treatment. They teach symptom management and coping strategies and provide initial management of crisis situations.

Other than the residential services, DMH support for clients living in DMH affiliated housing can include the following categories of services: respite care, community support clubhouses, social clubs, case management, employment assistance, medication management, outpatient services and flexible community support for adults. For children and adolescents living in DMH residential programs, DMH provides after school programming, school-based services, case management, day treatment and various types of family support.

Discharge Planning

DMH has long adhered to an inpatient discharge planning policy that includes housing search, among other measures, and is explicitly aimed at preventing homelessness. The policy prohibits DMH state hospitals and community mental health centers from electing to discharge clients from inpatient units with directions to seek housing or shelter in an emergency shelter. It directs

staff to make every effort to place clients in suitable, affordable housing coupled with clinically appropriate services.

At DMH, discharge planning is a process undertaken by a variety of DMH staff. It begins with a multi-disciplinary treatment team in the hospital or community mental health center and eventually involves a case manager, who interfaces with the network of DMH contracted community service providers, as well as other agencies that serve the DMH population.

Discharge planning begins when an individual is admitted to a DMH facility. If an individual is determined eligible and in need of DMH continuing care services post discharge, he/she is assigned a case manager. It is important to note that not all patients who are admitted to DMH inpatient facilities are deemed DMH eligible. Forensic admissions committed by the courts for evaluation, for example, may not meet DMH clinical eligibility criteria. For inpatients that have been deemed DMH eligible, however, a case manager is assigned once the client is on a discharge track. The case manager will establish and maintain periodic contact with the client and/or treatment team until the client is close to being ready for discharge. Usually, about two months prior to discharge, the case manager will begin more proactive work with the client and the treatment team to determine which community services will be most appropriate.

The case manager arranges for and completes a comprehensive assessment of the client's community service needs. The comprehensive assessment identifies the strengths, assets, and resources available to the client to assist him/her to maintain tenancy in the community. The process also identifies the client's goals and preferences along with barriers that may make it difficult for the client to attain the stated goals. Included in the process is consideration of the following: living arrangements, adequacy of housing, money management, daily living skills, education, employment, and involvement with other agencies. The comprehensive assessment is the foundation for the Individual Service Plan (ISP).

Individual Service Plan (ISP)

Once the comprehensive assessment is complete, the individual service planning process begins. Each client and family is given the opportunity to participate, to the maximum extent possible, in the service planning process. The Individual Service Plan (ISP) is based on the comprehensive assessment. The following areas are discussed at the individual service-planning meeting:

- the client's goals, preferences and needs;
- recommended and available services;
- current and/or potential service providers;
- linkage with primary health care;
- actual or anticipated dates for initiation of services;
- treatment and rehabilitation strategies;
- federal, state and local benefits to which the client is entitled; and
- the client's need, if any, for a guardian or representative payee.

Once the services are agreed upon and authorized, the case manager identifies the appropriate community provider(s) and begins a transition process. DMH customarily delivers residential and other services to clients after discharge through a network of service providers under contract with the Department. Once community services are arranged, the discharge takes place. The provider must develop a program specific treatment plan (PSTP) that addresses the goals established in the ISP. The case manager reviews each PSTP for compatibility with the ISP. The PSTP includes long- and short-range treatment/rehabilitation objectives that are stated in specific, measurable terms with target completion timelines, the specific treatment/rehabilitation interventions to be used, and the name of the person at the service provider agency responsible for the plan.

This process occurs annually thereafter. Participants consider changes in the service plan and treatment interventions that may be warranted as a result of attainment, or lack of attainment, of goals/objectives. In some instances, need areas and/or goals may need to be revised. When that occurs, the ISP is modified with the participation of the client.

Housing Search

Based on their needs and placement opportunities, most DMH clients are discharged to one of a wide variety of transitional or permanent residential placements under contract with DMH. These include: group homes, defined as shared living for four or more persons with staff available up to 24 hours a day; staffed and non-staffed apartments for three or fewer persons; single room occupancy units; and individual apartments.

If housing with services cannot be identified when a DMH client is no longer in need of hospitalization, DMH does not allow its hospitals to discharge the person unless the patient exercises his/her legal right to leave the facility. DMH cannot legally hold a client in its inpatient system that is no longer able to be committed and who refuses to remain in the hospital pending location of a housing placement. However, many clients do elect to remain hospitalized until a housing arrangement is located. At any given time, DMH has between 120 to 169 persons awaiting discharge from inpatient facilities that are unable to leave until and unless housing and service placements become available.

