From Prison to Home:
The Effect of Incarceration and Reentry on
Children, Families and Communities

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Services Integration:
Strengthening Offenders and Families,
While Promoting Community Health and Safety

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Introduction

Offenders often experience multiple problems, such as health and mental health illnesses, the breakdown of family structures, and unemployment or low income leading to difficulties in accessing or sustaining services to meet their basic needs. In some cases, the adversity offenders confront affects only them and their families. However, often the impact is more widespread, negatively impacting the larger community. For example, some health conditions (e.g., asthma, diabetes, heart disease, or high blood pressure) primarily affect the quality of life of the offender and his/her family or household; the impact on the community is largely limited to strains potentially introduced by increased need for health services or funding to treat those who lack health care coverage. Others health issues, however -- such as human immunodeficiency virus/auto immunodeficiency virus (HIV/AIDS), Hepatitis B and C (HBV and HCV, respectively), sexually transmitted diseases (STDs, such as syphilis, gonorrhea, and chlamydia), tuberculosis (TB), severe psychiatric disorders, and substance abuse -- not only disproportionately affect offenders in correctional facilities and in the community (Hammett et al., 1999), but also pose potential threats to the well-being of family members and the public as inmates return to the community.

Single agencies are unlikely to have the human or fiscal resources to fully address the diverse needs of offenders and their families -- unless, of course, the agency deliberately has implemented case management procedures and erected partnerships to span organizational boundaries, or developed a "one-stop shop" model of service delivery. As Hammett et al. (1999) suggest, an integrated continuum of care with continuity of providers is probably the best approach for addressing the medical and psychosocial needs of offenders in correctional facilities and as they return to their home communities.

Service providers should consider addressing offenders' needs for service as critically important because of how heavily they impact the well-being of the entire community. The community can benefit greatly by investing in treatment and supportive services for ex-offenders (and their families) that demonstrably reduce recidivism, which entails harm to local property and people and engenders huge social costs for crimes committed, conviction, and incarceration of offenders (Jacksonville Community Council, Inc., 2001). In addition, improving the community-based service delivery for offenders also benefits other segments of society who depend on the same service network.

Recent research underscores the importance of pre-release preparation and initial post-release support in reducing offender recidivism (Nelson and Trone, 2000). The National GAINS Center for People With Co-Occurring Disorders in Contact With the Justice System, for example, has identified four key components to promoting successful re-integration, sometimes referred to as the "APIC" model. These include:

- Assessment of offenders' clinical and social needs, and the risks they pose to public health and safety.

- Planning for the treatment and services required to address these needs.

- Identifying required correctional and community programs responsible for post-release services.

- Coordinating the transition plan to ensure appropriate service delivery and mitigate gaps in care.

Inter-agency collaborations, such as the one implied by the APIC model, have attracted considerable interest in recent years as vehicles for introducing more comprehensive service provision, while redressing fragmentation in health and human service systems. Service fragmentation is characterized by numerous, uncoordinated programs (with different administrative structures, rules, and eligibility criteria) resulting in such problems as delayed service delivery, inadequate responses, or, in some instances, failure to provide needed services. One factor contributing to fragmentation is the limited focus of many programs that seek to prevent or mitigate specific, often narrowly-defined problems or behaviors, rather than responding holistically to the needs of individuals. While there are various explanations for the existence of fragmented systems (e.g., tightly constrained organizational missions or reliance on categorical funding), there is growing recognition that collaboration across institutional lines may be beneficial not only in addressing the multi-faceted needs of clients who require health and human services, but also in making more efficient use of limited agency resources (Morley et al., 1998).

Integration of services occurs at the systems level, involving the coordination of policies and procedures of different institutions to achieve a multiorganizational infrastructure designed to ensure that individuals do not "fall through the cracks" formed by the boundaries of various institutional domains and service providers. Major objectives of services integration include:

- Identifying gaps in service delivery and assigning organizational responsibility for implementing needed services.

- Reducing barriers to obtaining services (e.g., streamlining applications procedures, reducing geographical distance between provider and client, decreasing unacceptably long waiting periods before treatment commences).

- Conserving institutional resources by sharing some efforts across systems or by reducing unnecessary duplication of efforts.

Services integration necessitates the development of collaborations across public agencies, or between public and private organizations. Such collaboratives may facilitate service coordination using various mechanisms, including: centralized intake, assessment, or referral; increased information sharing, possibly using transparent or linked management information systems; cross-disciplinary training and case staffing; joint fund-raising or resource sharing; and co-location of staff.

Medical and Psychosocial Issues that Shape Individual and Family Service Needs

Inmates have more health and psychosocial problems than the general populace. Factors that contribute to diseases among offenders include high-risk lifestyles, such as (Field, 1998; McVey, 2001; Nicodemus and Paris, 2001):

- Heavy use of tobacco, alcohol, and drugs.
- Injection drug use, or tattooing.
- Multiple sex partners.
- Unprotected sex, in or out of prison.
- Transience, particularly if it involves homelessness.
- Financial instability.
- Poor or delayed access to health care and treatment
- Emotional circumstances characterized by the lack of supportive relationships.
- Overcrowded conditions, and movement among prisons that spreads contagion.

Although some offenders first experience health, mental health, and psychosocial problems in prison, the fact remains that most enter the criminal justice system with problems that span multiple domains. Prior to incarceration, most offenders have been seriously underserved in terms of medical care, drug treatment, and psychosocial needs in the community (e.g., many had not received primary medical or dental care in years (Hammett et al., 1999).

The 1997 Survey of Inmates found that nearly 31 percent of males, and 34 percent of females, reported a physical impairment or mental condition: 10 percent had physical problems, 10 percent reported emotional or mental conditions, 10 percent reported learning disabilities (e.g., dyslexia or attention deficit disorders), 4 percent had speech disabilities, 6 percent had difficulty hearing normal conversations even with hearing aids, 8 percent could not see ordinary newsprint while wearing glasses. Taken together, 25 percent reported either that they had

multiple impairments or that the nature of their impediment limited the kind or amount of work they could do (Maruschak and Beck, 2001). Overall, McVey (2001) estimates that 25 to 40 percent of inmates have significant health care conditions that require continuity of care upon release to the community.

