

Coming home from jail: A review of health and social problems facing US jail populations and of opportunities for reentry interventions

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Introduction

As the consequences of America's increasing incarceration rates are experienced in communities around the nation, many public officials, service providers and advocates have focused attention on the problem of reentry from correctional facilities. How can prisons best prepare people leaving for successful reentry and how can communities best assist people returning from incarceration to make the transition? What is the impact of reentry on individuals and families? What policies and programs can improve reentry outcomes? How can officials in corrections, housing, employment, health care and public health, to name a few, best work together? To date, most of the attention has been focused on the 600,000 individuals returning each year from state and federal prisons. Increasingly, however, public officials have recognized that people returning from jail also affect public safety, community health, family cohesion and public budgets.

Jails differ from prisons in their shorter length of stay, the high level of interchange with communities, the higher number of people who pass through each year, the broad sweep of who ends up inside, the higher rates of recidivism, the higher annual per capita costs, and, in general, the greater reluctance and difficulty of providing services behind bars in this dynamic environment. In this paper, I provide an overview of the social and health needs of people leaving jail, describe some of the services now available in US jails, and identify opportunities for interventions to improve the well-being of people returning from jail as well as the communities and jurisdictions to which they return. Finally, I suggest possible directions for intervention and research.

Who's in jail?

Each year more than 11 million people are estimated to pass through US jails*. Jails are locally operated correctional facilities that confine people before or after adjudication, those sentenced to terms of less than a year, and parole and probation violators. On June 30, 2005, the last date for which data are available, the nation's more than 3,300 jail systems held 819,434 inmates. Since 1995, the per capita jail population has increased by 31%; the number of jail inmates per 100,000 population has increased from 193 to 252 inmates per 100,000 residents and the absolute number of people in jail has increased by 47%¹.

Jail populations are concentrated in larger jails and in certain geographic region. In 2004, the nation's 50 largest jails (about 6% of the total number) held 31% of all inmates. Two jurisdictions, Los Angeles and New York City, together held 5% of the national total.² The 15 Southern states and Washington, D.C. accounted for 36% of the US general population but 46% of all US jail inmates and Black women in the South accounted for more than 50% of all US female inmates.³

In 2002, the charges against US jail inmates fell into four approximately equal categories: violent offenses (25.4%), property offenses (24.4%), drug offenses (24%), and public order offenses (including obstruction of justice, traffic violations, weapons charges, driving while

* Kerle K, Managing Editor, American Jails, personal communication, May 16, 2006.

intoxicated, violations of parole or probation, and others) (24.9%).³ These charges varied considerably by gender and race/ethnicity. Women were 1.2 times more likely to be jailed for drug offenses than men and Blacks and Hispanics were almost 1.6 times more likely than whites to be jailed for drug offenses.³

Of those incarcerated in US jails in 2005, males comprised 87.3% of the population; whites made up 44.3%, Blacks 38.9%, Hispanics 15% and other races 1.7%. In the last 10 years, the adult female jail population has grown 10% annually while the adult male population has grown by 4.2%.¹ On a per capita basis, men were more than 7 times more likely to be jailed than women and Blacks 5 times more likely than whites and three times more likely than Hispanics.¹ Young people under the age of 18 constituted less than 1% of the total jail population, although in some jurisdictions the proportion is higher, e.g., in NYC young people under 19 accounted for 7% of jail inmates.⁴

A 1996 survey found that about 40% of US jail inmates had a high school diploma or more, 14% had earned a GED and more than 46% had not finished high school. Compared to the US general population over the age of 18, jail inmates were 2.4 times more likely to have left school before high school graduation.

Jail Conditions

Jail conditions affect the well-being of incarcerated populations and over-crowding can contribute to infectious diseases, safety problems and environmental hazards. Although data are lacking, it seems plausible that over-crowded jails would have less capacity to provide discharge planning or reentry services. In 2004, 20 of the nation's largest 50 jail jurisdictions operated over their rated capacity (e.g., Maricopa County at 176% over capacity, Polk County, Florida at 138% and Fulton County, Georgia at 131%).² Crowded jails contribute to transmission of infectious diseases such as tuberculosis, hepatitis B and methicillin-resistant staph aureus, both behind bars and in the wider community.⁵⁻⁷

Throughout the 1990s, legal advocates sued jail authorities for failing to maintain adequate jail conditions and as a result, many jail systems came under court supervision. A 1996 federal law limited the use of such suits and made it easier for jail systems to remove such external monitoring.⁸ Although correctional officials dislike court supervision, some advocates believe it contributed to better, healthier jail conditions.⁹

