

# **In Need of Help: Experiences of Seriously Ill Prisoners Returning to Cincinnati**

Christy A. Visher  
Rebecca L. Naser  
Demelza Baer  
Jesse Jannetta

The Urban Institute  
March 2005

This research was sponsored by The Health Foundation of Greater Cincinnati. The opinions and conclusions expressed in this document are solely those of the authors and do not necessarily reflect the views of The Health Foundation or the Urban Institute.

## **In Need of Help: Experiences of Seriously Ill Prisoners Returning to Cincinnati**

**A**mong the 650,000 persons released, nationally, from prison in 2004 is a large group of prisoners with serious medical and mental health conditions. In a survey of state and federal prisoners, for example, about one in five prisoners reported a physical or mental health problem that limited their ability to work.<sup>1</sup> Addressing the needs of such prisoners as they leave prison and return home is a complex process, one that must take into account the immediate health status of released prisoners, their expectations about health care, and the availability of and connections between prison health care and community health services.

To begin to shed light on this issue, as part of the *Returning Home* project in Ohio, the Urban Institute conducted a small, exploratory study of the experiences of prisoners with serious mental and medical health problems as they prepared for release and sought health care services upon their return to Cincinnati (see sidebar on the *Returning Home* study). This research brief presents information that was gathered through interviews and focus groups with 81 male prisoners who had identified mental and/or medical health problems, and focus groups with health care and social service providers who serve former prisoners in Cincinnati.

This brief provides a look at the service delivery system in Cincinnati for former prisoners with mental and medical health problems, including collaborations among service providers and local, state, and federal agencies and including organizational barriers to service delivery for this population. The brief begins with a description of our study and a profile of our study participants, including health conditions they were diagnosed with and preventive health care they received. Using information gathered from surveys and ex-prisoner and provider focus groups, it documents prisoners' transitions from prison to the community and through about 90 days after their release, with a focus on their medical and mental health care and substance abuse treatment needs and the services they received.

The brief concludes with some policy implications for the reentry transition from prison to the community for individuals with medical and mental health care conditions and substance abuse treatment needs. Both prisoners and service providers urged a focus on the development of service delivery systems that ensure a seamless transition from care inside the prison walls to care on the outside for this particular group of individuals who possess significant needs and face unique challenges.

## Key Findings

- Among a sample of male prisoners with serious medical or mental health conditions, the majority reported that *mental* health care in prison was generally available when needed, but they were unsatisfied with the quality and availability of *medical* and *dental* care.
- Prisoners reported long waits to see a doctor and high levels of insensitive, uncaring treatment from many of the doctors and nurses in prison.
- After release, former prisoners said that the lack of information provided to them before release about community services was the biggest obstacle to getting the health care and other services they needed.
- Former prisoners reported that they often had to rely on family, friends, and even the emergency room of the local hospital to obtain the medication they needed after release.
- Community service providers praised the proposed plan in Ohio to prepare prisoners for release (the “Ohio Plan”) but said that prisoners’ medical needs required more attention during the release preparation program.
- Service providers felt that former prisoners needed one place to go to obtain comprehensive information about health care and other community services.
- The lack of available resources for services, limitations local funders place on grants, and the competition for funding were identified by service providers as significant problems in delivering services to former prisoners, especially those with the most serious health needs.
- Service providers suggested establishing universal mental health screening for soon-to-be-released prisoners, including those who will not be under the supervision of a parole officer.

## **Returning Home Study**

The Returning Home Ohio Health Study is part of the Urban Institute's three-year, multi-state study of prisoner reentry entitled *Returning Home: Understanding the Challenges of Prisoner Reentry*, which is being conducted in Maryland, Illinois, Ohio, and Texas. Through *Returning Home*, we are examining factors that contribute to a successful or unsuccessful reentry experience and identifying how those factors may inform policy decisions.

Conceptually, our research examines five domains: the individual characteristics and experiences of the returning prisoner; the risks and assets of his or her family; the relationship of the returning prisoner to his or her peers; the strengths and weaknesses of his or her local community; and state corrections programs, policies, and social and economic climate. With the generous support of The Health Foundation of Greater Cincinnati, we launched a special exploratory study of the ways that prisoners with demonstrated mental and physical health needs connect or fail to connect with community health care providers upon their return home. The Ohio Health Study begins by examining the nexus between prisoner reentry and public health.

## **Study Overview**

This report describes the results and implications of research into the unique challenges that confront men with demonstrated mental and physical health problems who are returning home to Cincinnati after serving a state prison term. Both quantitative and qualitative data were collected through (1) one-on-one interviews with 81 male prisoners who demonstrated serious mental or medical health problems 30 to 45 days before their release, (2) eight focus groups with 48 members of the original sample, conducted about 90 days after release, (3) a brief post-release survey, which was administered at the time of the focus groups, and (4) two focus groups with a total of 14 social service and health care providers who serve this population in Cincinnati, Ohio. The prisoner survey was initiated in September 2003 and all focus groups were completed by July 2004. (See the appendix for further details on the study methodology and an explanation of the medical and mental health classification systems used to select the prisoner respondents.)

The pre-release interviews focused on the individual's health history, current health status, and planning for his return to the community, as it related to his mental and medical health care needs.<sup>2</sup> The post-release focus groups with former prisoners discussed health care services in prison, release planning, and access to health care after their release. In the focus groups with community social service and health care providers, participants talked about discharge planning, community linkages, service integration for former prisoners, and service capacity.

### **Profile of Study Participants**

- Our prerelease sample consisted of 81 male respondents, 51 percent of whom were under some form of supervision after release. The median time served was 11 months.<sup>3</sup>
- Ages of participants ranged from 20 to 75. The median age of respondents was 41 years.
- Sixty-nine percent were African-American, twenty-two percent were white, and the remaining nine percent identified with other racial groups. Across all racial groups, two percent identified as Hispanic.
- Almost half (47 percent) were single and had never been married, and 62 percent had children under the age of 18 years.
- Forty-six percent had a high school diploma or GED, or more education before entering prison.
- Fifty-three percent were employed during the six months prior to prison. Almost half of the forty-seven percent who were unemployed said that they were not working due to mental health reasons, physical health reasons, or both.