Facilities within the federal prison system are accredited and routinely surveyed by the Joint Commission on Accreditation in Health Care Organizations (JCAHO); however, national uniform standards are not applied across all state correctional facilities. Accreditation of facilities within individual states may be mandated by their respective governing bodies, but there is no single entity to which all facilities are accountable. As a result, health services offered to incarcerated individuals vary significantly.

Despite limitations, the criminal justice system often represents the primary route to health and human services that offenders receive: poor health due to long-term neglect may be addressed for the first time during long incarcerations. Thus, some will return to the community in better condition than when they entered prison. Others, however, will continue to struggle with unresolved pre-existing conditions, experience deterioration in health exacerbated by prison circumstances, or contract new diseases while incarcerated.

Relatively little attention has been focused on proactive prevention in either the correctional environment or when offenders return to the community. Virtually all inmates and their families could benefit from wellness education emphasizing adequate and consistent medical care, disease prevention, and nutrition. In addition, female offenders and female partners of male offenders might benefit from receiving information on family planning and prevention of domestic violence.

Individuals who have chronic health conditions requiring medication or other treatment -- and those who have, or are at risk for, communicable diseases -- need to be assessed and given satisfactory care while imprisoned. In addition, they should be linked with community-based providers who can continue to support and adjust their health regimens, as necessary, when they exit the facility. Typically, employment -- with benefits or sufficient income to cover fee-for-services -- is a prerequisite for accessing community-based health care. Therefore, to avoid disruptions in access to health care, inmates who do not have jobs awaiting them when they return home should receive assistance in obtaining needed identification and in filling out and submitting applications for Medicaid, prior to leaving the facility. Other transition planning should include arrangements to ensure that:

- Medical records can be transferred from the correctional facility to community-based providers.
- Offenders will be supplied with reasonable amounts of prescribed medications to tide them over during their early days in the community.

HIV/AIDS. Prison rates of HIV positive and confirmed AIDS cases are five times the rates in the U.S. general population; increases in incarceration coupled with high rates of HIV infection present a public health challenge (Holmes and Davis; Maruschak, 2001). At the end of 1999, 3.4 percent of females and 2.1 percent of males (i.e., 24,607 inmates or 2.3 percent of the total population) in state prisons were HIV positive. However, there was considerable variation across states: 50 percent were concentrated in New York, Florida, and Texas. Thus, the 7,000 inmates known to be HIV positive in New York accounted for more than 25 percent of the nationwide total, and 9.7 percent of the state's custody population. In three states, more than 20 percent of female inmates were HIV positive: Nevada (30.6 percent), District of Columbia (22.4 percent), and New York (21.5 percent) (Maruschak, 2001).

As Hammett et al. (1999) note, policies for HIV counseling and testing have assumed increasing importance given the promising results of early intervention with antiretroviral therapy. HIV antibody testing policies vary across correctional facilities, but virtually all systems offer HIV testing on request or if there is clinical indication warranting follow up. Only 17 states mandate such testing either at intake or release.

Despite the fact that 79 percent of inmates reportedly had been tested in 1997, there are some concerns about the heavy reliance on voluntary testing in prison settings (Hammett et al., 1999; Zack et al., 2000):

- Many individuals who are truly at-risk are in denial, and will not seek testing. They may well continue to engage in high-risk behaviors while incarcerated, and they are likely to do so without the opportunity to access condoms or other prevention protocols that are available to the outside community.

- Others may avoid testing and counseling because of confidentiality concerns. Inmates' concerns for confidentiality may be more heightened than those of the general populace, precisely because they are incarcerated and unable to choose service providers they trust.

A related, and serious, concern for children and families, exists with regard to female inmates. Given that AZT treatment significantly reduces perinatal HIV transmission, 1995 Public Health Service guidelines recommend routine counseling and voluntary testing of pregnant women as early as possible. Nevertheless, fewer than half of state correctional systems routinely test all incoming women for pregnancy, although 84 percent test on request, and all test if there are clinical indications. Overall, state systems typically have the same policy for HIV testing of pregnant women as they do for all inmates; only seven states have mandatory or routine HIV testing for pregnant women, and voluntary or on-request testing for other new inmates (Hammett et al., 1999) Thus, review of HIV and pregnancy testing policies is desirable given current standards for treating HIV/AIDS.

While HIV and STD educational programs for inmates are becoming more widespread in correctional facilities, some gaps remain (Hammett et al., 1999):

- 71 percent of state/federal systems mandate HIV/STD education for incoming inmates; 20 percent mandate such training at release, and 51 percent report that participation is voluntary at release.

- However, few have implemented comprehensive or intensive HIV prevention programs. For example, while 60 percent of state/federal systems offer multisession prevention counseling in at least one of their facilities, only 31 percent of facilities incorporate such intensive approaches.

- Approximately 86 percent of facilities offer pre- and post- HIV-test counseling. Basic information on disease and the meaning of test results tend to be covered; however, topics pertinent to behavioral risk reduction -- safer sex practices, negotiating safer sex, safer injection practices, triggers for behavioral relapse -- are less commonly covered (except in multisession programs, where such discussions are more likely).

- The 1997 NIJ/CDC survey of HIV/AIDS, STDs, and TB in correctional settings revealed that 39 percent of state and federal facilities were not providing instructor-led HIV/AIDS sessions. In addition, 87 percent were not providing peer- led programs (Hammett, 1998). Peer-based services and prevention education programs can be cost-effective: peers often have more inherent credibility with offenders than correctional staff or health practitioners (Hammett et al., 1999). Peer educators can offer formal and informal services and support, such as introductory workshops (e.g., AIDS 101), individual and group risk-reduction counseling. They can organize informal networks for those receiving treatment or in need of emotional support. And, an added benefit is that peer leadership skills may open the door for offenders to find employment in the community in service organizations that serve advocacy or prevention education functions.

