FY 2024 How to Best Meet the Need

Special Workgroup #2 – Various Topics
1:30 p.m., Monday April 17, 2023

Join the Zoom meeting:
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2022 - 2026 Houston Area Integrated HIV Plan Activities Organized By Pillar

Pillar	Activity	Responsible Parties (Name of entity)	Timeframe (By when)	Resources (Funding, staff, etc.)	Target Population	Data Indicator	Contact; Assigned Committee	Status and Brief Progress N
Pillar 1: Diagnose	Improve HIV-Related Health Outcomes of All People Being Tested for HIV [QoL]	Health departments, community-based organizations, FQHCs, correctional facilities, school-based clinics, sexual health clinics, women's health services/prenatal service providers, hospitals.	Annually	CDC HIV Prevention and Surveillance Programs, RWHAP, State and/or Local Funding.	People at risk for acquiring HIV	Number of newly identified persons with HIV; Establishment of protocols for HIV/AIDS treatment under incarceration, number of cases linked to care under incarceration.		☐ Complete (C) ☐ In Progress (P) ☐ Not Initiated (NI)
Pillar 1: Diagnose	Increase Knowledge and Understanding of HIV	Southern AIDS Education and Training Center (**AETC**), Texas Southern University (**TSU**), Houston HIV Prevention Community Planning Group (**CPG**) and Ryan White Planning Council (**RWPC**).	Annually	CDC, Ryan White, AETC and possibly TSU grant funds already secured to work with community groups such as The Houston Area HIV Education Coalition.		Increased knowledge among students measured by student pre and post tests		☐ Complete (C) ☐ In Progress (P) ☐ Not Initiated (NI)
Pillar 2: Treat	Increase Access to Care and Medication	Operation I.D., Texas I.D. Connect, The Beacon, Ryan White-funded agencies.	Annually	N/A		Ten percent more individuals have received identification in a 6-month period. Agency data on client service utilization		☐ Complete (C) ☐ In Progress (P) ☐ Not Initiated (NI)
Pillar 2: Treat	Increase access to HIV education, prevention and care services among priority populations.	Staff from various Ryan-White funded agencies	Annually	Ryan White Part A or B or State Services funding	People with a history of sexual offense	Case manager/service linkage worker is hired and secures a minimum caseload of 30 individuals within a 12 month period. RWPC incorporates the quarterly reports from the case manager/service linkage worker in its planning process and works to better meet the needs of this priority population.		☐ Complete (C) ☐ In Progress (P) ☐ Not Initiated (NI)

Pillar	Activity	Responsible Parties (Name of entity)	Timeframe (By when)	Resources (Funding, staff, etc.)	Target Population	Data Indicator	Contact; Assigned Committee	Status and Brief Progress N
Pillar 2: Treat	Increase access to care and medication by tying the distribution of prepaid cell phones for clients to pharmacies, making the phone a medical necessity (not an incentive).	Staff from various Ryan White-funded agencies	Annually	N/A		More clients receive cell phones in a 6-month period; Agency phone disbursement records		☐ Complete (C) ☐ In Progress (P) ☐ Not Initiated (NI)
Pillar 3: Prevent	Prevent new HIV Infections by increasing knowledge of HIV among people, communities and the health workforce; with particular emphasis on priority populations and non-Ryan White funded agencies with expertise in areas that intersect with HIV.	Southern AETC, TSU, CPG and the RWPC	Annually	CDC, Ryan White, AETC and possibly TSU grant funds already secured to work with community groups such as The Houston Area HIV Education Coalition.		Increased knowledge among students; student pre- and post-tests		
Pillar 3: Prevent	Gather data both for and against policy changes related to the following issues with the goal of making data driven decisions regarding support for: • Condom distribution in jails and prisons • Texas becoming a Medicaid Expansion state	Community-based organizations, FQHCs, sexual health clinics, hospitals, social media platform providers, social service providers, community task force, RWPC-OS (Potential non-RP partners: TDSHS; AETC; HHS), St. Luke's Episcopal Foundation	Annually	N/A	Ryan White Planning Council members	State and local policies		

Pillar	Activity	Responsible Parties (Name of entity)	Timeframe (By when)	Resources (Funding, staff, etc.)	Target Population	Data Indicator	Contact; Assigned Committee	Status and Brief Progress N
Pillar 4: Respond	Build a community-tailored program to investigate and intervene in active networks and ensure resources are delivered where need is the greatest.							
Pillar 5: Quality of Life	Improve Quality of Life for Persons Living with HIV.	People with HIV, CPG, RWPC, HHD, Houston Area HIV Data Committee (HDC)	Annually	HHD	People living with HIV	Quality of life survey indicates higher quality of life among people living with HIV.		
Pillar 5: Quality of Life	Increase the proportion of people with diagnosed HIV who report good or better health to 95% from a 2018 baseline of 71.5%.	Persons with HIV, Ryan White-funded clinics, Ryan White Administrative Agencies, CPG, RWPC, HDC.	Annually	N/A	People living with HIV	Centralized Patient Care Management System (CPCDMS) and Take Charge Texas (TCT) client level data systems.		
Pillar 5: Quality of Life	Decrease by 50% the proportion of people with diagnosed HIV who report an unmet need for services from a mental health professional from a 2017 baseline of 24.2%.	People with HIV, Ryan White-funded clinics, Ryan White Administrative Agencies, CPG, RWPC, HDC.	Annually	N/A	People living with HIV	CPCDMS and TCT		
Pillar 5: Quality of Life	Decrease by 50% the proportion of people with diagnosed HIV who report ever being hungry and not eating because there wasn't enough money for food from a 2017 baseline of 21.1%.	People with HIV, Ryan White-funded clinics, Ryan White Administrative Agencies, CPG, RWPC, Houston area food banks, local churches, HDC.	Annually	N/A	People living with HIV	CPCDMS and TCT		
Pillar 5: Quality of Life	Decrease by 50% the proportion of people with diagnosed HIV who report being out of work from a 2017 baseline of 14.9%.	People with HIV, Ryan White Administrative Agencies, CPG, RWPC, HDC	Annually	N/A	People living with HIV	CPCDMS, TCT, and employment records		

Pillar	Activity	Responsible Parties (Name of entity)	Timeframe (By when)	Resources (Funding, staff, etc.)	Target Population	Data Indicator	Contact; Assigned Committee	Status and Brief Progress N
Pillar 5: Quality of Life	Decrease by 50% the proportion of people with diagnosed HIV who report being unstably housed or homeless from a 2018 baseline of 21.0%.	People with HIV, Ryan White Administrative Agencies, CPG, RWPC, Housing Agencies, HOPWA and other housing funders, HDC.	Annually	N/A	People living with HIV	CPCDMS and TCT		
Pillar 5: Quality of Life	Increase coordination and cooperation among Houston area institutions, universities and agencies that collect HIV related data.	HHD/Bureau of HIV, HCPH/RWGA, CPG, RWPC, PACHA, Positive Women's Network – USA and Houston Chapter, Cizik School of Nursing, UTHealth, South Central AETC, Baylor College of Medicine, University of Houston Graduate School of Social Work, Houston Food Bank	Annually	N/A	People living with HIV	CPCDMS, TCT, and other data held by institutions listed above as Key Committed Partners.		

Quality of Life VISION for PLHIV

All people living with HIV will have unfettered and 'hassle-free,' access to a full range of life-extending high quality culturally sensitive, gender affirming care and social support free from all stigma and discrimination that prioritizes our mental, emotional, and spiritual health as well as our financial wellbeing. People living with HIV are "people first" and our quality of life is not defined by our race, gender identity, sexual orientation, HIV status or measured solely by viral suppression.

Quality of Life THEMES

1. Intersectional stigma, discrimination, racial and social justice, human rights and dignity
2. Overall wellbeing, mental, emotional and spiritual health
3. Aging, comorbidities and life span (can include functionality, cognitive ability, geriatrics)
4. Healthcare services access, care and support
5. Economic justice, employment, stable and safe housing, food security
6. Policy and research

Quality of Life DEFINITION

We demand a quality of life that achieves the following:

1. Ensures that all people living with HIV thrive and live long healthy dignified lives.
2. Recognizes that HIV is a racial and social justice issue and works to dismantle the structural barriers that marginalize and diminish our quality of life.
3. Uplifts our humanity and dignity as human beings; we are people living with HIV and not a public health threat.
4. Values our emotional labor and personal stories as worthy of compensation and meaningfully involves people living with HIV as subject matter experts in all decisions that impact our lives as paid staff and consultants and not just as volunteers.
5. Recognizes that because we have a large number of people aging with HIV that include those born with HIV, long term survivors and people over the age of 50, we need for accessible services, support and care to ensure that we age with dignity
6. Understands that safe and stable housing, healthcare and financial security are basic human rights. We should not have to live in poverty to be eligible for services.
7. Recognizes that we are human beings entitled to live full rich pleasurable sexually active lives without fear of prosecution and understands the importance of social support networks to our overall well being.
8. Embraces our rich diversity in race, age, gender identity or expression, language, sexual orientation, income, ethnicity, country of origin or where we live and tells the full story of our resilience and not just our diagnosis.

THEME #1: Intersectional stigma, discrimination, racial and social justice, human rights and dignity

Strategy	Actions/Activities	Responsible Party	Year 1, 2, 3, 4 or 5
Reduce the impact of intersectional stigma for PLHIV and communities vulnerable to HIV	Implement new research tool developed by the Global Network of PLHIV called stigma index		
Ensure that all funding, policies, programs and decisions use an intersectional racial/social justice lens approach	Develop & apply racial/social justice lens to all decision making		
Implement/Operationalize MIPA throughout all service delivery	Integrate MIPA into RW planning councils		

THEME #2: Overall well-being, mental, emotional and spiritual health

Strategy	Actions/Activities	Responsible Party	Year 1, 2, 3, 4 or 5
Focus on “people first” rather than just treating HIV	Re-evaluate rapid start and other programs to ensure that services are person centered		
Eliminate use of stigmatizing language by organizations, services and throughout the workforce	Include people first language training requirement in all contracts and pay PLHIV to deliver trainings		
Increase the availability of social support services	Require all Part A providers to provide support groups led by PLHIV Develop at least 3 support groups by December 2023 for high priority populations Develop list of peer/PLHIV willing to lead support groups and be compensated		

THEME #3: Aging, comorbidities and life span (can include functionality, cognitive ability, geriatrics)

Strategy	Actions/Activities	Responsible Party	Year 1, 2, 3, 4 or 5
Reduce mortality rates for PLHIV	Develop data that more adequately reflects mortality and comorbidities of PLHIV		
Address aging needs of PLHIV	Develop aging related services for PLHIV at all health care providers Ensure that all demographics are represented in research Create a research CAB focused on aging issues Develop needs assessment to gather data to address the special needs of verticals		

Ryan White Funded Agency Hours

AccessHealth 400 Austin Street; Richmond 77469	Monday-Friday 7am-7pm, Saturday 8am-12pm
AIDS Healthcare Foundation 1200 Binz Street, Ste 1290; Houston 77004 7400 Fannin Street, Ste 1118; Houston 77054	Monday-Friday 8:30am-5pm Monday-Friday 8am-5pm
Avenue 360 Health & Wellness 2150 West 18th Street; Houston 77008	Monday-Thursday 8am-6pm, Friday 8am-5pm
Legacy Community Health 1415 California Street; Houston, TX 77006	Monday-Thursday 8am-8pm, Friday 8am-6pm, Saturday 8am-5pm
The Montrose Center 401 Branard Street, 2nd Floor; Houston 77006	Monday-Thursday 8am-6:15pm, Friday 8am-5pm
St. Hope Foundation 6800 West Loop South, Ste 560; Bellaire 77401 255 Northpoint Dr., Ste 200, Houston 77060 14815 Southwest Fwy., Sugar Land 77478 1414 S. Frazier St., Conroe 77301	Monday-Thursday 8am-6pm, Friday 9am-1pm, 1st and 3rd Saturday 8am-1pm Monday-Thursday 8am-6pm, Friday 9am-1pm
Thomas Street Health Center 2015 Thomas Street; Houston 77009 (April) 3601 N. MacGregor Way; Houston 77004 (May)	Mon-Tues-Weds-Fri 7:30am-4:30pm, Thurs 7:30am-7:30pm, 3rd Weds 7:30am-Noon Unknown at this time if hours will be the same

5 reasons docs may want to extend their office hours

By Aine Cryts Nov 28, 2016 11:56am

Doctor talking to female patient and her husband. Photo credit: Getty/Olgachov

Today's patients want to schedule an appointment very much the same way they buy running shoes on Amazon or book a trip on Travelocity. They want the same convenience they enjoy as consumers. But many doctors find their practices also benefit when they extend their office hours.