### **Health Characteristics of Participants**

Of the 81 participants, 35 percent of respondents rated their health as “fair” when compared to others their age, 26 percent and 22 percent respectively rated their health as “good” or “very good,” and 7 percent described their health as “poor.” Few (10 percent) rated their health as “excellent.” Forty-two percent of respondents rated the condition of their teeth and mouth as “good” and almost half (48 percent) rated their teeth and mouth as being in “fair” or “poor” condition.

Despite the positive assessments of their overall health during the pre-release interview, over half (53 percent) of the respondents reported that their physical or mental health conditions limited the work and activities they could do. Further, for over half of the respondents (53 percent), pain interfered with their normal work or daily activities.

Respondents were asked a series of questions about current and prior mental and physical health conditions. Table 1 presents the percentage of our sample that had ever been diagnosed with each health condition, the percentage that were receiving treatment for each health condition, and the percentage that were taking prescription medication for each condition at the time of the pre-release interview. Depression was a common condition among study participants, with over half of the sample being previously diagnosed with depression and 38 percent both receiving treatment and taking prescription drugs for depression while incarcerated. For all conditions listed, a larger number of respondents had been diagnosed with each condition than the number who were currently receiving treatment and/or taking prescription medication for the condition while incarcerated.

**Table 1: Percent Diagnosed with Health Conditions, Receiving Treatment for that Condition, and Taking Prescription Medication for that Condition (N=81)**

<i>Condition</i>	<i>Diagnosed (%)</i>	<i>Receiving Treatment (%)</i>	<i>Taking Prescription (%)</i>
Depression	51.9	38.3	38.3
Hypertension	29.6	14.8	14.8
Asthma	27.2	13.6	14.8
Back pain	25.9	8.6	11.1
Other mental health	25.9	21.0	21.0
Arthritis	24.7	11.1	11.1
Hepatitis B or C	21.0	3.7	2.5
High cholesterol	19.8	7.4	6.2
Heart trouble	17.3	9.9	8.6
Diabetes	12.3	12.3	9.9
STD	12.3	0.0	0.0
Tuberculosis	12.3	1.2	0.0
Chronic lung disease	11.1	4.9	4.9
Stroke	4.9	2.5	3.7
Cancer	0.0	0.0	0.0
HIV/AIDS	0.0	0.0	0.0

*Note:* Based on prisoners' self-assessment of whether they had ever received a doctor's diagnosis, were receiving treatment, and/or were taking prescribed medication for the condition.

### **Preventive Health Care and Lifestyle**

Many respondents reported that they were engaged in high-risk health behaviors before their incarceration, such as smoking, excessive drinking, drug use, and frequently eating foods high in fat or cholesterol. A large majority (84 percent) said they had smoked at least 100 cigarettes over the course of their lifetimes, with 62 percent of the pre-release sample smoking daily. Two-thirds of the respondents reported drinking three or more alcoholic beverages on occasions when they drank in the six months prior to incarceration, with 11 percent drinking to the point of drunkenness daily and 21 percent doing so a few times a week. One quarter of our sample reported smoking marijuana on a daily basis, and another 12 percent reported doing so a few times a week; 15 percent reported daily use of cocaine, and 20 percent of respondents indicated that they used more than one illegal substance on a daily basis during the six months prior to their incarceration. Forty-two percent of respondents reported that a medical professional had told them that their alcohol or drug use was affecting their health.

About two-thirds (65 percent) of the respondents did not have continuous health insurance or coverage during the six months prior to their current prison terms. Furthermore, about one in four respondents said that there was a time in the six months prior to their prison terms when they delayed getting physical (27 percent) or mental health

care (19 percent) or prescription drugs (19 percent) when they thought they needed it. The most frequently cited reason for not getting or delaying care was the cost of care and/or the lack of health insurance. In addition, 30 percent of respondents said they did not get or delayed dental care at some point in the six months prior to their current prison terms.

### **Health Care in Prison**

Health care in prisons has improved dramatically in the last 30 years in response to several court cases that established a constitutional right to health care, including psychiatric services. However, many state correctional health care systems still struggle with poor management, overburdened staff, and inadequate services (see sidebar “Reforming Ohio Prison Health Care”). The creation of the National Commission on Correctional Health Care in 1981 has helped to develop standards for prison health care and offers voluntary accreditation. But the prevailing view among national experts is that the quality of prison health care remains low and that some prisoners, particularly the mentally ill, terminally ill, and sex offenders, are underserved.<sup>4</sup>

Almost all respondents in our sample availed themselves of health care services while in prison, which is not surprising among this sample with identified medical and mental health needs. Only two percent had no health appointments during their current prison term and over half (56 percent) had six or more appointments. The most common reasons for receiving health care while in prison were for mental health reasons (27 percent), chest pain or breathing problems (12 percent), and general check-ups (10 percent). About one in five spent at least one night in a hospital or prison infirmary, and 19 percent received emergency room care.

## Reforming Ohio Prison Health Care

In August 2003, the *Columbus Dispatch* and WBNS-TV released findings from their investigation of the quality of health care in Ohio prisons. They identified numerous problems with the prison health care system. In response, the governor requested that the Ohio Department of Rehabilitation and Correction (ODRC) conduct an internal review of the health care services in Ohio prisons. In December 2003, ODRC director Reginald Wilkinson released an extensive report that outlined 140 recommendations for improvements ranging from hiring additional staff to improved oversight of medical contractors and a detailed quality assurance program. Director Wilkinson ordered all recommendations implemented, and many changes have been made. However, state budget problems have prevented the timely implementation of some recommendations, including the recommended staff expansion.

The study described in this report is part of a study of prisoner reentry in Ohio and is unrelated to either the original investigation or any follow-up activities. Our survey of a small sample of prisoners with serious health problems and focus groups with them after their release was conducted from October 2003 through April 2004. Thus, most of our respondents' experiences occurred before recommendations from the statewide prison health care review were implemented. The primary focus of this report is on understanding the challenges faced by former prisoners in need of health services, and how they are prepared for release and connected with health care and other support services after they return to Hamilton County.

Respondents had mixed experiences with preventive health procedures in prison (see table 2), despite their age and health condition. Nearly all of our participants reported that they had their blood pressure checked (89 percent), 59 percent reported having a physical, and 40 percent had their cholesterol level tested while in prison. However, 21 percent reported having their teeth cleaned in prison, and nearly half of our respondents (47 percent) had never had their teeth cleaned.