Offenders who are HIV positive or living with AIDS have considerable needs for health care and social support. Many learn their health status while incarcerated. Under such circumstances, release from prison marks the first time these individuals will have to manage the physical and emotional challenges of living in the community with a chronic or terminal illness (Conly, 1998). Like other offenders returning from incarceration, they may have no established network for health care, and also may be lacking an adequate social support system. Many return with inadequate information about sources of treatment and about transmission prevention that will protect their lives and the lives of others with whom they interact.

Other Communicable Diseases. Recent outbreaks of communicable diseases in correctional settings (e.g., TB in three Alabama state prisons in 1999 and in South Carolina in 2000, and HBV in Georgia in 2001) underscore the importance of identifying communicable

diseases, educating inmates and staff, and ensuring provision of appropriate treatment (Nicodemus and Paris, 2001). Nevertheless, very little information is available about the transmission of communicable diseases in prison, or regarding the spread of prison-incubated diseases to the outside community.

Less is information is available with respect to STDs, HBV, HCV, and TB in prison populations than is known about HIV/AIDS, reflecting the relative rarity of screening for these infections. For example, testing for STDs appears to be less widespread than for HIV/AIDS. Approximately 88 percent of state/federal systems have instituted mandatory or routine testing for syphilis at intake; 16 percent have mandatory testing for gonorrhea; and 8 percent conduct mandatory screening for chlamydia (Hammett et al., 1999).

Behavioral profiles and anecdotal reports consistently suggest that inmates are a high-risk group that is disproportionately infected with STDs; however, there is markedly little data available from state systems to document this. Although the policies of most state correctional systems require mandatory or routine screening of inmates for syphilis, 64 percent of state/federal systems did not report rates for this infection on the 1997 NIJ/CDC survey of HIV/AIDS, STDs, and TB in Correctional Facilities. Systems that provided information reported syphilis positivity rates of less than five percent (Hammett et al., 1999). Correctional systems apparently make even less attempt to routinely screen for gonorrhea or chlamydia (73 percent of state/federal systems do not have mandatory or routine gonorrhea screening, while 80 percent do not have mandatory or routine screening for chlamydia); however, those that do screen reported positivity rates of less than five percent for incoming inmates (Hammett et al., 1999).

Hammett et al. (1999) suggest that despite incomplete data, HBV and HCV are believed to be higher among inmates than the general population. Various studies report 22 to 41 percent of inmates were positive for HCV. HCV antibody positive rates are particularly high among IDUs and HIV-positive inmates; for example, 70 percent of female IDUs in a study of the Connecticut prison system were HCV positive, as were 36 percent of their sexual partners (Hammett et al., 1999).

The incidence of TB increased in the 1980s and early 1990s, spurring concerns not only because of the resurgence of the disease, but also because some cases -- including a 1991 outbreak among New York inmates -- were multidrug resistant. More recently, the incidence of TB has declined in both the general population and the inmate population. However, the incidence remains higher among inmates; improvements are needed in use of directly observed therapy, as well as support systems to monitor post- release adherence to treatment for TB disease and illness (Hammett et al., 1999).

Mental health. Estimates of the prevalence of mental illness among state prisoners vary widely, with some suggesting that more than one-third of the population have some degree of

mental health impairment. Existing mental illnesses may be exacerbated by incarceration, and conditions of incarceration may precipitate mental illness: prolonged idleness; the constant threat of violence; feelings of guilt, hopelessness, or helplessness may all contribute to psychological disorders.

Based on inmates who reported either a mental or emotional condition or an overnight stay in a mental hospital or program, Ditton (1999) estimates that 16 percent of the individuals incarcerated in state prisons are mentally ill:

- 53 percent were incarcerated for violent offenses.

- 69 percent were under the influence of alcohol or drugs at the time they committed the current offense.

- 20 percent had been homeless in the year preceding their most recent arrest.

In addition, more than 30 percent of mentally ill male offenders and 78 percent of females reported prior physical or sexual abuse (Ditton, 1999; Ortiz, 2000).

Roughly 12 percent received mental health therapy or counseling in 2000, and 10 percent received psychotropics, including antidepressants, stimulants, sedatives, tranquilizers, or other anti-psychotic drugs (Beck and Maruschak, 2001; Fabelo, 2000). Such estimates likely underestimate the need for mental health intervention since some individuals may refuse to participate or be ineligible to receive services; for example only 61 percent of mentally ill inmates reported receiving counseling, medication or other mental health services in prison (Ditton, 1999; Fabelo, 2000).

Between 15 and 20 percent of inmates who experience mental health difficulties, particularly those requiring psychotropic medications, have sufficiently serious disorders to require continuity of care (McVey, 2001). Older offenders, and those released after periods of incarceration, may experience depression, isolation, or loneliness, all of which can contribute to difficult community reintegration McVey (2001). Often, offenders returning to the community confront multiple challenges, including homelessness, unemployment, substance abuse, and impaired physical health (Conly, 1999).

Without adequate continuing care that coordinates treatment in prison with community-based services, released offenders are likely to deteriorate and run the risk of returning to prison.

Depending on the services received while in prison, offenders released to the community may need periodic re-assessment; continuing or new medication; or linkage to therapeutic and support groups.

Many mentally ill offenders are poorly equipped to advocate for their own welfare. Those who are fortunate can turn to family and friends for assistance in this regard; although such informal support networks may require preparation to effectively assume advocacy roles.

Also, mental illnesses often place severe strains on personal relationships. Thus, some offenders are estranged from family and friends, sometimes directly related to unstable or anti-social behavior stemming from their mental or emotional state. In such cases, offenders may require assistance managing not only their mental health needs, but also their efforts to re-build viable family and friendship networks.

