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Reintegrating Women Leaving Jail Into Urban Communities: A Description of a Model Program

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ABSTRACT *Women are the fastest-growing population in the criminal justice system, and jails reach more people than any other component of the correctional system. About 1 million women pass through US jails each year. Most return to their communities within a few weeks of arrest, and few receive help for the substance abuse, health, psychological or social problems that contribute to incarceration. We describe a model program, Health Link, designed to assist drug-using jailed women in New York City to return to their communities, reduce drug use and HIV risk behavior, and avoid rearrest. The program operates on four levels: direct services, including case management for individual women in the jail and for 1 year after release; technical assistance, training, and financial support for community service providers that serve ex-offenders; staff support for a network of local service providers that coordinate services and advocate for resources; and policy analysis and advocacy to identify and reduce barriers to successful community reintegration of women released from jail. We describe the characteristics of 386 women enrolled in Health Link in 1997 and 1998; define the elements of this intervention; and assess the lessons we have learned from 10 years of experience working with jailed women.*

KEYWORDS *Case Management, Community Reintegration, Drug-Using Women, Jail, Substance Abuse Services.*

WOMEN IN JAIL IN THE UNITED STATES

Since the 1970s, the United States has experienced explosive growth in incarceration rates, described as "unprecedented in our own history, or in that of any other industrial democracy."[1(p12)] In the United States, 1 in 20 persons, or 5% of the population, can be expected to serve an average sentence of 60 months of incarceration in federal or state prison.[2]

This startling rise in incarceration, most heavily affecting poor communities of color, has complex economic, legal, and political causes and has attracted wide attention from social scientists, public health professionals, policymakers, and criminal justice authorities. Media focus on high-profile issues such as the falsely accused in death penalty cases, heinous hate crimes, and violent juvenile offenders has fascinated the public. Conservatives have argued for harsher treatment of criminals in more punitive settings, while more progressive forces call for alternative

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responses to the problems of law and justice, such as community-based sentencing and restorative justice programs.[3–5]

Too often, the ideological, scientific, and political debates about US criminal justice policies obscure their profound impact on low-income urban communities and families. Each year, more than 10 million people pass through jails in the United States[6]; an estimated 1 million of these are women.[7] Contrary to stereotyped public perceptions, many are "ordinary" women who have faced extraordinary odds in an effort to survive in their chronically troubled communities. The majority are women of color, under the age of 35, and mothers, and they live in low-income urban neighborhoods in which the rates of unemployment and undereducation continue to be high despite the longest period of prosperity in US history.[7,8] Most of these women have been arrested and detained for nonviolent offenses related to drugs.[9] Some have had problems with illicit drugs or alcohol for most of their adult lives, while others were lured into the illegal drug economy in an attempt to make money.[10,11] Surveys show that the majority were victimized prior to incarceration by family members, acquaintances, or strangers.[12] Most will return from jail to the same neighborhoods and conditions without having received any services to address their underlying problems.[13–16]

The rise in incarceration has had a disproportionate impact on women. The number of women in prison has multiplied almost four-fold in the past 10 years, while the general prison population has doubled. Much of this increase has been driven by the "war on drugs"[17]: By the late 1990s, approximately 60% of incarcerated women were sentenced for drug convictions, compared to fewer than 15% in 1986.[18]

In 1998, 3.2 million women were arrested, accounting for 22% of all arrests[7]; more than 950,000 women were under correctional supervision, about 1% of the US female population; and more than 1 million women spent some time in jail that year. According to the Bureau of Justice Statistics,[7] 63,791 women were incarcerated in US jails on June 30, 1998. Between 1990 and 1998, there was a 17% increase in the proportion of women in jails,[19] while the number of jailed women increased by 71%, primarily due to increasing arrests of drug-using women. In New York State, the number of women arrested for drug offenses increased by 98% between 1986 and 1995, convictions increased by 256%, and there was a 487% increase in prison sentences.[9]

Women in jail in this country face a unique constellation of health and social problems, both in comparison to demographically similar nonjailed women and, in some cases, to jailed men.[20] Compared to nonjailed low-income women, jailed women have higher rates of human immunodeficiency virus (HIV) and other sexually transmitted diseases[21–23]; recent and chronic substance abuse[10,24,25]; domestic and sexual violence and early childhood victimization[12,26,27]; and mental health problems.[28]