To **compete** with retail health providers, such as CVS Health and American Family Care, and keep patients out of the emergency room, Lawrence, Kansas-based Family Medicine Associates opens its doors at 7 a.m. each weekday—and offers a walk-in clinic for current patients and the general public alike, reports Medical Economics. One of Jackson, Michigan-based Henry Ford Allegiance Medical Group's practices starts even earlier, welcoming patients at 5 a.m. until 9 p.m. Monday through Friday; it's also open on Saturdays.

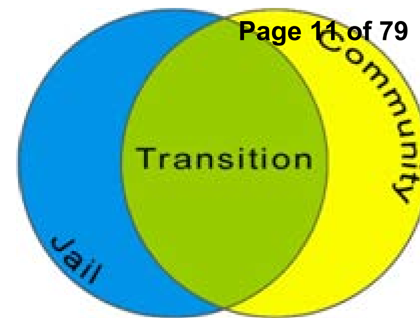
Nathan Bloom, M.D., a physician at Family Medicine Associates, says the extended hours allow his practice to provide quality care that's **cost-effective** and personalized. Another benefit to extending his practice hours? Providers at his practice know their patients and have access to their records—and that **reduces waste**.

More proof that convenience is king: **New patients** have joined his practice because of its extended hours, Brian Adamczyk, M.D., interim medical director at Henry Ford Allegiance Medical Group, tells Medical Economics.

Extending hours seems to keep patients **out of the ER.** UK researchers found that primary care practices with extended hours experienced a 26% relative reduction in patient-initiated ER visits for minor problems. Further,

for every three appointments booked at a primary care practice, an ER visit was avoided. While there was no fall in ER visits overall, the UK National Health Service saved $767,000.

Still, practices should be mindful about the possibility of physician burnout. That's because extending practice hours makes work-life balance a challenge, reports Medical Economics.



CASE MANAGEMENT STRATEGIES FOR SUCCESSFUL JAIL REENTRY

BY KEVIN WARWICK, HANNAH DODD, AND S. REBECCA NEUSTETER
September 2012

The National Institute of Corrections (NIC) partnered with the Urban Institute (UI) in 2007 to launch the Transition from Jail to Community (TJC) initiative with the goal of improving public safety and reintegration outcomes.

TJC involves the development, implementation, and evaluation of a model for jail to community transition. The TJC model is not a discrete program; it is a new way of doing business that entails systems change and the development of collaborative relationships between jail and community partners. The TJC approach is being implemented in six jurisdictions and technical assistance products will be created for communities across the country.

More information is available at www.jailtransition.com.

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From the perspective of a transition initiative, perhaps the most important factor distinguishing jail reentry from prisoner reentry is length of stay. While prisoners may be incarcerated for months or years, allowing programming staff ample time to prepare them for the transition, individuals housed in jails typically stay for just days or weeks, making the community handoff process even more crucial. Reducing recidivism and improving reentry outcomes require that jails, community-based organizations, and supervision agencies work together to meet the needs of the returning population, both while incarcerated and upon release. To do so, it is imperative that jurisdictions use an effective case management process that includes a strong community handoff component, particularly at the moment of release, and that ensures continuity of care between in-jail and community-based programs and services.

This brief presents the Transition from Jail to Community (TJC) initiative's approach to case planning and community handoff. In the following sections, we discuss the role of case planning in the TJC model, case plan content and structure, the referral process, the importance of continuity of care between the jail and community, interagency information-sharing, and the role community supervision agencies can play in case management and handoff. Throughout the brief, we draw upon the implementation experiences of six TJC learning sites, all of which implemented elements of the TJC case management process to varying degrees and were continuing to work toward a more seamless and integrated process at the close of the TJC technical assistance period.

Due to the complexity and difficulties inherent in creating a unified system of case management and community handoff for jail clients, jurisdictions should be aware that the implementation of the TJC case management approach is a time-consuming and intensive process requiring the involvement of multiple agencies. This brief intends to provide concrete examples and strategies from the TJC sites so other jurisdictions can learn from the TJC case management approach—recognizing, however, that each jurisdiction is unique and will be confronted with different challenges and opportunities, depending partly on the availability of local resources. Additional information about implementation of case management, as well as tools and examples from the TJC initiative, are available in module 7 of the TJC Online Learning Toolkit, at http://www.urban.org/projects/tjc/Toolkit/module7/index.html.

The Transition from Jail to Community (TJC) Initiative

The National Institute of Corrections (NIC) partnered with the Urban Institute in 2007 to launch TJC in order to address the unique challenges of jail reentry and thereby improve public safety and enhance the success of individuals returning to the community from local jails. The TJC team worked to achieve these objectives by developing, implementing, and evaluating a comprehensive jail-to-community transition model (see box 1 on page 2). The TJC model represents a systems approach to jail-to-community transition, in which jails and communities jointly "own" local reentry. Jail stays are too short and

the issues present in jail populations are too difficult for either the jail or the community to achieve success alone.

The TJC model is intended to be adaptable so it can be applied in a wide variety of jurisdictions with diverse jail populations. Implementation of the TJC model began in Douglas County, Kansas, and Denver, Colorado, in fall 2008. Four additional TJC sites were selected through a competitive application process in August 2009: Davidson County, Tennessee; Kent County, Michigan; La Crosse County, Wisconsin; and Orange County, California. Each site received tailored technical assistance to implement the model through January 2012.

For more information on the TJC initiative, see http://www.jailtransition.com.

A Triage Approach to Interventions

Central to the TJC model is the notion of triaging the jail population and providing the appropriate interventions to those segments of the population most likely to benefit from them. Because jurisdictions are rarely, if ever, able to provide comprehensive services to all individuals exiting jail, it is crucial to determine which individuals have the highest risk of recidivating in order to allow jurisdictions to direct limited resources toward those most in need of services. The TJC model involves an initial screening of the entire jail population to determine each individual's risk to reoffend. Core interventions—including in-depth assessment, case management, and programming—are then provided to those individuals identified as the highest risk.[1] This approach is consistent with previous research indicating that high-risk clients reap the greatest benefits from interventions and services, while low-risk clients may actually experience worse outcomes as a result of these services (Lowenkamp and Latessa 2002).

The TJC model also encourages jurisdictions to develop a triage matrix, which categorizes clients based on risk to reoffend, offense type, length of stay, and disposition status (sentenced or pretrial), and indicates the appropriate treatment strategy for each type of client. Length of stay is particularly important as it determines which interventions can occur within the jail and which will need to occur in the community. A sample triage matrix is available in the TJC Online Learning Toolkit (module 1).

[1] For more information on this process, please see the TJC companion brief on screening and assessment (Christensen, Jannetta, and Willison 2012), available at http://www.jailtransition.com.

Box 1. The TJC Model

The TJC model incorporates findings from the considerable body of prisoner reentry research and the growing literature on evidence-based practices. The model consists of five elements:

- *Leadership, Vision, and Organizational Culture*–Leaders from both the jail and the community must be actively engaged, articulate a clear vision, set expectations, identify important issues, and involve other key constituencies.
- *Collaborative Structure and Joint Ownership*–Effective transition strategies rely on collaboration and information-sharing among jail and community-based partners and joint ownership of the problem and the solution.
- *Data-Driven Understanding of Local Reentry*–Regular analysis of objective data, including analysis of the jail population characteristics, informs and drives decisionmaking and policy formation.
- *Targeted Intervention Strategies*–The strategy to improve transition at the individual level involves introducing specific interventions at critical points along the jail-to-community continuum.
- *Self-Evaluation and Sustainability*–Self-evaluation involves the use of objective data to guide operations, monitor progress, and inform decisionmaking. Sustainability involves planning to maintain initiative progress despite changes in leadership, policy, funding, and staffing.

In the TJC model, this screening process is followed by an in-depth assessment of criminogenic needs for those individuals screened as medium or high risk to reoffend. Criminogenic needs are those that are likely to affect future criminal behavior (and that, consequently, can reduce recidivism when addressed appropriately).[2] Such assessment then informs the development of targeted treatment strategies (who gets what) and case plans, both within the jail and after release in the community. Screening and assessment results, as well as case plans, can be shared with community-based service providers to minimize duplication of effort, promote a consistent

[2] Criminogenic needs include antisocial personality pattern, procriminal attitudes, social supports for crime, substance abuse, family/marital relationships, school/work, and prosocial recreational activities (Bonta and Andrews 2007). While individuals may have other needs, these seven areas of need have been shown, through research, to be related to future criminal offending.

approach to working with clients, and ensure continuity of care after release. In the TJC approach, individuals who are screened as low risk are provided with less intensive interventions, such as a guide to resources available in the community.

While all six TJC learning sites used screening and assessment to determine which clients should receive which services, the size and composition of the population targeted for intensive services varied. Some sites were able to provide assessment, case management, and programming to a relatively large proportion of their high- and medium-risk clients, while other sites, due to resource constraints or logistical considerations, opted to provide these services to smaller subsets of their high-risk populations (such as those sentenced to a certain length of time in jail or those classified at a certain security level). Each strategy is consistent with the TJC model, which stipulates that available resources are directed toward those individuals most likely to benefit from them (i.e., those most likely to recidivate).

The TJC Case Management Approach

Case management plays a crucial role in the TJC model. Employed effectively, it can bridge the services received inside the jail facility and those received after release in the community, connecting clients to appropriate services and improving interagency information-sharing and continuity of care.

To properly provide these case management services, each community should have a case manager or a team of case managers working with clients in the jail and in the community. Case management services may be provided by jail staff, staff from other criminal justice agencies (such as probation), or staff from community-based organizations. For example, in Kent County, case management was provided by a local nonprofit agency in the jail's co-occurring intensive treatment unit, while in Davidson County, these services were provided by jail staff. Ideal as it may be to have staff dedicated to these activities, many jurisdictions do not have this capacity. In this case, it is advisable that institutions develop the case management resource, but much can be done with existing staff in the meantime. For the purposes of this brief, we refer to "case managers" as those staff members responsible for providing these vital services; however, with the proper support and training, any number of staff can fulfill this crucial role. Staff acting as case managers should be trained to administer assessments, develop comprehensive case plans, make referrals to appropriate programs or services, and establish rapport with clients.

TJC Case Management Principles

1. Case management services are provided to clients who have been screened as medium or high risk to reoffend.
2. Clients receive a comprehensive case plan that builds upon needs assessment by specifying interventions that address the client's identified criminogenic needs.
3. A single case plan is used by all agencies interacting with the client—including the jail, probation, and community-based service providers—and the case plan follows the client into the community upon release from jail.
4. Jail staff coordinate with staff from community-based organizations to ensure that clients are referred to appropriate programs and services.

Development of the Case Plan

In the TJC model, case plans are created during the incarceration period and follow clients into the community after release. Three components that should be present in any case plan include: (1) interventions to be carried out while the client is in jail that prepare the individual for release, (2) interventions that address the client's immediate post-release needs at the moment of discharge from jail, and (3) interventions that address the longer-term transitional period in the community. Specifying interventions aimed at each of these three stages in the transition process will help ensure continuity of care as the individual transitions back to the community. These case plans should be revised when needed during this process in response to changes in the client's circumstances.