Area Housing Coordinators are integrally tied to their Area's discharge planning process. They not only strive to develop housing options that can be accessed by case managers for their clients, but they also identify housing options for clients to move to as they progress with recovery. This anticipation of movement by clients along a continuum of housing and service types is an important aspect of the overall housing strategy of DMH. Having worked collaboratively with other governmental agencies to develop and gain access to appropriate and affordable housing for its clients, the housing search process is designed to best utilize those resources on behalf of its entire client population.

A significant threat to the overall housing strategy adopted by DMH is the "gridlock" that a tight housing supply at any point of the housing continuum can pose to the supply of housing throughout the continuum. In the current environment, for example, where modestly priced market rate apartments for single persons have become increasingly scarce, the entire continuum comes under pressure. With few such apartments available, those clients in lightly subsidized

units cannot move out of those units along the continuum of services and housing support because of a lack of affordable options. The apartments of these clients are subsequently unavailable for those clinically able to leave a group-home setting and go into a subsidized independent living situation with less intensive services. Such gridlock of the system, coupled with rapidly rising development costs for suitable and affordable housing for DMH clients, has put significant pressure on the Department's capacity to maintain access to an adequate supply of housing resources.

The Department of Mental Health went further in quantifying the housing and service needs of its clients than any of the other agencies represented on the Working Group. The Department's continuing involvement with its clients post discharge, its longstanding policy of promoting community reintegration, and its provision of rental assistance and community-based residential services puts them in a better position to do so than any of the other participating agencies.

DMH estimates that there are slightly more than 500 DMH-eligible homeless clients statewide. Generally, these individuals are currently living in shelters, including DMH transitional housing/shelters for the homeless, on the streets, or other temporary living accommodations. While many of these clients are service-resistant, the Department would experience additional strain on its services if all of these clients were to seek rental assistance and supportive services from the Department. DMH also estimates that nearly 500 individuals are ready to move from its residential programs, including some from its 18-24 hour staffed home settings, to subsidized housing with fewer or no residential services provided if such subsidized housing was available to the Department.³⁵

The above stated figures are a count of the clients identified as waiting for a change in status from their current homelessness, inpatient hospitalization, inappropriate housing, and /or no longer appropriate residential service placement. Movement at any one point on the continuum of housing resources relieves the demand for units elsewhere along the continuum and changes the count in other categories. Where such relief should be focused along the continuum certainly warrants the attention of the Commonwealth's policy makers so that DMH may be provided with strategic assistance. This continued attention will enable the Department to appropriately and cost-effectively meet the changing needs of its clients.

Homeless Initiative

The Department of Mental Health's Homeless Initiative funds are used primarily to provide clinical and residential services and to leverage housing supply or subsidy resources primarily from the federal Department of Housing and Urban Development. DMH is almost never a grantee of these resources, but collaborates with the Department of Housing and Community Development and numerous local housing and community development agencies across the Commonwealth to gain access to housing resources for its clients. With such collaboration, DMH is able to leverage \$22.2 million in Commonwealth resources to secure over \$71 million in federal funds.

³⁵ Figures presented to the Working Group on Discharge Planning by the Department of Mental Health. Figures generated from DMH Wait List/ Needs Assessment Process through mid point of Fiscal Year 2000.

This special Homeless Initiative was established in 1992 with support from the Administration, the legislature, and homeless advocates. What began as a \$1 million program with state appropriated funds in Fiscal Year 1992, grew to \$21.2 million in annualized state funding in Fiscal Year 2000. A \$1 million expansion is planned for Fiscal Year 2001. The primary goal of the Initiative has been to address the cyclical nature of homelessness by creating transitional and affordable permanent housing with a full range of support services. This housing is designed to help individuals recover from their mental illness to the fullest extent possible and live successfully in the community. It has provided a range of community-based services such as first aid, counseling, referral, and case management to a total of 6,633 homeless individuals.

Local community housing organizations sponsor the state or federal grant applications for permanent and transitional housing dollars. Federal applications often require that state dollars be identified to fund support services and/or to match the federal grant. DMH Homeless Initiative funding provides for residential and other support services in conjunction with the housing resources. Through this program, 961 new housing units have been leveraged or accessed from state and federal housing programs. Through the utilization of these units, and others, the Department has been able to place 1,916 homeless clients into new or existing housing with residential support services. This number includes all clients who "moved in" regardless of length of stay. This number is exclusive of client relocations and, as such, is an unduplicated count of placements.

Interagency Collaborations

As the preceding discussion of discharge planning practices at DMH indicates, the Department collaborates with a variety of state and federal agencies to provide rental assistance and housing resources to its clients. The Department also works collaboratively with other state and local agencies and their contracted vendors to improve the quality of life for adults and children with mental illness or severe emotional disturbance. Initiatives such as the Department's Forensic Transition Team and Homeless Outreach Team are examples of how the department works with other government agencies to assist individuals with mental illness.