A majority of our respondents reported that they were not satisfied with the quality (75 percent) or the availability (63 percent) of health care they received while incarcerated. About two-thirds (65 percent) reported not receiving medical care they thought they needed and 41 reported not receiving necessary dental care. By contrast, only 14 percent reported not getting mental health treatment and 2 percent reported not getting substance abuse treatment they needed.

**Table 2. Preventive Health Care in Prison**

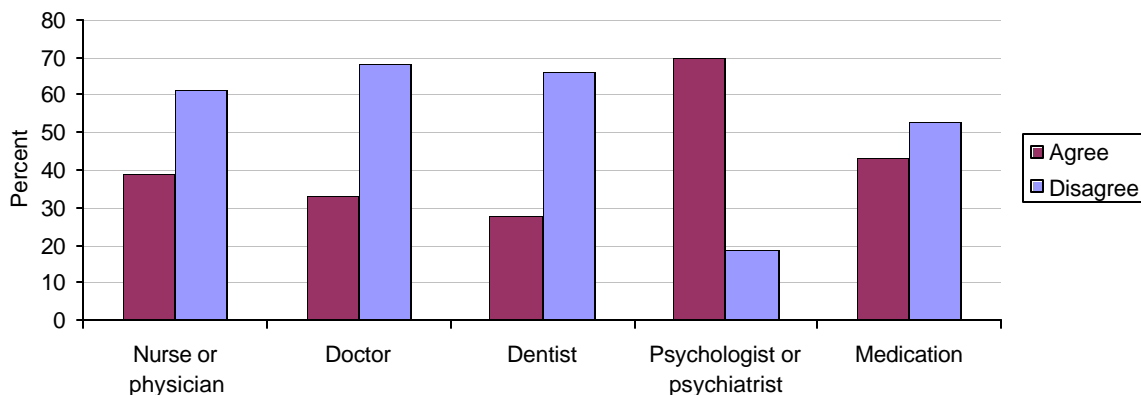
Health care procedure	<i>Percent who reported receiving procedure in prison</i>
Blood pressure check	88.9
Routine physical	59.2
Blood cholesterol test	39.5
Teeth cleaned	21.0



About one-third *agreed or strongly agreed* that they had access to a nurse, doctor, or dentist when needed, 42 percent felt they had access to medication, and a majority (70 percent) *agreed or strongly agreed* that they had access to a psychologist or psychiatrist when they needed it (figure 1). Thus, among our sample of prisoners with identified mental or medical health needs, mental health treatment was much more accessible than medical or dental care. Focus group discussions with respondents after their release from prison and with service providers confirmed the apparent imbalance between attention to mental and medical health needs in prison.

*The mental health [services] in the penal system is the best thing...but as far as physical health, it's zero, but mental health is 110 percent.*  
— former prisoner

**Figure 1. Availability of Prison Health Services According to Prisoners' Reports**



The most frequent complaints from former prisoners about health care in prison were (1) long waits—a week or more—to see a doctor or a nurse when the medical problem was urgent (e.g., infections, acute pain, broken bones), (2) the Ohio Department of Rehabilitation and Correction's (ODRC) requirement that prisoners pay three dollars for each sick call visit<sup>5</sup>, (3) an inability to get needed medication besides ibuprofen for most conditions, (4) a lack of timely transfer of medical records after moving from one institution to another, and (5) a general perception that many of the doctors and nurses did not care about prisoners' medical needs.

*Sometimes you might need medical attention right then, and then they put you on a sick call list, and you're waiting and waiting and waiting and getting worse.*  
— former prisoner

Former prisoners who were taking medication for chronic medical and mental health conditions said that they were often given substitute medication (i.e., generic version or a different drug) and if they complained, they risked being sent to solitary confinement.

*I'll tell you a lot of times, a lot of the guys, something could be wrong with them but they just didn't want to go through the hassle [of getting treatment]. And then they know [ODRC is] going to take their \$3 and they weren't getting [any money] from home. They wouldn't even go seek medical [treatment].*

—former prisoner

## **Preparation for Release**

Nationwide, discharge planning for prisoners with health problems is just beginning in many correctional agencies.<sup>6</sup> Ohio is unique in that a system-wide effort is underway to prepare all prisoners for release and connect them with needed services after their release to the community. Referred to as the “Ohio Plan” (see sidebar), it is being implemented statewide over a five-year period.

However, the new release preparation program had not yet reached most of the respondents in our sample. The majority (80 percent) reported no programming or assistance in preparing them to deal with their health care needs upon release, despite their identified medical or mental health needs. While over half of our sample had been diagnosed with depression at some point in their lives, 12 percent of respondents received information about accessing mental health treatment or counseling during release planning; and five percent were referred to a program out in the community. Few participants received information about drug or alcohol treatment (11 percent) or accessing medical care (6 percent) in their release planning, with about five percent receiving referrals to community drug or alcohol treatment programs and medical providers.

Respondents felt that health problems and health care access would present substantial obstacles to them after their release from prison. Almost half (48 percent) thought they would need *a lot of help* getting health care after their release, and over one-third thought they would need *some help*. Over half (52 percent) thought they would need help getting mental health care after their release. Moreover, 42 percent thought it *likely or very likely* that mental or physical health conditions would affect their ability to secure a job after their release.

When asked about release preparation, community service providers stressed the importance of full implementation of the Ohio Plan, which would provide better discharge planning for prisoners with health care needs. Service providers in our focus groups expressed great optimism about the Ohio Plan; however, some concerns were expressed about the availability of funding for statewide implementation. Service providers were aware that ODRC has a release preparation program that tries to identify the services prisoners will need and includes a series of modules about available community services.

