

Increasing Collaboration between Corrections and Mental Health Organizations: Kansas Case Study



I. Introduction

In 1992, Kansas constructed the Larned Correctional Mental Health Facility, a prison dedicated to inmates with mental illness. Ten years later, with the nearly 300 beds in that facility long-since filled, the Department of Corrections (DOC) began to look more closely at the prevalence of mental illness among the state's prison population, and what happened to this subset of the population when they were released to the community. The findings were disconcerting.

DOC found that almost 20 percent of inmates had significant mental health needs, with about half of that 20 percent meeting the state's criteria for "serious and persistent mental illness."¹ Of perhaps even greater concern, offenders with mental illness were 67 percent more likely than others to be reincarcerated within six months of being released to community supervision.² DOC staff and leadership recognized that something had to be done. Not only were inmates with mental illness more likely to recidivate than other offenders, but they were also more expensive to treat and had longer average

lengths of stay than other prisoners. With little ability to control the influx of people with mental illness into state prison, DOC began to look for ways to improve their success upon re-entry.

At the same time, concern was growing in the Department of Social and Rehabilitation Services (SRS) (which oversees mental health treatment in the state) and among community mental health providers about the high percentage of people with mental illness ending up under the supervision of DOC. Beginning in 2001, DOC, SRS, and community providers began work on the following series of initiatives: the design of a specialized discharge planning program for offenders with mental illness, the establishment of partnerships between DOC and specific community providers, improvements in data-sharing, and the implementation of specialized mental health parole caseloads.

Since then, DOC, SRS, and community providers have made progress, but they also recognize that the results of their work to date only scratch the surface of the problem. The prevalence of offenders with mental illness in the state's prisons remains

¹ Kansas application for technical assistance to CSG/NIC. July 30, 2004. Internal DOC statistic. As in most states, Kansas prioritizes community mental health services for people with certain conditions. In Kansas, these

conditions are referred to as "serious and persistent mental illness," including all Axis I diagnoses (severe depression, bipolar disorder, schizophrenia) and borderline personality disorder.

² Kansas application for technical assistance to CSG/NIC. July 30, 2004. Internal DOC statistic.

high, improved services are generally limited to those who receive help from specialized staff, and most offenders still return to their communities with minimal support in place. In addition, recent studies measuring the impact of these improved services and specialized caseloads do not necessarily reflect significant improvements in outcomes for this population.

The Kansas agencies responsible for corrections and mental health treatment have taken significant and dramatic steps to work together. As it is generally accepted that no major strides can be made to improve the transition of people with mental illness from prison to the community unless these two systems collaborate extensively, the experiences of SRS and DOC are instructive. Administrators of these agencies have assumed joint responsibility for their shared population, and the work they have done to get to this point provides valuable, positive lessons from which corrections and mental health officials in other states can learn.

This case study is part of a technical assistance project launched by the Council of State Governments (CSG) and the National Institute of Corrections (NIC) to improve collaboration between corrections and mental health systems.³ In July 2003, CSG and NIC invited state and local corrections and mental health agencies to jointly apply for technical assistance related to any shared undertaking. Of more than 60 applications received, NIC and CSG provided initial technical assistance to 13 jurisdictions and, from those 13, selected four sites to receive long-term, intensive assistance and serve as “learning sites” for the rest of the country. Kansas is one of those four sites.

II. Summary of Initiatives

The efforts in Kansas to improve re-entry for offenders with mental illness comprise a variety of discrete

initiatives. Some are full-scale collaborations between DOC and SRS, and DOC has spearheaded others on its own. They vary in scope, geographic focus, and longevity. This case study will describe how the following patchwork of strategies has evolved:

- *COR-Pathways transition planning program*—DOC and SRS have jointly established and funded the Community Offender Resources-Pathways (COR-Pathways) program, which created two community resource coordinators (*i.e.*, transition planners) to provide specialized transition planning for offenders with mental illness and other special needs.
- *Specialized parole caseloads*—DOC has established specialized mental health parole caseloads; there are now five specialized parole officers across the state.
- *Enhanced transition planning by DOC mental health provider*—DOC negotiated a new contract with its mental health provider, Correct Care Solutions (CCS), to include four new transition planners in addition to the two existing contracted transition planners, who will serve offenders with mental illness and other special needs.
- *Enhanced aftercare by DOC mental health provider*—The new contract with CCS also includes a requirement for a 30-day supply of post-release medication, prescriptions for an additional 15 days of medications, and 90 days of post-release aftercare.
- *Data sharing between DOC and SRS*—DOC and SRS have devised a system by which information about offenders’ mental health, substance abuse, and Medicaid history can be provided to DOC at intake.
- *Partnerships with community mental health centers*—DOC has established separate agreements with community mental health centers in the state’s

³ CSG is the coordinator of the Criminal Justice / Mental Health Consensus Project, a nationwide effort to improve the response to people

with mental illness involved with the criminal justice system. NIC is the training and technical assistance arm of the Federal Bureau of

Prisons, and has a longstanding commitment to helping corrections agencies respond to offenders with mental illness.

two largest counties, Sedgwick (Wichita) and Wyandotte (Kansas City), to improve the transition of offenders returning to those communities.

III. Building Collaboration: 2001–2003

Crossing agency lines

In 2001, then Secretary of SRS Janet Schlansky, recognizing that SRS shared populations with numerous other state agencies, charged two staff members with developing joint initiatives with agencies outside of SRS. In addition to working with the public school and the foster care systems, these SRS staff members quickly reached out to the DOC to explore possible collaboration.