Homeless Outreach Team (HOT)

DMH's Homeless Outreach Team (HOT) has been in existence for 14 years in the Metro Boston Area, which has the highest incidence of homelessness in the state. It is staffed by the equivalent 11.5 full-time clinicians and homelessness specialists. The objective of the program is to find homeless persons with mental illness who are, or who potentially may be, eligible for DMH services and offer them service assistance from the Department and/or other appropriate sources.

HOT works on the streets and other public places where homeless individuals may be found. It visits each shelter once or twice a week on a regularly scheduled basis. The team brokers and advocates for services on behalf of homeless mentally ill persons by connecting them to specialized medical and psychiatric services and available substance abuse treatment. It also enrolls them for DMH housing and residential service opportunities, where appropriate. Team members accept referrals of mentally ill individuals from homeless shelters for assessment, referral to the DMH network of mental health centers, and placement into the Department's transitional housing/shelters for the homeless. They provide medical assistance, ongoing support, and counseling to homeless individuals who are not ready for, or not accepting of, more

formal DMH services. HOT also serves homeless persons on a walk-in basis, providing information and support upon request and linking these individuals to DMH and other resources.

In addition to finding clients through outreach, walk-ins and referrals from shelters, HOT receives referrals from many sources including private hospitals, courts, correctional facilities, and detoxification units. The Team works with DMH inpatient units and maintains a liaison with inpatient units at private hospitals. These facilities inform the HOT Team of particularly demanding homeless admissions and discharges and often receive assistance in their disposition. Furthermore, HOT is notified by hospital inpatient units and DMH residential programs when patients walk away or are absent without authorization, so that they may be found and reconnected to the mental health and social service systems.

The Forensic Transition Team

The Forensic Transition Team (FTT) serves DMH-eligible adults being released from state and county correctional facilities and young adults leaving the custody of the Department of Youth Services (DYS). The members of this team are called in to facilitate the transition of inmates approaching their release date who have been identified as future recipients of DMH services. If the inmate is determined to be a candidate for DMH services by eligibility specialists in the Area office of DMH, the FTT member will assist the inmate in securing a proper community placement upon release. Often this involves coordination of the application process for DMH eligibility, coordination between various Area offices of DMH, and determination of the community-based resources appropriate to the inmate. FTT members often participate in the triage meetings with correctional and parole staff and facilitate an effective collaboration among state agencies to offer a continuity of care for those who are mentally ill. Upon release, client progress is then monitored by the FTT for a three-month period. (Further discussion of the DMH Forensic Transition Team is included in the *Cross Cutting Initiatives* section below).

Best Practices

In reviewing the policies and procedures related to discharge planning in place at the Department of Mental Health, the Working Group found many to be consistent with the *Characteristics of an Effective Discharge Planning Policy and System* listed earlier in this report. As such, they constitute *Best Practices* that can be built upon by the Department and serve as suggestive models for others.

- The Department of Mental Health (DMH) has a long standing discharge planning policy for clients leaving inpatient facilities that explicitly aims to prevent discharges to homelessness. This includes an explicit prohibition against discharging clients into homelessness.
- Discharge planning begins when an individual is admitted to a DMH facility. If an individual is determined eligible and in need of DMH continuing care services post discharge, he/she is assigned a case manager who oversees the discharge planning process.
- The case manager arranges for and completes a comprehensive assessment of the client's community service needs. The comprehensive assessment identifies the strengths, assets, and resources available to the client to assist him/her to maintain

tenancy in the community. The needs assessment includes such areas as housing, employment, health care, and other supportive services.

- Based upon the completed comprehensive assessment, an Individual Service Plan (ISP) is developed to guide the process of matching client need with the provision of community-based services. Each client and family is given the opportunity to participate, to the maximum extent possible, in the service planning process.
- The discharge planning process includes collaboration with other governmental agencies, particularly housing agencies, to secure services and entitlements for discharged clients.
- Individuals with expertise in the range of housing options available to discharged clients are involved in providing discharge planning services and making post-discharge arrangements.
- The discharge planning process anticipates changes in the service and resource needs of clients over time and has established both a mechanism to identify changing needs and a range of service and housing options to address client needs as they change.
- DMH has procedures in place to identify, calculate, and communicate the relationship between the available supply and demand for its community-based services and housing resources. This information is utilized by departmental policy-makers in program development.
- DMH has utilized its licensing authority to enhance the discharge planning process in private psychiatric hospitals and psychiatric units in general hospitals and to add reporting requirements on homeless discharges. Through a review of this homeless discharge data, DMH will be able to work with those hospitals that appear to be having difficulty in this area.
- Area Housing Coordinators serve as liaisons between discharge planners and the state and local housing agencies in securing housing resources for DMH clients.
- The Forensic Transition Team is an example of inter-agency service coordination that mitigates against costly service failures and reduces the likelihood of both homelessness and criminal recidivism.
- Homeless Outreach Team (HOT) – This aggressive outreach and referral initiative strives to ensure that homeless people who are potential clients of DMH do not fall through the cracks of the housing and services delivery system. HOT refers clients into the DMH system and also provides assistance to those clients who demand discharge from DMH or leave private hospitals without the required services or housing being in place.