Case plans should be clear and concise and should specify the client's risk level and identified criminogenic needs. As noted by Burke (2008), case plans should include realistic goals directly related to the client's needs, a timeline for achieving these goals, and the client's responsibilities in meeting these goals. Case plans should also indicate when these goals have been achieved, as well as which agency or organization is responsible for providing each service listed in the case plan. These services may include referrals to substance abuse or mental health treatment, employment or educational services, cognitive-behavioral classes aimed at

addressing criminal thinking, or other jail- and community-based programs as appropriate. For example, through its TJC efforts, Kent County implemented a process in which jail transition services began in the jail's intensive treatment unit and followed the individual into the community through referrals to local treatment providers.

"We're working on case management plans that include everyone in the community that might help the person transitioning, so that one person only does not have access to the case plan."

--TJC Stakeholder

Case plans should also include any relevant information pertaining to community supervision. If the client has been sentenced to a period of probation (or, in some local jurisdictions, to a period of parole), information about the assigned officer, when the client must report, and any other key information about terms and conditions of supervision should be included in the plan. Importantly, the development and handoff of the case plan should be coordinated with any community supervising officer before the client's release from jail (more information on this topic is provided below in the section on the role of probation/community corrections).

The TJC model also asserts that clients themselves should be active participants in the case planning process, working with their case managers to set short-term and long-term goals. Ideally, case managers should develop a supportive relationship with the client and endeavor to offer a welcoming atmosphere. These efforts should take into account the client's individual characteristics, including cultural and gender-specific factors (one site in particular, Denver, focused on enhancing cultural competency within its case management approach). The case manager should also review progress on case plan goals with the client regularly. In the TJC model, the client receives a printed copy of the case plan to take with him or her during the transition process. Wherever possible, case managers should also work with jail administrators to offer incentives and rewards, such as access to additional services or visitation privileges, to assist clients in accomplishing their goals. Finally, case managers should use techniques to enhance clients' internal motivation to change. One such technique is motivational interviewing, an empathic, nonconfrontational, and client-centered approach in which the goal is to help the client explore and resolve ambivalence (Miller and Rose 2009). Motivational interviewing can be used by case management and program staff to develop and implement the case plan both before and after release.

Referral Process

Given the short length of time that most people remain in jail, it is essential that they are referred to programs and services in the community that can appropriately address their criminogenic needs. According to the TJC model, these programs should be evidence based (i.e., programs that have been found empirically to reduce recidivism or to demonstrate great promise in doing so) and should match the client's risk and needs in intensity and duration. For example, a high-risk individual for whom substance abuse is a criminogenic need should be referred to an intensive, evidence-based treatment program upon release. Less intensive services, such as support groups or 12-step programs, should serve as primary referrals only for lower-risk individuals and could supplement intensive programming for high-risk individuals.

Inventorying Available Programs and Services

To refer clients to the community-based services that best address their criminogenic needs, case managers must first be aware of what resources are available in the community, what types of individuals are most appropriate for each program (in terms of risk level and needs), whether each program adheres to evidence-based practices, and what eligibility restrictions may exist. Identifying existing evidence-based services is critical to reentry. In addition, this information can help justify funding requests and efforts to develop additional services by documenting programming gaps. Through their involvement with TJC, the learning sites worked to inventory both jail- and community-based programs. For example, Davidson and La Crosse counties used tools developed through the TJC initiative to gather information about existing programs and sort them according to the criminogenic needs addressed by each program. Denver conducted a survey of its community-based providers to gather information on specific services offered and program curricula used.

Equally important, clients should be referred to only those programs that are accessible and willing to serve the jail reentry population. Community-based providers listed on the case plan must also be willing to collaborate with jail programs staff and jail-based case managers. Ideally, these providers should focus on the reentry population, with programs that are designed to address specific criminogenic needs and that have been demonstrated effective for a jail-involved population.

Program staff should be familiar and comfortable working with this population.

Creating a Seamless Referral Process

In addition to developing a base of information on existing programs and services in the community, the TJC approach recommends that jurisdictions institute a systematic process for transitioning clients from the jail to these programs. This process requires developing close working relationships between jail staff (including program providers and case managers) and key community-based organizations. In Denver, for example, a transition process was developed between a core in-jail program, Life Skills, and a community provider as part of the county's overall TJC implementation strategy. Through this process, individuals participating in Life Skills received an assessment and a case plan and participated in programming within the jail. Upon release, all Life Skills clients were referred to the Community Reentry Project (CRP), a one-stop, community-based reentry center that provided programs and services to these clients and referred them to other providers as needed.

> *"We're working on using the assessment in our reentry success plans and using our relationships with our community partners. We'd never had a relationship with them like we have now. It's great to have a situation come up and be able to just call someone for assistance."*
>
> *--TJC Stakeholder*

Similarly, in Orange County, the jail offered a pre-release reentry class known as the Great Escape program. Once participants in the Great Escape program were discharged from the jail, they became eligible to use the services of the Great Escape Resource Center. The Resource Center also enabled staff to access the custodial program participation and release information for their clients. At the Resource Center, case managers worked with clients to offer employment assistance, deliver additional resources (including clothing and transportation), and provide referrals. This center was also positioned very close to the local probation department office.

In the TJC model, the referral process includes the transfer of transition plans and assessments to referral agencies. Sharing these materials with community-based providers is a crucial step toward facilitating continuity of care in the transition process and ensuring that the goals set for the client in the jail are carried out in the community. It also reduces duplication of effort, relieving community-based organizations of the need to develop a new assessment and case plan and preventing the client from being asked to repeat the same information over and over again. Ideally, these documents should be electronic to maximize the ease with which they can be shared and used. Denver, through its TJC efforts, developed a case plan intended to be used by multiple agencies; however, because this case plan was not automated, it had to be shared in hard copy form, limiting its utility. As of the conclusion of the TJC technical assistance period, Denver was working to transfer the case plan it developed into an automated case management system, which would allow case plans to quickly and easily be shared with community partners.

When making referrals, case managers should schedule appointments for specific times, if possible, and should ensure that the program has the time and resources to take on a new client. The referral should include the date, time, and address for the appointment. It is critical that these appointments occur as close to the client's release date as possible, as this is the time at which the client is at greatest risk of recidivating (National Research Council 2007). Whether or not the service is free should also be considered, as those returning from jail frequently have very limited financial resources.[3] Strategizing with service providers about the use of appointments may ensure a more successful transition, as some clients may have difficulties making their appointments due to lack of transportation or other logistical challenges, and may therefore benefit from drop-in hours.

To be useful to the client and to understand the impact of the services referred and/or provided, it is also important to track whether the client made it to the appointment and to determine what, if any, follow-up activities were arranged. This will require a great deal of information-sharing among all parties; it may also require community-based agencies to begin collecting information about which clients were referred to them from the jail and what services each client receives, if they do not already do so. For example, Denver was able to determine how many of the clients that were referred to the community-based CRP from the jail's Life Skills Program actually visited the CRP. This process is more complex when the jail makes referrals to several different community-based agencies. In Davidson County, for

[3] Given these financial difficulties, many clients may need assistance in applying for public benefits, such as Medicaid, Supplemental Security Income (SSI), or food stamps, prior to release.

example, a wide range of service providers are available to serve clients in the community. Through TJC, the jail began to ask these providers to share data about the clients they were serving.

Establishing Continuity of Care

The term "continuity of care" originated from the medical field, referring to a plan for treatment in the community after discharge from a medical institution. The medical continuity-of-care process most typically involves two activities: (1) securing an appointment for follow-up in the community, post-institutional discharge (or, occasionally, placement into an inpatient treatment program); and (2) for those clients who have been prescribed medications, providing a sufficient dosage (or, at a minimum, a prescription) that will last until the client's follow-up appointment date in the community (American Academy of Family Physicians 1982/2008). Since the late 1990s, correctional institutions (to varying degrees) have attempted to establish continuity of care for the purposes of stabilizing and managing clients with medical conditions, especially mental health diagnoses.[4] In the TJC model, the concept of continuity of care extends beyond medical needs to target *all* criminogenic needs, including substance abuse, employment, family, and other needed services—although many strategies and core components remain the same.

As discussed above, the typical jail stay is quite short, often only a few days. Moreover, exact discharge dates are frequently unknown; in many jurisdictions, individuals are commonly discharged from regularly scheduled court appearances. Thus, it can be very difficult to plan services for clients while they are in custody and to prepare for their release. This uncertainty makes continuity of care in case management all the more important, especially for those individuals who pose the highest risk to reoffend. Due to the challenges involved and the importance of this work, it is crucial to implement strategies that simplify and encourage the provision of continuous case management services for the jail reentry population. Below, we describe a few key strategies used by the TJC initiative to promote continuity of care for individuals released from jail, all of which should be coordinated by a case manager and through a case plan.

Jail "In-Reach"

One effective strategy, used to varying degrees in many jails across the country (including all the TJC learning sites), involves providing the opportunity for community-based agencies to meet with clients in the jail before release, a strategy known as "in-reach." These in-reach activities may consist of informal informational sessions to educate clients about post-release services, formal interviews to determine acceptance of clients into programs before release, or the provision of programming or other services in the jail. In-reach provides an opportunity to develop rapport with clients before release, which is particularly important for high-risk individuals, who tend to have the greatest needs both while in jail and after release. A heightened level of trust will help ensure that the client follows through with accessing the necessary services in the community upon discharge, thus promoting continuity of care. Regardless of the level of service intensity that may be able to be provided in the jail (due to space, security, and other challenges), for the purposes of continuity of care, the value of conducting in-reach in the jail cannot be overstated.

In achieving continuity of care, it can also be valuable for personnel based in the community to co-facilitate classes with jail staff inside the correctional institution, or even for staff to be colocated at both the jail and a community-based reentry center. These partnerships can be very helpful for clients in bridging the gap between the two environments. For example, in two TJC learning sites—Douglas and Orange counties—some case managers split their time between the jail and a reentry center in the community. In Kent County, the corrections department established a community-based reentry center to provide for continuity of care in service provision. Staff from a nonprofit organization provided case management to clients in the jail's co-occurring treatment unit, and these staff continued to meet with clients after release at the community-based reentry center. As described above, staff at Denver's CRP reentry center worked closely with the jail's Life Skills Program, including providing some jail-based services. Similarly, in La Crosse County, jail-based case management services were provided by a community-based government agency.

[4] In fact, the impetus to provide discharge planning services in several state and local jurisdictions was born out of a desire, and sometimes even a mandate, to provide continuity of care for medically involved clientele, including those diagnosed with mental illnesses. For example, discharge planning efforts in New York City largely grew from the *Brad H., et al. v. The City of New York, et al.* (1999) lawsuit; more information about this settlement and the origins of the city's discharge planning for health care can be found in Mellow et al. (2008).

Consistency of Programming and Services

Maintaining consistency across agencies in the service delivery process is another key factor related to continuity of care in the TJC approach. This element involves providing consistent assessment, case planning, programming, and other services between the jail, community-based service providers, and supervision agencies. A number of the TJC learning sites employed strategies to establish consistency in their service delivery approach, most notably through the provision of assessment and cognitive-based therapy. For example, as of the conclusion of the TJC technical assistance period, jail staff in Orange County were designing a format that would allow various agencies to use information from in-jail assessments and case planning as clients moved from the jail to the community. Probation officers would still be able to make adjustments based on policy and individual compliance, but the information would flow from one agency to the next, reducing duplication of effort and providing a cohesive, holistic approach.

Similarly, in La Crosse County, the community agency responsible for providing assessment and case planning to clients involved with the justice system—Chemical Health and Justice Sanctions (CHJS)—conducted assessments for jail-involved clients, and then made that information available to jail staff as well as the judiciary and legal providers (district attorney and public defender). CHJS used the assessment information in working with clients released from the jail who were sentenced to their agency and, as of the conclusion of the TJC technical assistance period, were examining opportunities to share this information more widely with other community-based organizations.

While participating in the TJC effort, several learning sites received training from NIC on Thinking for a Change (T4C), a cognitive-based curriculum. These sites were able to integrate this evidence-based curriculum into their overall case management and intervention approaches. Each site was able to train both in-jail and community-based providers, and these providers worked to coordinate their efforts to deliver consistent transitional services. For example, La Crosse County implemented T4C in both the jail and the community, and staff from various agencies in the county worked together to ensure coordinated delivery of the curriculum, in terms of both timing (so individuals discharged from the jail before finishing T4C could pick up where they left off after release) and content. In Denver, the jail-based Life Skills program and the community-based CRP both implemented T4C as a core component of their service provision. In Orange County, T4C had been used by local probation for a number of years, and the jail began to offer T4C classes as well to promote consistency between the two agencies. In Kent County, the full T4C curriculum was provided by staff while in the jail to ensure that all modules were covered before release.