At the same time, corrections officials were developing a better understanding of the obstacles to re-entry faced by offenders with mental illness. Parole officers reported time and again that offenders were leaving prison without sufficient medication,

applications for SSI submitted for still-incarcerated offenders seemed to be rejected automatically, and community mental health centers were turning away clients for fear of violence or because offenders were “not in the priority population.” Given these circumstances, the reincarceration of people with mental illness released from prison, not surprisingly, was the norm.

It was against this backdrop that DOC and SRS began in earnest to work together across systems. They made their initial focus the process through which people with mental illness were released from prison and returned to the community.

Discharge planners working in DOC facilities lacked the training to meet the unique needs of prisoners with mental illness, and the level of multi-system coordination required was not in their job descriptions. SRS and DOC staff determined that specially trained transition planners with broader mandates and smaller caseloads might achieve better outcomes. And so, the COR-Pathways program was born.

CORRECTIONS AND MENTAL HEALTH SERVICES IN KANSAS

The Kansas Department of Corrections (DOC) is responsible for the incarceration of felony offenders and their post-release supervision. The department's eight correctional facilities house approximately 9,000 inmates, and each year more than 6,000 are released into the community. Of those 6,000, approximately 75 percent are released to the state's four largest counties: Sedgwick (Wichita), Wyandotte (Kansas City), Shawnee (Topeka), and Johnson (Olathe). Mental health services in Kansas prisons are provided by a private contractor, which for the past several years has been Correct Care Solutions.

There are two types of parole supervision in Kansas, depending on when an offender was sentenced. For those sentenced prior to September 1993, the parole board determines a release date and time for parole. For those sentenced after September 1993, there is

a determinate sentence and a court ordered period, usually between three and five years, of post-release supervision.

The Kansas Department of Social and Rehabilitation Services (SRS) oversees and administers a wide array of health and social services in the state, including substance abuse and mental health treatment; TANF, food stamps, and other benefit programs; foster care and Head Start; and dozens of other family services.

Mental health services in Kansas are provided at the local level by 29 community mental health centers (CMHCs) throughout the state. The CMHCs are private organizations that operate under contracts and licenses with SRS, which administers their state general funds and federal block grant funds. Funding for community mental health services in Kansas prioritizes treatment for people with serious and persistent mental illness (SPMI), which in Kansas is defined as all Axis I diagnoses (severe depression, bipolar disorder, schizophrenia) and borderline personality disorder.

Intended as a pilot, COR-Pathways began with one community resource coordinator (*i.e.*, transition planner) housed at the El Dorado correctional facility where many of the offenders with mental illness and other disabilities were located. The resource coordinator's caseload comprised offenders with mental illness and other disabilities returning to Sedgwick County (Wichita)—the largest county in the state. The COR-Pathways community resource coordinator helped offenders prepare for every aspect of their re-entry: treatment, housing, benefits, employment, and the profound psychological shift of returning to life in the community. In addition, SRS and DOC instructed the community resource coordinator to focus not exclusively on pre-release services, but also to develop relationships with service providers in the community as part of the coordinator's responsibilities.

As the brainchild of DOC and SRS, COR-Pathways was funded by both agencies. The warden of the El Dorado correctional facility had long recognized the need for improved transition planning, and devoted a portion of his existing discharge planning funds to the COR-Pathways position. SRS drew on federal dollars provided through a block grant to fund the other half. After six months of planning, COR-Pathways accepted its first client on January 1, 2003.

Knocking on community providers' doors

COR-Pathways first targeted offenders returning to Sedgwick County because of the longstanding commitment of the county's mental health center, COMCARE, to serve people released from prison. The head of COMCARE actively participated in a countywide initiative to improve offender re-entry and consistently promoted the responsibility of the mental health system to serve this population.

But many community providers in Kansas did not necessarily share this commitment. In fact, across the state, community mental health centers were generally reluctant to serve, at least knowingly,

people with criminal records. Some refused outright to serve clients leaving prison. Others simply declined to make appointments while offenders were still incarcerated, ensuring a four- to six-week delay in treatment once they were released.⁴

After hearing about community mental health centers' resistance to serving people released from prison (who had been referred by COR-Pathways planners), SRS Secretary Schlansky decided that every community mental health center's contract should specifically require that services be provided to this population. In 2003, the contracts were revised accordingly. In some ways, these contract modifications were nothing new; community providers had always been required to treat offenders who fit their priority population. But even if the revised contracts did little more than explicitly emphasize existing requirements, they demonstrated SRS's commitment to ensuring that individuals with mental illness received the services to which they were entitled.

Developing an informal specialized parole caseload

During 2001 and 2002, when the seeds of COR-Pathways were being planted, another DOC staff member developed an interest in serving offenders with mental illness. A parole officer in the Sedgwick County office with a background in social work realized that parolees with mental illness needed a level of support that most officers could not provide. Using her training, this officer spent extra time helping parolees with mental illness gain access to the services they needed. She advocated for these parolees at mental health clinics, found them supportive housing, and helped them manage their medications. She also notified the regional director of her willingness to take mental health cases. Her request was granted, and gradually an informal specialized parole caseload for offenders with mental illness was developed.

⁴ This reluctance among community providers to serve people who have been incarcerated is not unique to treatment providers in Kansas.

In the face of budget shortfalls and concerns including—but not limited to—liability and the safety of staff, community mental health

agencies across the country often focus their efforts on populations that are not involved with the criminal justice system.