## The Ohio Plan

- Through the Ohio Plan, the Ohio Department of Rehabilitation and Correction (ODRC) staff and prisoners begin to focus on the reentry process as soon as incarceration begins.
- All ODRC prisoners take part in the Release Preparation Program, which begins 180 days prior to their release.
- With their institutional case manager and other relevant staff, all ODRC prisoners develop a personalized Reentry Accountability Plan (RAP) to assist in their transition back to the community after release.
- Reentry Management Teams (RMT) and eventually Community Reentry Management Teams (CRMT) are established for those prisoners identified as “reentry intensive”<sup>7</sup> and for those who are identified as having disproportionately high levels of need (i.e., those with chronic health conditions or other physical or mental health care needs). The RMT is formed immediately upon the prisoner’s entry into prison and consists of the prisoner, his or her prison case manager, his or her unit manager, recovery service personnel, education staff, and other relevant staff that are needed according to the prisoner’s RAP.
- RMTs meet annually up to 36 months prior to the prisoner’s release. Within 36 months of release, the RMTs meet on a quarterly basis to assist the prisoner in identifying the appropriate programming and services to assist in their transition back to the community.
- CRMTs, consisting of the prisoner, appropriate Department of Parole and Community Service Offender Service Network personnel, the parole officer, and participating community service providers, meet 30 days prior to the prisoner’s release, every 90 days for the first six months after release, and every six months thereafter, depending on the former prisoner’s needs.
- Each CRMT engages in prerelease planning, connects former prisoners to services in the community, and monitors and assists the former prisoner for a full year after release.
- Local reentry coalitions meet regularly to provide guidance to service providers and other agencies in the community.
- ODRC is trying to broaden participation in the Reentry Management Teams to include social service providers of all types.
- The Ohio Plan began in the fall of 2002 and has a five-year timeline for full implementation.

For more information, see <http://www.drc.state.oh.us/web/offenderreentry.htm>.

However, service providers said that there is no formal module in the release preparation program for identified medical, as opposed to mental health, problems. Better coordination existed between the prison health care system and community service providers for prisoners who have been diagnosed with severe mental illnesses like schizophrenia and bipolar depression. They are often asked to go into the prisons or participate in videoconferencing to carry out diagnostic assessments and begin prerelease planning.

*The Ohio Plan is a beautiful, beautiful plan. And [ODRC] readily admits that it's going to take five years to roll it out.*

—Cincinnati service provider

During the focus group conversations, many service providers expressed the opinion that large numbers of men and women being released from Ohio prisons have undiagnosed mental health problems. They believe that some prisoners do not seek help in prison because of the stigma attached to mental illness in prison, or because they lack the initiative or resources needed to go through the procedures to access services. Thus, these prisoners are not identified before release and return to the community in need of mental health services but are without any referrals or knowledge of where to go for help. Prisoners echoed these views in their focus groups discussions after release.

*I think coming out ... you have mental health issues because ...[of] that lifestyle and that situation, and then [you are] thrown back...into society. Not everybody can acclimate...some people when they get out, [they feel] hopeless and desperate...[with] nowhere to turn. You just want to talk to somebody about how you feel.*

—former prisoner

## **Transition from Prison to Community**

While many prison health experts agree that discharge planning is more common for prisoners with serious mental and physical health problems, nationwide, only about one-fourth of state and federal prisons reported making appointments for HIV-infected releasees.<sup>8</sup> We asked our respondents about health care that they received immediately after their release. About 40 percent reported having an appointment with a health care professional in their first week after release.

In the focus groups held after release, former prisoners identified the lack of information provided to them before release about community services—where to go, how to get it, whom to talk to—as the biggest obstacle to getting the health care and other services that they needed after release. Some respondents who had been through the ODRC pre-release program in the past felt that the quality of the program had declined. Some participants also said that medication that was supposed to be mailed to them never arrived<sup>9</sup> and that the parole office did not have copies of their discharge papers describing their health conditions. In some focus groups, respondents learned about available services from each other's experiences.

Service providers agreed that ODRC provides reasonable services immediately after release, such as appointments on the first day of release, a two-week supply of medication, and referrals for other needed services, for former prisoners with serious mental health problems and for HIV-infected individuals. However, they also pointed out that a two-week supply of medication frequently runs out before service providers can perform an assessment and issue a new

prescription. Many service providers expressed concern that some former prisoners may be illiterate, disoriented, or mentally ill and therefore cannot navigate service provision bureaucracies. More intensive case management may be needed for these releasees during the transition period from prison to the community.

Service providers suggested that more resources be devoted to screening soon-to-be released prisoners for mental health needs and identifying those with disorders that will qualify them for government assistance. In addition, service providers proposed that a process be established so that prisoners with mental illness who do not have housing arranged before release could be identified and officially designated as homeless *before* their release, which would immediately qualify them for various forms of post-release assistance.<sup>10</sup> These types of pre-release preparations are especially important for those prisoners who will not be under supervision after release.

If mentally ill prisoners are released without supervision conditions and are not identified as homeless prior to their release, they must spend at least one night on the street before they qualify, according to the service providers that participated in our focus groups.

Another barrier to accessing health care services identified by service providers is a lack of legal identification when individuals are released from prison. ODRC issues identification to persons released to parole supervision, although the card issued at the

parole office clearly identifies the individual as a [former] offender. To obtain a state identification card, which is needed to secure employment, housing, and some health services, former prisoners must have other legal identification such as a Social Security card or a birth certificate. Many persons leave prison without birth certificates or Social Security cards and must obtain these documents after release.

*There are many, many, many of these folks that are not literate and cannot manage the paperwork that they have to manage, because they don't want to tell you they can't read if they don't understand the directions, or they cognitively do not have the ability to follow through on it.*

—Cincinnati service provider

*[Getting clients services] is best [scheduled] immediately upon release. What happens is there's a delay until things can be implemented or appointments or whatever. By the time that the appointment comes around, they're already using [drugs].*

—Cincinnati service provider

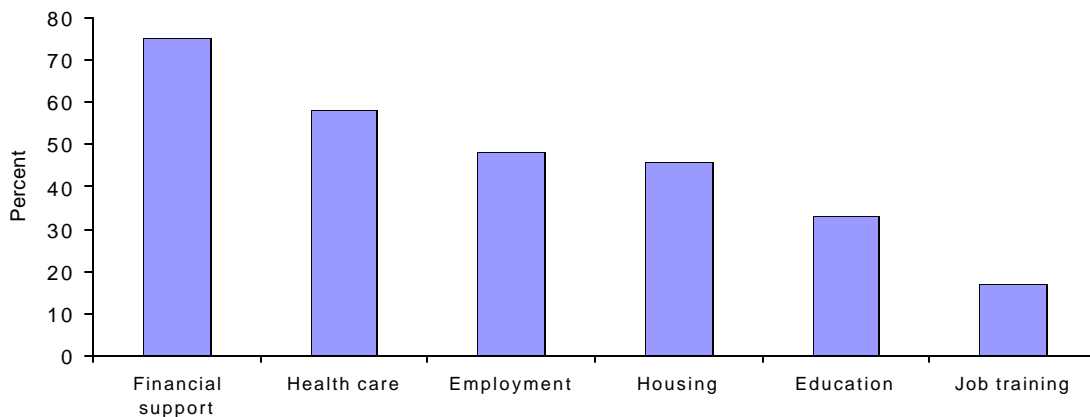
### Needs of Former Prisoners as Identified by Service Providers