Effective communication is a critical element to maintaining consistency in service delivery across agencies. Communication among all participants ensures that the client has consistent and clear messages about his or her post-release efforts. To address this issue, some TJC learning sites, including Douglas and Kent Counties, held regular meetings with key stakeholders to review case plans. To assist with this effort, it is advisable that, whenever possible, all related agencies and partners use consistent forms, terminology, and processes. This is especially important for the use of transition case plans and assessment tools. When all involved parties use the same sets of tools and vocabulary when working with clients, agencies are more able to be clear about goals and objectives with their clients and help clients understand what is expected of them and where to go to seek assistance.

Information-Sharing

Providing effective continuity of care and case management services in general requires a great deal of information-sharing. The TJC approach recommends that the case plan and assessment be automated. Electronic versions of these documents allow for easy communication and transfer of information from jail providers to community-based services, and they allow the case plan to be updated over time. Some jails purchase case management software, while others develop tools internally and use them within their case management systems.

Jail-based case managers should provide community-based organizations with information on client needs—including the client's assessment and case plan—as well as the services that the client received in the jail. This not only reduces duplication of effort, but also helps enhance continuity of care. However, in the TJC model, information-sharing is a two-way street, and jail staff should also be provided with information from community-based case workers, including whether the client has received services in the community. For example, in La Crosse County, the community-based CHJS agency created case plans that were shared with jail programs staff. Moreover, in the event that a client returns to the jail, jail staff

should immediately inform the relevant community-based provider(s) that have worked with the client. This can allow all parties to work as a team in addressing any crises, relapses, or other problems the client may have encountered and can help stabilize the client when he or she returns to the community.

"We're trying to include our community providers to create a more seamless approach. When the client gets to an agency, the provider already knows what is going on with the client and helps the client move ahead more quickly than they would if they didn't have that information."

--TJC Stakeholder

When sharing case plans containing medical, substance abuse, or mental health information, agencies must comply with HIPAA[5] and other federal, state, and local laws governing the proper use of this information. Only the information that is needed for transition planning should be included in the case plan, while maintaining the confidentiality of the individual. In order to share any protected information, jurisdictions should develop and implement appropriate Release of Information (ROI) procedures and forms that allow clients to grant permission for their information to be shared. In Davidson County's electronic system, the ROI form was located in the same place as the assessment and case plan so case managers could easily access it as a core part of the case management process. The ROI form should list the specific providers with whom client information may be shared and detail what information (only relevant information) will be shared. Moreover, at the system level, agencies should develop and implement interagency agreements or memoranda of understanding (MOUs) to explicitly specify the agreements of data sharing (i.e., who will share what information, how, and with what frequency). The TJC Online Learning Toolkit has more information on ROIs and MOUs (module 9, section 4), along with examples that TJC sites have adapted and implemented.

Technological limitations discourage many jurisdictions from implementing case management procedures and sharing information. These challenges, however, should not serve as a deterrent to conducting case management activities, including implementing and sharing data from risk/needs assessments. Hard copies are an acceptable alternative. Another option is to designate an agency or individual as the "keeper" of assessment and case planning information and for all parties to provide updates and revisions so there is always a master and up-to-date version of these living tools. Irrespective of how information is shared (i.e., electronically or manually), successful case management cannot occur in a vacuum and, as such, requires real-time, accurate data.

Role of Probation/Community Corrections

Many of the considerations discussed above are just as important, if not more so, to implement with jail clients who are also involved with probation or other community supervision agencies. Large numbers of individuals discharged from local jails across the country are released to a period of community supervision; most typically, this is probation. To ease the transition from structured institutional jail living, the TJC approach advocates that clients meet with their probation officers prior to release so expectations, conditions, and terms of supervision are clear. Ideally, this can be achieved through probation officers conducting in-reach into the jail for those clients who they know will be discharged to their supervision.

Due to scheduling difficulties, resource constraints, or a lack of information about who will be released onto probation or when releases may occur, in-reach services may not always be feasible. In these instances, it is useful for jail staff to be provided with a copy of the probation terms and conditions so they can work with clients to ensure understanding of their conditional release onto community supervision. This requires coordination and information-sharing between the jail and probation department. Jail staff should also provide information to probation officers, such as the client's assessment and case plan, as well as information on what (if any) services the client received while in jail.

Probation and parole agencies are critical partners in the TJC case planning and handoff process, particularly given that these agencies are able to compel clients to participate in needed services post-release. The supervision officer can play an important role in monitoring compliance with the case plan and often has access to contracted programs and services, such as inpatient drug treatment to which clients can be referred or even enter directly upon release. The more coordination that occurs between the jail and supervision agencies, the more likely

[5] HIPAA refers to the Health Insurance Portability and Accountability Act of 1996 privacy and security rules, which regulate the sharing of personally identifiable health information.

that a coordinated case plan will be carried out at the point of transition.

Two TJC learning sites institutionalized processes for jail clients who would be released onto probation. The probation offices in La Crosse County were colocated with the jail during the county's participation in TJC, which enhanced the opportunity for these two agencies to work together and provide a seamless case management approach. Similarly, in Orange County, two probation officers were assigned to work in the jail, and, as previously mentioned, the jail's community-based Great Escape Resource Center was built adjacent to a probation office. Although the two probation officers were not assigned to work with every client released from the jail onto probation supervision, the process and opportunity for seamless case management was present for the clients of these individual officers.

There are numerous other ways in which personnel from the jail and probation can mutually reinforce and support the goals of case management and community handoff. For example, in Orange County, the role of probation in the TJC process extended beyond that of the two reentry probation officers located at the jail. The Orange County Sheriff's Department chose to implement the same criminogenic risk/needs assessment tool as the county's probation department had been using for many years. This allowed the two agencies to use the same vocabulary and risk categories for their shared clients, and it allowed the local jails to use a tool that the probation department had already validated. Jail staff also benefited from receiving training from probation staff in administering the tool; this provided an opportunity for the two agencies to come together and learn from each other. Moreover, several years before TJC implementation, the probation department implemented Thinking for a Change as the cognitive-based curriculum used with probation clients in day reporting centers and probation offices throughout the county. During the TJC initiative, the same curriculum was also implemented in the Orange County jails, allowing the two departments to support the same goals and share a common approach to addressing the cognitive-behavioral needs of their shared clients.

Conclusion

An effective case management and community handoff process is undeniably important for successful reentry from prison. This is even more true in the case of jail reentry. Short and often unpredictable lengths of stay, combined with high rates of recidivism, necessitate a systematic and coordinated approach to ensure that individuals returning from the community are provided with programming and services that address their criminogenic needs and reduce the likelihood that they will return to jail.

The TJC model advocates a systems approach in which reentry is the sole responsibility of neither the jail nor the community, but a joint effort between the two. Those clients at the highest risk of recidivism should be assessed to identify their needs and provided with services both within the facility and upon their release to promote a successful transition process. Solid case management provides the roadmap for transition back to the community.

To be effective, this process requires strong coordination and collaboration among key stakeholders in both the jail and the community. In particular, jurisdictions should institute strong case management and referral processes in which the case manager works with the client to develop a clear transition plan and makes post-release appointments for the client with the appropriate community providers.

Creating such a unified system of case management can be a long and difficult road, as evidenced by implementation of the TJC model in the six learning sites. While many sites made substantial progress in their case management procedures, none was able to fully implement every element of the TJC model's approach to case management during the three-year technical assistance period. This was due partly to the fact that, in the TJC model, jurisdictions first concentrate their efforts on several other key processes to lay the groundwork for the initiative (including implementing screening and assessment, building an organizational structure for TJC implementation, strengthening interagency partnerships, implementing a system of core performance measurement, and assessing information on the jail population and current system gaps) before turning to the case management and coordinated handoff elements of the model. Therefore, for the most part, the learning sites began to focus heavily on this component relatively late in the technical assistance period, and they were continuing to move forward on their efforts as technical assistance came to a close.

In addition, jurisdictions encountered a number of challenges to fully implementing integrated case management approaches, including technological and

resource limitations. Nonetheless, each learning site was able to identify ways of improving upon their existing processes, often while dealing with serious resource constraints. As described throughout this brief, many sites were able to target case management services to high-risk clients; enhance the structure and content of their case plans (and, in some cases, implement a single case plan used by multiple agencies); build a base of information on services to which clients may be referred after release; improve coordination and information-sharing between the jail, community-based service providers, and supervision agencies; engage community-based providers in jail "in-reach" or even colocate staff in the jail and in the community; and increase consistency between services provided by various agencies (for example, by offering the same curricula in both the jail and community).

Moreover, each site's approach to enhancing its case management and community handoff process depended upon the structure of the local system and the availability of resources, and each site developed unique strategies that built upon existing capacities. For example, Denver developed a case handoff process based upon an existing in-jail program, Life Skills, and a community-based reentry center, the CRP. All Life Skills participants were referred to the CRP, and assessments and case planning were conducted by both programs. Orange County used a similar strategy, with clients proceeding from the jail to a community-based resource center operated by the Sheriff's Department. Orange County also coordinated the jail's activities with those of the local probation department. In Kent County, in-jail case management services were provided by a community-based organization that continued to work with clients upon release. In contrast, Davidson County used its substantial jail programs and case management staff to carry out case planning and assessment responsibilities in the jail, then referred clients to various community-based service providers. La Crosse County used the capacity it had developed in creating Chemical Health and Justice Sanctions to conduct assessments, create case plans, and provide case management in that jail and in the community.

Despite the challenges inherent in implementing a seamless approach to case management, each of these sites was able to work within its existing systems to achieve greater collaboration, reduce duplication of effort, and create a more successful transition process for clients exiting the jail.

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Can Social Support Overcome the Individual and Structural Challenges of Being a Sex Offender? Assessing the Social Support-Recidivism Link

Kimberly R. Kras[1]

Abstract

Social support is important for individual's successful reentry; however, little is known about how it operates or is influenced by individual and structural factors. Understanding how social support matters for individuals convicted of a sex offense is especially important as they may have a different reentry experience due to the nature of their crime and post-conviction restrictions. This study examines the nature and effects of instrumental and expressive social support from family, friends, intimate partners, and parole officers on recidivism for a sample of men convicted of sex offenses using mixed methods. Results show that family, friend, and intimate partner support had no effects on recidivism, however participants reporting a positive relationship with their parole officer were more likely to return to prison. Qualitative analysis of in-depth interviews sheds light on how the nature of these relationships might explain the social support-recidivism link in a high stakes population.

Keywords

social support, reentry, sex offenders, recidivism, mixed methods

Introduction

Recidivism rates are high in the United States. Totally, 4 years post-release, nearly three-quarters of offenders return to prison, making reentry an important topic for

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study (Durose, Cooper, & Snyder, 2014). Despite the well-established body of literature about reentry, we know little about the underlying mechanisms related to success or failure upon release (Wright & Cesar, 2013). Social support has emerged as a "black box" factor for understanding this linkage (Bonta, Rugge, Scott, Bourgon, & Yessine, 2008). Numerous studies show social support acts as a protective factor against recidivism (Bahr, Harris, Fisher, & Harker Armstrong, 2010; Hochstetler, DeLisi, & Pratt, 2010; Petersilia, 2003; Visher, Knight, Chalfin, & Roman, 2009), but its core processes remain under-developed in the literature. In particular, the cultural and structural factors influencing how social support is delivered to and received by individuals has not often been considered in relation to recidivism (Wright & Cesar, 2013).