Social problems of people in jail

Substance use

In 2002, 82.2% of US jail inmates reported ever using illicit drugs and 68.7% said they had at some point used drugs regularly.³ The most frequently reported drugs used regularly were marijuana (57.6%), cocaine or crack (30.5%), heroin or opiates (11.9%), stimulants such as amphetamines and methamphetamine (16.8%), hallucinogens such as LSD, ecstasy and PCP (13.2%) and depressants such as barbiturates and tranquilizers (10.6%). Among convicted inmates, more than half (52.6%) reported drug use in the month before arrest and 28.8% reported using drugs at the time of the offense. Two-thirds of inmates reported regular alcohol use and 34.5% were using alcohol at the time of their offense.³ An earlier survey found that 70% of jail inmates had committed a drug offense or used drugs regularly.¹⁰ Patterns of drug involvement varied by gender, race/ethnicity and age, with women, Blacks and those aged 25-44 having higher rates of such involvement than their respective counterparts.¹⁰

In 1996, about half (51.4%) of all US jail inmates had ever participated in drug treatment and 55.7% of regular users had done so.¹⁰ As shown below, only a small proportion of people received treatment while in jail. Thus, in 1996, of the 339,612 inmates jailed at mid-year who were identified as having active drug involvement, fewer than 50,000 received any drug treatment while in jail and fewer than 14,000 received any of the services experts deem most effective in reducing drug use.

Substance abuse treatment history of US jail inmates, by reported prior drug use, 1996

Participated in	Ever used drugs %	Ever used regularly %
Any substance abuse treatment program ever	51.4	55.7
While under correctional supervision	35.1	38.7
Since admission to jail	12.5	14.0
Detoxification	0.9	1.0
Special facility	1.9	2.3
Counseling	1.4	1.7
Self-help	9.3	10.4
Education or awareness	3.8	4.5

Source: Wilson, 2000.

Jails use a variety of strategies to address drug use. According to a 1998 survey, 7 in 10 jails had some drug testing program. More than half of inmates were in jails that tested for illegal drug use, most frequently based on indication of use.¹⁰ About three quarters of US jails report any type of jail-based substance abuse treatment program, most commonly self-help groups (63.7% of jails), followed by education or awareness groups (29.3%) and detoxification services (32.1%). Large jail systems are more likely to offer substance abuse treatment than smaller ones. Few systems offer the range of services deemed most effective in reducing drug use¹¹ and few provide the gender and age specific treatment options that are associated with improved outcomes.¹²⁻¹³

Housing

Homeless people are at higher risk for incarceration than the housed and incarceration can precipitate loss of housing.¹⁴ Even a short incarceration can have detrimental effects on the stability of housing.¹⁵ Jails are a primary supplier for homeless shelters. For example, a NYC survey found that more than 30% of single adults entering homeless shelters are persons recently released from city and state correctional institutions.¹⁶ Results from a recent study of individuals in the San Francisco County jail system showed that 16% of all episodes of incarceration involved a person who was homeless. Inmates who were homeless were also significantly more likely to receive a diagnosis of co-occurring severe mental disorder and substance-related disorder and on average had a length of stay that was 4.5 days longer than non-homeless inmates.¹⁷ Among incarcerated women, rates of homelessness are particularly high, with some studies showing rates as high as 40%.¹⁸ Women in particular face many challenges to securing safe and affordable housing upon returning home from jail, as they may need to find a home for their children or escape an abusive partner.¹⁹

As a result of changes in public assistance laws in 1996, many forms of housing and housing assistance are no longer available to people returning from correctional facilities, especially those with drug convictions. While jurisdictions chose different approaches to implementing

these new regulations, many inmates and families were forced to choose between providing shelter to a returning family member, thus risking eviction, or, refusing housing to the family member back from jail or prison, thus safeguarding their own tenancy but putting the ex-inmate at risk of homelessness.²⁰

Employment

For people leaving incarceration, employment provides income for basic needs, structures daily life so as to reduce the temptation to use drugs or engage in crime, and reduces the pressure to earn money through illegal activities. Some research shows that vocational training and employment, especially better paying and higher quality jobs, reduce reincarceration.^{10, 21} In 2004, less than 1% of those under jail supervision in the US participated in community-based work programs (e.g., work release, work gangs or other work alternatives); between 1995 and 2004, the number of persons participating in such programs declined by 22%.² About a quarter of US jail inmates are estimated to have an institution-based job,²² although these placements may not provide inmates with relevant post-release work skills. After release, people leaving jail compete with other low-income and low education workers for low wage jobs. By 2004, the Bush Administration had cut Federal job training budgets by \$597 million, further reducing options for low income workers.²³