Because of their role in parenting and family support, increased incarceration rates for women have a particularly adverse impact on their children, families, and communities. Approximately three quarters of women in prison are mothers. Fewer than 1 in 4 can rely on the fathers of these children to provide care while the mothers are incarcerated.[29] Children whose parents are incarcerated are at greatly increased risk of eventually being incarcerated themselves. Forty percent of young people in California who are in custody have at least one parent who has been incarcerated.[30]

The problems facing women in jail cannot be separated from those facing their

communities. Jobs have disappeared, and until recently, real wages have declined.[31] Urban schools often fail to educate young people,[32,33] and both inadequate housing and homelessness have increased.[34] Urban crime rates remain higher than in other areas, and many basic services have been reduced or eliminated. While some agencies and community organizations have remained active, cuts in funding for health and human services have often strained the goodwill of those who place the best interest of the community at the center of their work.[35]

In the last several years, law enforcement has played a contradictory role. On the one hand, violent crime rates are sharply down from the early 1990s, a trend that has especially benefited low-income communities of color.[34] On the other hand, police intervention is at an all-time high.[36] Media attention on racial profiling, police brutality and corruption, street sweeps, and the disproportionate arrest and incarceration of young people of color demonstrate the continuing mistrust of police in many urban areas. The war on drugs has failed to deliver the improvements in community well-being its proponents promised.[37] At best, criminal justice policies and practices have had a mixed result in creating the necessary conditions to deter crime, enhance safety, expand opportunity, and create forums for improving justice.[5,30,38]

The interactions between women in jails and the conditions of the neighborhoods they return to have been inadequately studied. Yet, women from these communities constitute the fastest growing cohort of people incarcerated in this country, and their experiences represent an almost routine pattern of arrest, incarceration, and release to communities in which conditions dictate that most will soon be arrested again.[7,15,39] Moreover, in the past 15 years, increasing arrest rates of women in low-income urban communities, combined with the HIV and crack epidemics, may have played a key role in community destabilization, pushing children into foster care and fracturing social networks.[40] Finding alternative policy and programmatic approaches may have a positive impact on both public health and community stabilization.

HEALTH LINK: AN ALTERNATIVE APPROACH TO PUBLIC HEALTH AND PUBLIC SAFETY

Rationale and Goals

Health Link is a model program designed to test such an alternative. It helps women released from New York City jails to reduce recidivism and drug use and to improve their quality of life after release, and it aims to contribute to public health and public safety in New York City's low-income neighborhoods. Health Link seeks to achieve its goals both by working directly with women in the jail and after release and by addressing the community conditions that hamper successful reintegration. Strategies to achieve address community conditions include strengthening the capacity of community organizations to serve ex-offenders, building neighborhood networks of concerned service providers, and shifting law enforcement and other dimensions of public policy that negatively affect women's lives. This more comprehensive approach seeks to interrupt the cycle of repeat arrests, lack of jail-based rehabilitative services, and the subsequent return to deteriorating communities that encourage another cycle of crime.

The program is based on several social science theoretical foundations, including empowerment theories, which suggest strengthening individual capacity to ana-

lyze and then change social circumstances[41]; social capital theories, which support mobilizing local assets and networks[42,43]; and ecological models, which argue that changes on several levels are needed to reduce complex social problems.[44]

Health Link was deliberately designed to operate from a jail rather than a prison. Jails are facilities that confine people between arrest and sentencing and for sentences of less than 1 year. More people pass through jails each year than any other sector of the correctional system, and most return to their communities within a few weeks after arrest. Thus, jails offer a unique opportunity to engage incarcerated women and to link them to the resources they will need to stabilize their lives. In addition, because of the particular relationship among arrest, detention, and social position in this country, jails have become assembly points for low-income women of color with multiple health and social problems. Since helping systems have often had difficulty reaching women with these problems,[13,16,45] jails offer an ironic "opportunity" to connect women to the services that may help them make changes in their lives.