INITIATIVES TO IMPROVE DISCHARGE PLANNING

To address the issues raised by the Working Group, the Department will work toward implementing the following initiatives throughout Fiscal Year 2001:

1. In conjunction with its state housing partners, DMH will identify new housing and service resources that will most effectively prevent gridlock in its housing and service continuum. It will propose changes to existing housing programs that will improve the housing circumstances of DMH clients. This will include an estimation of any current financial cost of inappropriate resource utilization along the continuum and any potential savings that could be realized from a more appropriate use of existing resources.
2. DMH will work with the Department of Correction, the Massachusetts Sheriffs Association, and other relevant parties to explore how they may assist them in improving discharge planning for mentally ill inmates who do not meet DMH eligibility criteria. While the Forensic Transition Team is serving DMH eligible inmates, those not meeting the DMH eligibility criteria could experience significant service enhancement as a result of such assistance. Potential areas of assistance such as cross-training, program design, or joint resource development will be explored.
3. DMH will explore how its expertise in gaining access to housing may be of technical assistance to the Massachusetts Behavioral Health Partnership network of providers and/or other agencies conducting housing searches for mentally ill persons.
4. DMH will enlist the support of statewide housing organizations and advocacy groups to review this report and advance the Department's future housing agenda.

THE DIVISION OF MEDICAL ASSISTANCE / THE MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP

The Massachusetts Behavioral Health Partnership (the Partnership) is a private, for-profit managed care organization that has been contracted by the Division of Medical Assistance (DMA) to manage mental health and substance abuse services for over 500,000 MassHealth members in the Commonwealth. With financing provided through an interagency service agreement between DMA and the Department of Mental Health (DMH), the Partnership also offers uninsured clients of DMH coverage for acute inpatient and emergency psychiatric services. The Partnership does not provide care and services directly to patients but arranges for service provision through a network of providers whose delivery of care they manage on behalf of the Commonwealth. Among the Partnership's network of providers are: 33 emergency services programs; 38 diversionary service providers; 39 inpatient facilities; 597 outpatient clinics; 365 psychiatrists; 370 psychologists; and 54 master's level clinicians and nurse specialists. In Fiscal Year 2000, Partnership providers had over 10,000 adult discharges from inpatient mental health facilities. These 10,000 discharges represented approximately 6,400 individuals to whom services had been provided. In addition, there were over 25,000 adult discharges from detoxification facilities. These represented approximately 11,000 individuals to whom services had been provided.

III. CROSS-CUTTING INITIATIVES

As part of its overall review and evaluation of discharge planning policies, the Working Group on Discharge Planning identified five areas that could be improved with collaborative efforts among the organizations represented in the Group. Accordingly, the Commonwealth will implement five initiatives that cut across organizational boundaries. They are described below.

1. Ensure Consistency in Discharge Planning among the Commonwealth's Vendors

For discharge plans to be effective, organizations must effectively assess the needs of individuals to be discharged, match those needs with available post-discharge options, and maintain a high level of government agency coordination. The Working Group's initiatives described throughout Section II of this report will significantly improve the ability of each agency and facility to achieve these objectives. However, in addition to state-managed programs, there are numerous state-funded purchases of human and social service programs for individuals who are homeless or at risk of homelessness that are provided by contracted vendors. Because several state agencies manage numerous contracts with providers of services for this population, the Working Group has launched a multi-agency initiative to ensure consistency in discharge planning policies and practices among the Commonwealth's vendors. The Operational Services Division, the Executive Office of Health and Human Services, and the Executive Office of Public Safety are leading this initiative, which is being implemented by a multi-agency "procurement review team." The team consists of representatives from the Departments of Correction, Youth Services, Mental Health, Social Services, and Public Health; the county correctional system; the Division of Medical Assistance; and the Departments of Transitional Assistance and Veterans' Services.