- Legal identification.
- Transportation assistance.
- *Current* information (often what they do receive is out of date) about the purpose, availability, requirements, and location of health care, social, and other support services in the community, especially for those not on parole or community supervision.
- Copies of medical records and medications, so that service providers do not have to conduct costly and time-consuming re-evaluations.
- Counseling to address moderate mental health problems such as depression and the stress and psychological effects of incarceration and reintegration.

### Prisoners' Experiences and Services Received after Release

Nationwide, prisoners return to communities that face significant challenges in providing health care services to a population lacking health insurance coverage but with serious health and social needs.<sup>11</sup> About 90 days after release, our respondents<sup>12</sup> were asked what kinds of health care services they had received since their release. Nearly one-third (29 percent) had received physical health care services and 25 percent had received mental health services. Almost one-quarter (23 percent) received prescription medications, eight percent received substance abuse treatment or counseling, and six percent received dental care in the first 90 days after release. However, approximately one-third of respondents reported not getting or delaying mental health care (31 percent) and dental care (33 percent) after release, and roughly one-quarter reported not getting or delaying physical health care (25 percent) or prescription medications (27 percent). Twenty percent reported not getting or delaying substance abuse treatment. The primary reasons they provided for delaying or not getting care were lack of insurance coverage and their inability to pay for such care (or medication).

**Figure 2. Types of Post-Release Assistance Needed**



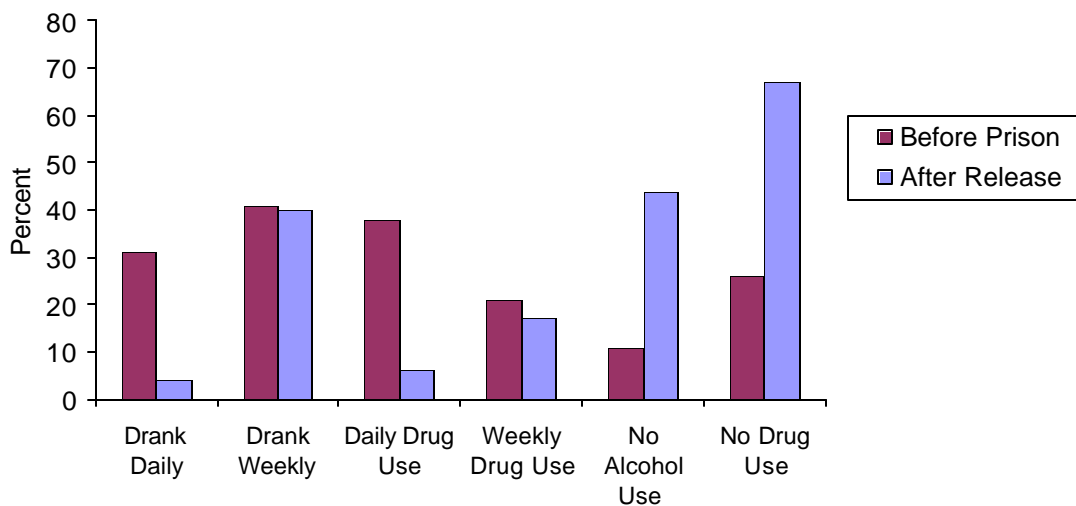
About 90 days after release, respondents were also asked what types of assistance or services they needed (see figure 2). The second most frequently cited service (behind financial support, which 75 percent of respondents mentioned) was health insurance or coverage, with 58 percent of respondents identifying it as a service that would be useful to them. Nearly half (48 percent) mentioned a job, and 46 percent mentioned housing. One-third of respondents identified education as something that would be useful, and 17 percent mentioned job training. About one-third (33 percent) reported having health insurance coverage either through federal or state assistance or their employer, and 60 percent reported having no health insurance or coverage 90 days after their release.

*....They don't provide that information [on where to go to get health care]. There are people out there [that can help] get you that health service. You got to search around for it. You got to know where to go.*  
 —former prisoner

In the post-release focus groups, respondents with serious medical conditions such as epilepsy and high blood pressure discussed the difficulty they encountered paying for the cost of the medication they needed. After their two-week supply ran out, they borrowed money from family and friends, went to the emergency room or the psychiatric department of the local hospital, or simply went without medication.

Our respondents had been correct in anticipating difficulties awaiting them upon release. More than two-thirds (69 percent) of respondents were unemployed at the time of the post-release survey. Family support appeared to be somewhat more tenuous than the respondents had anticipated: 15 percent reported no close family relationships after release, compared to 12 percent in the pre-release survey. And whereas 41 percent reported four or more close family relationships in the pre-release survey, fewer (23 percent) reported that level of family support after release.

**Figure 3. Substance Use Before Incarceration and After Release**



Self-reported use of alcohol and drugs since release was much lower in our post-release subsample than reports of use before incarceration in our full sample (see figure 3).<sup>13</sup> Two-thirds (67 percent) reported not using any drugs and 44 percent reported not drinking at all since release, compared to 26 percent (no drug use) and 11 percent (no alcohol use) before incarceration. Nonetheless, significant numbers of respondents reported daily or weekly drinking or drug use after their release: 4 percent reported drinking daily, 40 percent reported drinking at least once a week; 6 percent reported using drugs daily and 17 percent reported using drugs at least once a week.