IV. Breaking New Ground: 2003–2005

Increasing SRS involvement

The collaborative origins and funding of COR-Pathways did not immediately carry over to its day-to-day operations. Soon after the program began, the SRS staff members involved in its design left the department. So, for the first year of the program, SRS involvement amounted to little more than check writing.

Kansas' selection for the CSG/NIC technical assistance project in the fall of 2003 brought SRS back into the COR-Pathways fold. To prepare for the initial site visit, SRS staff met regularly with DOC and became more engaged in the daily administration of COR-Pathways. In the first year of the CSG/NIC technical assistance project, DOC and SRS established a second COR-Pathways position, this one at the Lansing correctional facility.

Formalizing specialized parole caseloads

As COR-Pathways proceeded fitfully through its first several years, the move toward specialized parole caseloads gradually progressed. The informal specialized parole caseload in Wichita garnered acclaim from community providers, who appreciated the added expertise and support and the ability to centralize their communications with one officer. Based on this feedback, the southern regional parole director established a second specialized caseload in Sedgwick County in the fall of 2003. As he reflected recently, “the positive response from community mental health providers and the improved results for offenders made dedicated caseloads a clear win-win situation.”

Meanwhile, in the northern parole region, several officers in Shawnee County (Topeka) had also been focusing on parolees with mental illness, developing closer relationships with community mental health centers, and educating themselves about how to effectively serve offenders with mental illness. Just as in Sedgwick County, their organic, self-directed

initiatives were eventually formalized. The northern parole region established a specialized caseload in Shawnee County in the spring of 2005. And in the fall of 2005, two more specialized officers were added in Wyandotte County, bringing the total number of specialized parole officers across the state up to five.

It is no coincidence that the specialized caseloads were established in Kansas' largest parole districts. The high number of offenders returning to these districts allowed parole managers to gradually centralize mental health cases without any new funding. But this transition has been a mixed blessing for other parole officers. Mental health cases are among the most time intensive and complicated. Consequently, specialized caseloads in Kansas are smaller—between 40 and 50 cases—than the traditional assignments of between 60 and 80 cases. Fewer cases for specialized officers meant more for traditional caseloads, at times frustrating other staff in the parole division. This resentment notwithstanding, parole administrators have reported an interesting outgrowth from this trend; some general caseload officers have begun to employ strategies that the specialized parole officers use for their more difficult cases.

Opening community providers' doors

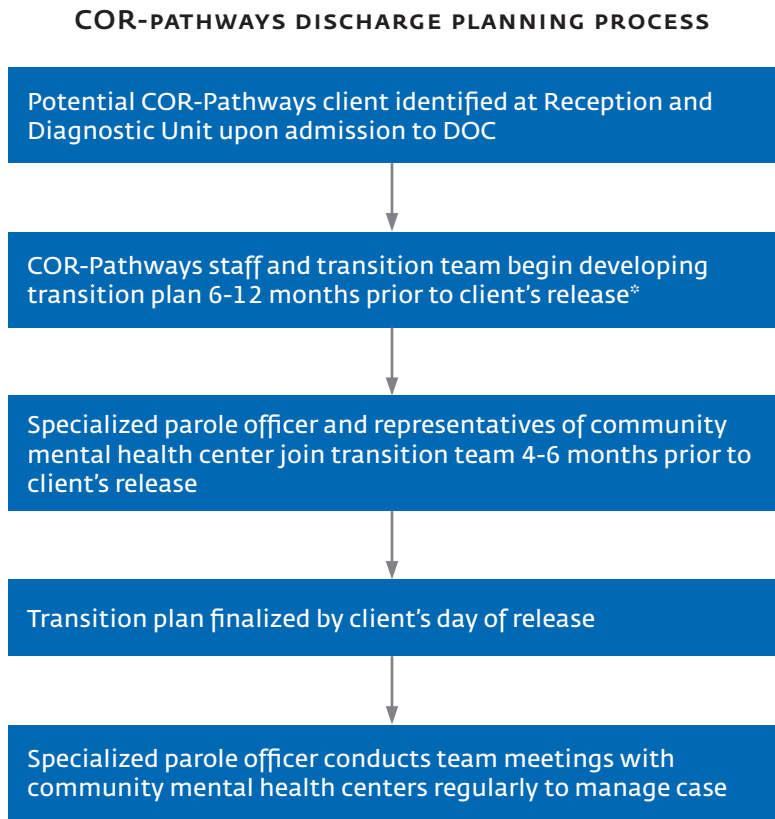
Over the course of 2003 and 2004, the combination of COR-Pathways, specialized parole caseloads, and the revised contract with SRS improved the receptiveness of community mental health centers to serving people released from prison. Nevertheless, COR-Pathways staff realized that a general willingness among mental health centers to provide services was not enough to guarantee this population access to mental health services. Re-entry is a complicated, time-sensitive process, and many people released from prison, even those receiving specialized services through COR-Pathways, were falling through the cracks. So, at the urging of the COR-Pathways transition planner, the El Dorado correctional facility entered into a memorandum of agreement with COMCARE, the mental health center in Sedgwick County.

The agreement laid out clear protocols for eligibility, referral procedures, and information transfer. For example, the agreement stipulated that no offenders would be denied services based on their housing status or criminal histories. In addition, COMCARE agreed to conduct telephone interviews with prospective clients at least 14 days before their release and to then specify exactly what information should be transferred from DOC. The COR-Pathways transition planner, parole officers, and the community mental health staff all found that the agreement helped clarify responsibilities and improve coordination. In addition—for the first time—SRS, DOC, and COMCARE had a clear picture for how individuals were enrolled in the COR-Pathways discharge planning program and transitioned back into the community.