During their discussions about this initiative, the departments and facilities represented on the Working Group identified the types of state contracted services that would likely benefit from the establishment of consistent discharge planning expectations. A preliminary list of those services appears below:

- Substance abuse treatment;
- Sex offender treatment;
- Rehabilitative treatment;
- Medical and mental health services;
- Inpatient healthcare;
- AIDS treatment;
- Discharge planning services;
- Housing search and placement;
- Pre-Release Centers;
- Day Reporting Centers;

- Long-term secure treatment facilities;
- Residential/group care;
- Transitional living programs;
- Independent living programs;
- Young parent programs;
- Specialized foster care;
- Teen living programs; and
- Pharmaceutical programs.

Currently, the discharge planning requirements included within the contracts for services listed above range from minimal to extensive. The appropriate characteristics and extent of discharge planning efforts are dependent upon the unique characteristics of each program and population served. However, the Working Group recommended that the multi-agency procurement review team make every effort to ensure that Requests for Responses, i.e., procurement solicitations, for similar programs and services require similar and effective discharge planning activities.

Because most state procurements of this nature begin with a Request for Response (RFR), the procurement review team will review best practices and develop a generic “discharge planning module” to include in relevant upcoming RFRs. To identify the relevant RFRs, the procurement review team will review and amend the Working Group’s preliminary list of services listed above. Although the RFR module can be tailored by agencies to conform to the unique needs of each agency and program, it will include generic language that reflects the procurement review team’s consensus on effective discharge planning policies and practices. To help guide the development of the RFR module, the procurement review team is using the list of “Characteristics of an Effective Discharge Planning Policy and System,” included as Section I of this report. The end result will be the establishment of consistent discharge planning expectations within each relevant contract’s specifications, performance indicators, and reporting requirements.

As part of this initiative, the procurement review team will also assess the potential for joint procurement efforts, which would allow two or more state agencies that purchase the same or similar services to jointly procure those services. This would reduce the number of administrative tasks associated with state procurements, ensure consistent contract expectations related to discharge planning, coordinate contract and program monitoring functions, and provide potential vendors with the opportunity to respond to one RFR rather than several RFRs for the same or similar services.

To implement this initiative, the procurement review team will:

1. identify relevant contracted service types (fall 2000);
2. list relevant upcoming procurements by date (winter 2000);

3. develop generic discharge planning language for RFRs (spring 2001);
4. identify potential joint procurement opportunities (spring 2001);
5. incorporate language into single- and multiple-department procurements, as developed by the team and further customized by departments (implement as procurements are issued, beginning in Spring 2001); and
6. report progress to the Executive Office for Administration and Finance (submit reports quarterly, beginning in winter 2000).

Because of the extensive network of state-funded services provided by contracted vendors to individuals at risk of homelessness, requiring consistent discharge planning efforts among the Commonwealth's vendors, while implementing similar improvements in state-managed programs, will ensure greater success in the Commonwealth's efforts to promote public safety, economic self-sufficiency, and the prevention of homelessness.

2. Pilot Program to Allow Inmates in Correctional Facilities to Apply for MassHealth Coverage

Many members of the Working Group identified the prohibition on filing MassHealth applications on behalf of inmates in correctional facilities as a major obstacle to successful discharge planning for those inmates. Under a current state regulation, the application of an inmate for MassHealth coverage cannot be considered until after that inmate's release from a correctional facility. This means that a determination of eligibility can not begin until after an inmate has already been released from the facility. The resulting delays and breaks in service that occur while the subsequent application process takes place cause numerous problems for both the released inmates and the Commonwealth.

At the invitation of the Working Group, representatives of the Division of Medical Assistance (DMA) met with the Group and discussed their plans to pilot a program to change the state regulation that precludes the filing of MassHealth applications during the pre-release period. The pilot project is to be run at the Bristol County House of Correction and is designed to test a process by which incarcerated individuals apply for MassHealth coverage while still incarcerated. Under the pilot, eligibility for coverage during the post-incarceration period will be determined prior to an inmate's release date. Bristol County House of Correction was chosen as the pilot site because of the manageable number of inmates being released from the facility each month (35 to 45). DMA did indicate that, as part of the program evaluation process, they would explore and assess the feasibility of conducting outreach to county jails as well as houses of correction.