Service providers in our focus groups had much to say about the delivery of health care services for persons released from prison, and they identified a number of challenges in delivering services (see sidebar “Service Providers Identify Challenges in Health Care Delivery”). In their experience, the primary factor affecting former prisoners’ use of or access to health care services, even among those with serious mental or physical problems, is that most lack income and must go through a lengthy qualification process to get federal or state benefits. Under federal law, prisoners who had been eligible for the Supplemental Security Income (SSI) program before their incarceration are dropped from the program during their prison term, and it can take six months to a year for them to regain eligibility and benefits after release. Former male prisoners are unable to access Medicaid benefits unless they have been qualified for SSI. Service providers indicated that the majority of former prisoners in need of medical and mental health services fail to meet the criteria for SSI and Medicaid because their illness is not considered a qualifying disability under the regulations.

*Almost always, the Social Security outpatient gets denied [benefits] initially, and [the former prisoner] has to appeal [that decision]. They can have 15 years of active hallucinations and an inability to function, at level one RTU [housed in ODRC Residential Treatment Unit for inmates with most serious mental illnesses], and they’re going to get denied.*  
—Cincinnati service provider

Community providers also pointed out that getting clients services for mental health problems is frequently complicated if they have a history of substance abuse. Recently released prisoners with co-occurring disorders are caught in a system that is not designed to address their unique needs. Mental health programs may decline to accept people if they have current substance abuse problems, and substance abuse treatment programs often exclude people with current mental health problems. Thus, former prisoners with co-occurring disorders, which are common among those with serious illness and this population, can be bounced back and forth between the two systems. In addition, some agencies cannot or will not provide services to violent offenders and sex offenders.

*It’s impossible to place a sex offender in a residential substance abuse [treatment] program in this county.*  
—Cincinnati service provider



### **Service Providers Identify Challenges in Health Care Delivery**

- Intensive case management is required, as some former prisoners have comprehensive needs and require extensive interaction (e.g., driving them to referrals to ensure that they show up).
- High no-show rate for appointments—estimated to exceed 50 percent.
- Long waiting lists for substance abuse treatment.
- Discouraged clients who may give up seeking services after encountering a barrier and then relapse to drug or alcohol abuse.
- Lack of insurance coverage for former prisoners.
- Prisoners released without supervision as they have less access to services (and no case management) compared with prisoners released to parole supervision.

### **Health Care Service Delivery: Organizational Barriers and Collaboration**

In attempting to obtain access to mental and physical health care services, individual factors and characteristics are obstacles to returning prisoners accessing care. Organizational and structural problems within the community service delivery system also create service delivery problems. During the focus group discussions, providers expressed the belief that, for former prisoners seeking health care and other services, information about community resources is difficult to obtain. Parolees can visit the regional parole office where information is available, but those who are not under community supervision are unlikely to know about that resource. Service providers in our focus groups felt that, for the most part, the service community is not well-organized.

The Ohio Plan is viewed as an opportunity to better prepare prisoners for release, provide them with information on available services, and coordinate service providers, so that former prisoners can receive the information and services they need. Most of the prisoners in our sample, however, did not appear to receive much case management upon release, perhaps because the Ohio Plan had not yet been fully implemented and because some prisoners were not under supervision after their release. In the focus groups, former prisoners suggested that an office in the community be established that would have information about how to access services and programs that address the issues they face: how to get health care, where to go to find a job with an employer that will hire persons with a criminal record, how to find housing, and how to receive temporary financial assistance, including food stamps.

One former prisoner offered his recommendation for a new system to address health care needs after release, a recommendation that mirrors the vision for the Ohio Plan:

*If they would address everybody's medical needs before they left the prison, say a month before ... and then when you get out, they've already got an appointment set up...and if the guy [needs] a ride they provide a [bus] token or cab [fare] so that you can get there and the person doesn't have to feel embarrassed about going up there because [of lack of insurance]. It could be that ... these people know what your needs are because they [have] already corresponded with the institution and so [your medicine is ready], and you don't have to worry, what am I going to have to do to get this medicine?*

Service providers also discussed the role of local and state funding of service delivery to former prisoners. Some participants mentioned that the primary focus of many funding streams appears to be getting former prisoners into employment. Other needs, such as mental and physical health care and substance abuse treatment, are treated as a secondary priority. However, service providers and former prisoners noted that those “other needs” often require attention before employment is even feasible. Service providers complained that some funders in Cincinnati use client employment outcomes as performance measures for continued funding, yet many of their clients are either not employable or will need considerable assistance to become employable.

Other funding is tied to very specific populations including those in court diversion programs and men who are married or in committed relationships. Moreover, most Cincinnati agencies will not accept the most difficult clients, those with serious substance abuse and/or mental health problems, because these clients are expensive to treat and funds are limited. Thus, service providers lamented that they are chronically short of funds and are unable to offer services that are needed, especially substance abuse treatment and mental health services for the typical former prisoner who does not qualify for SSI. Inherent in the system are disincentives to work with the individuals who often face the most difficult challenges and have the greatest needs.

*We are dealing with clients that don't get well fast enough for [the funding agencies] ... or at all. Clients who are too ill, too screwed up, too mentally retarded, too something to exhibit the right outcomes fast enough to be [managed] in a one-year funding cycle basically don't get any service.*

—Cincinnati service provider

Focus groups with community service providers revealed that collaboration among agencies and with parole exists, but improvement is needed. An ex-offender community task force meets regularly in Cincinnati to discuss needs of former prisoners and how to deliver services to this population. Service providers receive calls from parole officers to set up appointments for their clients, and at least one service provider runs monthly discussion groups with parolees at the parole office. However, financial resources for serving this population are scarce, which can foster a spirit of competition rather than collaboration; some service providers call such competition a “serious problem.”

*I think people are meeting-ed to death. I mean, you can't run an agency, be present at all the meetings you need to be present at, supervise the staff, and provide the services, and then live. It's just impossible.*

—Cincinnati service provider

As is typical in many communities, service providers mentioned that they suffer from a lack of information about each other, including the resources they have and the services they provide. Lack of communication among service providers, often with a former prisoner caught in the middle, can result in frustration and resentment for everyone. Different service provision systems, such as substance abuse and mental health, have different procedures for handling clients. Some service providers are familiar with only one system, but many former prisoners need coordinated services from multiple systems. Moreover, some service providers are resistant to working with former prisoners. Some providers believe that former prisoners turn to illegal drugs and alcohol if they become frustrated in receiving services.