Providing improved services behind the walls

After a considerable effort to improve the delivery of services by community-based providers, DOC officials turned their attention to Correct Care Solutions (CCS), which provides mental health services to people while they are still incarcerated. In late 2004, the DOC contract with CCS was up for renewal. DOC re-entry staff used this opportunity to recommend CCS take additional steps to prepare offenders for re-entry, and many of these recommendations were incorporated into the new contract.

Providing medication to people with mental illness upon their release from prison was the first issue that DOC tackled. Under the previous contract, CCS was required to provide 14 days of transitional medications. This supply usually ran out before the



*Time frames vary depending on when COR-Pathways staff receive a referral and on the complexity of the transition plan.

person released from prison could obtain replacement medications in the community. Furthermore, the mental health formulary relied heavily on an older generation of medications that were less effective and less popular than their newer counterparts. In the new contract, DOC required CCS to enter into joint purchasing agreements with county jails and other large buyers in order to cut costs. The contract also required expanding the formulary to include newer medications, such as atypical antipsychotics. DOC also required CCS to provide a 30 day supply of post-release medication and 15 more days' worth of prescriptions.

Along with access to newer medications and longer transitional supplies, the DOC contract increased the size of the CCS transition planning team. Previously, CCS employed two transition planners to work with offenders with medical and mental health problems. The new contract increased this to six and required that the transition planners provide 90 days of aftercare. This could mean, for example, ongoing work with community providers to help clients obtain housing or mental health services even after they had re-entered the community.⁵

Sharing data

In order to maximize the impact of the new contract and the collaboration bred by COR-Pathways and other joint initiatives, information sharing between DOC and SRS became crucial. The ongoing collaboration between DOC and SRS led the two agencies to turn their attention from the prison's back door (up until 2005, DOC and SRS initiatives related to offenders with mental illness had focused on re-entry) to its front in order to gain a better understanding of the individuals entering the correctional system. But evaluating the COR-Pathways program, for example, would require DOC and SRS to pull information from two entirely separate data systems. This process led to discussions about how DOC

could obtain better data about the mental health treatment history of offenders upon intake.

Despite the considerable overlap in their populations, DOC and SRS had never attempted to cross-reference their data systems. But to the surprise of DOC and SRS managers, information technology staff in both departments agreed that it would not be difficult. The question then became whether there was, in fact, significant crossover between data in the two systems. So DOC sent information from one month of admissions—278 offenders—to SRS, where it was matched with the Automated Information Mapping System (AIMS), the data system into which community mental health centers across the state regularly input data. Fifty-four of the 278 intakes matched, meaning they had some history of mental health treatment in Kansas. Clearly data matching was not only possible, but also worthwhile.

After their success obtaining mental health data for new intakes, DOC and SRS staff investigated whether the same could be done with the state's substance abuse and Medicaid data systems. Once again, information technology staff in those systems obliged. By the end of 2005, DOC and SRS had laid out a system for the AIMS database to obtain information on the mental health, substance abuse, and Medicaid history of every admitted offender. The plan called for DOC to send records of new intakes at the beginning of every week to information staff at SRS. The staff would cross-reference the data and send back reports using fields that DOC had requested. DOC would then use this information to inform the treatment and housing of offenders, to obtain more detailed information from local providers, and ultimately to plan for offenders' release. The new data matching protocol was approved by both DOC and SRS and at the time of this writing was scheduled to launch in August 2006.

While few technological obstacles to the data matching protocol had arisen, concerns about sharing privileged information did surface. In fact, the

⁵ Because these new services were embedded into a multi-million dollar contract, it is difficult to isolate their impact on the size of the contract. The expense of added staff positions

was clearly passed along to DOC. But the bulk medication-purchasing program was designed to bring down prices and may have actually reduced the overall cost of mental

health medications, even with the reliance on newer generation medications and longer transitional supplies.

DOC data matching strategy appeared to run afoul of the Health Insurance Portability and Accountability Act (HIPAA), which prevents the sharing of privileged treatment information without an individual's consent. Recognizing this obstacle, SRS and DOC staff took the issue to the Kansas Legislature, where they found a receptive audience.

In 2004, legislative leaders initiated a broad review of the entire criminal justice system—the Kansas Criminal Justice Recodification, Rehabilitation and Restoration Project (or 3Rs) committee.⁶ The project's behavioral health subcommittee was already well aware of the work on COR-Pathways and offender re-entry, and when SRS and DOC raised the issue of improved data sharing, the committee proposed legislation to make it possible. HB 2130, which was passed during the 2005 session, amended an existing law allowing treatment agencies to share privileged information for the purposes of continuity of care. The bill added juvenile and adult correctional facilities to the list of agencies that could share such information, thus making the DOC data matching scheme viable.

Replicating the program

Pleased with the momentum generated by their pilot project in Wichita, DOC officials turned their attention to other counties receiving large numbers of people released from prison. In the spring of 2005, officials from Kansas attended a meeting of the four CSG/NIC learning sites. Along with SRS and DOC staff, the Kansas team included the head of the mental health center in Wyandotte County (Kansas City)—the Wyandot Center—as a representative from the community mental health system.⁷

Based on the initial discussions at this forum, staff at Lansing correctional facility established an agreement with Wyandot Center similar to the El Dorado memorandum of understanding (MOU) with COMCARE. But the Wyandot Center was willing to go one step further. Instead of using

phone calls, the Wyandot Center agreed to conduct meetings in person, at the prison, for all people with mental illness returning to Wyandotte County. To make this possible, DOC agreed to transfer people with mental illness returning to Wyandotte County to the Lansing facility, the closest facility to the county, prior to their release. At the time of this writing, plans to ensure this “in-reach” by community-based providers remain under development.

