



The Source

WOMEN'S CHOICES: CASE MANAGEMENT FOR WOMEN LEAVING JAILS AND PRISONS

Introduction

Behaviors associated with addiction

(e.g., drug sales, theft and prostitution) bring many people, particularly those who are poor and from communities of color, into the criminal justice system. Data on prisoners show the population to have higher rates of substance abuse, HIV, and mental illness than the general population, with lower rates of skills that make for healthy, independent lives, i.e., education and job skills. Kennedy, Hammett, and Rosenberg (2001) describe the correctional/criminal justice population as “disproportionately burdened” with physical and mental health problems, and the Bureau of Justice Statistics data indicate that 31 percent of people incarcerated in state prisons report a medical problem (Maruschak & Beck, 2001). Therefore, effective health-related case management services, that address the multiple dimensions of reentry (health, employment, housing), are necessary to help facilitate the process of “prisoner reentry” to the community (Travis, Solomon & Waul, 2001).

Post-release case management is especially important for women, who tend to have the highest rates of health and mental health problems and the least of life’s accoutrements. Teplin, Abram & McClelland (1996) found that 19 percent of women detainees are diagnosed with schizophrenia, bipolar disorder or major depression, compared to 9 percent of male detainees; 34 percent of women in jails and prisons are diagnosed with post traumatic stress disorder; and 75 percent of severely mentally ill women detainees have a co-occurring substance abuse problem.

Women in the criminal justice system also have high rates of HIV as shown in New York State where an estimated 18 percent of the female prison population is HIV positive (NYS Department of Health, 2002).

Additionally, most incarcerated women are parents (Mumola, 2000), and imprisonment and attendant problems (e.g., addiction and HIV) have consequences for their families and communities. Two-thirds of women in prison in the United States have at least one child under the age of 18, and 71 percent of these women lived with their children prior to incarceration (Greenfeld & Snell, 1999). Nonetheless, issues related to post-release family reunification have until recently been overlooked. The social stigma attached to incarceration discourages both children and families (caretakers) from seeking help and contributes to the social isolation of the entire family, including the children (Sack, 1977; Jacobs, 1995). Therefore, services that help women plan for reuniting with children as they transition from a total (custodial) institution to the community are a particularly important part of case management and reentry services.

While case management is a term used to cover diverse approaches to service integration, common “best practice” elements include: an individualized client assessment using a strength-based approach, development of a service plan to address needs and interests identified through the assessment, service brokering (i.e., referral to services), and service plan monitoring (i.e., tracking service utilization). The unique and complex social contexts surrounding women transitioning from jail or prison also require a case management approach that is advocacy-oriented

and embraces a “stages of change” methodology and an open door policy that allows clients to drop in and out of services.

Women’s CHOICES: A Case Management Program for Women Leaving Jail

Women’s CHOICES, a prevention case management program conducted by the Center for Community Alternatives in Syracuse, New York, is a CDC/HRSA-funded project of the “New York State Demonstration Projects for Individuals Involved in the Criminal Justice System in Correctional Settings and the Community.” New York State and six other states were awarded grants to implement and evaluate the effectiveness of enhanced, innovative, continuity-of-care programs whose goals are to break the cycle of recidivism, disease and substance abuse for inmates released from prisons and jails.

There are currently about 3,100 women in New York State prisons and 200 in the Onondaga County Correctional Facility, the site of the described project. Few inmates receive treatment for the underlying problems that led to their incarceration (e.g., substance abuse, mental illness), and even fewer receive discharge plans to community treatment providers. The release of prisoners without effective supports creates a community health problem as they return home at risk for continuing substance use, contracting and spreading HIV, psychological problems, and behavioral dysfunction. Prisoners are often released without the information to find the resources they need, and many are wary of service providers. Women’s CHOICES seeks to bridge these service gaps for female inmates incarcerated at Onondaga County Correctional Facility (OCCF) in upstate New York.

Since August 2000, Women’s CHOICES has served 84 women: 67 percent African-American, 31 percent Caucasian, and 2 percent Latina. The average age of program participants is 37, and 70 percent have children, although about half of them do not have custody.

The intervention model relies on the use of a Prevention Case Manager (PCM) who had over 14 years of experience providing case management and supportive services to homeless and dual diagnosis clients prior to assuming her current role as PCM of Women’s CHOICES. She serves between 24 and 40 clients per year. At any given time, she works with

4-5 women in jail and 12-15 women in the community post-release.

The PCM attempts to bridge the service gaps for incarcerated women by providing pre-release and post-release services. The first involves the introduction of services to women while they are still incarcerated. The PCM engages the inmate two or more months before her release date. Through weekly jail-based case management meetings, the PCM completes a thorough needs assessment that results in a client-centered discharge plan. In addition to these weekly meetings, the inmate participates in twice weekly Self-Development Group meetings. Co-facilitated by the PCM and the Women’s CHOICES Project Director, these group sessions cover an eight-week curriculum designed to help the inmate develop future goals, gain problem solving and self-management skills, and acquire critical information about substance use, sexual health, interpersonal relationships, and employment that will be utilized to continue behavior change following release. Additionally, if Child Protective Services is involved, the PCM works closely with the child welfare worker to help prepare the family for reunification. She also serves as an advocate for the mother and works with service providers with whom the child is involved (e.g., day care, pediatrician) to help the mother fulfill her parental obligations.