The Bristol County Pilot Program

The Bristol County pilot program began in September of 2000. Its objective is to ensure that MassHealth-eligible individuals will be able to secure medical, mental health, and substance abuse appointments as well as have prescription medication regimes go uninterrupted upon release, thereby ensuring continuity of care. Caseworkers will provide MassHealth eligibility

information and application assistance to inmates at a regularly held monthly meeting. As part of the pilot process:

- informational materials, MassHealth cards, and Managed Care Enrollment materials will be supplied to the Bristol County Reintegration Program;
- Fourteen days prior to an inmate's release date, Bristol County staff members will complete the MassHealth Benefit Request form along with a prescribed form which will indicate the intended release date and the length of incarceration;
- the applications will be processed through the Central Processing Unit of DMA and will be identified by a Bristol County stamp in the upper right-hand corner. The eligibility of inmates will be determined according to the same MassHealth rules used for all applicants in the Commonwealth;
- staff at Bristol County will assist the applicant with selecting a managed care provider. A standard enrollment form will be faxed or called into the enrollment broker three days prior to an inmate's release date in order to facilitate managed care enrollment;
- Bristol County staff will notify the appropriate MassHealth Enrollment Center three days prior to the inmate's release with change of address information; and
- Bristol County staff will track MassHealth eligible inmates for one year as part of their overall Reintegration Program. A Community Resource Center in Fall River, which is part of that program, is open to assist individuals with securing post-release services. Inmates will be asked to sign a waiver form that allows the program to track their service utilization for purposes of program evaluation. DMA staff will then track the type and frequency of services received by former inmates and assess the success of the Bristol County pilot in securing MassHealth benefits for eligible inmates upon release.

The Bristol County pilot program will be continually monitored and evaluated through the winter of 2001. Allowing time for any needed program modifications and implementation, the Division of Medical Assistance anticipates introducing the new system statewide by June 30, 2001.

The Working Group on Discharge Planning enthusiastically welcomes this important initiative by the Division of Medical Assistance. It believes that these efforts will facilitate improved discharge planning, help avoid costly breaks in service, and improve public safety.

3. Promote the Successful Transition of Youth to Independence from State Custody and/or Care

In 1999, Health and Human Services Secretary William D. O'Leary opened the Office of Youth Development (OYD) at the Massachusetts Executive Office of Health and Human Services (EOHHS). The goals of the OYD are to support and establish effective youth development programs at the state and local level, and to promote state, local, and federal collaboration in order to address the needs of youth who transition to and from state agencies, particularly homeless and runaway youth.

To further support his efforts on behalf of youth, Secretary O’Leary has also appointed a statewide Youth Development Advisory Council (YDAC). YDAC’s role is to advise EOHHS regarding youth development policy and to assist in the implementation of initiatives. YDAC membership includes 23 organizations and agencies. These include youth-serving governmental agencies, community-based service agencies, advocates, law enforcement officials, and representatives of client youth themselves. Since its inception, YDAC has helped to leverage over \$20 million in state and federal resources for youth initiatives in Massachusetts; many of them targeted towards the prevention of homelessness.

Beyond some of the initiatives detailed under the individual agencies earlier in this report, the Office of Youth Development (OYD) and the Youth Development Advisory Council (YDAC) have been instrumental in developing and implementing the following cross-cutting initiatives targeted at youth at risk of becoming homeless. All of these initiatives have been recently embarked upon and are currently being implemented.

Health Care

A report issued in December, 1999 by the Executive Office for Administration and Finance (EOAF), entitled “Homelessness in Massachusetts” reported that, “...(f)ormer clients of DYS and DSS often lose their access to health care after being discharged from state custody.”³⁷ Following the release of this report, the Youth Development Advisory Council (YDAC) convened a team consisting of representatives from the Departments of Social Services (DSS) and Youth Services (DYS), the Division of Medical Assistance (DMA), and the Executive Office of Health and Human Services (EOHHS) in order to address the problem. The work of this group has resulted in the following initiatives:

- DSS and DYS will complete a Medical Benefit Request (MBR) for each youth aging-out of state custody.
- DMA has identified a single point of contact at their Central Processing Unit to process and track MBR’s for youth that are wards of the Commonwealth and are “aging-out” of the system.
- The Division of Medical Assistance (DMA) is providing DSS and DYS with a list of all DMA-funded, local resources, i.e., mini-grant organizations, to assist staff in completing the MBR. DMA has agreed to provide additional training for local DSS and DYS staff regarding health care access.
- DMA, DYS and DSS are exploring ways to automate the application process.
- Youth aging-out of state custody have been identified as a target priority for health care outreach mini-grants during Fiscal Year 2001.
- EOHHS has conducted training for mini-grant recipients regarding the needs of custodial youth populations.