Despite the documented benefits of jail-based programs for some populations of vulnerable women,[20,46–49] few correctional systems have developed systematic intervention programs to realize the opportunity to address underlying problems. A recent national survey of administrators for women's jails documented that 72% of the 54 jails surveyed screened women for substance abuse problems, 70% for mental health problems, 60% for health problems, and fewer than 30% for math and reading ability, childhood sexual abuse, spouse abuse, or parenting needs.[13] It is estimated that no more than 10% of drug-abusing women offenders are offered drug treatment in jail or prison,[50] and most jails lack comprehensive discharge planning or community aftercare.[14] Lack of aftercare has been identified as a significant predictor of recidivism to drug use and criminal activity for ex-offenders.[45,51,52] In sum, far fewer women leaving jail are offered crisis intervention, counseling, mental health evaluations and treatment, medications, crisis intervention, or discharge planning than need these services.[53] For example, New York City is currently under suit by advocates for the mentally ill, with a primary allegation that mentally ill jail inmates on psychotropic medications are released from incarceration without even the basic discharge planning needed to ensure enough medication to continue their treatment until they receive a prescription.[54]

Women drug users—the majority of women in jail in this country—face particular difficulties in finding community aftercare. Their responsibility for children often precludes active participation in drug treatment, and many treatment programs have been designed by men for men.[55–57] The development of new ways to engage women in services after they return to their communities may help women change their behavior and the conditions of their lives by reducing their drug use, improving their health, avoiding dangerous relationships, and improving their employment skills. These changes, coupled with structural shifts in community resources, may help women avoid another cycle of involvement with the criminal justice system, benefiting themselves, their children, and the health and safety of their communities.[23,58,59]

Program Description

Health Link has been working with women at the Rose M. Singer Detention Center for Women at the Rikers Island Correctional Facility in New York City since 1992. The program was based on a series of needs assessment activities and pilot studies conducted to ensure an accurate understanding of women's needs. These studies

showed that most women at Rikers were affected by substance abuse and violence, either directly or indirectly; that the majority came from a few low-income New York City neighborhoods; and that women were eager to participate in programs that offered the opportunity to make changes in their lives. However, many women found it difficult to implement these changes once they returned to their community.[47] Because the developers of Health Link had ongoing relationships with organizations in two specific neighborhoods, Harlem and the South Bronx, that accounted for more than 15% of all inmates in the New York City jail,[60] it was decided to focus on these two areas. This decision also reflected a belief that low-income urban communities could play an important role in reintegrating those returning from jails and prisons.

Community Setting

Harlem and the South Bronx are among the poorest communities in the country, with rates of poverty, homicide, and health problems that are among the highest in the nation.[61,62] Rates of HIV infection, homicide, sexually transmitted diseases, and drug dependency are often more than two times higher than for New York City as a whole. The two communities illustrate the concentration of urban problems that coexist with the high rates of incarceration, both in New York City and elsewhere.

At the same time, Harlem and the South Bronx, like other low-income urban communities, have significant resources. Some community organizations thrive despite reductions in government funding; cultural institutions nurture local talent, and networks of families and grassroots organizations take care of one another, even when public agencies do not.[62,63] This social capital is the primary asset of low-income neighborhoods. Health Link seeks to sustain and strengthen this capacity, building on the historical trend of resiliency that has helped these communities overcome previous challenges.

Population Characteristics

The particular population of women involved in Health Link reflects the larger population of women in jail. Intake interviews with the 386 jailed women who volunteered to enroll in Health Link in 1997 and 1998 showed that 69% were African American, 26% were Latina, and 6% were white. The mean age was 34 years. Of the women, 85% had children, and 31% were married or living with a partner. There were 45% who had completed high school or its equivalent; 87% had received some type of public assistance; and 83% reported they at some time had worked for pay.

One third of the women enrolled in Health Link reported a current partner who used illegal drugs. More than a third (37%) had been homeless in the year prior to their arrest. In their lifetime, 57% had been beaten so badly that they required medical treatment, and 54% had been forced to have sex against their will. The women who participated in the program reported high levels of drug and alcohol use. In the 6 months prior to arrest, 39% reported heroin use, 64% used crack, and 36% used cocaine. More than a quarter (26%) had ever injected drugs. At some time in the past 6 months, 30% reported having five or more servings of alcohol a day. Two thirds of the women had previously been treated for drug use, 34% three or more times, suggesting that many of these women were long-time drug users. Almost half of the women (48%) had been arrested for selling or possessing drugs; smaller proportions had been arrested on other charges, such as loitering, assault, shoplifting, and burglary, also often related to drug use. On the

average, these women had 11 previous arrests (median 5) at the time of this index incarceration.

Although Health Link is a voluntary program, its participants demographically resemble the larger population of women in the New York City jails. In 1998, there were 16,164 women admitted to New York City jails, 12.4% of the total admissions of 130,109. Of these women, 54% were black, 25% Hispanic, and 11% white. A drug offense was the highest charge for 40% (M. Weiner, New York City Department of Correction, personal communication, January 30, 2001).