ODRC is working to involve more community service agencies in the Community Reentry Management Teams envisioned by the Ohio Plan and to get these agencies to send staff to meet with soon-to-be-released prisoners. Some older prisoners remembered a time when community providers did come into the prisons regularly. Now, however, these agencies are understaffed and short on resources. Pressed for time, they have to pick and choose the meetings they are able to attend. This limits service provider participation in Community Reentry Management Teams and the community ex-offender task force.

### **Policy Implications**

The information presented in this report expresses the views of 81 prisoners with serious medical and mental health problems and approximately two dozen health care and social service providers that serve this population in the Cincinnati community. Through the Ohio Plan and other reentry initiatives, the State of Ohio and the ODRC are engaged in serious efforts to establish processes and programs that will help facilitate a successful reentry transition for men and women who are being released from ODRC prisons. However, as evidenced by the information collected from our study participants and presented herein, significant problem areas, gaps in services, and barriers to service delivery remain, specifically as they relate to former prisoners with serious mental and medical health care and substance abuse treatment needs (see sidebar “Recommendations from Service Providers”). The policy implications of our study point to broad policy changes as well as

specific measures that could improve the social service and health care delivery systems for former prisoners with mental and medical health care needs.

In general, a web or safety net of service delivery systems must be established to ensure a seamless transition from care inside the prison walls to care on the outside. Such a system requires extensive pre-release planning and close collaboration and coordination between ODRC prison facility staff (mental and medical health care providers, substance abuse counselors, and case managers), parole officers, and social service, health care, and substance abuse treatment providers in the community. Then, the service delivery system must be communicated widely to prisoners, prison caseworkers, community service providers, and parole officers.

Involvement is also needed from local, state, and federal agency staff, such as those who determine eligibility for and process applications for a variety of programs, including, but not limited to Medicaid, Social Security (SSI and Social Security Disability), food stamps, housing assistance programs, substance abuse treatment, veterans' benefits, and other employment and support services. And, while obvious, it should be emphasized that new programs and additional efforts to enhance and improve collaboration and coordination must be adequately funded and staffed.

#### **Recommendations from Service Providers**

- Enhance the capacity of the ODRC Release Preparation Program to look at the entirety of a prisoner's post-release needs rather than at a few specific areas.
- Enhance post-release planning, housing assistance, and referrals to community services for individuals with physical and mental health conditions who are not being released to supervision.
- Educate parole officers on the need to connect clients with medical and mental health problems to services immediately upon release and provide transportation assistance for clients to travel to service referrals.
- Place computers with access to a county resource guide in local community centers, public libraries, and parole offices, and educate former prisoners about their availability and how to use them.
- More vigorously screen mentally ill prisoners who are not being released to supervision to determine if they have post-release housing lined up, so that they can immediately access housing assistance through programs designed to fill this need.
- Enhance mental health and residential substance abuse treatment capacity for former prisoners and fund programs specifically targeted to former prisoners with co-occurring disorders.
- Develop universal programs for prisoners to obtain legal identification and apply for state and federal benefits programs before release.
- Devise a statewide agreement between county mental health boards to address the needs of residents who are out of their county of residence but in the state.

*(continued)*

### **Recommendations from Service Providers (continued)**

- Encourage local and state funders to include service providers in discussions about outcome measures, in addition to or in place of the traditional employment and training outcomes, in an effort to develop better indicators of success for programs that serve former prisoners with serious substance abuse, mental, and/or medical health problems.
- Implement a public education campaign targeted to health care and service providers, employers, local leaders, and other community stakeholders on the importance of addressing prisoner reentry needs, with the goal of changing attitudes and building support for directing resources toward prisoner reentry.

## APPENDIX: STUDY METHODOLOGY AND ODRC MEDICAL AND MENTAL HEALTH CLASSIFICATION SYSTEM

The sample of 81 prisoners, all of whom were returning to Hamilton County, was drawn from one of five pre-selected Ohio Department of Rehabilitation and Correction (ODRC) prisons to reflect certain health conditions, based on the ODRC medical and mental health classification systems. Medical health classifications range from Level 1 to Level 4, with Level 1 representing the lowest level of medical need and Level 4 the greatest level of medical need. Mental health classifications range from C1 to C3, with C3 representing the lowest level and C1 the greatest level of mental health treatment needs. For this study, prisoners who met the abovementioned sampling criteria and who had Medical Health Classifications Level 2 or Level 3 and/or Mental Health Classifications C1, C2, C3 or some dual medical-mental classification of these levels were selected.

The sample did not include any prisoners with Level 3 medical classifications or C3 mental health classifications, which is reflective of the small proportion of Ohio prisoners with either a Level 3 medical classification (0.5 percent) or a C3 mental health classification (2 percent). Table A-1 provides the medical and mental health classifications of our sample.

**Table A-1. Medical and Mental Health Classifications of Study Sample (N=76)**

<i>Classification</i>	<i>Number</i>	<i>Percentage of Sample</i>
Medical Level 2	28	36.8
Mental C1	28	36.8
Mental C2	9	11.8
Mental C1/Medical Level 2	6	7.9
Mental C2/Medical Level 2	5	6.6

*Note:* Five participants were identified as having either a Mental C1 or C2 classification. We were unable to determine which classification they had at the time of the pre-release interview, so they are excluded.

Given the nature of the sample, the results of this study only reflect the experiences and perceptions of Ohio prisoners who were classified as having certain medical and mental health conditions, as indicated by the ODRC. It was the intent of this study to present both the prisoners' point of view and that of community service providers. As with all self-reported data, our findings may include factual inaccuracies resulting from lapses in memory and the potential for respondents to overreport or underreport certain types of experiences and behaviors. Nonetheless, use of surveys and focus groups to elicit sensitive information is a time-honored research method.

## ODRC Medical and Mental Classification Levels

The Medical Level, indicated by a number, designates level of need for medical services as defined by specified criteria. Table A-2 provides the definition of each classification and the percentage of the prison population in 2001 that was classified at each level. The Mental Health Classification System uses standardized criteria and nomenclature to clarify the treatment (and program) needs of offenders who are seriously mentally ill (SMI). Table A-3 presents the codes, their defining criteria, and the percent of the prison population in 2001 that was classified at each level.