In competing with other low income workers, people returning from incarceration face additional obstacles. State law bans people with a history of incarceration from dozens of occupations,²⁴ and employers consistently and legally discriminate against applicants with a history of incarceration.²⁵ These policies make it significantly more difficult for returning inmates to become productive members of their communities and increase the likelihood of illegal activities to generate income. Women with inadequate incomes may engage in income-generating activities that put them at risk of violence, sex work, and HIV, as well as reincarceration.^{18, 26-27}

Education

As noted above, 60% of jail inmates lack a high school diploma. Three quarters of incarcerated young people under age 18 had not passed 10th grade; typically these youth are four years behind grade level. In juvenile justice populations, 70% of young people have been diagnosed with learning disabilities,²⁸ with similar rates likely for adult jail inmates. In most cases, jails are obliged to provide educational programming only to those under the age of 21. According to the US Department of Justice, in 1999, 60.3% of US jails had some form of educational program; 54.8% reported secondary education, 24.7% basic education, 10.8% special education; 6.5% vocational education and only 3.4% college courses.³ In 1996, the latest year for which data are available, 14.1% of jail inmates participated in education programs, most commonly GED or high school programs (8.6% of all jail inmates). Fewer than 5% participated in vocational programs and less than 1% in basic education programs.³

Other studies show that participation in correctional education programs is associated with lower recidivism rates²⁹⁻³⁰ although few studies have assessed the impact of jail-based rather than prison-based educational programs.

Upon release, many young people have trouble finding their way back into the educational system and high schools often erect barriers to re-enrollment of those returning from jail.³¹⁻³²

Public benefits

For people who leave jail without a job, an employment history, education or job skills, or with a health problem, disability or addiction, public benefits provide a safety net that can reduce homelessness, drug use or a return to criminal activity to generate income. Relevant programs include public assistance, Food Stamps, Medicaid (discussed below), Social Security, Unemployment and disability.

Public policies can either facilitate or erect obstacles to use of such benefits and jail-based discharge planning or reentry programs can assist people leaving jail to gain benefits for which they are eligible or fail to provide such linkages. Policy barriers include explicit bans on receiving benefits as a result of a prior incarceration (e.g., some forms of public assistance, housing assistance or higher education aid are not provided to people with certain types of convictions); enrollment barriers that discourage people leaving jail from applying or maintaining eligibility; and actual or perceived prejudice on the part of benefit programs staff that leads people leaving jail not to apply. In the last decade, many public benefit programs have restricted access for those returning from jail or prison.

Public benefits in NYC

Following passage of federal welfare reform in 1996, the number of people on public assistance and those receiving Food Stamps in NYC fell by almost 500,000 by 2000.³³ These two safety net programs can help to supplement the income of low-income people. In one study of women and male adolescents leaving NYC jails³¹ half the women (51%) and less than 1% of adolescent males in this study reported receiving Food Stamps in the year after release from jail, although almost all met the eligibility standards for Food Stamps. To reduce dependency and the cost of public services, NYC had tightened eligibility standards and erected barriers to enrollment in these program,³⁴ barriers subsequently found to violate federal law.³⁵ These changes made it more difficult for low-income people, including those leaving jail, to meet basic needs. For some, this pressure may have contributed to illegal activities that increased risks for rearrest.

Health and health care

Infectious diseases

In 1999, 1.7% of US jail inmates were known to be positive for HIV, with rates varying from 7.6% in Washington, D.C. and 4.3% in New York State to less than 0.5% in six states.³ The rate of HIV infection in the nation's largest jail systems was more than twice the rate found in jurisdictions with fewer than 100 inmates.³⁶ These rates are 10-20 times higher than the estimated HIV prevalence in the general population.³⁷ In 1999, AIDS related deaths accounted for 8.5% of all US jail deaths; in 3 states, AIDS accounted for more than 25% of all deaths.³

A study by the National Institute of Justice and the National Commission on Correctional Health Care (NCCHC) estimated that in 1996, HIV-positive inmates released from jail or prison to their communities accounted for 13-19% of all HIV-positive people in the United States.³⁷ Women in jail generally have HIV infection rates twice as high as men's, possibly because of higher levels of drug use and higher likelihood of having infected sexual partners. Jail HIV infection rates are higher in the Northeast and the South than in other parts of the country.