Program Levels and Activities

Health Link was designed to achieve objectives at four levels. First, it seeks to deliver coordinated and integrated services to reduce drug use and rearrest rates of women who are likely to return to Harlem and the South Bronx from the city jail. The second objective is to increase the capacity of community-based organizations and service providers in these two neighborhoods to serve effectively women who have been detained at Rikers Island. Third, the program works to strengthen a network of local service providers that coordinates service for women coming out of the jail. Last, Health Link works to change correctional policy and to secure ongoing resources to improve the quality of life for women and their families in the communities to which they return. These multilevel activities are expected to interact synergistically to improve the health and safety of these communities. The Figure provides a model of the program.[64]

Health Link is a collaborative project among the Hunter College Center on AIDS, Drugs and Community Health; several local community organizations; a citywide advocacy and service organization, the Fortune Society; and the New York City Department of Correction. It operates from the Rikers Island jail and from community offices in its two neighborhoods.

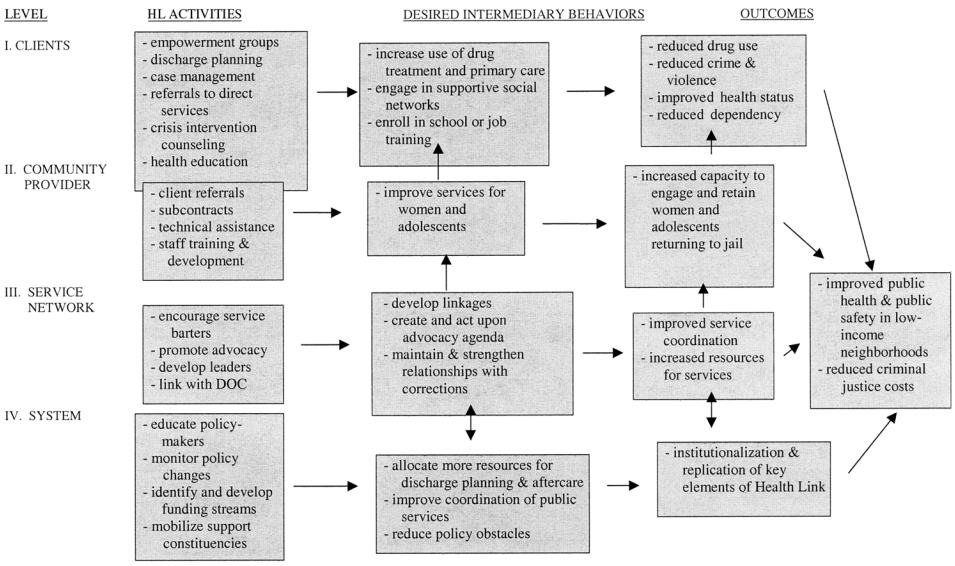

FIGURE. Health Link (HL) program model.

Client Services The first level of intervention is directed at individual clients while they are in jail. To encourage participants to reduce drug use and other risk behaviors, become more engaged in prosocial networks, and use health and social services effectively, Health Link offers ongoing support and educational groups that follow a 6-week curriculum, individual counseling, discharge planning, and case management. Other researchers have documented that the case management approach can help meet some of the unique challenges of working in a jail setting.[14,16,45,49] This strategy engages the client in the treatment process by helping her assess her own needs, developing a service plan, linking her with appropriate services, monitoring her progress, and when necessary, intervening with advocacy on her behalf.[65]

Case management programs vary significantly, but typically share key characteristics: small caseloads, intensity of services, links to other community resources, and efforts to reach those who are disengaged.[66,67] While few case management programs have been subject to rigorous evaluation, Health Link was designed based on outcome data from some programs that indicated success.[49,68] Like other intervention programs for women in jails, the emphasis of Health Link is on rigorous needs assessment and counseling sessions,[69] a client-centered approach,[70] empathetic counselors from similar communities and circumstances,[71] the ability to address prior trauma,[72] and the ability to link with established programs that offer gender-specific approaches to service delivery.[20] The services are provided by staff with extensive personal or professional experiences with incarceration and intimate knowledge of the realities of life in Harlem and the South Bronx.

Caseworkers assist participants to enroll in a range of postrelease substance abuse services, from residential treatment to harm reduction; find transitional or permanent housing; gain needed financial support; locate appropriate primary, reproductive, and mental health services; and facilitate opportunities for education or employment. To realize these aims, caseworkers offer a six-session curriculum, provide several sessions of individual counseling, and refer clients to community programs. In many cases, staff from the community programs will visit participants while they are still incarcerated to verify eligibility and develop a personal rapport.