V. Evaluating Program Impact

Early in 2005, facing budget cuts from the legislature and a shrinking allocation from the federal government, SRS budget officials decided that they could no longer apply a portion of their federal funds to the budget for the COR-Pathways program. As a result, plans to expand the program were scrapped, and its general existence was jeopardized. SRS program staff, now engaged in the daily administration of COR-Pathways, urged its continuation. Based on this recommendation, SRS decided to use a portion of its state funding to keep COR-Pathways in operation.

The near interruption of COR-Pathways funding and the plans to replicate the program in another county highlighted the need for a data-driven analysis of COR-Pathways. Such information could be used to make the case for continued funding and to inform the design of the program in Wyandotte County.

State officials were interested in the impact of the program on participants' engagement in mental health services and, more importantly, their successful completion of parole. They also realized they had a more immediate gap in information: how many people were eligible for the COR Pathways program, how many people actually participated in the program, and how many completed it? As DOC and SRS continued to increase their activities to improve collaboration between their two systems—

⁶ For more on this initiative visit <http://www.kansas.gov/RRR>

⁷ The difference in spelling between the Wyandot Community Behavioral Health Center and Wyandotte County is intentional. The former

is a private nonprofit agency and is not affiliated with the county government.

with improved transition planning, specialized parole officers, in-reach by community providers, and data sharing—officials were anxious to see the results of the COR-Pathways program evaluation.

Yet neither DOC nor SRS had the funds available to conduct an impact evaluation. By this point, Kansas had been working with consultants from CSG/NIC for more than a year. Based on these consultants' familiarity with the state's criminal justice and mental health systems and an opportunity they saw to gather data that could inform future decisions in Kansas, CSG/NIC recommended that the Bureau of Justice Assistance (BJA) Corrections Options Technical Assistance Program fund a study to examine the impact of the COR-Pathways program. BJA agreed, and the study, drawing on data collected from the DOC and SRS systems over a two year period, began in late 2005; it was completed in spring 2006. The study comprised two analyses: The first profiled the characteristics of released individuals with serious and persistent mental illness (SPMI)⁸—including those who participated in the COR-Pathways program—as compared with the general population of released individuals. The second analysis assessed the COR-Pathway program's impact.

A. Profiling the characteristics of releasees with SPMI

Before determining the impact of the COR-Pathways program, state officials were interested in learning more about the releasees whom the program was designed to target. The first analysis produced two profiles of released individuals with SPMI. Researchers 1) gathered data comparing released offenders that were diagnosed with an SPMI with the general population of released offenders and then

2) compared the individuals with SPMI who participated in the COR-Pathways Program with those who did not participate in the program.

For the first profile, researchers looked at data from July 1, 2002 to June 30, 2004 and found that 1,111 of the 6,363 offenders released from Kansas correctional facilities (or 17 percent) were diagnosed with a serious and persistent mental illness.⁹

Several characteristics distinguished the offenders with SPMI from the general population of released offenders. These individuals were:

- More likely to be younger and female
- More likely to have higher substance abuse and social needs as measured by DOC assessment instruments
- More likely to have been convicted as a sex offender
- More likely to have a record of committing a felony against a person
- More likely to have higher “recycle rates”: 34 percent of the SPMI population had more than one release during the two-year study period compared to 22 percent of offenders without SPMI.¹⁰

For the second profile, researchers compared the characteristics of releasees with SPMI who participated in the COR-Pathways program (individuals who received COR-Pathways discharge planning and a specialized parole officer) to those with SPMI who did not.¹¹

Compared to other offenders with SPMI, the COR-Pathways participants were:

- Even more likely to be younger

⁸ An SPMI diagnosis indicates that individuals scored a three or higher on the DOC mental health assessment instrument.

⁹ Tony Fabelo and Angie Guenter, “Analysis of Mental Health Population in KDOC and Impact of Pathway Diversion Program: Report 1, Profile of Populations”, November 20, 2005. Bureau of Justice Assistance, Corrections Options Technical Assistance Program. Note: The findings reported in this section are based on samples of varying size of the 1,111 offenders

with SPMI, due to the availability of data.

¹⁰ Offenders with SPMI were somewhat more likely to serve shorter sentences than offenders without mental illness. More than half of the offenders with SPMI (51 percent) served less than six months before their first release compared to offenders without severe and persistent mental illness (46 percent). This may indicate that individuals with SPMI were serving short prison terms for violations of their conditions of parole or probation. A

survey of parole officers anecdotally suggests that COR-pathways participants may have had difficulty complying with the rules of supervision, medication, and treatment, which further illustrates the challenges that this population faces reintegrating into community settings.

¹¹ Only 38 of the 1,111 offenders with SPMI (3.4 percent) released during the two-year period of the study participated in the program.