The NCCHC study also concluded that approximately 200,000 incarcerated people had at least one sexually transmitted infection (STI) that year. The NCCHC estimated that about 30% of all hepatitis C-infected people, and up to 15% of people with hepatitis B in the United States served time in a correctional facility in 1996.³⁷ The prevalence of hepatitis C in incarcerated populations is about 9-10 times that of the national prevalence.³⁷

Most jails test for STIs based only on reported symptoms,³⁸ and only a few have fully implemented rapid testing programs. Routine monitoring and wider implementation of rapid testing programs offer significant opportunities for better STI control.³⁹

Some big city jails have instituted case management, discharge planning or specialized reentry services for inmates leaving jail, often in partnerships with community provider⁴⁰ and limited evaluation studies suggest such programs can link people to post-release care and improve outcomes.⁴¹⁻⁴² Fewer jails have implemented HIV prevention interventions that continue beyond release.⁴³⁻⁴⁵

Chronic diseases

Several studies show that people in jail have high rates of chronic conditions. The NCCHC study estimated that jail and prison inmates had an asthma prevalence of 8-9%, a diabetes rate of 5%, and hypertension rate of 18%.³⁷ Another study compared planning for post-release treatment needs for people with mental illness, HIV infection and heart disease in 17 county jails in New Jersey.⁴⁶ While jail staff rated the importance of pre-release planning for people with these conditions as high, virtually all the jails also reported that they provided “no real release planning” for any of these conditions. For inmates with heart disease, more than 80% of these jails reported they provided no case management, no housing arrangements, no provision of a clinical report to outside or prison providers, and no communication with outside providers.

Jails could provide an opportunity to initiate chronic disease management for people with asthma, diabetes, hypertension and other chronic conditions, thus reducing jail-based medical visits and hospitalizations and providing new self-management skills. Some correctional health authorities, however, believe that the complexity of this task makes jails unlikely settings for such activities.

Injuries and violence

Since jails house people at high risk of being perpetrators and victims of violence, it is not surprising that inmates report high levels of injury.^{47, 48} In one unpublished study of male adolescent inmates in New York City, injuries were the most common cause of emergency room visits and hospitalizations in the year prior to incarceration.

Jails offer opportunities for interventions that include anger management and violence prevention⁴⁹ but few systems make such services routinely available either inside the jail or post-release. Post-release violence reduction services may be especially important since the level of aggression that many inmates perceive to be necessary inside the jail may increase risk of injury or reincarceration post-release. Reducing the availability of guns would also reduce risk of firearm injuries for those moving through the criminal justice system.⁵⁰

Dental care

Surveys in jails and prisons find that inmates report that dental health problems are frequently an important unmet need.^{31, 51} Dental problems can cause discomfort or pain, exacerbate other health problems and hinder employment prospects. Improving the dental health of people in jail may bring psychological, health and employment benefits.⁵²

Deaths in custody

In 1999, the death rate in US jails was 155/100,000, of which 8.5% were AIDS-related deaths; a total of 919 people died while in jail custody.³ For the general US population aged 25 to 44, the death rate was 177/100,000. Jail death rates varied widely, from a high of 1,084 per 100,000 inmates in Washington, D.C to a low of 70 in Michigan.

Mental health and mental health care

According to the 1998 survey of the mental health status of US jail inmates, 15.6% of male jail inmates and 22.7% of female inmates were identified as mentally ill.⁵³ Whites had higher rates of mental illness than Blacks or Hispanics (21.7%, 13.7% and 11.1%, respectively) and the prevalence of mental illness increased with age.⁵³ The most common diagnoses were anxiety disorders and major depression. According to the NCCHC study, the estimated prevalence of mental illness among people in prison was slightly higher than among those in jail.³⁷ Some jail studies, however, show significantly higher rates. For example, a study in Los Angeles jails found that 28% of the female and 31% of the males booked into the system in an eight month period met at least one of the screening criteria for mental illness.⁵⁴

As a result of de-institutionalization of the mentally ill, the Los Angeles, Chicago and New York City jails are now the three largest mental health services in the nation. According to the Bureau of Justice Statistics, four in ten mentally ill jail inmates in the US received mental health services while incarcerated, with mentally ill women more likely to receive services than men (56.2% vs. 38.4%) and whites more likely to receive treatment than Blacks or Hispanics (44.7%, 34.2%, 40.6% respectively).⁵⁵ Jail inmates with mental illness often spend longer in jail than those without mental illness. In New York City, for example, the average length of stay for an inmate with a serious mental illness in 1998 was 215 days compared to the general population average of 42 days.⁵⁶

Various strategies have been implemented to better meet the needs of people in jail with mental illness and to better prepare them for release. One approach is to divert people with mental illness from jail to mental health services. Such programs require effective collaboration between the mental health and criminal justice systems and a commitment to provide adequate treatment to avoid reincarceration.^{57, 58} One recent evaluation of six jail diversion programs found that jail diversion reduces time spent in jail without increasing the public safety risk, while linking participants to community-based services.⁵⁹

Post-release case management programs seek to help individuals to manage their mental illness after release. Some evaluation studies suggest that such programs may be effective in reducing costs.⁶⁰ For example, a program in Chicago reported that in the year after participation in such services, the 30 individuals served spent 2,200 fewer days in jail (at \$70 per day) and 2,100 fewer days in hospitals (at \$500 a day than in the year before participating).⁶¹