Once clients are released from jail, Health Link caseworkers continue to offer services for 1 year. In general, clients continue to work with the same staff member who served them in jail, allowing the personal trust that developed to serve as a resource for engagement. For those clients who accept a referral to an intensive or multiservice community program (e.g., a residential drug treatment program), Health Link staff becomes secondary case managers, ensuring that participants continue their engagement with the program and making additional referrals as needed. For clients who choose not to engage in more comprehensive services, Health Link caseworkers continue to provide primary case management. Those who are rearrested can reenter the program in the jail. All community clients have full telephone access to their caseworker and can attend regular Health Link community group sessions.

Services for Community Providers A second level of activities prepares community organizations and neighborhoods to reintegrate ex-offenders into productive community life and to identify and reduce systemic barriers to such reintegration. As women develop a readiness to use services, these services must be made accessible to them. Program activities include providing training and technical assistance on the needs of incarcerated women to community organizations, strengthening the capacity of agencies to respond to the needs of women at risk of involvement in

illegal activity, and providing direct financial support to participating organizations to allow them to expand or tailor their services. In 1997 and 1998, Health Link provided direct financial support to 10 organizations and technical assistance, training, or other services to another 15 agencies.

Community Organizing and Policy Third, Health Link works at the level of community organization. Staff seeks to engage existing community organizations and activists in local issues, such as access to drug treatment, coordination with correctional facilities, and improved availability of low-income housing. In 1994, this capacity-building effort led to the creation of the Community Coordinating Council (CCC), a network of more than 50 South Bronx and Harlem agencies serving ex-offenders, women, drug users, homeless people, and other vulnerable populations.

The CCC was established to share community resources, to advocate for needed changes in the policies and procedures of public agencies serving ex-offenders, and to develop an effective working relationship with the New York City Department of Correction and other city agencies that work with the target population. The overarching objective of the community organizing work was to define a community mission that includes responding to the needs of vulnerable women, reducing crime in their neighborhoods, and improving the overall well-being of the residents of the neighborhood. Another important goal of the CCC was to make a public statement that these communities were willing to accept responsibility for reintegrating ex-offenders, but expected public agencies to offer the resources and to alter policies as needed to achieve this aim.

Policy and System Level The fourth level of activities is the endeavors to institutionalize Health Link's work in the landscape of New York City correctional programs and to assist others who want to replicate essential elements in other jurisdictions. In this way, Health Link hopes to influence the national debate regarding approaches in low-income urban communities in the United States on the questions of crime, justice, and health, with a particular emphasis on women. For example, Health Link staff have urged local departments of correction and other city agencies and local elected officials to provide gender-specific discharge planning, expand community aftercare services, and better coordinate and integrate the services cities currently provide to those leaving jail. Health Link is now working with the New York City Department of Health to replicate and evaluate the program for men jailed at Rikers Island and to assist a community organization to establish a program like Health Link in a county jail in a smaller city in upstate New York.

Health Link supports the case for policy change not only with public health and social justice arguments, but also with economic ones. New York City currently spends almost $60,000 per year to incarcerate one inmate. Several recent studies show that jail-based drug treatment services are cost-effective, and improved coordination of criminal justice, social service, and public health approaches may lead to substantial savings, as well as improved public safety and public health outcomes.[50,59,73]

Program Evaluation Changing public policy on criminal justice will require grassroots and national advocacy, as well as research data that demonstrate the efficacy of alternative approaches. To contribute to this goal, Health Link investigators began a randomized trial in 1997 to evaluate the effectiveness of this intervention. The evaluation for this intervention was designed in collaboration with Mathemat-

ica Policy Research, Incorporated, a national evaluation firm that is carrying out the follow-up study.

To assess the impact of Health Link on drug use, rearrest, and use of health and social services, Health Link has enrolled 700 women in its program. After completing an informed consent procedure approved by the Hunter College and the New York City Department of Health institutional review boards and an intake interview of 60–75 minutes, participants are randomly assigned to receive either only Health Link's jail-based services (jail services only) or jail-based services and 1 year of postrelease community services. Staff from Mathematica Policy Research conducts 12-month postrelease interviews with women from both groups. The assessment of program impact will be based on a comparison of changes in outcomes of interest between these two groups. Enrollment of the study population was completed in May 2000, and final results are expected to be available in early 2002.