Substance Abuse. While various studies capture offender self report of substance use, few studies systemically address the prevalence of drug abuse and drug dependency/addiction disorders in correctional facilities, as defined by the American Psychological Association's Diagnostic Statistical Manual, fourth edition (DSM-IV) (Mears et al., 2001). Nevertheless, substance abuse disorders are perceived to disproportionately affect incarcerated individuals: a recent study suggests that although only 21 percent of state inmates had drug convictions as their most current offense, 83 percent had some history of illegal drug use, and 70 percent reported having used drugs regularly (i.e., at least once weekly for a period of at least one month) prior to incarceration (GAO, 2001). Further, this population is significantly undertreated:

- With the exception of detoxification, most offenders have not received treatment in the community (Field, 1998).

- Only about 24 percent of offenders in state prisons participated in drug treatment programs while incarcerated (GAO, 2001).

- A SAMHSA study suggests that nearly half of state prisons offer no treatment, and even where treatment is provided, the programs are minimal and generally not provided in the segregated settings that have been found to be most effective. Thus, substance-abusing offenders returning to the community are at high risk of relapse, and possibly crime (GAO, 2001).

Periods of incarceration provide opportunities for treatment; however, treatment that stops with release from prison may not be effective: those who are coerced into treatment and remain substance free while in prison still are at great risk of relapse and recidivism when released (Field, 1998). Such individuals require a variety of services to support continued sobriety; and, at minimum, their family or informal support networks need to understand how to avoid enabling substance abuse.

Basic Survival, Family Dynamics, and Other Psychosocial Issues. Offenders are a diverse population, but they display certain common characteristics: low income, low level of education, disrupted home and family life, low level of job skills and employment experience,

and alcohol or drug addiction. Aside from medical, mental health, and substance abuse treatment, the key service requirements for those returning to the local community are related to immediate basic needs (food, shelter, clothing), ongoing personal support, housing, education, employment, and legal assistance. Correctional facilities offer some programs that assist offenders with meeting these needs. For example (GAO, 2001):

- 38 percent of inmates participated in education classes.

- 31 percent participated in vocational training programs, including in-class training or on-the-job training (not including institutional job assignments).

- 3 percent worked in income-producing prison industry jobs; although 60 percent had some work assignment (such as food service, laundry, grounds maintenance).

- 12 percent participated in pre-release programs covering such topics as: budgeting, stress reduction, and job interviewing skills.

These programs are necessary, but not sufficient to provide the level of assistance offenders require.

Offenders returning to the community are in need of safe, affordable housing. Some can return to the households they occupied prior to incarceration, or can find suitable accommodations with family or friends. However, many returning offenders are homeless -- a fact they may try to conceal to avoid delaying their early release. Some may need emergency shelter immediately on release, others may require transitional housing while gaining life, educational, and employment skills. Transitional housing services have an added benefit -- often they help offenders to establish residency credentials that facilitate their access to other needed services.

Families generally are expected to be the first line of defense in providing on-going personal support to their members; however, families of offenders sometimes are ambivalent about relatives returning to the community (Denckla and Berman, 2001; Jacksonville Community Council, Inc., 2001; Nelson and Trone 2000). Often the period of incarceration, the location or regulations of the facility, or the offender's own behavior have created physical or psychological distance. There may be unresolved issues related to harms inflicted on family members by the offender prior to incarceration. Newly released offenders may be unable to respond appropriately. Under stress, those with histories of violent behavior may lash out physically or emotionally. Parents who have been incarcerated may have added problems of reconnecting emotionally with their children, re-establishing custody rights or gaining visitation privileges, and covering financial support. Needed family services may include: family therapy, anger management, parenting classes, family bridge building and child reunification.

Offenders also need to acquire basic life skills, such as: time management, financial management, communication skills, problem solving, anger management and conflict resolution,

and decision making (Nelson and Trone, 2000; Rossman et al., 1999). Many people who end up in prison have impaired judgement -- they need to learn to wait before acting, consider several alternatives, and choose wisely among different courses of action. Cognitive-behavior therapy, which has become increasingly common in correctional environments, can help offenders acquire better skills. Nelson and Trone (2000) suggest that exposure to this type of intervention can help at any time, but is especially useful close to release.

Legal advice and assistance available during incarceration, or immediately thereafter, could help offenders anticipate and deal with legal issues before they spiral out of control (Jacksonville Community Council, Inc., 2001). For example, changes in family situations may warrant legal action. Offenders may want or need a divorce; or they may have to deal with property transfers. During their incarceration, fathers may not have paid child support, triggering legal actions; they may need to ask the court to alter payment requirements. Parental custody may have been lost or may require court action to re-establish.

Additionally, offenders may lose certain civil rights, and need legal assistance to understand the eligibility requirements and to petition the court to have their rights re-established. For example, Florida is one of 13 states that permanently disenfranchises ex-felons unless they are specifically granted clemency, for which those with only one felony conviction are eligible (Jacksonville Community Council, Inc., 2001). Only 24.5 percent of those eligible for clemency had it granted in l998-99. Applicants were denied if they still owed on sentence-imposed fines or had other outstanding debts that could be used to question their "readiness" for full citizenship. Some have questioned the constitutionality of this practice; nonetheless, this restriction on ex-felons diminishes their ability to rebuild lifestyles as stable productive citizens in the fullest sense -- and also undermines the civic life of communities impacted by high felony rates.

Collaborations Among Criminal Justice System and Health and Human Service Systems to Meet the Needs of Returning Prisoners and Their Families

Historically, corrections systems have focused their efforts only on offenders during the period of their incarceration, concentrating on such key concerns as security and classification, as well as some basic services, including: limited education and vocational training, basic health care, and the provision of some counseling (McVey, 2001). As such, the major concerns of correctional agents have been the offender -- exclusive of family considerations -- and protection of public safety. Consequently, few services were extended to families; in fact, family advocates often point to various prison policies or practices that adversely affect families (e.g., movement of offenders to facilities that a great distance from their home community, entrance procedures that are intimidating to visitors, waiting areas that are not family friendly).