Individuals convicted of sex offenses present a unique challenge to the social support-recidivism link. First, regardless of actual risk level, this type of offenders are deemed as "high stakes" (Turner, 2011). Compared to other types of offenders, individuals convicted of sex offenses are deemed most dangerous and as such face additional challenges when returning to the community, such as residency restrictions, registration requirements, and enhanced monitoring, which might impact their reentry experience (Levenson, 2008; Sample & Bray, 2003; Tewksbury, 2005; Willis & Grace, 2009). The additional restrictions imposed on those convicted of sex offenses may increase stress thereby heightening the risk of recidivism (Hanson & Bussiere, 1998; Hanson & Harris, 2000; Veysey & Zgoba, 2010). Social support networks may mitigate this stress amid the added challenges of reentry for individuals convicted of sex offenses, but the stigma, shame, and the loss of contact with family and friends due to their crime may reduce chances of successful reintegration (Levenson & Cotter, 2005; Robbers, 2009). In the face of tenuous support networks and community acceptance, the most stringent test of the social support-recidivism link might be with individuals in this offending group. Thus, this study answers two important and interrelated questions: (a) does instrumental and emotional social support as provided by family, friends, intimate partners, and parole officers relate to recidivism, and (b) how these do these types of support elucidate upon the social support-recidivism link.

The Social Support Paradigm

Social support acts as a mediating or moderating variable with crime in a number of criminological theories, such as ameliorating strain or enhancing social bonds, but is nearly always seen as having an inverse relationship with crime (Cullen, 1994). Cullen (1994) advanced social support as an organizing principle for studying crime that specifies the types of support needed and who delivers that support. Social support is defined as "perceived or actual instrumental and/or expressive provisions supplied by the community, social networks, and confiding partners" (Lin, 1986, p. 18). Instrumental support consists of material and financial assistance such as providing money or transportation, and expressive support refers to the emotional and psychological assistance that enhances a person's self-esteem or provides a way to cope with negative life circumstances (Lin, 1986).

Social supports are identified as many different actors including family, intimate partners, and friends. Support from friends and family can enhance levels of informal social control, and mitigate the negative effects of chronic stressors, such as those associated with reentry experiences (e.g., financial problems, housing issues, and substance abuse) because they can provide tangible resources or emotional coping (Berg & Huebner, 2011; Farrell, Barnes, & Banerjee, 1995; Laub & Sampson, 2003; Vaux, 1988). Studies show the objective features of a social relationship, such as the frequency of engagement or resources provided, can translate into positive effects on well-being (Semmer et al., 2008; Thoits, 1986). This may be particularly salient for individuals returning from prison who might not have the physical or emotional resources to address the challenges they face.

A unique feature of the social support paradigm is the inclusion of criminal justice agents as support actors who can provide formal social control (Cullen, 1994). Wright and Cesar (2013, p. 377) propose that social support from criminal justice agents, when consistently applied, "is in line with a continuum of care approach to offender reentry." The prevailing approach to reentry considers the working relationship with the Probation and Parole Officer (PO) to a core correctional practice successful at reducing recidivism, and one of these mechanisms is via support of meeting goals, achieving sobriety, and remaining crime-free (Bonta et al., 2008).

Scholars distinguish between the delivery and perceptions of support as positive or negative (Cullen, 1994; Lin, 1986). Perceptions of support are important to understand because the cognitive interpretations influence affective states and may ameliorate negative behavioral responses more so than the objective nature of the support received (Listwan, Colvin, Hanley, & Flannery, 2010; Wethington & Kessler, 1986). Support can be positive or negative, or both, but depends on how the individual interprets it. For example, Pettus-Davis, Howard, Roberts-Lewis, and Scheyett (2011, p. 480) assert, "a family member that provides encouragement, but who models substance using behaviors or a romantic partner that offers material support, but who is abusive is negative social support." Even if combined with positive qualities, social support can be perceived as negative by an individual if the outcome (such as return to substance use or emotional distress) is negative.

Social Support and Reentry

Reentering individuals encounter many challenges that may increase their risk of recidivism, such as obtaining employment and finding adequate housing (Petersilia, 2003). To address these needs individuals often rely on support of family and friends, as well as community resource agencies. Social support is important upon reentry because it emphasizes the use of networks and resources to address problems and challenges related to reintegration (Colvin, Cullen, & Vander Ven, 2002). Despite the breadth of scholarship on social support for returning individuals in general, less is understood about the nature of social support networks for individuals convicted of sex offenses. This is an important gap to address considering structural conditions of reentry related to the restrictions and regulations for individuals convicted of sex

offenses and collateral consequences, especially structural stigma (Levenson & Cotter, 2005; Link & Phelan, 2001; Robbers, 2009; Tewksbury, 2005).

Family. Family support is central to successful reentry (Mills & Codd, 2008; Naser & La Vigne, 2006; Visher & Travis, 2003), and parents are the most likely providers of this support (Pettus-Davis, Scheyett, & Lewis, 2014). Visher and Courtney (2007) found that 63% of participants in their sample identified family support as the most important factor in avoiding return to prison. Other studies show that families provide emotional support, housing, financial assistance, and improve sobriety for individuals after their release from prison (Mallik-Kane & Visher, 2008; Solomon, Visher, La Vigne, & Osborne, 2006). For individuals convicted of sex offenses this support may be diluted due to residency restrictions forcing housing options farther away from support systems or in locations that are more socially disorganized (Hipp, Petersilia, & Turner, 2010; Hughes & Burchfield, 2008; Kras, Pleggenkuhle, & Huebner, 2016). Despite this, recent studies demonstrate that family support is associated with reduced offending among samples with sex offense convictions (Walker, Kazemian, Lussier, & Na, 2017).

Intimate partners. Positive, prosocial relationships with a spouse or intimate partner are also associated with success as they can provide informal social control (King, Massoglia, & MacMillan, 2007; Laub & Sampson, 2003; Vaux, 1988). Research suggests that being married is a strong predictor of success after release as indicated by lower levels of subsequent criminal activity and drug use and enhanced social capital (Laub & Sampson, 2003; La Vigne, Visher, & Castro, 2004; Visher et al., 2009). The research on marriage for individuals convicted of sex offenses is mixed. Some studies have shown that sexual recidivism is associated with poor social relationships, loneliness, isolation, and never being married (Hanson & Harris, 2000; Hanson, Steffy, & Gauthier, 1993; Robbers, 2009; Ward, Hudson, Johnston, & Marshall, 1997), while other studies find no link (Kruttschnitt, Uggen, & Shelton, 2000; Lussier & McCuish, 2016). As in other research, the quality of marriage may matter for desistance. In one study, participants convicted of sex offenses who were in a committed relationship and with residential stability were less likely to be rearrested (Meloy, 2005). Two recent studies (Farmer, McAlinden, & Maruna, 2015; Lytle, Bailey, & ten Bensel, 2017) found sex offending desisters who were married did not attribute desistance to marriage, rather it was a result of "support reciprocity," reflecting deeper and more prosocial features of the support relationship.

Friends. Friends can also be a source of social support. Friends can provide positive instrumental and expressive support, such as employment connections and improved self-esteem (Mallik-Kane & Visher, 2008). However, friendships are complicated by the fact that most offenders' friends are part of their criminogenic social network (Cobbina, Huebner, & Berg, 2012; La Vigne et al., 2004; Visher & Travis, 2003). In Visher and Courtney's (2007) sample, only 22% men in the study had positive peer support, and a similar sample admitted that over half of their friends were involved in illegal activity (La Vigne et al., 2004). Cobbina and colleagues (2012) found that men

who had criminal friends failed on supervision more quickly than those without friends or who had positive friendships. There remains a gap in the literature regarding peer networks of individuals convicted of sex offenses, but some research suggests these relationships can be supportive of positive reentry due to shared experiences of treatment and structural reentry barriers (Perrin, Blagden, Winder, & Dillon, 2017).

POs. POs provide formal social control through supervision and sanctions, and informal social control through rapport building with individuals and their social supports (Grattet, Lin, & Petersilia, 2011; Kruttschnitt et al., 2000; Mills & Codd, 2008). In one study, Blasko, Friedmann, Rhodes, and Taxman (2015) found that a better relationship between the PO and individual, regardless of caseload type, resulted in fewer violations. In contrast, a punitive style is associated with increased anxiety and reactance among probationers (Morash, Kashy, Smith, & Cobbina, 2015). This caring and fair relationship between POs and individuals on supervision seems to be most important to reducing negative outcomes and increasing motivation to stay away from criminogenic situations (Rex, 1999; Skeem, Louden, Polaschek, & Camp, 2007; Yahner, Visher, & Solomon, 2008). In the face of the structural limitations on individuals convicted of sex offenses the relationship with criminal justice system actors is an important source of formal and informal social control, but little research explores the relationship. In one study, Bailey and Sample (2017) found officer-parolee dyads with greater social distance was marked by negative attitudes of the PO, which the participant attributed to their label and prevailing sex offender stereotypes. In a study by Cooley, Moore, and Sample (2017), 40% of their sample did not think their PO deterred their deviant behavior, with some citing increased strain because of enhanced surveillance. However, some participants noted that their PO helped them obtain the treatment they need (Cooley et al., 2017), and in another study POs linked them with informal networks (Meloy, 2005).

Studies considering desistance from sex offending tend to highlight the important role of social support, but not specify the effects of support from distinct actors or consider the structural and cultural factors that may impede access to or variation of support. The present study adds to the scholarship regarding social support and reentry by examining the nature and quality of social support and its effects on recidivism among a sample of men convicted of sex offenses. It is expected that positively perceived social support by all actors will be associated with reduced recidivism. Qualitative analyses elucidate on the quantitative analyses to address the gap in our understanding of *how* social support influences outcomes and informs measurement of social support for individuals convicted of sex offenses.

Method

Study Design

The present study is part of a larger research project on reentry experiences of individuals convicted of sex offenses. Data for this study come from in-depth interviews

and official records with a sample of men convicted of a sex offense (n = 72) and supervised on probation or parole by Missouri Department of Corrections (MoDOC).[1] This study utilized concurrent embedded mixed methods design, in which quantitative data are extracted from qualitative interviews through interpretive approaches and then linked with outcome data in a follow-up data collection (Creswell, 2008). This methodology is consistent with trends in criminology and criminal justice research to rely on smaller-sized quantitative samples where the "qualitative inspection of individuals cases" can inform future theory and empirical studies (Wright & Bouffard, 2016, p. 2).

With cooperation from MoDOC, seven sites were selected for qualitative interviews, including three probation offices (n = 25), one prison (n = 20), and three community supervision centers (n = 27). As a primary goal of the original research was to explore an array of reentry experiences, a nonprobability quota sampling procedure was used to obtain a relatively equal number of respondents from each location. To be eligible for the study, participants had to be on probation, parole, or in prison for a sex offense and subject to residency restrictions and registration requirements.[2] Participants who were interviewed in prison are included in the sample because they were within weeks of their release date (average of 36 days) and had begun the reentry process, including establishing forms of social support. Although prisoners might display a different level of access to support, interviewing them close to their release date and with reentry planning in place provides a comparable experience of support to those who were recently released.

Interviews in the community were conducted at probation and parole offices on random report days and eligible participants who reported on those days were asked to participate. Participants interviewed in prison or the community release centers were first identified by corrections personnel as eligible for the study and close to their release date and then randomly selected from this list by the research team. Interviews occurred in private offices at each location and lasted 90 minutes on average. Participants were provided information regarding the study, assured confidentiality, and signed a consent form. Interviews were digitally recorded and transcribed, and pseudonyms were assigned to each participant. Participants on parole received an incentive of US$20.

The interview guide was semi-structured and modeled after prior research on reentry (see Visher, La Vigne, & Travis, 2004). The interview guide covered a range of domains including prison life and reentry, housing, employment, substance abuse, treatment, and sex offender restrictions. Participants were also asked to describe the nature of various support actors, including family, intimate partners, and friends. To gather information about participants' relationship with their PO, questions such as "Overall, how helpful has your parole officer been in making the transition back to the community?" and "Describe an experience that has been helpful/detrimental" were asked. Considerable probing in each domain gathered more detailed information about these networks. Using these types of open-ended questions allowed all participants to self-define the support in their lives.