³⁷ *Homelessness in Massachusetts: Are State-Funded Resources and Services Allocated and Coordinated Effectively?* Fiscal Affairs Division, Executive Office for Administration and Finance (Boston: December 1999) p. 19

Educational Support

In partnership with the foster children from the DSS Youth Advisory Board, the Youth Development Advisory Council (YDAC) drafted and advanced a tuition waiver proposal that resulted in state college tuition waivers for foster and adoptive youth. On June 21, 2000, the Massachusetts Board of Higher Education voted to provide tuition waivers to:

- all youth age 24 and under who were adopted through the state Department of Social Services, and
- all foster youth, age 24 and under, who came into the system under a Care and Protection petition and “aged out” of the system without being adopted or returned home.

YDAC is continuing to work with the Board of Higher Education, member agencies, and the public to improve educational outcomes for current and former foster youth.

Job Development

YDAC members assisted the City of Brockton in obtaining a five-year, \$18 million Youth Opportunity Grant from the U.S. Department of Labor (DOL). The grant was awarded in February 2000. Through the "Targeted Cities Initiative" of the Executive Office of Health and Human Services (EOHHS), The Office of Youth Development (OYD) assembled a state team to support the Brockton Private Industry Council in their successful application to the DOL. The team included representatives from the Departments of Social Services, Youth Services, Mental Health (DMH), Public Health and Transitional Assistance. The grant money awarded will provide for education and job development services to all 14-21 year olds within designated census tracts in Brockton. Eligible youth include foster youth, homeless and runaway youth, and delinquents. The grant also funds state agency liaison positions that will connect DSS, DYS and DMH to grant-funded services. As a follow-up to earlier assistance, OYD is now providing technical support to the City in its implementation of the grant-supported programs.

4. Forensic Transition Team and Discharge Planning for Mentally Ill Inmates

The Forensic Transition Team (FTT) of the Department of Mental Health (DMH) is a statewide program covering all state and county correctional facilities. It was established in 1998 as a collaborative effort among the Department of Correction (DOC), County Correctional Facilities, the Massachusetts Parole Board and the Department of Mental Health. The FTT serves mentally ill inmates who are approaching their release date and are identified as potential DMH clients. Its goals are:

- to reduce recidivism and inpatient psychiatric hospitalization;
- to coordinate services for DMH eligible inmates during transitions between incarceration and the community;
- to maintain continuity of care for mentally ill inmates through early engagement, consistent support, and a monitored transition to community services;

- to enhance community safety through close collaboration and well-defined cooperation with public safety agencies including Parole, Probation, and the Department of Correction; and
- to maintain a database that supports sound programming, appropriate funding, and research on mentally ill offenders.

The Forensic Transition Team represents an important advancement in interagency collaboration in the aftercare of mentally ill offenders. With the Department of Correction having identified 17% of its inmates as open mental health cases, the importance of such collaboration is not easily overstated.³⁸ Accepting nearly 60% of those referred for evaluation, the Forensic Transition Team has assisted hundreds of released inmates secure community-based services since its inception. The benefits in terms of both public safety and monetary savings are likely significant.³⁹

The Forensic Transition Team's (FTT) structure is well suited to serve the Department of Correction (DOC). By serving as a liaison between the DOC, the potential client, and the local Site Offices of the Department of Mental Health, Team members can transverse the geographic scope of the DOC system. When an offender is being released from a facility in one geographic region of the Commonwealth and returning to another, the Team serves as an important resource in navigating the bureaucratic maze that such cross-district placements typically pose for both DOC and DMH personnel. On the other hand, county facilities that serve a local population need a strong, direct relationship with the local Site Offices of DMH and the cadre of local service providers they utilize. Strengthening this relationship might facilitate the kind of community links and continuum of care identified as a characteristic of effective discharge planning systems.

As this innovative initiative matures, and as correctional facilities gain more experience in the area of discharge planning, the Departments of Mental Health and Correction, the Massachusetts Sheriff's Association, the Massachusetts Parole Board, the Office of Probation, the Department of Public Health, and the Office of Community Corrections need to build on the success of the FTT and explore ways to improve and enhance existing agreements.

During the fall of 2000, the above named agencies will establish a working group to:

1. review the guidelines and protocols governing the current agreement between DMH, DOC, and the Board of Parole. Specifically, examine ways to incorporate the needs of county facilities and the Office of Probation into the existing agreement and clarify the role of each in providing discharge planning services to inmates;

³⁸ Massachusetts Department of Correction. *Department of Correction Health Services Division*. (Medfield, MA: 1999)

³⁹ A recent policy brief by the John W. McCormack Institute of Public Affairs relied on recent studies in the field to estimate the cost savings of diverting a mentally ill offender from a return to prison at \$56.70 per day. *Transitioning Mentally Ill Offenders from Correctional Custody to the Community*. Stephanie W. Hartwell, Ph.D., McCormack Institute (1999) p.8