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For the most part, state corrections systems really have not forged seamless connections to community-based criminal justice entities, much less to health and human service systems. For example, in evaluating the community-based case management model implemented to serve substance- abusing felons returning to targeted communities, Rossman et al. (1999) found that correctional facilities often did not even inform probation officers (POs) in advance of inmates' impending or actual release. Instead, prison administrators relied on offenders to report to their POs within stipulated time frames (e.g., 72 hours after return to the community). Although most complied, some did not, resulting in long time lags before individuals were linked to planned services.

Relatively little attention has been paid to developing substantial partnerships with health and human service providers or to linking inmates with community-based services. For those discharged without any further requirements for supervision, there is no guarantee that any entity will assume responsibility for assessing individual needs across different service sectors or for ensuring that needed services are forthcoming.

Individuals released with community supervision requirements, on the other hand, become the responsibility of the probation/parole system. Although probation and parole departments have varied across time and place, they typically have provided some direct or sub-contracted services to returning offenders, in addition to fulfilling their monitoring and oversight functions. Some offenders -- such as sex offenders and others assigned to specialty caseloads -- may receive more varied services, as well as increased service intensity. However, such involvement usually is not predicated on robust services integration across institutional lines, nor has it reached the level of comprehensive case management. In general, POs have huge caseloads, and are focused on primary mission of public safety, rendering them unlikely to provide the intensive, individualized assistance needed by many offenders.

In addition to parole and probation agencies, departments of health, alcoholism and substance abuse, labor, and social services have a stake in improving what happens to inmates after release -- since returned offenders comprise much of these organizations' client base. However, staff in these systems generally have had little or no access to inmates prior to their release. As Nelson and Trone (2000) suggest, involving such agencies in the custody side of programming could improve outcomes by creating a more transparent system of continuous care. In addition, correctional systems can benefit from both the infusion of expertise available from other substantive domains and the additional resources that may translate into stronger prison programs and services.

Increasingly, correctional systems have exhibited interest in developing partnerships with other institutional stakeholders (e.g., state health departments, community-based service providers) to conduct health screening, deliver health education, or incorporate transition

mechanisms such as release planning. Nevertheless, these efforts often fall short of achieving the goal of meaningful and seamless transition and provision of care for returning offenders with extensive health, mental health, and psychosocial problems. Typically, prison and parole systems' functional boundaries are not adequately integrated with one another -- and also are not sufficiently integrated with health and human service systems -- to achieve seamless transition (McVey, 2001).

Barriers to Coordinating Prison and Community-Based Services

Barriers to coordinated care exist at both the level of individual clients and at institutional/service system and staff levels. Client barriers include (Holmes et al.; Rossman et al., 1999):

- Anticipation of rejection by service agencies based on prior difficulty in trying to negotiate system requirements.

- Desire to deny the reality of their at-risk behaviors or their need for medical/mental health intervention.

- Distrust of providers, or of services (e.g., some subcultures are biased against accepting mental health services).

- Poor decision making and often irresponsible choices.

Various factors can impede service coordination from prison to the community, or services integration within the community. Correctional institutions often are highly independent and resistant to change; correctional officials have to be willing to open their facilities to outside organizations (Hammett, 1998; Holmes et al.). Also, because prisons are frequently located a distance from the community to which offenders are returning, state agencies and community-based organizations sometimes adopt an "out of sight, out of mind" perspective: they don't serve the inmates in prison, and do not come to regard them as potential clients (McVey, 2001).

Different organizational missions and "corporate cultures" have to be negotiated. Correctional facilities and community-based service agencies (public welfare, probation and parole, health and mental health, and other social service providers) have individually mandated responsibilities, which they have become used to unilaterally completing. They may lack information that facilitates collaboration, or they may be operating on questionable information that undermines interest in collaborating. For example:

- As part of their legal mandate to make reasonable efforts to reunify families, child welfare case workers are obligated to facilitate links between parents and children, even when parents are incarcerated. Thus, for example, caseworkers need to prepare

and support kinship and foster families to deal with: 1) children's psychosocial needs related to parental dysfunction; 2) challenges to parent-child contact during parental incarceration; and 3) preparation and planning for family reunification, or if that is not possible, permanent placements. In addition, caseworkers are expected to help parents access services that will assist them in properly parenting their children while they are incarcerated and post-release. As Seymour (1998) notes: case workers may recognize parents' service needs, but have little knowledge of services available within prisons, or have difficulty linking parents to these services. In addition, geographic distance, prison security requirements, and high caseloads may impede case worker-parent communication.

- Denckla and Berman (2001) suggest that the behavioral health treatment community (e.g., state and county agencies of mental health, mental retardation, substance abuse, and the programs they fund, including psychiatric hospitals and community-based service providers) historically has shied away from addressing the issue of people with mental illness who have repeated contacts with the criminal justice system. Community-based providers often find mentally ill offenders challenging to serve because of their co-existing conditions, non- compliance, unkempt appearance, and their clinically difficult and challenging presentation (Conly, 1999). Further, providers often do not have experience in treating "forensic clients." Where providers can select their own clients, they frequently avoid offenders, who they associate with disruptive or violent behavior. As a result, people coming directly from the criminal justice system may be underserved because staff: fear for their own safety and that of other clients; perceive forensic clients as having a host of very severe problems that are difficult to treat effectively; recognize the more challenging cases are likely to require more expensive resources (e.g., hospitalization); and worry that treatment failure may jeopardize funding that is performance based (Denckla and Berman, 2001).

Institutional staff also may be put off by "cultural clashes."Hammett (1998: 9), for example, notes that there "real differences between the philosophies, perspectives, and priorities of public health and correctional agencies that can make collaboration difficult if they are not sensitively handled":

- Correctional staff have a primary mission of security -- protection of inmates, staff, and visitors from violence. Care providers are concerned with health status and quality of life of individuals. The social work view of client self-determination may not be valid or safe, and may well conflict with criminal justices policies. For example, community-based health prevention educators often try to improve clients' independent decision making and self-efficacy skills; however, prison staff may be concerned that empowering inmates in this way will undermine discipline and order in the facility.