Draine and colleagues have observed that effective interventions to reduce recidivism improve mental health and facilitate community reentry for people with mental illness must simultaneously consider service provider, public agency and client perspectives, a formidable challenge.⁶²

Parenting and Relationships

Many jail inmates are also parents and many are involved in intimate relationships that put them at risk of violence or HIV. A special report on family life by the Bureau of Justice Statistics⁶³ found that 67% of incarcerated women had children under the age of 18. Women also bear more parenting responsibilities than their jailed male counterparts⁶³ and often have to negotiate complicated arrangements with their own parents, relatives or the foster care system. Nationally, around 6% of women enter prison pregnant;⁶³ for jails, the rates are higher.

While women bring a full range of reproductive health needs to jail—from birth control to abortion to prenatal care—few jails have the capacity to address these needs comprehensively.⁶⁴⁻⁶⁵

After release, responsibilities for parenting and child care may make women more dependent on abusive male partners, less able to work and earn an adequate income and less able to focus on their own health, thus increasing HIV and other risks. Between 60-95% of women in the criminal justice system have reported histories of physical and sexual abuse.⁶⁶⁻⁶⁷

Upon returning home from jail, women have to re-establish relationships with children, other family members and partners. Depending on the complexity of a woman's childcare arrangements during incarceration, whether she is negotiating with family members or the child welfare system, the tasks to re-establish parent-child living arrangements can be daunting.^{63, 68} Women may return to a violent or abusive relationship or one in which her partner abuses drugs in order to ensure higher levels of support for her children. Such choices can elevate HIV risks.^{66-67, 69} In addition, since healthy family relationships are good predictors of success after release from the criminal justice system,⁶⁸ interventions to improve family functioning may reduce recidivism, family disruption and associated HIV risks.

Priorities

How do people leaving jail rank their problems and how do inmate perceptions of priorities differ from service providers?

In one study that illustrates gender and age differences in post-release priorities, investigators asked people leaving NYC jails to identify their three most reentry priorities.⁷⁰ As shown below, the study showed that adult and adolescent males most often rate unemployment and educational needs as their top needs while women regard substance abuse as a top priority. Both male and female adults rate housing as a high priority while male adolescents do not. Only 30% of adults rate medical or health problems in their top priorities and almost no adolescents do so. In most cases, caseworkers agreed with client's self-assessment, although in some cases, case workers rated problems more significant than did clients. For example, case workers were more likely to report that the male adolescents' substance use was a top problem than were the young men themselves.³¹ These findings suggest the importance of tailoring reentry programs by age and gender.

**Self-Reported Priority Needs Upon Release by Age and Gender
(top three in bold)**

Most Difficult Release Problems	Adult Females (n=704)	Adult Males (n=536)	Adolescent Males (n=706)
Unemployment	38.1% (268) ^{***}	79.8% (419)	86.0% (607)^{***}
Educational ¹	26.1% (184) ^{***}	76.2% (342)	81.9% (578)^{***}
Housing	71.9% (506)	72.4% (376)	18.0% (127) ^{***}
Financial	60.8% (428)[*]	67.8% (356)	25.9% (183)^{***}
Substance Abuse	69.2% (487)^{***}	39.3% (206)	22.0% (155) ^{***}
Medical or Health Problems	25.1% (178) ^{***}	37.5% (191)	3.3% (23) ^{***}
Family Problems	29.5% (208) ^{***}	14.8% (76)	9.0% (64) ^{**}
Legal Problems	11.8% (83)	13.1% (67)	10.6% (75)
Child Care	9.1% (64)	12.0% (62)	7.6% (54) [*]
Mental Health	6.7% (47)	8.4% (43)	3.8% (27) ^{**}
Other	5.8% (41)	5.4% (27)	8.6% (61) [*]
Sexual/Physical Abuse	6.3% (44)	NA	0

***p<.001 **p<.01 *p<.05 ¹ Includes vocational training.

Strategies to improve reentry outcomes

In the past decade, public officials, correctional and health authorities, advocates and researchers have created a variety of interventions design to improve reentry outcomes for people leaving correctional facilities. While more attention has been focused on those leaving prison, recently reentry from jail has also attracted attention.^{31, 59,71} Other papers presented at this meeting will provide more detailed analyses of selected intervention strategies. Here I suggest a framework for categorizing various approaches to improving reentry outcomes. The aim of this framework is to assist reentry planners to assess capacity for improving reentry outcomes in their jurisdiction and to develop a systematic plan for change.