After lengthy deliberations and protocol adjustments, the procedures for randomizing in the jail setting have been accepted and provide few obstacles to recruitment, in part because all Health Link participants receive more services than the regular jail population who do not enroll in the program.

Results of an earlier evaluation of data collected from 1994 to 1996 showed that, at 6 months, 46% of the enrolled women had been retained in the program at various levels of engagement. The retention rate at 12 months was 35%. On average, women spent more than 200 days engaged in Health Link services at varying levels of intensity. A quasi-experimental evaluation compared rearrest rates of those women who had volunteered for the jail program but not been eligible for community services because of their address prior to arrest (N = 44) with those who had received jail and 1 year of community services (N = 100). Women in these two groups did not differ by age or criminal charges at the index arrest. Women receiving full Health Link services had a rearrest rate that was 21% lower than for the jail services only group (38% vs. 59%).[47] While this is a statistically significant difference ($P = .02$), it is important to note that the measurement of recidivism and the factors that influence rearrest are complicated.[47] This preliminary finding provided the impetus for the previously described randomized trial that will provide more definitive answers on the impact of the Health Link program.

CONCLUSIONS

Our experience to date suggests several preliminary conclusions. These are based on existing program data, a decade of operational experience in the jail and the community, and a review of the existing literature on women in jail.

First, our broader experience suggests that incarceration policies are inextricably linked with living conditions in low-income urban communities. The growing proportion of African American and Latino young men and women who pass through urban jails has a profound impact on the economic development, political participation, parenting, social cohesion, and trust of public authority in these communities.[9,38,74,75] Continuing current policies of mass arrest and mass incarceration even as crime and violence decline may lead to further unintended adverse outcomes.

Second, as jails have become gathering points for low-income, primarily nonviolent, but drug-involved residents of urban neighborhoods, it is important to consider the jails as possible sites of intervention for vulnerable populations not easily

reached by other service systems. Public health, mental health, social service, drug treatment, and other providers may want to expand their involvement in jails. Our experience suggests that it is possible to engage vulnerable women in jail and to maintain contact after release. However, it is also apparent that numerous policy, programmatic, and resource constraints serve as obstacles to more effective programs. Reducing these barriers is an important priority for improving services.

Third, we have found that many women experience arrest and incarceration as both a crisis and an opportunity to reflect on life circumstances and consider options for changes that will improve their situation. Although most women in jail are anxious to get out and start over, the first few days after release from jail represent a particularly vulnerable time. The pull toward substance use, abusive but familiar relationships, crime, and risky behavior, especially for those women returning to a disorganized community without adequate support, make it difficult to transform good intentions into real-life changes. This suggests the importance of "front-loading" services into the first hours, days, and weeks after release from jail. Programs can use the time of incarceration to engage women and to build a trusting relationship, then take advantage of this bond to help women through the difficult transitional period after release. In addition, programs must address women's gender-specific needs related to parenting, abusive relationships, mental health, and appropriate drug treatment. Failure to do so leads to higher rates of dropout, drug use, or rearrest.

While many substance abuse researchers have emphasized the benefits of mandatory treatment for drug-involved offenders.[59,76] the experience of Health Link suggests that some drug-using women are willing to enter and stay in voluntary programs. An ethical policy should make such voluntary services readily available to those who seek them.

Our experience has also helped us to understand the dynamic tension between building on the strengths of low-income urban communities and acknowledging their limitations. Women return from jail with multiple needs, and communities can meet only some of these needs with existing resources. Indigenous assets include community providers with a history of serving disadvantaged populations; organizations and individuals with a tradition of fighting for community improvements, additional resources, and social justice; and the networks of formal and informal organizations that can shape normative views on crime, violence, and drug use. Providers and advocacy organizations must learn how to use these resources effectively on behalf of incarcerated women and female ex-offenders. At the same time, this social capital cannot by itself correct a fragmented and anarchic social service system, social policies that seek to stigmatize and punish rather than rehabilitate vulnerable populations, or the growing trend toward income inequality that underlies urban poverty.

These conclusions suggest that empowerment approaches and community organizing strategies can play an important role in crime prevention and the promotion of community health. Successful interventions will need to bring about change at several levels, and community organizations can play an important role in linking individual-, community-, and policy-level approaches. By bringing these stakeholders into policy discussions on reintegration strategies for female ex-offenders, public officials may be able to contribute to further improvements in public safety and public health. In the process, our nation may benefit from more humane, just, and effective crime and drug policies.

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