The PCM continues working with the client for a year following release in order to maintain a strong relationship with and reassess the needs of the client, refine service plans, and provide ongoing support. The PCM functions as a safety net ensuring that clients do not fall through the cracks and that they will have an advocate to re-engage them in services should they lose connections to referral agencies. Specifically, during the first month post-release, inmates are scheduled to meet with the PCM twice weekly in order to facilitate a smooth transition back into the community. Once they are stable, the PCM meets with each client twice a month to assess their progress. During this period, the PCM makes referrals based on emerging treatment and service needs, and has routine face-to-face and telephone contact with program participants and other service providers assisting them. Additionally, clients attend a twice monthly community-based support group that is co-facilitated by the PCM and the Project Director. Group members support and advise each other as they struggle to make changes in their behaviors and relationships. Providing these services within a “stages of change” approach has resulted in the

retention of 66 percent of the women in the post-release case management services in the last year.

The Challenges of Effective Prevention Case Management

Women's CHOICES clients are not mandated to participate in services. Nearly all are released without Probation, Parole or [Drug] Treatment Court requirements. Consequently, one of the PCM's greatest challenges is to engage clients who are reluctant to engage in services, particularly substance abuse treatment. Most of the women in jail have participated in drug treatment prior to their incarceration and have reservations about reengaging in services that were not successful in the past. Moreover, they are not interested in entering residential treatment after spending a year in confinement. Many of the clients also have histories of abuse and trauma, and report anxiety, depression and interpersonal conflicts that compromise their adjustment in the community. Few have recognized the need for counseling, and although many would benefit from a dual-diagnosis program, there are almost no services that treat co-occurring disorders, particularly within a gender-responsive context.

The Women's CHOICES clients are also challenging to assist because of their crisis-driven life style fostered in part by extreme poverty. Their lives are characterized by instability and new, emerging needs and crises that disrupt the PCM's efforts to engage the clients in long-term planning. Further, ongoing family problems may contribute to parenting challenges. Some clients have temporarily or permanently lost custody of their children. Those who retain custody may have difficulty effectively parenting their children due to their own histories of childhood neglect and abuse, absence of effective parental role models, and lack of opportunity to develop parenting skills.

Additionally, their children have experienced the loss and trauma associated with their mothers' substance abuse, psychopathology, and incarceration; and some experience attention problems and developmental impairments.

When clients are in constant crisis, it is hard to focus on their substance abuse or their risk for contracting HIV. Their basic needs must be met first. For many of these clients, finishing a treatment program or staying connected with a case manager is a measure of success.

Philosophical Approach

Abstinence only models set unrealistic expectations for clients who struggle with recovery among many other daily challenges. Thus, Women's CHOICES employs a client-centered, harm reduction focus that utilizes stage-based behavioral counseling based on the Transtheoretical Model of Behavior Change Theory in order to help clients reduce the risk and harm associated with their substance use and sexual behavior (Prochaska, DiClemente, & Norcross, 1992). Stage-based behavioral counseling requires the PCM to assess the client's motivation to change a target behavior (e.g., substance abuse, unprotected sexual activity with multiple partners), and to deliver an intervention most likely to be effective given the client's motivational level. For example, clients who see no need to change their substance use are more likely to become motivated to consider behavior change if they are provided with information about the problem drinking and its effects on their life or examples from other substance users' lives.

The Role of Case Management Supervision

Case management with women inmates struggling with the multiple burdens of substance abuse, psychopathology, intergenerational family problems, the legal consequences of their dysfunctional behavior, and socioeconomic challenges stemming from discrimination and community-wide poverty, is challenging. Helping professionals enter the field with a conviction to make a "big" difference in the lives of their clients. When their expectations are not realized, PCMs can become frustrated, overwhelmed and demoralized. When efforts to promote healthier choices and sound decision making stall, PCMs may blame themselves or the client, their family or others involved in the case; avoid contact with the client; or leave the agency burned out and cynical (Kagan & Schlosberg, 1989). Clinical supervision thus becomes a key factor in helping PCMs manage their feelings and expectations so that they can remain engaged with, but not overwhelmed by, the client.

Clinical supervision, distinct from administrative supervision, focuses on the interpersonal behavior patterns of the client and the manner in which those dynamics are revealed in the relationship with the case manager (Kagan & Schlosberg, 1989). Such supervision also reviews the ongoing needs assessment of the client and aids in treatment plan development.

Clinical supervision must be regularly scheduled and not driven by the clients' crises. Scheduled supervision helps the PCM prioritize and plan the case issues on which to seek consultation. The supervisor assists the PCM to maintain a broad view of the competing needs and problems with which the client is struggling so that important issues for intervention aren't neglected when clients move through various crises.

Regular supervision provides PCMs with support in using their reactions to better understand clients' behavioral patterns and maintaining realistic expectations. In doing so, the supervisor must avoid becoming overly identified with the PCM or they, too, will be caught up in the PCM's frustration and disappointment with the client and be less effective as a supervisor.

Conclusion

With experience, training and ongoing clinical supervision in a harm reduction, stage-based and client-centered approach, case managers can learn not to impose their own opinions or goals on their clients. Instead, they are able to ask their clients how they can be of help to them. Based on the experience of Women's CHOICES, this approach appears to be effective at helping women prisoners address the multiple, challenging issues they face as they attempt to reenter to the community.

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