Data

Quantitative data were extracted from interviews regarding the type (instrumental or expressive) and quality (positive or negative) of support provided by each actor: family, intimate partners, friends, and POs. In the criminological literature, the influence of social support on reentry has been measured by the presence of various social support actors (La Vigne et al., 2004), and counts of social support events, like prison visits (Hochstetler et al., 2010); however, fewer studies have examined the qualities of these social supports on reentry success via qualitative data from the perspectives of the offenders (see Ward et al., 1997). The current coding scheme was developed based on validated social support measures (Zimet, Dahlem, Zimet, & Farley, 1988), methodology used in other sex offender research on social relationships (Ward et al., 1997), and the theoretical propositions of Cullen (1994).

Dependent variables. The two dependent variables are derived from official records provided by MoDOC 3 years post-release. *Technical violations* (no = 0, yes = 1) are measured by the first violation incurred following the participant's release from prison. Technical violations are considered because they may indicate failure or triggering behaviors indicative of relapse for those convicted of sex offenses (English, 1998). Over half of the sample received a technical violation (51%) during the post-release period. *Reimprisonment* (no = 0, yes = 1) documents the return to prison for a new offense (sexual or nonsexual) or technical violation. Reimprisonment is considered as opposed to rearrest or reconviction because for individuals convicted of sex offenses, it is often the case that heightened restrictions and supervision conditions mean they may incur a violation and be revoked more often and more quickly than other types of offenders (Meloy, 2005). In this study, reimprisonment is measured as a return to prison, as opposed to jail, and must be determined through a revocation hearing by a judge or the parole board. In this sample, 25% of participants were reimprisoned after 3 years.

Independent variables. Social support variables of *Instrumental* and *Expressive* support were assigned to three actors: family, intimate partners, and friends. If the participant received support and considered it positive, it was coded as 1; and if they did not receive support, did not have that actor in their lives, or indicated the support was negative, it was coded as 0. The social support perspective infers that negative and nonexistent support will have the same effects on crime because the outcome perceptions will be the same (Cullen, 1994; see also Cobbina et al., 2012). For family, friends and intimate partners, *Instrumental Support* captures if participants received positively viewed financial support or other tangible resources from family, intimate partners, and friends (positive support = 1; negative or nonexistent support = 0). For example, if a participant reported they had received money and transportation from a parent this would be coded as 1. *Expressive Support* from family, intimate partners and friends is a dichotomous variable scored 1 if the participant indicated he received emotional, psychological, or spiritual assistance, and 0 if he reported negative or nonexistent

expressive support. For instance, if a participant reported their significant other as someone they could talk to it was coded as 1. *PO support* is a dichotomous measure of the perceived quality of the support relationship (positive support=1; negative or non-existent support = 0). A solitary measure was chosen because officers are not authorized, in most cases, to provide instrumental support in the same ways other social support actors can.

Additional variables collected from close-ended interview questions and official data were included as controls. Variables for *age* (at time of release), *black* (white = 0; black = 1),[3] and number of *prior imprisonments* are included. A control for being in prison at the time of the interview (*incarcerated*) was also included to account for differences among those interviewed in prison and those in the community.[4] Finally, research demonstrates a link between offense and victim characteristics and increased likelihood of sex offender recidivism (Kruttschnitt et al., 2000). To account for this, analyses include a measure of *minor victim* (1 = victim was 17 or under; 0 = victim was over 17).

Qualitative data come primarily from the excerpts captured in the in-depth interviews pertaining to social support from various actors. Because aspects of social support and its relationship to the structural experiences of being labeled a sex offender were present throughout interviews, the entire narrative was included in initial analyses. Relying on the entire narrative provides additional context for analyses to consider the individual and structural dimensions of social support.

Analytic Strategies

Quantitative analyses consisted of both bivariate and multivariate approaches. First, bivariate analyses examined differences between recidivism groups on all variables of interest. Second, logistic regression models assess the relationship between the measures of social support and the dependent variables, controlling for relevant factors. A power analysis determined that an appropriate sample size was achieved for power at .84 when considering a large effect size and significance value of .10 (Cohen, 1992). In mixed methods studies with small samples, these thresholds are appropriate.

To elucidate upon statistical relationships between social support and recidivism, and uncover how the nature of social supports acts as a mechanism, interviews were analyzed using thematic analysis (Braun & Clarke, 2006). Thematic analysis is a "theoretically-flexible" strategy allowing the researcher to rely upon both indicative and deductive coding techniques (Braun & Clarke, 2006, p. 5). This is useful in mixed methods studies when researchers rely on a priori coding schemes but also aim to enrich them through inductive approaches. To begin, interview excerpts related to social support were inductively coded using the qualitative software program NVivo. NVivo allows for systematic coding of themes and patterns in the data, enhancing the efficiency and rigor of the analyses. To strengthen the integrity of the coding strategies, initial coding was conducted prior to knowledge of recidivism outcomes. NVivo also assists in the comparative analysis of participant characteristics, themes, and outcomes to deepen analysis. Matrix queries were built focusing on comparing the rich

descriptions of social support, both positive and negative, to contextualize experiences. Only the most representative excerpts from interviews are presented and language remains intact to preserve the integrity of the participant's voice.

Results

Quantitative Results

Summary statistics and bivariate analyses indicating statistically significant differences between those who were successful and those who recidivated on explanatory variables are presented in Table 1. Black participants were more likely to incur a violation than white participants (43% vs. 14%), while those who had an offense against a minor (80% vs. 59%) and were incarcerated at the time of the interview (19% vs. 37%) were less likely to receive a violation. Participants who violated supervision were also more likely to report intimate partner instrumental support (38% vs. 20%). Participants who were reimprisoned were more likely to report intimate partner instrumental (50% vs. 22%) and expressive support (72% vs. 48%), as well as positive PO support than successful participants (78% vs. 46%).

Next, separate models for family, intimate partners, friends, and PO support were estimated using logistic regression. No statistically significant relationships emerged between the measures of instrumental and expressive support and the occurrence of a technical violation (results not shown). However, it should be noted that age and race were significant factors in each of the models in that being younger and black predicted the occurrence of a technical violation in the follow-up period. The models predicting reimprisonment are presented in Table 2. Models for family, intimate partners, and friends did not yield statistically significant relationships between social support and being reimprisoned. As shown in Model 4, positive PO support significantly predicted reimprisonment for participants in this sample. In fact, participants who perceived receiving positive PO support were four times more likely to be reimprisoned than those perceiving negative support. Notably, in the reimprisonment models race and age did not predict a return to prison.[5]

Qualitative Results

Analysis of participant narratives augments the quantitative findings by contextualizing social support with the structural and cultural aspects of being labeled a sex offender. There were few substantive qualitative differences in the experience of family, friend, and intimate partner support domains between recidivists and nonrecidivists as also reflected by the lack of statistically significant findings, however, qualitative analysis reveals *how* support is provided. Regarding PO support, analysis illuminates on the quantitative finding that positive PO support is associated with increased incarceration.

Family. Family support is the most often reported support among recidivists and nonrecidivists in this study. Nearly half of the sample (43%) reported receiving instrumental

Table 1. Summary Statistics (n = 72).

	Total sample (n = 72)		Technical violators (n = 37)		Nonviolators (n = 35)		Reimprison (n = 18)		Nonreimprison (n = 54)	
Variable	*M*/%	*SD*	*M*/%	*SD*	*M*/%	*SD*	*M*/%	*SD*	*M*/%	*SD*
Dependent										
Technical violation	51%		51%		49%					
Reimprisonment	25%						25%		75%	
Independent										
Age	41.03	(13.01)	38.91	(12.27)	43.26	(13.57)	42.38	(10.45)	40.58	(13.82)
Black	29%		43%**		14%		39%		26%	
Minor victim	69%		59%		80%**		61%		72%	
Prior imprisonment	1.85	(1.14)	1.98	(1.23)	1.71	(1.04)	2.09	(1.14)	1.77	(1.14)
Incarcerated	28%		19%		37%*		17%		31%	
Family support										
Instrumental	43%		46%		40%		39%		44%	
Expressive	71%		70%		71%		67%		72%	
Intimate partner										
Instrumental	29%		38%*		20%		50%**		22%	
Expressive	54%		59%		49%		72%*		48%	
Friends										
Instrumental	14%		11%		17%		11%		15%	
Expressive	38%		35%		40%		33%		39%	
PO support	54%		59%		49%		78%**		46%	

Note. Significant differences found between violators and nonviolators or reimprisoned and those not reimprisoned.
PO = parole officer.
*p < .10. **p < .05.

support from family via housing, transportation, paying bills, paying for treatment classes, and providing spending money. Almost three-quarters of the sample (71%) reported receiving expressive support, such as holding the individual accountable, showing care, acceptance, and "just being there." The experience of both instrumental and expressive support from family is often intertwined (Pettus-Davis, 2012; Semmer et al., 2008). For example, Ernest (nonrecidivist) stated, "My parents been (sic) helping me out financially . . . support, advice, just about anything my parents can do to help me out, they have been. I actually feel like my family wants me around." Feeling the entire family's support was important to Ernest, but even more so was the feeling of being wanted. This sentiment was common among participants in the face of being shunned by others in society due to the sex offender label. However, for some participants, family support was not enough to overcome the stigma and restrictions of being a sex offender. Andrew (recidivist) stated his sister "covers it all . . . anything she can do, she does. She's real frank with me, real nice, honest to a fault. And uh, like I say . . . that's a strong reason for me staying out." Despite the support from his sister, Andrew had difficulty finding a home plan within the residency restrictions and returned to prison for a new misdemeanor offense and residency violations 4 months after release.

Table 2. Social Support and Reimprisonment Models (n = 72).

	Model 1			Model 2			Model 3			Model 4		
Variable	*B*	(Exp[*b*])	*SE*	*B*	(Exp[*b*])	*SE*	*B*	(Exp[*b*])	*SE*	*B*	(Exp[*b*])	*SE*
Age	0.00	(1.00)	0.02	0.01	(1.02)	0.02	0.01	(0.67)	0.02	0.01	(1.01)	0.02
Black	0.63	(1.86)	0.63	0.51	(1.67)	0.63	0.49	(0.44)	0.64	0.47	(1.60)	0.63
Minor victim	−0.52	(0.59)	0.67	−0.39	(0.68)	0.63	−0.31	(0.62)	0.62	−0.33	(0.72)	0.64
Prior imprisonments	0.21	(1.23)	0.26	0.18	(1.19)	0.26	0.18	(0.48)	0.25	0.34	(1.40)	0.26
Incarcerated	−1.10	(0.33)	0.77	−1.02	(0.36)	0.79	−1.2	(0.12)	0.79	−1.03	(0.36)	0.81
Family support												
Instrumental	−0.54	(0.58)	0.70									
Expressive	0.04	(1.04)	0.72									
Intimate partner support												
Instrumental				0.60	(1.82)	0.80						
Expressive				0.57	(1.76)	0.78						
Friend support												
Instrumental							0.08	(0.94)	1.03			
Expressive							−0.30	(0.68)	0.73			
PO support (positive)										1.41	(4.09)	0.70**
Nagelkerke R^2		.124			.165			.114			.196	

Note. PO = parole officer.
**p < .05.

Participants also experienced a fair amount of negative or nonexistent support from family (36%). Both recidivists and nonrecidivists reported that their families rejected them due to the nature of their crime. In some cases, the family shunned the participant by not speaking to them or moving away. For those who reported no support from family, the nature of their offense was often identified as the reason. For example, Justin (recidivist) discussed how much things had changed in his family while he was in prison. Justin recalled, "When I got out things had changed a lot. You know, family members, half of them, they really didn't have nothing to do with me and that's why most of the time I was, you know, all alone." Justin's experience typifies being isolated from family and the difficulty dealing with feelings of loneliness. Justin violated his probation for failing to complete treatment and to comply with special conditions and was returned to prison less than 2 years after release.

Intimate partners. A majority of the sample (71%) indicated they were in a committed relationship at the time of the interview. One discernable pattern emerged across interviews regarding this support. Over half (52%) of nonrecidivists reported positive intimate partner support, while 68% of those who were returned to prison felt that way. In fact, those who returned to prison made twice as many statements about receiving both positive instrumental and expressive support. While this thematic difference is consistent with the bivariate findings linking positive intimate partner instrumental support with reimprisonment, this relationship did not reach statistical significance in the multivariate model.