**Table A-2. Percent of 2001 Ohio Inmate Population by Medical Health Classification**

<i>Medical Classification</i>	<i>Percent</i>
Level 1: Medically stable, requiring only periodic care and not requiring chronic care clinic or infirmary monitoring	79.4
Level 2: Medically stable, requiring routine follow-up care and examinations Includes conditions, when stabilized, such as diabetes, respiratory conditions (asthma, COPD, etc.), HIV-AIDS (with limited symptomology), cardiovascular conditions, epilepsy, and cancer in remission and/or minimal treatment	20.0
Level 3: Requiring frequent intensive, skilled medical care but able to maintain their own activities of daily living (ADLs) Includes such conditions as diabetes (unstable or with complications), renal failure requiring dialysis, severe chronic lung disease or those requiring oxygen therapy, HIV-AIDS (advanced), cardiovascular disease (advanced), unstable epilepsy, and cancer requiring aggressive treatment. Also includes paraplegics and hemiplegics.	0.5
Level 4: Requiring constant skilled medical care and/or assistance with multiple ADLs Includes conditions such as diabetes (unstable and/or with serious complications), respiratory diseases requiring continued oxygen therapy, HIV/AIDS (advanced), cardiovascular disease (advanced), unstable epilepsy, and advanced and/or terminal cancer. Also includes quadriplegics.	0.1

**Table A-3. Percent of 2001 Ohio Inmate Population by Mental Health Classification**

<i>Mental Health Classification</i>	<i>Percent</i>
N: No Mental Health Services No current mental health services required.	83.0
C1: Psychiatric Caseload (SMI)  Offender is on the psychiatric caseload and meets criteria for SMI designation. SMI is defined as “a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or cope with the ordinary demands of life within the prison environment and which is manifested by substantial pain or disability.”  Serious mental illness requires a mental health diagnosis, prognosis, and treatment, as appropriate, by mental health staff.	9.0
C2: Psychiatric Caseload (non-SMI)  Offender is on the psychiatric caseload but does not meet the criteria for SMI. He/she is receiving mental health care and supportive services that include medication prescription and monitoring, individual and group counseling and therapy, crisis intervention, and behavior management.	6.0
C3: General Caseload  Offender is receiving group or individual counseling, therapy, and skill-building services. He/she has a mental health diagnosis and treatment plan, is being treated by mental health staff <i>other</i> than the psychiatrist, and is not on psychotropic medication.	2.0

**Acknowledgements**

The authors would like to thank the many individuals and organizations that made valuable contributions to this report. Nancy La Vigne, Daniel Mears, and Amy Solomon of the Urban Institute gave us helpful comments and suggestions. We are indebted to the research and facility staff of the Ohio Department of Rehabilitation and Correction, and specifically Kay Northrup, for providing access to the prisoner study respondents. The Returning Home Ohio Health Study was conducted at the request and support of The Health Foundation of Greater Cincinnati. We also thank Jeremy Travis, whose vision, support, and encouragement have guided the overall *Returning Home* project. This study would not have been possible without the dedication of Dr. Alisu Schoua-Glusberg of Research Support Services, Inc. who led a team of interviewers that conducted the in-prison interviews and personally conducted the focus groups with former prisoners.



## Endnotes

---

1. Maruschak, L., and Beck, A. 2001. "Medical Problems of Inmates, 1997." Washington, D.C.: Bureau of Justice Statistics.

2. This report distinguishes between mental health and medical (i.e., physical) health, following the Ohio Department of Rehabilitation and Correction's (ODRC) classification system. The term "health care" refers to both types of care.

3. Forty-one percent of our sample served over two years in prison.

4. Anno, B. J. 2003. "Prison Health Services: An Overview." *Journal of Correctional Health Care* 10: 287–302.

5. The majority of states require a health care copayment in the range of \$2 to \$5 for inmate-requested health care. ODRC charges prisoners \$3 for each visit to see a doctor, to help defray costs and reduce frivolous requests. Visits to the nurse or for chronic care are exempt, and, according to official ODRC policy, prisoners who are deemed indigent are exempt from the copayment. In our focus groups, former prisoners complained about the fee. According to our participants, their monthly income from prison work is about \$18, and many do not receive additional money from family. For those not deemed indigent, any incurred fees are deducted from future state pay. Prisoners need cash for basic toiletries (e.g., soap, toothpaste) and for some food purchases. In addition, child support payments and other fines may be taken out of prison pay.

6. Anno, 2003.

7. Upon entering prison, all ODRC prisoners are evaluated with a risk assessment tool and are identified as "reentry basic" or "reentry intensive," so that staff and providers can ensure that those who have the most need receive intensive reentry planning and other services and programming as appropriate. In 2004, 74 percent of the ODRC prison population was identified as "reentry basic", and the remaining 26 percent were identified as "reentry intensive."

8. Hammett, T.M., Roberts, C., and Kennedy, S. 2001. "Health-Related Issues in Prisoner Reentry." *Crime and Delinquency* 47(3): 390–409.

9. According to ODRC staff, it is official ODRC policy that medications not be mailed to recently released prisoners. However, several focus group participants indicated they were told by prison staff their medication would be mailed to them upon release, and, in attempting to locate one study participant after release, we were told by a family member that she had received in the mail a box of medication from the prison.

---

10. Programs include the Projects for Assistance in Transition from Homelessness (PATH) Reentry Prison Pilot Project, which is intended to assist prison or jail inmates with serious and persistent mental illness who do not have housing secured for after their release. Through the program, seriously mentally ill former prisoners receive assistance in accessing a wide variety of social, physical, and mental health services, in addition to housing. The program is funded through the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA allocates grant funding to the Ohio Department of Mental Health (ODMH), and the Ohio Department of Development provides additional funding for rental subsidies.

11. Freudenberg, N. 2003. "Community Health Services for Returning Jail and Prison Inmates." *Journal of Correctional Health Care* 10 (3): 369–98.

12. From our original sample of 81 men, 48 men were administered a short survey and participated in post-release focus groups. All members of our original sample were invited to take part in the focus group discussions. However, we found it difficult to locate some respondents and found that "no-shows" were not uncommon, even after respondents confirmed their intentions to attend during confirmation phone calls made the day before each focus group.

13. There are many possible reasons for this decline, including the fact that over 40 percent of the post-release sample was on supervision and the possibility that those who we did not locate after release were at higher risk of substance use.