- Similarly, community-based providers addressing issues such as HIV/AIDS or STDs may adopt harm reduction -- rather than abstinence-based -- models. Therefore, they are prepared to educate individuals on when and how to use condoms during sexual

encounters or how to reduce risks associated with injection drug use by cleaning needles and works. Such information is antithetical to criminal justice policies; for example, only two state/federal systems make condoms available (Hammett et al. 1999). Further the harm reduction stance may be particularly troubling to some correctional officials since sexual and needle-using activities (e.g., drug use and tattooing) are expressly prohibited in prison, and administrators may not want to acknowledge the existence of such problems on their premises.

Resources are always a concern. Inflexible or inadequate funding is frequently cited as a major impediment to coordination of services within and across institutional systems. In addition, limitations on physical plants and manpower may undermine both correctional institution and service system capacities to offer enhanced services (e.g., there may be no infrastructure or space available). Other logistical issues impede coordination; for example, uncertain release dates complicate transition planning (McVey, 2001; Rossman et al., 1999).

Adequate in-prison resources are needed to assess and treat inmates, and to prepare transition plans. Resources also must be found to support community-based service delivery where offenders are unable to cover "fees-for-services." Often, resourcing is hampered by inadequate understanding of post-release assistance entitlement. For example, Medicaid and Social Security Income (SSI) may be viable approaches to securing funding for long-term health and mental health care for some offenders. However, associated paperwork is cumbersome and unfamiliar, and it can take months to process applications during which time needy people may not be receiving medical services, housing, etc. Applications should be initiated well in advance of release dates (states differ in processing time, but several months should probably be expected). Cooperative agreements should be established between Departments of Corrections and state agencies administering entitlement programs, such as Medicaid, with the goal of avoiding care interruption upon release; for example, transition planning should try to have Medicaid approval within two days of release to ensure continuity of medication renewal and health monitoring/treatment.

Information sharing across systems is notoriously troublesome -- data-sharing agreements across systems typically are not in place (Morley et al., 1998; Rossman et al., 1999). Record keeping is often scanty or erroneous. For example, Jacksonville Community Council, Inc., a nonprofit, nonpartisan, civic organization that seeks to improve quality of life based on informed participation of citizens undertook a local study to strategically plan for improved community responses to the need of returning offenders. They reported considerable difficulty in obtaining information from the county and state corrections systems that would allow them to be proactive (Jacksonville Community Council, Inc., 2001) :

- The state system was unable to provide data on offender needs with respect to emergency spending money, clothes, or personal identification when released from prison; the state system only was able to indicate what they provide offenders upon release: $100, clothes if needed to wear at release (and the costs are deducted from the $100), and a corrections department picture id.

- DOC could not provide information on the proportion who have a home to return to, those financially capable of paying rent or a mortgage, or those ready after period of incarceration to assume responsibilities of rental or home ownership.

- The state system reported about 58 percent tested at less than 5th grade reading level; it could not provide data on degree of literacy or advancement in education classes during incarceration, nor was information available on the marketable skills of those returning to the community.

- Information was not available on the percentage who have jobs to return to when they are released, or the number who have physical disabilities, mental illness, or other conditions that limit their ability to work competitively. The state provides a bus ticket upon release to offender's destination of choice within the state; no information is available on those who have access to cars or cannot use public transport due to location or limitations.

- The state is aware of the incidence of certain health conditions because of the importance of treating them to maintain health and order within the correctional facility, but apparently is not aware of those who lack health insurance or the ability to pay for care when released

- Data were not available on the percentage of offenders who have families to return to; the degree to which families are functional and supportive; the percentage of offenders who have minor children, are required to pay child support, have officially lost custody of children, or the status and location of those children.

Inmates and offenders returning to the community tend to be fairly mobile (e.g., prisoners are often transferred from one facility to another; while those in the community experience unstable housing situations). Personal information should go with them as they move within correctional facilities and throughout the community; however, in many cases, vital medical records (including test results and medication status) and other information relevant to service coordination are never sent to new health and human service providers, or are seriously delayed. Information may be manually recorded, making it difficult to share widely across different organizations and staff. Or, it may be automated, but subjected too long delays prior to data entry, rendering the information obsolete by the time it is accessible.

Putting families into the mix represents a new approach for some agencies, challenging them to find effective ways to work with and engage family members. Staff may need to re-think the assumptions that service systems have made about families: Who should be included in family?

Who should determine what is right for family members? Should involvement be coerced or voluntary? Service provision across different domains hold different perspectives and may be challenged to achieve consensus.

Barriers to Service Delivery at the Local Level

Barriers to services integration at the local level occur for a variety of reasons (Jacksonville Community Council, Inc., 2001; Morley et al., 1998; Rossman et al., 1999). Significant gaps exist between offender needs and locally available resources. There may be deficiencies in the spectrum of services; insufficient resources to address the full need; a changing landscape of local service providers, and high staff turnover in the service sector, that undermine stable cross-agency interaction; and an ineffective network of information sharing to helps offenders become aware of services and take advantage of them.

The recent Jacksonville study (2001) identifies many of the same difficulties encountered by local OPTS programs as they attempted to implement case management and services integration (Jacksonville Community Council, Inc., 2001; Morley et al., 1998; Rossman et al., 1999). For example:

- Information is not easily available about existing services and how to access them. Individuals with immediate needs experience a knowledge gap regarding where to go and how to gain quick access to emergency services. There is no single, easily accessible, authoritative source of information. An informal word-of-mouth, information-sharing network may exist among offenders, but not all are connected to it. Returning offenders need assistance in understanding, contacting, and obtaining services.

- Services to meet offender needs are fragmented and not comprehensively available. A detailed inventory of community-based resources to meet service needs of ex-offenders concluded that at least some services are available locally to deal with each of the major kinds of needs identified; however, the spectrum of services is incomplete, their capacity to serve is limited, and links between pre-release and post-release service are weak. Although many services are provided formally, there are unknown amounts of informal services. Resource people generally concurred that as a whole, even taking informal resources into account, services are insufficient to meet existing needs. Additionally, the effectiveness of formal services is limited by the degree of fragmentation among service providers, and by lack of coordination among providers.