Nonrecidivists highlighted the expressive features of their relationships more so than the instrumental. Nonrecidivists described financial assistance and transportation from their partners, but more often and referenced accountability, advice, and positive feelings. Brian (nonrecidivist) felt his girlfriend kept a positive attitude and provided accountability:

> She keeps me on the straight and narrow, if you will. She keeps me looking forward and not backwards. That makes a lot of difference. I know she cares. Most people don't give a damn. But she does. She's one of the few that do.

Brian reflects that despite many others in this life not caring about him, his girlfriend provides enough support to overcome that deficit. In contrast, recidivists' statements revealed that support was related to tangible resources: they were being "taken care of" with food, shelter, clothing, and transportation. The relative lack of expressive support statements in these narratives compared to nonrecidivists suggests that instrumental support was perceived as more important than expressive support, despite not actually impacting the ultimate outcome. Joseph (recidivist), who was returned to prison 7 months after his release for violating the law and other technical violations, described the instrumental and expressive nature of the support from his girlfriend. Joseph felt his girlfriend expected greater commitment than he was ready for in return for all she does for him, and this caused strain in their relationship:

> If I need anything all I got to do is ask her to come help me out. Laundry, she helped me with laundry . . . she always has towels and showers ready for me if I need to come take a shower, because you need somebody to support you. You need help, you need somebody you can rely on . . ., but also there's, there's the part where she wants me to be there all the time and . . . expects me to be more responsible to her than my responsibilities.

Joseph's narrative reflects the stress and strain of pursuing relationships in the face of the numerous restrictions, requirements, and responsibilities of sex offenders while on supervision in the community. Joseph's commentary also suggests that recidivists who relied on their partner's instrumental support were not receiving or recognizing the emotional support offered by them, or the accompanying relationship demands caused stress. In contrast, nonrecidivists who highlighted the mental and emotional support of their intimate partner may have had a greater incentive to desist because of their commitment to them, or perhaps felt compelled to prove they had changed (Lytle et al., 2017).

Friends. Participants reflected that friend relationships were detrimental to their success, stating that friends were a bad influence on them to participate in criminal activity (61%). Most of the sample indicated they received negative or no instrumental support from friends (86%) and more than half (62%) felt that expressive support was negative. Shawn (nonrecidivist) stated, "Got a lot of those [bad friends]. 'C'mon man, let's skip school.' Drugs, or do dope. That's not a friend. That's a trouble-maker." Some also reported losing friends because of the sex offense conviction. Arthur stated,

> I had a real good friend of mine for the longest, and when I got out this time, I looked him up and he came over, and I talked to him, and I told him what I got in trouble for, and that was the last time he talked to me.

When participants described positive support from friends, it was primarily expressive and most often in the form of job connections or leads to tangible resources, or acting as a positive example of someone who has been in trouble with the law. Andrew (recidivist) stated, "They've helped me a little bit, they network for me, they give me job tips. I mean, I've got really good support from the few friends that are not involved in criminal enterprises."

PO. According to the social support perspective, positive perceptions of the PO relationship should result in positive outcomes, yet in this sample participants reporting a helpful officer are four times more likely to go back to prison. Qualitative analysis reveals the complexity in this relationship. Although some nonrecidivists felt their PO was helpful in their transition back to the community, nearly half (46%) felt their officer was not helpful at all or hindered their transition. The most common theme among nonrecidivists was a sense of judgment for their offense, highlighting sex offenders' stigmatization (Robbers, 2009). Some nonrecidivists perceived that their officer did not like supervising individuals convicted of sex offenses. Terry (nonrecidivist), who served 3 years in prison, stated,

> He didn't want to deal with me because I was a sex offender. The first two [POs] were not willing to listen. They were very prejudicial. That was just my side of the story. God knows how many stories they had heard. How many unique criminals that they had to deal with before they got me. When I told them something, I meant what I said. I was trying to be honest and truthful. They looked at me like I was a P.O.S.[6]

In contrast, many recidivists highlighted the positive aspects of their relationship with their PO. Kirby (recidivist), who served 16 years in prison, said, "He's been in my corner. We talk, you know what I'm saying, but, I trust him, I can say things to him, and I know he's not going to go out and tell his people." Kirby felt his PO was one person he could trust to reveal things related to his offending behavior. However, Kirby was returned to prison 3 years after his release for drug use and not complying with his sex offender conditions. As Kirby's return to prison resulted from failing to comply with conditions of being supervised as a sex offender, the nature of disclosure to the PO reveals an important dynamic about the heightened surveillance of these individuals in the community.

Arthur (recidivist) detailed his experience with several different POs. Having a PO who acted as if she cared was meaningful for Arthur, although he was eventually returned to prison for new misdemeanor charges and unauthorized travel outside the jurisdiction:

> I've had some [POs] that just really don't care. I'm just a number. Don't really do nothing. The ones I got now have been . . . pretty positive, I mean as far as POs go. They give me a little bit more slack probably, you know, where I can actually breathe and actually do something, instead of just being, "This is what you have to do, you have to do exactly like this, and there's no ifs ands or buts." And that's it. You know, every home plan I've turned into her she's checked on it and found out, and been sympathetic when it don't (sic) work. And job wise when I got out, she was on top of it, and 'Oh here's some numbers if you wanna call "em and this that and the other." They actually act like they care.

Despite having a PO who cared, and assisted him with aspects of reentry, the relationship alone was not enough to keep Arthur from violating his parole and returning to prison (Cooley et al., 2017). Many participants who were returned to prison highlighted that their officer had shown leniency when they made a mistake which was an important factor for building trust (Kras, 2013), perhaps causing them to feel too comfortable in the relationship (Bailey & Sample, 2017). But, a positive relationship with a PO did not always reflect full disclosure and trust. Eric (recidivist) valued his relationship with his PO so much that he did not want to tell her about his drinking problem for fear of disappointing her. Eric stated,

> My biggest problem with Martha (PO) is I get to looking at her as a friend, somebody that helps me, when I start to stumble and fall I don't want to tell her 'cause I don't want to disappoint her. It's just like both times that I got revoked for drinking. There were so many times that I wanted to tell her that I was in trouble that I was drinking. But I thought so highly of her that I didn't want to tell her cause I didn't want to disappoint her.

Eric was returned to prison for violating his parole after being arrested and failing to comply with his sex offender conditions 3 years post-release. Eric's "friendly" relationship with his PO reflects deficits in his abilities to form normative and prosocial relationships with adults (Ward et al., 1997).

Discussion

This study considers the perceived positive and negative instrumental and expressive support provided by family, friends, intimate partners, and positive or negative support by POs to uncover the underlying mechanisms of the social support-recidivism link among men convicted of sex offenses. Contrary to prior research and the prevailing theoretical connections, quantitative analyses produced no statistically significant relationships between perceived support from family, intimate partners, or friends, and recidivism, and a positive association between perceptions of a helpful PO and recidivism. However, qualitative analyses revealed the individual and structural elements that may condition the prosocial effects of social support.

Participants reported needing the support, both instrumental and expressive, of family, intimate partners and friends. Participants indicated the instrumental support received from family members improved their reentry circumstances and translated to expressive support (Semmer et al., 2008). However, neither instrumental nor expressive support affected recidivism and there were no distinctions between recidivists and nonrecidivists in their perceptions of support from family and friends. It may be that the individuals' perception of support from their family member was different from the actual support received. Future studies should consider triangulating data by including support dyads to assess the perceived vs. actual occurrence of support (Pettus-Davis et al., 2011; Wethington & Kessler, 1986). As there was no relationship between these sources of support independently, it may be that there are specific interactions, such as positive family support and negative peer support, which may cancel out the potentially positive effects on reentry (Boman & Mowen, 2017).

Despite no statistically significant relationship between intimate partner relationships and recidivism in the multivariate analyses, the qualitative analysis suggests that most support received by recidivists was instrumental in nature. This may be explained by the same reasoning as the receipt of instrumental support from family translates into expressive support; however, an alternate explanation may be more consistent with this study's findings. It may be that intimate partners of men who returned to prison enabled deviant or criminal behavior by providing financial support, housing, and transportation, but not the type of accountability needed for the individual to remain in the community (Lytle et al., 2017; Simons & Barr, 2014). Other studies have shown intimate partners can be detrimental to success because they do not engage in treatment or have unrealistic expectations for the individual's success, or contribute to negative behaviors and cause distress, conflict, and anxiety (Gideon, 2007; Pettus-Davis et al., 2011). Recent research suggests that the quality of the intimate partner relationships plays a much larger role in desistance than simply being in one (Simons & Barr, 2014). For recidivists, receiving instrumental support from a partner was

important to them in their reentry process, but it may not have translated into the "support reciprocity" necessary for change, whereas nonrecidivists wanted to achieve success despite their challenges and not be solely reliant on their partner (Farmer et al., 2015; Lytle et al., 2017). An additional explanation for tenuous intimate partner relationships involves considering intimacy deficits in sex offenders (Hanson & Bussiere, 1998; Ward et al., 1997). Although the nature of participants' relationships with intimate partners was not probed regarding specific features, future research should explore differences between those with identified deficits in relationship building or where these deficiencies contribute to sexual offending cycles (Ward et al., 1997).

The most contrary finding of this study is that a positive relationship with a PO was associated with increased likelihood of reimprisonment. While a positive working relationship is a core correctional practice (Bonta et al., 2008) and theoretically linked to reduced recidivism (Cullen, 1994), the contrary finding in this study may speak to several potential mediating processes as revealed by the qualitative analysis. First, it could be the case that the individual feels an exaggerated relationship with their PO such that they are disclosing more information about their behaviors that result in violations. As all participants were under heightened supervision those who were more likely to return to prison may have perceived their officer as taking an interest in their case or have a skewed or unrealistic perspective about their chances for success or the genuineness of their relationship with the officer (Applegate, Smith, Sitren, & Springer, 2009). For example, some participants saw their PO as a friend and did not want to disappoint them, which may signal deficits in interpersonal skills that are linked with recidivism (Ward et al., 1997). Perhaps this study's findings suggest a unidirectional relationship in the face of stigma and lack of other types of social support, where participants see the PO as the only or best source of social support available because they are always in the context of them being a sex offender (Waldram, 2010). Second, the PO may not be delivering the humanist approach as supported by Evidence-Based Practices, and rather presenting greater social distance (Bailey & Sample, 2017; Bonta et al., 2008). While some participants reflected that their PO saw them as a "human being," it may not have been enough to overcome the nature of stigma and lack of social support in other arenas. Limited knowledge of PO style, aspects of case management, and nature of initiatives geared toward sex offender supervision warrant further exploration.

Third, and perhaps most likely, POs could be responding to the participant's disclosures in ways consistent with organizational goals or norms about sex offender case management in the vein of the high risk/high stakes protocol (Turner, 2011; Wright & Cesar, 2013). While the working relationship between POs and their supervisees is positive and acts in ways that will ultimately help the individual desist from sexually reoffending, the current management strategy of this class of offenders involves the justice system responding to behavior differently than with other types of caseloads that might result in reimprisonment for less serious infractions or behavior. As the prevention of sexual reoffending is a necessary role of community supervision, future research should explore the complexity of the working relationship with the sex offender caseload, and the policies and procedures used to guide PO decision making

in response to behavior. A growing body of work examines the relationship between POs and their clients, but this relationship has yet to be explored with sex offenders (see Bailey & Sample, 2017). As a positive working relationship is an evidence-based practice with probationers and parolees (Bonta et al., 2008), how this relationship might be further refined and developed by considering the type of offender on the caseload and their risks and needs, as well as the complex relationship with other social support actors may be important.