As shown below, jail reentry interventions differ in various dimensions. These include the population served; service needs addressed; intervention setting, strategies and characteristics; and intervention outcomes. In addition (not shown in table), interventions can seek to bring about change at various levels, i.e., in individuals, families, institutions, communities, jurisdictions (cities or counties), or at the national level. Program dynamics vary considerably at these different levels and only a few programs have systematically sought to integrate activities at these different levels. By identifying the continuum of reentry services and approaches within a particular jurisdiction, it may be possible to identify unmet needs, unrecognized assets, duplication and opportunities for synergy. At the correctional facility or community level, planners can use the table as a menu, matching options from various columns to meet identified needs. In addition, researchers can use this schema to make decisions about where to focus evaluation efforts, based both on existing evidence and priority of need.

Characteristics of Jail Reentry Interventions

Populations	Service Sectors	Settings	Strategies	Intervention Characteristics	Outcomes
All people leaving jail Sentenced inmates only Detainees only Men/women Adults/ adolescents Only those with diagnosis(e.g. HIV, TB, serious mental illness, drug or alcohol abuse) Those returning to specified area Those with specified charges(e.g., non-violent offenses) First time offenders	Substance abuse Housing Education Employment Public benefits HIV/AIDS Health Mental health Parenting/families Legal	Jail only Community only Jail and community Hospital Community service provider Parole	Case management Service integration Counseling Self-help Education/training Information/referrals Basic needs(e.g., housing, food) Direct services (e.g., drug treatment, health care)	Service intensity (e.g., visit/week) Service duration (e.g., one year) Definition of completion Staffing (e.g., professional vs. peer) Cultural/ethnic tailoring Termination criteria (e.g., abstinence required) Number of services offered	Recidivism Drug or alcohol use Employment Income Education Health behavior, status or care utilization Client satisfaction Parenting Family reunification Cost

Deciding when to intervene

Interventions to improve reentry outcomes for people leaving jail can take place at a variety of points on the criminal justice system engagement continuum. I briefly review various points in this spectrum.

Early intervention (prior to arrest)

The surest way to improve reentry outcomes is to reduce the number of people going to jail. Incarceration is by definition a disruptive process that adversely affects individuals, families and communities. As a society, we have decided by default that the benefits of our current policies outweigh the mostly unintended costs but this calculus can change as new information enters the public discourse.

Among the early interventions associated with lower delinquency, crime, incarceration, or reincarceration rates are early childhood education,⁷² youth development,⁷³ and substance abuse treatment.⁷⁴ Keeping more people out of jail reduces the cost of our criminal justice system, frees resources to meet other social needs, and allows existing criminal justice and correctional resources to be more clearly focused on those that pose the greatest threat to public safety.

Alternatives to incarceration

Alternatives to incarceration divert individuals, usually from the court following arrest but prior to sentencing, to other types of facilities such as drug treatment or mental health programs, domestic violence interventions, community service, or restorative justice programs. This use of what some call “therapeutic jurisprudence” –an effort to use the justice system to treat underlying problems in addition to sanctioning illegal behavior has grown significantly in the last decade but remains a relatively small component of the criminal justice system.⁷⁵

Jail-based programs

Jail-based programs provide mental health services, drug treatment, health care, vocational training, education, counseling, case management or other services. The usual rationale for these interventions is that they use the time of incarceration to address problems that might impede successful reentry and to provide knowledge or skills that can improve reentry outcomes. These programs vary widely in intensity, duration, quality and proportion of population in need served. In the last decade, fiscal pressures and ideological concerns have led many prison and jail systems to reduce the services they offer.⁷⁶⁻⁷⁷

Discharge planning/transitional programs

Discharge planning or transitional programs provide services in the days and weeks prior to and sometimes immediately after release. Their goals are to link people leaving jail to services such as job training or employment, health or mental health care, drug treatment, and housing; to provide social and other forms of support and a structure for daily living in the first days and week after release, often identified as a vulnerable time for people leaving jail; and to provide a safety net in case of relapse to drug use or criminal behavior. Program activities include case management, counseling, support group, information and referrals, or direct services. As in other categories, these interventions vary in intensity, duration (usually a few days to one year), quality, and populations served. Few jail systems offer such services to all inmates.

Long term programs

Long term programs provide ongoing (usually one year or more) housing, employment, drug treatment, health or mental health services to people leaving jail. In some cases, these programs define a specific geographic community as their focus (e.g. La Bodega la Familia in Lower Manhattan⁷⁸) and provide ongoing support to individuals in that community. More frequently, however, these programs serve individuals with conditions such as HIV infection or serious mental illness.

In summary, those planning to improve reentry outcomes can intervene at multiple points in the criminal justice cycle. Each intervention point has a specific rationale and unique advantages, disadvantages, and costs.