- Data to plan for services are insufficiently available (see earlier discussion).

- The recent political climate has favored punitive, over rehabilitative, responses; get tough on crime attitudes have prevailed. Consequently, members of the public and some service providing organizations lack both an accurate understanding of the needs and services for ex-offenders, and the political will to respond appropriately.

Also, certain legal restrictions society feels justified in imposing have the effect of impeding efforts of offenders to obtain needed services and build stable, productive lives:

- Emergency housing is in big demand, but there are limited beds (Jacksonville Community Council, Inc., 2001). Offenders who committed certain kinds of crime are legally excluded from some housing; in addition, housing applications for apartment rental request information about prior convictions permitting rental agents to informally discriminate, limiting housing choices. Some also face informal discrimination from lenders when they seek to establish credit for mortgage approval or apartment rental. Laws requiring notification of sex offender residence may trigger some discriminatory reactions.

- Given labor market conditions and generally limited individual skills, there is a gap between the wages offenders can earn and their financial needs. In addition, there are some limits on employability due to criminal histories. For example, sex offenders have limitations on some jobs, by law or practice (e.g., they can't work in businesses or agencies serving the public - especially women and children - directly); those with theft may not be able to work where there is money handling.

Promising Models

Several promising models have been suggested. These models are not panaceas, but provide guidance in working toward improved services. Two key features they illustrate are: creation and maintenance of a coordinated continuum of service delivery that overcomes fragmentation, and heavy reliance on mentoring and case management that provide strong, ongoing personal support for ex-offenders.

The AIDS Institute of the New York State Department of Health collaboration with the Department of Correctional Services involves a comprehensive suite of services, including: HIV counseling and testing, education (including peer education provided by current inmates and ex-offenders), and supportive and transitional services for HIV positive inmates (Hammett, 1998). Regional teams implemented in 1989 to provide HIV counseling and education for inmates and correctional staff were expanded in 1993 to include community-based organizations. The model includes an AIDS in Prison Hotline, funded by the AIDS Institute and operated by the Osborne Association in NYC. The hotline provides counseling, education, support, and referral to community-based services; inmate collect calls are encouraged.

The Fortune Society's Empowerment Through HIV Information, Community and Services Coordinated Health Care (ETHICS 3/CHC; New York) program provides transitional services from prison to community for HIV-positive offenders, using a family-focused approach, intensive case management (including crisis intervention, counseling, and

service referral), partnerships with networked medical care facilities, and formal and informal social and recreational group interaction that provides peer support and opportunities for staff to encourage the development of social skills that facilitate smoother re-integration into the community.

All clients are assessed upon release (and every two months thereafter) and provided with an initial medical referral; medical services are available through a linkage agreement with the Institute of Urban Family Health, although clients often choose other health providers. Depending on individual needs, additional referrals may include: financial benefits, housing, substance abuse counseling, psychotherapy, food resources, educational and vocational services, and day treatment programs. Staff or peer counselors/educators escort clients to referrals, and case managers confirm acceptance and monitor on-going participation.

One of the criteria for participation is that offenders' family must be willing to participate in the program and access health services through ETHICS 3. Project staff make home visits to engage and assist family members, in addition to hosting family-oriented events (e.g., picnics, parties, and completion ceremonies). Despite agreement, families have been less engaged than expected; reasons for low participation include:

- Offenders' relationships with family members have deteriorated beyond repair.
- Family members are engaged in other programs or receive services from other providers they are comfortable with.
- Family members are willing to offer support, but at a distance.
- Clients have not disclosed their health status to family members.

A Rhode Island collaboration involves State Department of Health, State Department of Corrections, the Miriam Hospital (medical center affiliated with Brown University) and 40 community-based organization (Hammett, 1998). Initially funded by the Department of Health, an increasing share of funding now comes from the Department of Corrections. Early goals were to provide treatment and supportive services for HIV-positive inmates and to facilitate continuity of care between providers in prison and the community; subsequently, the program expanded to address pre-and post-test HIV counseling, discharge planning, transitional services, and community linkages for HIV-positive inmates and at-risk HIV-negative inmates.

A disease investigation specialist, funded by the Department of Health and based at the correctional facility, notifies inmates' sexual partners and performs primarily HIV outreach. This individual also locates inmates released from the correctional facility prior to receiving their HIV test results to link them to services at Miriam Hospital or another community-based service provider.

CDC funds two additional public health educators who provide prevention education within the correctional facility.

Post-release services include: medical treatment, housing, substance abuse treatment, job development, psychological support, and long-term case management. Evaluation results revealed reduced recidivism rates for female participants. Compliance with post-release medical and other service appointments increased substantially.

Project Bridge in Rhode Island (Holmes et al., Holmes and Davis); serven=92) reported that 78 percent of clients were IDUs; 40 percent were multiply diagnosed with Axis 1 Mental Disorder, 65 percent were homeless at the point of prison release. All clients are assessed for readiness for substance abuse treatment, but sobriety is not a condition of enrollment. Case managers identify all medications clients are taking, and submit applications to the state AIDS Drug Assistance Program to ensure that HIV medications are obtainable after release. Psychiatric and other non-HIV drugs have to be secured through other means. Clients receive a medical appointment within 10 days of discharge; and are accompanied to medical appointments by the social worker (a social work assistant generally accompanies clients to social service appointments) -- this is important to ensure that clients ask pertinent questions concerning care.

Clients are considered particularly vulnerable during the first 24 hours post-release. More often than not offenders return to same geographic area where their arrest occurred; their social contacts revolve around drug use and illicit behaviors. Therefore, it is critical for case manager to make contact within the first week, and the first visit is home-based or in the community.

Physicians who see clients after release are the same ones who treated them during incarceration, which ensures continuity of medical care.

The Maryland Community Criminal Justice Treatment Program (MCCJTP). MCCJTP brings treatment and criminal justice professionals together to: screen mentally ill individuals while they are confined in local jails, prepare treatment and aftercare plans, and provide community follow up post release. The program targets those 18 or older who have serious mental illness (i.e., schizophrenia, major affective disorder, organic mental disorder, other psychotic disorders) with or without co-occurring substance abuse. Although the focus is on jail populations, parolees from state prison may be referred to an MCCJTP case manager by prison or parole officials, or may self refer following release.