2. make recommendations regarding service improvement to county correctional facilities. Alternative service models such as direct links between county facilities and local Site Offices of DMH should be examined;
3. identify ways to improve discharge planning for, and post-release resource utilization by, non-DMH-eligible inmates who are, nevertheless, mentally ill. Interagency agreements, for example, could be expanded to improve access to the post-release resources available to this population. These inmates can be difficult placements for discharge planners in correctional facilities and the experience of DMH could inform officials at these facilities in their efforts to improve service;
4. arrange for the provision of technical assistance to correctional facilities regarding the procurement of mental health services. This should include assistance in the procurement of in-house mental health services that promote linkages to community-based providers that will continue to provide inmates with mental health services after their return to the community; and
5. offer proposals on how the Commonwealth can best maintain oversight of mentally ill inmates during the post-release period of community reintegration.

5. Data Collection Processes and Evaluation of Discharge Planning Systems and Outcomes

For discharge planning to be effective, the Working Group believes that discharge planning policies and systems must support the goals of public safety, social and economic self-sufficiency, and homelessness prevention. In order to sustain such goals in an effective manner, the Working Group supports the collection and analysis of: (1) pertinent data about the status of discharged individuals; (2) information about the availability and appropriateness of community-based resources for those being discharged; (3) statewide, reliable, uniform, and unduplicated information on homeless persons served by the Commonwealth; and (4) accurate information about the impact of homelessness on state-funded services.

Ongoing Evaluation of Discharge Planning Systems and Outcomes

To ensure the effective delivery of discharge planning services, organizations must have the ability to ascertain whether they are successfully matching the needs of the consumer or inmate with post-discharge housing options, programs, and resources. This requires that appropriate mechanisms be in place to collect pertinent data about the status of discharged individuals and the availability and appropriateness of community-based resources for those being discharged.

The Working Group's initiatives described throughout Section II of this report include numerous plans among the agencies to develop data collection and program evaluation systems. Many of those initiatives reflect agencies' plans to put into place procedures or mechanisms to:

- conduct ongoing collection and reporting of data regarding the status of discharged individuals;
- gather or receive feedback from aftercare and housing providers as to the sufficiency of discharge planning services rendered or appropriateness of placement in their facilities or programs; and
- assess, and communicate information about, the supply of and demand for community-based resources available to those being discharged.

Collection of Statewide Data about Homeless Persons

Through the Executive Office for Administration and Finance, Executive Office of Health and Human Services, and the University of Massachusetts Boston, the Commonwealth will continue to invest in the Connection, Service and Partnership through Technology (CSP Tech) project (formerly the ANCHoR project). This project is designed to provide statewide quantitative data that are critical for informing the state's homeless services planning decisions. CSP Tech works with more than 140 homeless service programs from across the state to gather and collect reliable, uniform, and unduplicated information on homeless persons in Massachusetts. These data include information such as demographic characteristics, residential history, service usage and outcomes, and the number of homeless persons receiving services from multiple state agencies.

The Commonwealth's investment in CSP Tech will be fully realized when the project meets its planned goals for full implementation by the end of Fiscal Year 2001. At that time, the system will include data for 90% of individuals and 80% of families served in the state's emergency shelter programs. The statewide data provided by CSP Tech will answer critical policy questions, including those related to discharge planning. For example, these data will assist the Commonwealth's policy-makers in identifying state agencies or facilities whose consumers or inmates are ending up in the shelter system and ascertaining the extent to which state agencies could improve services to individuals at risk of becoming chronic shelter residents.

An Examination of the Impact of Homelessness and Supportive Housing on State-Funded Services

Dr. Dennis Culhane of the University of Pennsylvania has assembled a team of researchers to collect and analyze data from the Department of Mental Health, the Division of Medical Assistance, and other public and private organizations. The team's research proposal lists two primary goals: "(1) to determine whether there is evidence that support(ive) housing is associated with a decline in state-funded services, and if so, how much; and (2) to determine whether people who are homeless are disproportionate users of state-funded services compared to non-homeless controls, and if so, how much."⁴⁰

⁴⁰ Culhane, Dennis and William Fisher, "Research Proposal. *The Impact of Homelessness and Supported Housing on State-funded Services in Massachusetts*" (June 12, 2000)

The research team proposes to answer many important service planning and policy questions about the cost of homelessness by examining the health status, health care utilization, and criminal justice system involvement of homeless persons in Massachusetts. Such research would help policy-makers assess the effectiveness of state-funded services for homeless persons and the appropriateness of supportive housing as a transitional or permanent housing option for persons at risk of homelessness, including those being discharged from the care or custody of state agencies.