Recommendations

Choosing Intervention Priorities

Even this brief review of the needs of people leaving jail illustrates the complexity of the task. Individuals face multiple problems and those problems influence and are influenced by not just those returning from jail but also their families, peers and communities. The jail environment --

high turnover, over crowding, short lengths-of-stay, and varying legal statuses of inmates-- makes planning difficult and stability of services elusive. After release, no single institution or sector has the resources, expertise or capacity to address the range of needs and no single official is responsible or accountable for reentry outcomes. Moreover, needs vary among different sub-populations, in different jurisdictions and in different regions, making it difficult to develop generalizable solutions. In addition, there are numerous models and entry points for reentry interventions but few have been evaluated and no guidelines assist public officials to choose among these options. For these reasons, some have labeled reentry the classic "wicked problem"⁷⁹ --immune to single, simple or superficial solutions.

As a result of this complexity, reentry planners face a variety of dilemmas. On one hand, the traditional solution to multiple problems is to make priorities: to choose one or two problems or populations on which to focus. But for people leaving jail, their problems are often so intertwined that several must be tackled simultaneously. For example, the drug user returning from jail can't begin to address his addiction until he has a roof over his head but many housing programs insist on sobriety as a condition of employment. The schizophrenic woman may need mental health services, drug treatment, housing and legal assistance yet lack the capacity to negotiate the service maze, especially if she has been released from jail without her medications. Some agencies choose a focus and hope the clients who walk through their door in fact need the service they offer; others offer a range of services but may lack the resources or capacity to deliver some of these effectively. Some jurisdictions focus on the inmates easiest to serve, e.g., those already sentenced, even if this population is smaller or poses less risk to public health or safety than, say, detainees. Helping jurisdictions to make informed, evidence-based choices is an urgent priority.

Perhaps one way to devise solutions to these dilemmas is to consider the problem from different perspectives. For the individual returning from jail, or his case manager, the task is to identify the particular service package this person needs, then find the options available within the specific community or jurisdiction. For the service provider, creating community networks may be a strategy to bring together different types of programs—drug treatment agencies, health centers, housing programs, etc. —that are needed to meet the needs of the diverse population coming back from jail. Finally, for the municipality or county, the task may be different. Rather than selecting a single approach for reentry, local officials may want to establish a diverse portfolio of interventions —designed to meet the varying needs of men and women, drug users and people with HIV, and detainees and those completing sentences. This approach has been used to address other health and social problems. "Portfolio planners" look to have a well-balanced set of investments —long and short term, in various sectors and with varying levels of risk.⁸⁰⁻⁸² Thus, a municipality that wants to improve reentry outcomes may begin by creating an inventory of existing interventions, then assess how to balance this "portfolio" with new initiatives. This approach acknowledges that no single reentry approach will suit all jurisdictions and provides reentry planners with differing resources, power and commitments an opportunity to begin to make changes needed to improve reentry outcomes.

New Directions for Research

How can researchers best contribute to the newfound interest in jail reentry? Other papers presented at the Reentry Roundtable will focus on research questions related to specific service sectors, settings, populations and evaluation methods. I focus here on research that will assist jurisdictions to make more informed choices about how to improve reentry outcomes; my primary goal is to provoke discussion rather than to prescribe specific research studies.

1. Develop consistent definitions and typologies of reentry interventions that allow systematic consideration of results, costs and benefits, and program characteristics.

In order to make decisions on reentry services, policy makers will want evidence-based recommendations. To create a systematic literature on the impact of policies and programs on jail reentry outcomes is a five to ten year task. Thus, the sooner researchers, decisions makers, administrators and advocates can agree on the parameters of such a systematic evidence base, the sooner its creation can begin.

One possible starting point might be to reach agreement on outcomes of interest and consistent ways of defining and assessing such outcomes. Appendix 1 lists some commonly used outcomes in reentry research to date. To illustrate, currently a variety of measures are used to measure recidivism. Just as standard definitions of high school completion have helped to focus discussion on high school dropout and its remedies, so consistent definitions of jail recidivism will help to clarify goals and evaluate interventions more systematically. Similarly, using consistent cost measures will help to document the cost effectiveness and benefits of various interventions. Jurisdictions differ in their methods of accounting for the costs for jail –for example, some exclude pension and employee benefits for correctional staff, capital and borrowing costs and jail services provided by other municipal agencies, these exclusions impose a higher standard on cost benefit evaluations than analyses that include such costs.

Developing standard definitions or a defined continuum of case management, discharge planning and information and referral services for people leaving jail will allow evaluators to compare apples to apples, rather than forcing policy makers to sample an unknown fruit salad. While no body has the mandate to impose such definitions or standards, the development of consensus guidelines on such issues will enable funders, policy makers, researchers and practitioners to construct the evidence base needed for informed policy decisions.