In most jurisdictions, county health departments receive funding to hire fulltime MCCJTP case managers who are experienced mental health professionals with advanced counseling degrees. Caseload size is approximately 35individuals/manager. The general protocol includes: screening and needs assessment (including determination and provision of medication if indicated); counseling and discharge planning (covering such considerations as mental health

and substance abuse counseling, recreational activities, educational services, employment training, and housing placement); criminal justice system liaison; and referral and monitoring in the community (Conly, 1999).

The Women's Prison Association (WPA) program recognizes that women offenders require more, as well as different services, than their male counterparts. The Women's Prison Association (WPA) program directly offers or brokers institutional and community-based services to women offenders through several interrelated programs including:

- Transitional Services Unit that provides transitional and intensive case management for HIV+ women released from prisons, as well as HIV/AIDS services, peer group support, prerelease planning, and housing placement for inmates who are HIV+ or at risk for infection; With AIDS Institute funding, TSU staff -- working with correctional staff supervision from the Deputy Superintendent of Programs in both the Bedford Hills maximum security facility (that also serves as diagnostic/classification center for all women sentenced to prison for more than one year) and the Taconic medium security prison provide a full range of HIV services, including prevention education, pre- and post-test counseling for those who voluntarily request HIV testing, training of correctional staff and peer educators, and facilitation of peer support through inmate volunteers who assume active roles in shaping the programs. In addition, discharge planning is offered to women who have six or fewer months remaining on their sentences; this includes: reviewing available community services, discussing parole regulations, collecting all paperwork needed for a smooth transition (e.g., birth certificates, medical release summaries to access documentation needed to qualify for Medicaid and other financial assistance), considering housing options and connecting women to TSU's housing experts upon their release, and establishing appointments for community-based medical care. Once in the community, women can receive transitional case management for up to three months, by which time they are likely to have qualified for to participate in the TSU's Community Follow-Up Program (CFP), a fee-for-service component that supports case management to nonincarcerated offenders for as long as they are eligible to receive Medicaid .

- The Sarah Powell Huntington House, a transitional residence for homeless female offenders, including those with HIV/AIDS, who seek to reunite with their children; over time women can have supervised visits with their children and later children can visit overnight; somewhere between 6 and 9 months women & children move into their own apartments within Huntington House. The facility has both a Children's Center for infants and preschoolers. Mothers are expected to volunteer in the center 1 hr/week, which is set up as a classroom with age-appropriate educational supplies and a set curriculum. Also a comprehensive program for school aged children 6-18, meetings are convened with mom, children, mom's caseworker and key cjs or service staff (po, drug treatment staff, child welfare workers) to discuss family's goals and familiarize all service providers with the program. After school and week end activities includes such features as counseling and recreational therapy, homework assistance and tutoring, cultural and recreational activities both on site

and as outings. While in family unit receive assistance in locating suitable permanent housing.

- The Steps to Independence Program targets homeless women. Designed to provide housing assistance [housing readiness workshops and individual counseling assist client to learn how to inspect apartments, negotiate leases, obtain furniture, establish a household; for up to 1 year after permanent housing, aftercare workers help women maintain housing and negotiate with landlords for repairs, or access other services; also have emergency services earmarked for rent arrears, security deposits, utilities, food clothing] and job placement assistance (how to find and keep a job, resumes job applications interviewing, managing job conflicts) employment testing, training when appropriate, employment counseling, outreach to local business community to id employ opportunities, , independent living skills development (decision making and problem solving skills development; time mgmt, household budgeting, opening and maintaining checking accounts, accessing community services) 10-week parenting skills training; peer mentoring, relapse prevention, and women's support groups aftercare services to women in the other WPA programs.

The program excludes women diagnosed with severe mental illness (due to resource constraints), and those charged with arson (for residential programs). Case management involves development of individualized service plans and provision of individual counseling; helps clients organize and prioritize their service needs, and learn how to advocate for themselves. WPA case managers work with clients on recovery, relapse, and reunification issues. They facilitate peer support through group workshops, support groups, and household assignments: WPA also coordinates other services in the community, having negotiated formal agreements with 44 service providers in the community who assist women or offenders.

The organization reportedly is concerned that welfare reform will adversely impact availability of housing, drug treatment, HIV/AIDs services, and child care, as well as restrict level and duration of support clients can receive. It sees the need to add a community center that can house 24-hr emergency assistance for those just released; more intensive education and vocational services for those further along in their adjustment; and expanded capacity to work with the entire family and provide longer term support for those living in the community.

The Maryland Montgomery County Pre-Release Center believes families need to prepare before the inmate returns home. The Center requires every inmate to have a sponsor -- parent, grandparent, spouse or partner, even a child -- who agrees to attend six weekly educational sessions. Also, it provides family therapy for inmates and their sponsors who want counseling (Nelson and Trone, 2000).

For those with a substance abuse issues, the Center runs a two-week relapse prevention course that provides techniques for living clean in a drug-filled world. The course suggests how

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to locate and receive optimal benefit from outpatient treatment programs; and also offers a basic course in the principle of addiction and recovery for those who have not received incarceration treatment.

Families need to be prepared for the invasiveness of supervision -- e.g., home visits at odd hours; and also to understand supervision requirements so they do not unwittingly enable or encourage behavior that is inappropriate or illegal or those under supervision (Nelson and Trone, 2000). La Bodega de la Familia assists families whose newly released relatives are in drug treatment, but the model could be applied to a broader range of circumstances. NY parole officers have to inspect offender's anticipated housing prior to release; Bodega staff accompany certain POs on home inspections to inform families of available services, including intensive family counseling and 24-hour emergency support. Bodega staff work with families, and keep POs informed, to help offenders whose behavior endangers their continued ability to remain in the community (Nelson and Trone, 2000).

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