- Even more likely to be convicted of sex offense felonies
- Even more likely to have one or more person felonies

Unlike other offenders with SPMI, however, the COR-Pathways participants were:

- All male
- More likely to have lower drug abuse and needs scores

B. Assessing the Impact of the COR-Pathways Program

After developing a better understanding of the releasees whom the program was designed to target, researchers conducted a second analysis to determine the effect of the COR-Pathways Program on offenders' ability to successfully transition back to the community in the two years after their release. Researchers analyzed the revocation rates of 27 COR-Pathways participants against the rates of offenders from three comparison groups drawn from the 1,111 individuals with SPMI released between July 1, 2002 and June 30, 2004. The three comparison groups included:

- 76 offenders with SPMI who receive specialized parole officer (PO) services
- 30 offenders with SPMI who were offered but refused specialized PO services
- 81 offenders with SPMI and high substance abuse scores that received "treatment as usual"

Researchers used DOC admissions records to determine how many offenders from the study were

subsequently admitted to prison during the follow-up period ending in January 2006.¹²

The findings were inconclusive and did not indicate that the COR-Pathways program had an obvious effect on revocation rates:

- Individuals from all four groups (the COR-Pathways group and the three comparison groups) had high rates of parole revocation, and COR-Pathways participants had higher rates of revocation (74 percent) than those who received only specialized PO services (51 percent), those who refused the specialized PO services (60 percent), and those who received treatment as usual (62 percent).
- The majority of revocations for individuals in all four groups occurred within one year after their release.¹³

C. Interpreting the Findings

The apparent limited impact of the COR-Pathways program can be attributed to a number of factors. While revocation rates were very high for all individuals in the study, they should be viewed in the context of a state with relatively high rates of revocation for all releasees.¹⁴ Furthermore, a majority of COR-Pathways participants had their parole revoked for administrative reasons (such as technical violations), which may suggest broader problems with the revocation practices for this population.

Another possible explanation for the high revocation rates is that many COR-Pathways participants may not have received the full extent of the program's services. Most of the individuals whose parole was revoked had short stays in prison after the revocation, making the development of treatment plans, the delivery of services, and additional transitional planning difficult.

¹² Therefore, regardless of their release dates, all study participants had at least a two-year follow-up period from their last release date. Some cases had to be dropped from the study groups during the follow-up due to missing information.

¹³ 80 percent of the COR-Pathway participants, 79 percent of those receiving only specialized PO services, 78 percent of those who refused the specialized PO services, and 86 percent of those who received treatment as usual were revoked within 12 months.

¹⁴ Kansas has a high revocation rate with 55.2 percent of all offenders released from prison in Fiscal Year 2003 having their parole revoked within two years (Kansas Department of Corrections, Statistical Profile, FY 2005. "Table 9 Return Rate of Offenders Released From KDOC Facilities During FY 1997–2004 by Type of Readmission and Length of Follow-up Period")

The inconclusive findings may also be the result of problems with the implementation of the COR-Pathways program rather than flaws in the program design itself. For example, many participants experienced significant delays between their releases from prison and their first appointment with a community mental health provider: approximately 38 percent of COR-Pathways participants waited more than 14 days for their first appointment. These delays may be due to the fact that community mental health centers were *not* conducting in-reach to DOC facilities to assist with participants' transition plans prior to their release and as a result were not fulfilling their role in the COR-Pathways program.

The fact that DOC and SRS use different definitions of SPMI represents an overarching problem with program implementation. For example, participants considered eligible for the program under the DOC definition who are referred to community mental health services after their release might not be considered eligible under the SRS definition, and as a result may not be able to access these services.

Finally, the experimental design of the COR-Pathways evaluation made it difficult to determine the impact of the program; the sizes of the groups studied were too small to establish statistically significant comparisons.

VI. Looking Ahead: Challenges

Despite its limitations, the study described above highlighted some important questions for DOC and SRS to consider:

- (a) Does it make sense to focus so much attention on a pilot project that serves only a fraction of the population with SPMI released from prison?
- (b) What policies exist that encourage such high rates of revocation among individuals with SPMI? What is the culture among parole officers and their relationship with community service providers that might contribute to these high revocation rates?
- (c) Why are program participants revoked so quickly, typically within one year of release?

- (d) Why do program participants in particular have such a difficult time transitioning back to the community?

These questions correspond to the challenges, described below, that DOC and SRS face as they look to strengthen their collaboration and the impact of their work.

Community-based service providers

As jail and prison officials are wont to point out, corrections agencies are uniquely unable to choose their clientele. No corrections commissioner, let alone an individual warden, can refuse to incarcerate an offender remanded to them by the courts. In fact, it is the corrections system's very inability to opt out of serving offenders with mental illness, and the budgetary and operational strains resulting from serving this population, that led DOC officials in Kansas to improve re-entry strategies for this population.

Admission criteria in the mental health system, on the other hand, are not so simple. Like other states, Kansas has established a priority population for public mental health services—people with serious and persistent mental illness. But community-based mental health providers throughout the state have long erected obstacles for qualified offenders seeking services. As mentioned previously, providers in some counties have completely refused to serve all or some portion of formerly incarcerated individuals; in other counties, mental health centers have merely declined to set appointments prior to release, creating a four- to six-week lag time that often leads to decompensation and reincarceration. Officials in Kansas report that the number of obstacles for offenders seeking services has decreased, but challenges remain.

The reluctance of community providers to serve offenders stems from a combination of concerns. Mental health centers are justifiably worried about safety, liability, and reliability with some segments of the offender population; nevertheless, care must be provided to these individuals. It bears noting that within this context of closed mental health system doors, providing effective treatment to people with mental illness leaving state prison requires more

than just willingness—but rather proactive engagement—to enable them to overcome the psychologically and logistically complicated transition of returning to the community. Thus, community mental health providers are generally willing to do a little less for offenders, when what is needed is a little more. This problem is hardly unique to Kansas, and the experiences there reflect that progress is incremental.