2. Study the political and administrative processes by which reentry programs are planned and implemented and identify factors associated with successful outcomes.

For “wicked problems” knowing how to bring about change is as important as knowing what to change. Currently, jail reentry interventions are launched by community-based coalitions, jails, city or county governments or state and federal government. They involve a wide variety of stakeholders who use a multitude of strategies to achieve their goals. The advantage of this complexity is it provides opportunities for research to identify more and less successful planning and implementation strategies. Questions of interest might include:

- Who needs to be at the table?
- What are the pros and cons of Mayoral or county executive leadership compared to Department of Corrections leadership?
- What is the impact of framing the questions narrowly, e.g., how to improve jail-based discharge planning services, versus, broadly, e.g. how to improve outcomes of reentry process?
- What is the value of adding health outcomes to reentry initiatives?

3. Develop a research program on jails-as-institutions and identify jail characteristics associated with successful reentry outcomes.

Despite the importance of jails as a social institution, they remain relatively under-studied as compared to prisons. Developing a better understanding of how jail characteristics affect

reentry outcomes is an important research priority. While correctional officials correctly note that many factors outside their control influence reentry outcomes, it is also important to identify factors that are under their control. Identifying jail staffing, service, cultural and other factors that contribute to improve reentry will help municipalities create jails that release people ready to become successfully reintegrated rather than more skilled or angry criminals.

Some European prisons and jails have advanced the notion of “healthy correctional facilities”, institutions whose environment and culture promote health rather than illness.⁸³ What would a “reentry jail”, organized to reduce recidivism and improve life prospects for those released, look like? Reviewing best practices from jails here in the United States and other nations and developing, funding and evaluating model systems to improve reentry outcomes constitute an alternative strategy to the incremental approach now in place in both jurisdictions.

4. Initiate reentry research that will bring new stakeholders into the public discussion on reentry.

For jail reentry to become a priority for local officials, advocates and correctional agencies, new constituencies will need to be brought into the discussion. Who are the key players and what types of research or evidence is needed in order to interest these stakeholders? The table below lists some examples that may generate further discussion.

Constituencies	Research questions
Mayors and county executives (US Conference of Mayors; National League of Cities)	What are the costs and benefits of various approaches to improving jail reentry outcomes? What are processes by which municipalities can focus attention on jail reentry?
Education officials	How does involvement in criminal justice system influence school completion? What approaches best assist young people caught up in the criminal justice system to complete high school?
Public health and health care	How does incarceration contribute to disparities in health? What reentry practices can reduce the adverse health impact of incarceration?
Welfare and job training	What types of vocational and employment programs prepare people leaving jail to gain and sustain employment and reduce dependency? What mix of incentives and penalties contribute to reduction in dependency?
Police and public safety	How do various policing practices contribute to use of jails? What is public safety impact of various strategies? What policing strategies optimize safety and cost?

Conclusion

The Reentry Roundtable on Jails provides an opportunity to consider national jail reentry strategies for the next decade. The current dominant approach is to initiate incremental changes in reentry practices or policies in a few places in a few sectors with some small proportion of the jail population. This strategy is likely to continue with or without national leadership and promises important new opportunities for learning lessons and building an evidence base for future decisions. Thus, the incremental strategy deserves support and encouragement.

However, by itself, this approach is unlikely to bring about change at the level needed to improve reentry outcomes substantially and thus may not generate the political support needed for a more transformative approach to jail reentry. This Roundtable Discussion can make its most significant contributions by considering more transformative approaches and weighing their costs and benefits

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Appendix 1

Selected Outcomes for the Evaluation of Reentry Programs

Outcome	Measures
<i>Criminal justice</i>	Reincarceration, days to next arrest or incarceration, time served, probation status, involvement in criminal activities
<i>Drug use</i>	Categories/amounts of drug used, abstinence, days drug-free, risky drug behavior(e.g., sharing needles), enrollment in harm reduction or drug treatment services, completion of drug treatment
<i>Health</i>	Self-rated health, diagnoses of selected infectious or chronic diseases, health care utilization, disability, health insurance status; enrollment in primary health care; management of various conditions
<i>Mental health</i>	Utilization of psychiatric services, compliance with medical regimens, cost of care, institutionalization, self-rated mental health
<i>Housing</i>	Housing status, use of homeless services, stability of housing
<i>Employment /Income</i>	Legal income, employment status, days/months worked,
<i>Public benefits/ services</i>	Enrollment in Medicaid, Social Security, Public Assistance, Food Stamps, or other benefit programs
<i>Education</i>	Enrollment in or completion of educational or vocational program; completion of high school, GED, college or other programs,
<i>Parenting</i>	Reunification with children, level and quality of child/parent interactions, maintenance of custody, child assessment