Resource constraints

The limited amount of resources in the corrections and mental health systems is a significant challenge. Kansas, like states across the country, fought budget shortfalls throughout the early part of this decade. During the same time period, the corrections population was steadily increasing, while the number of state-sponsored mental health beds had been cut to 340, down from 1,000 just 15 years earlier.¹⁵

The lack of resources has also been apparent in the limited number of specialized staff available to improve the transition and community supervision of offenders with mental illness. Anecdotal evidence from across the state suggests that offenders receiving these specialized services benefit tremendously. Unfortunately, as is the case with many such programs, the number of people served is only a fraction of the total number of people in need. COR-Pathways, which targets offenders with various special needs, served 38 mental health cases in its first two years; during the same period, DOC released 1,111 offenders with SPMI. The percentage of offenders with SPMI supervised by specialized parole officers was similarly small.

These factors have converged to place enormous strains on the prisons and the community mental health systems. Officials in those systems have been hard-pressed to maintain a basic level of services for all of their clientele, let alone expand services to a traditionally neglected population.

Staff specialization

Kansas recognizes that it does not have enough transition planners to serve the population of individuals with mental illness leaving the state prison system, but even if the number of specialized transition planners was substantially increased, many offenders with mental illness would still be served by non-specialized staff. The challenge is using the specialized programs as a means to introduce new strategies system-wide. But in Kansas, as in many other jurisdictions, that process has been slow. For example, plans for regular cross-training between all parole officers and community mental health providers remain on the drawing board. This is not to say that system-wide training modifications are easily achieved, but efforts to enhance the ability of all corrections staff in Kansas to serve offenders with mental illness have lagged behind the establishment of specialized positions.

The importance of moving beyond specialization is particularly evident in the parole system. As discussed above, the number of parolees in larger counties allows for the centralization of mental health cases without overloading general caseloads. But in a smaller parole district, with perhaps one or two officers and around 100 cases, there are simply not enough parolees with mental illness to justify a dedicated caseload. In areas like these, where a substantial number of offenders with mental illness still return, traditional parole officers will continue to bear the burden of supporting offenders with mental illness.

VII. Looking Ahead: Opportunities

DOC and SRS must confront the challenges described above in order to address the issues raised by the study of the COR-Pathways initiative. At the

¹⁵ Association of Community Mental Health Centers of Kansas, 2006 Legislative Priorities, <http://www.acmhck.org/index.asp?NID=159>

same time, these challenges must not overshadow the extraordinary partnership that has emerged between DOC and SRS and the opportunities that exist as a result of this partnership.

The leaders of both systems have developed a shared commitment to serving and improving outcomes for individuals with mental illness. As former SRS Secretary Janet Schlansky remarked just before her retirement, “I have spent more time talking to corrections officials in the past year than in the previous 28.” Secretary of Corrections Roger Werholz has been equally supportive of efforts to better serve offenders with mental illness. As he is fond of saying, “We have 29 community mental health centers in Kansas. We want DOC to be considered the 30th.” But the commitment of leadership does not stop with DOC and SRS. The heads of the community mental health centers in Sedgwick and Wyandotte counties have committed time, staff, and resources far beyond what is technically required. As the collaborative efforts reflect, these officials and staff have backed up their words with resources and action. Much has been accomplished, and a foundation exists (which is hardly the case in many states) upon which the two agencies can build.

New political momentum and the infusion of new resources are two recent developments indicating that DOC and SRS will indeed capitalize on their previous efforts to bring their agencies closer together. As an outgrowth of the Kansas 3Rs Committee, a new interagency coordinating entity called the Kansas Re-Entry Policy Council is being established to formalize collaboration among state agencies. With the full support of Governor Kathleen Sebelius, U.S. Senator Sam Brownback, and a major commitment from the JEHT Foundation, state leaders are embarking on a comprehensive statewide strategy to ensure the safe and successful re-entry of people released from prison. A portion of the strategy and funding may be dedicated to the transition of offenders with mental illness. One of the potential new uses for this funding is the establishment of DOC staff positions within community mental health centers. These positions would offer

the kind of case management and in-reach that the Wyandotte Center is planning on its own.

Reducing recidivism rates, easing the burden corrections staff shoulder to care for the state’s population with mental illness, and improving the effectiveness of service delivery are all factors that motivate state leaders and staff in institutions and communities to improve the response to people with mental illness involved with the corrections system. But at its core, their commitment stems from the belief that helping offenders with mental illness successfully return to their communities is the right thing to do. It is this belief, more than anything else, that keeps Kansas striving to improve the response to people whose needs are too often overlooked.

VII. Dimensions of Collaboration

The account of Kansas’ work during the last five years around re-entry for offenders with mental illness is, in many ways, a story about cross-system collaboration. Most of the initiatives described in this case study are joint endeavors between DOC and either SRS or a community provider. Those initiatives that are solely the purview of DOC, such as specialized parole caseloads, are important precisely because they improve the ability of the corrections system to work with mental health partners.

Along with supporting the efforts in Kansas and other state and local jurisdictions, the CSG/NIC technical assistance project from which this case study emerged is intended to help corrections and mental health agencies across the country better understand what cross-system collaboration entails. The chart below describes the collaboration in Kansas according to four dimensions: systems, services, knowledge, and resources. Within those four dimensions, the chart identifies different aspects of collaboration and how they have played out in Kansas. This analysis is not meant to be comprehensive, but rather to provide a framework that may guide corrections and mental health agencies in other jurisdictions striving to better serve their shared population.

	ACTIVITIES	CHALLENGES	LOOKING AHEAD
SYSTEMS			
Joint oversight	<p>The administration of collaborative initiatives has been overseen by <i>ad hoc</i> groups of staff and agency directors.</p> <p>A special legislative committee reviewing the entire criminal justice system has worked closely with DOC and SRS staff to provide legislative support related to re-entry of offenders with mental illness.</p>	<p>The lack of a consistent joint oversight group has, at times, threatened program continuity and hampered communication.</p> <p>The relationship between the legislative committee and the DOC and SRS collaborative efforts is not well defined.</p>	<p>DOC and SRS are considering plans to formalize a cross-agency oversight group to coordinate their joint initiatives.</p>
Memoranda of understanding	<p>DOC and SRS created an MOU to describe the funding and oversight of two specialized transition planner positions (COR-Pathways).</p> <p>DOC has also established separate MOUs with community mental health centers in two of the largest counties.</p>	<p>The MOU is limited to the two joint positions and does not address other DOC and SRS staff.</p> <p>Creating unique agreements with individual community mental health centers is time-consuming and incremental, but is difficult to avoid in a decentralized service system.</p>	<p>There are no plans to extend the parameters of the initial MOU.</p> <p>DOC is considering the establishment of MOUs with community mental health centers in several more of the state's larger counties, to which the bulk of offenders return.</p>
Target population	<p>Two of the state's largest community mental health centers have agreed to give priority to offenders with SPMI leaving prison.</p>	<p>The overall SRS target population is not limited to people with mental illness. This creates confusion for DOC staff in understanding the scope of their joint initiatives.</p> <p>Offenders with mental health needs who do not fit the SPMI definition tend to be deprioritized for services in the community.</p>	<p>The jointly funded specialized transition planners (COR-Pathways) will continue to serve a broad target population, including offenders with mental illness, developmental disability, and advanced age. DOC plans eventually to train all staff on which offenders are eligible for this service.</p>
Boundary spanners	<p>Specialized parole officers and discharge planners (COR-Pathways) serve as boundary spanners, working closely with community mental health center staff, benefits officials, and other service providers.</p>	<p>There are few boundary spanners to serve the many offenders whose needs span multiple service systems.</p>	<p>DOC and SRS eventually hope to expand the number of specialized positions.</p>
Cross training	<p>Cross-training has been limited to <i>ad hoc</i> interactions between specialized staff and isolated treatment providers.</p>	<p>The lack of regular cross-training limits the impact of collaboration to specialized staff members.</p>	<p>There are plans to establish regular cross-training across the state.</p>
SERVICES			
Commitment to provide services	<p>DOC and SRS have made improved re-entry services a priority, as have select community providers across the state.</p>	<p>Many community mental health providers across the state remain reluctant to serve offenders and unwilling to actively facilitate their transition from prison.</p>	<p>DOC and SRS plan to continue working with community providers to address their concerns about serving offenders.</p>

	ACTIVITIES	CHALLENGES	LOOKING AHEAD
Data sharing at client level	Specialized discharge planners and parole officers regularly share client-level information with community providers.	Non-specialized staff share client-level data on a more intermittent basis.	DOC and SRS hope that expansion of specialized staff and improved training for all staff will enhance client-level data sharing.
Systemic data sharing	DOC has established a system for matching intake records with the mental health, substance abuse, and Medicaid data systems.	The system is not yet operational, so its effectiveness has yet to be established.	DOC plans to launch this system in August 2006.
Continuity of care	DOC's contracted mental health services provider provides 30 days of transitional medication (as opposed to 14) and 90 days of aftercare. Some of the added medication costs are offset through collective purchasing with local jails.	Contracted transition planners are still learning how to navigate the many systems and processes with which offenders with mental illness are involved upon their release.	DOC plans to continue to train contracted transition planners.
KNOWLEDGE			
Information on demographics and service needs	DOC has estimates about the percentage of offenders with mental health needs based largely on percentages receiving medication.	DOC and community providers do not use the same classification system to describe severity of mental illness. SRS has no systemic data on the percentage of mental health clients that have been incarcerated.	
Program evaluation	No systemic program evaluation of the specialized transition planning or parole positions has been conducted.	The lack of a program evaluation has made it difficult to clarify the difference between specialized and traditional transition planning.	
Impact evaluation	An impact evaluation of the specialized discharge planning program was completed.	Evaluators are unable to develop a matched comparison group due to sample size and data limitations, yet in spite of the limited number of people involved in COR-Pathways, most were revoked within the first year of their release from prison.	DOC and SRS will: (1) develop a clear service model for the COR-Pathways program; (2) identify and access a menu of community services available to COR-Pathways participants upon their release from prison; (3) select additional parole officers interested in working with the COR-Pathways target population; and (4) re-evaluate the program for potential impact.
RESOURCES			
Joint funding	DOC and SRS have jointly funded two specialized discharge planning positions.	Plans to expand the number of jointly funded positions have been delayed due to lack of resources.	
Resources leveraged	DOC and SRS have received funding from BJA to evaluate the COR-Pathways transition planning program.		A statewide legislative re-entry initiative is planned for 2006 and may provide funding targeted to offenders with mental illness.



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A publication of the Council of State Governments Justice Center prepared for the National Institute of Corrections

This document was prepared under cooperative agreement number 06HI01GJ19 from the National Institute of Corrections, U.S. Department of Justice. Points of view or opinions stated in this document are those of the author(s) and do not necessarily represent the official position or policies of the U.S. Department of Justice, nor the members of the Council of State Governments.

January 2007

Suggested citation:

Council of State Governments Justice Center. (2007). *Increasing Collaboration between Corrections and Mental Health Organizations: Kansas Case Study*. New York, NY: Council of State Governments Justice Center.