While this study contributes to the larger body of sex offender recidivism research by considering the relationship and nature of social support through mixed methodology, the results should be considered in context of some limitations. First, while the sample size is consistent with mixed methods approaches, it is small so future studies with larger samples are needed to explore statistical relationships. Second, a strength of this study is the measurement of positive and negative aspects of instrumental and expressive support from a variety of actors however, they are cross-sectional. It may be relationship between social support variables and recidivism is very different 3 years following the initial account. A recent study by Walker and colleagues (2017) accounted for variation in support over time among a sample of individuals convicted of sex offenses and detected that stable support was linked with reduced reoffending. In addition, participants may have had other factors inhibiting the mechanism of social support from acting in protective ways not included here. For example, a binary measure of victim age is a common method of controlling for impacts of offense characteristics in samples of individuals convicted of sex offenses; it is limited in that some offenses against victims of different ages are perceived in different ways. That is, someone abusing a very young person, compared to a "Romeo and Juliet" relationship, is perceived drastically different, therefore, presenting different structural barriers from social support actors. In addition, the inability to capture risk and need information, or histories of abuse, or substance abuse, presents a limitation to accounting for other impediments to reintegration for which social support is key. The qualitative results also revealed greater complexity in the perceived receipt of social support suggesting there is more to the construct than a binary measurement of instrumental and expressive. Future quantitative studies including repeated measures of degrees of support over time may reveal the dynamic nature of social support, as well as strengthen multivariate models by including time-varying covariates (Colvin et al., 2002).

Despite these limitations, this study presents avenues for future research. While prior studies have shown an inverse relationship between social support and crime at the macro-level (Colvin et al., 2002; Pratt & Godsey, 2002), little research has evaluated how social support works at the individual level across offender types and in different social strata and political climates (see Wright & Cesar, 2013). Future work should consider including contextual measures such as political orientations and legal restrictions to link macro- and micro-level indicators. Research also suggests that community support for offenders might result in reduced levels of crime (Chamlin & Cochran, 1997). The highly regulated nature of residency and supervision for individuals convicted of sex offenses may affect the nature and value of social support for this group so future research should explore other measures of community-level

social support. Current strategies to address this in other countries include Circles of Support and Accountability, which attend to the individual and structural dimensions of reentry and stigma for individuals convicted of sex offenses returning to the community and might provide avenues for future research regarding community-level social support (see Fox, 2014). The current study also highlights the important contribution of mixed methods research. Contextualizing quantitative relationships with case information, especially narrative accounts, allows the field to make deeper theoretical connections between data points (Wright & Bouffard, 2016). Furthermore, mixed methods research provides an avenue for uncovering social processes in ways previously undetected. Importantly for desistance research, the current study demonstrates support for critics of the value of traditional mechanisms of change such as marriage (Leverentz, 2006).

This research contributes to the growing body of literature surrounding reintegration of individuals convicted of sex offenses and the social support-recidivism link. By using mixed methodology, and measures of instrumental and expressive support, this study allowed for the analysis of social support actors in the lives of those convicted of sex offenses. Although the measures of social support were not linked with recidivism outcomes in expected directions, the qualitative analyses demonstrate that social support is relevant, and the importance of family and other social support networks, like POs, for individuals returning to the community is undeniable; however, the individual, cultural, and structural dimensions of reentry for this population condition the experience such that the underlying mechanisms of social support require more theoretical and empirical approaches.

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Notes

1. In Missouri, both probationers and parolees are supervised by one agency. In most cases, sex offenders are a specialized caseload where a PO supervises both probationers and parolees. A comparison with the total sex offender population provided in the *2010 MoDOC Profile of the Institutional and Supervised Offender Population* suggests the present sample is

representative of sex offenders supervised in Missouri in regard to type of offense, criminal history, age, and race (Lombardi, 2010).
2. Individuals with a sex offense conviction may not reside within 1,000 feet of a school, park, or daycare, and must also register on the public sex offender registry for life.
3. No other races were represented in this study. Although a limitation of the sample, this distribution is consistent with the distribution of sex offenders in Missouri (Lombardi, 2010).
4. Participants interviewed in prison were within an average of 36 days prior to release. Individuals interviewed while in prison were originally selected to diversify the sample, and they were also asked the questions related to social support. Robustness check indicates there were no significant differences for those who were interviewed in prison and those on community supervision.
5. Multiple checks of the robustness of findings were performed to rule out possible bias due to research design and data limitations, such as the small sample size. Although it is common in research on individuals convicted of sex offenses to rely on small sample sizes (see Furby, Weinrott, & Blackshaw, 1989), power analysis supports the use of the current procedures, recognizing caution in interpretation and being considered in context of the larger purpose of mixed methods studies (Creswell, 2008). Second, participants interviewed while in prison raise concerns about sample selection bias as these individuals may differ in recall and reporting of social support experiences. Tests for group differences revealed that individuals interviewed in prison were more likely to have a current conviction for a sex offense against a minor, 85% vs. 63%; χ^2 (1) = 3.158, p = .064, less likely to think their PO was helpful, 35% vs. 65%; χ^2 (1) 4.098, p = .039, and less likely to incur a technical violation upon release, 35% vs. 58%; χ^2 (1) 2.978, p = .072.
6. "Piece of shit."

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BJS fuels myths about sex offense recidivism, contradicting its own new data

Prison Policy Initiative

A new government report reinforces harmful misconceptions about people convicted of sex offenses. Here's our take on how to parse the data.

by Wendy Sawyer, June 6, 2019

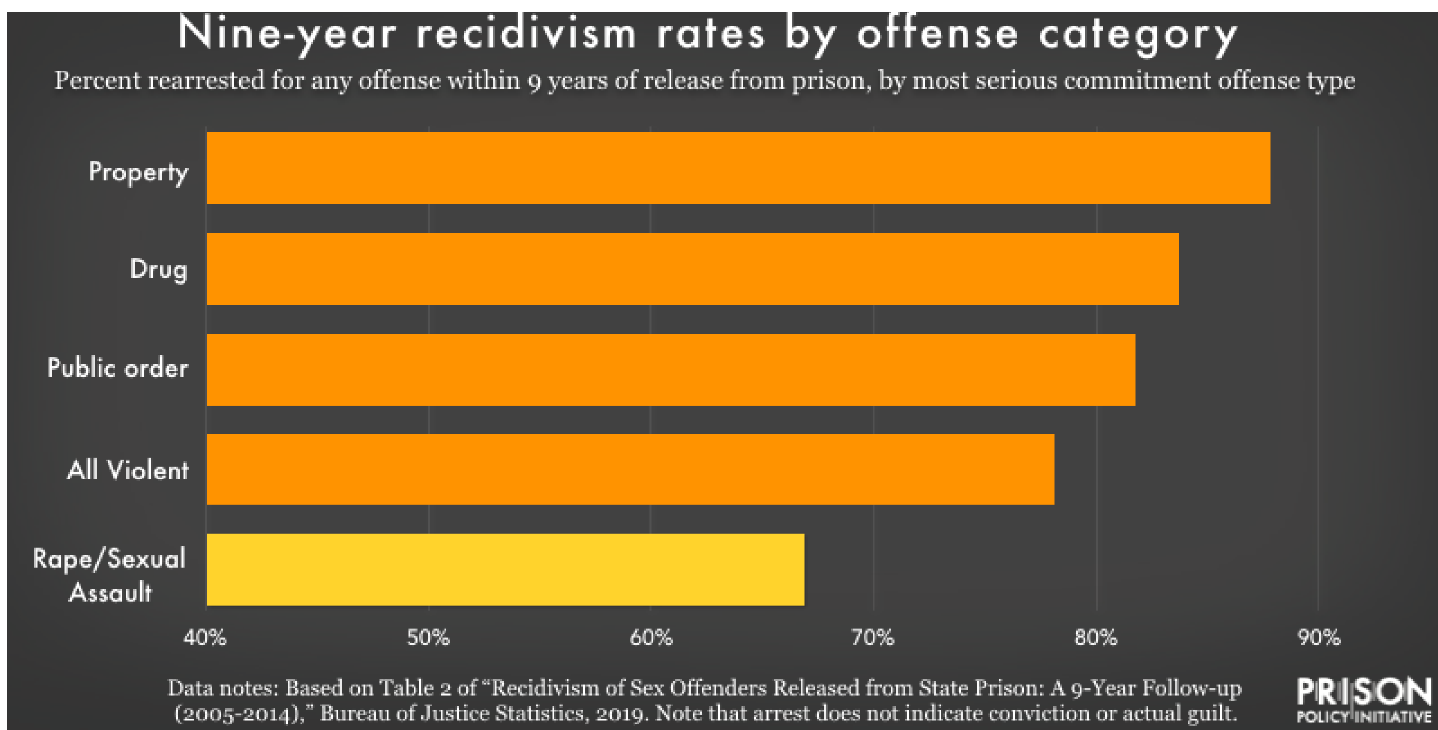
By now, most people who pay any attention to criminal justice reform know better than to label people convicted of drug offenses "drug offenders," a dehumanizing label that presumes that these individuals will be criminals for life. But we continue to label people "sex offenders" – implying that people convicted of sex offenses are somehow different.

A new report released by the Bureau of Justice Statistics should put an end to this misconception: The report, Recidivism of Sex Offenders Released from State Prison: A 9-Year Follow-Up (2005-2014), shows that people convicted of sex offenses are actually much less likely than people convicted of other offenses to be rearrested or to go back to prison.

Unfortunately, this BJS report is a good example of how our perception of sex offenses is distorted by alarmist framing, which in turn contributes to bad policy.

But you wouldn't know this by looking at the report's press release and certain parts of the report itself, which reinforce inaccurate and harmful depictions of people convicted of sex offenses as uniquely dangerous career criminals. The press release and report both emphasize what appears to be the central finding: "Released sex offenders were three times as likely as other released prisoners to be re-arrested for a sex offense." That was the headline of the press release. The report itself re-states this finding *three different ways*, using similar mathematical comparisons, in a single paragraph.

What the report doesn't say is that the same comparisons can be made for the other offense categories: People released from sentences for homicide were more than twice as likely to be rearrested for a homicide; those who served sentences for robbery were more than twice as likely to be rearrested for robbery; and those who served time for assault, property crimes, or drug offenses were also more likely (by 1.3-1.4 times) to be rearrested for similar offenses. And with the exception of homicide, those who served sentences for these other offense types were *much more likely* to be rearrested at all.



The new BJS report, unfortunately, is a good example of how our perception of sex offenses is distorted by alarmist framing, which in turn contributes to bad policy. That this publication was a priority for BJS at all is revealing: this is the only offense category out of all of the offenders included in the recidivism study to which BJS has devoted an entire 35-page report, even though this group makes up just 5% of the release cohort. This might make sense if it was published in an effort to dispel some myths about this population, but that's not what's happening here.

Framing aside, the recidivism data presented in the BJS report can offer helpful perspective on the risks posed by people after release. Whether measured as rearrest, reconviction, or return to prison, BJS found that people whose most serious commitment offense was rape or sexual assault were much less likely to reoffend after release than those who served time for other offense types. The BJS report shows that within 9 years after release:

Less than 67% of those who served time for rape or sexual assault were rearrested for any offense, making rearrest 20% less likely for this group than all other offense categories combined (84%). Only those who served time for homicide had a lower rate of rearrest (60%).

People who served sentences for sex offenses were much less likely to be rearrested for another sex offense (7.7%) than for a property (24%), drug (18.5%), or public order (59%) offense (a category which includes probation and parole violations).

Only half of those who served sentences for rape or sexual assault had a new arrest that led to a conviction (for any offense), compared to 69% of everyone released in 2005 (in the 29 states with data).

While the data was more limited on returns to prison,[1] the study found that within 5 years after release, people who had served sentences for rape or sexual assault also had a lower return-to-prison rate (40%) compared to the overall rate for all offense types combined (55%). BJS notes that some of these returns to prison were likely for parole or probation violations, but because of data limitations, it is impossible to say how many were for new offenses, much less how many were for rape or sexual assault.

In sum, the BJS data show that people who served time for sex offenses had markedly lower recidivism rates than almost any other group. Yet the data continue to be framed in misleading ways that make it harder to rethink the various harmful and ineffective punishments imposed on people convicted of sex offenses.

The recidivism data suggest that current legal responses to people convicted of sex offenses are less about managing risk than maximizing punishment. The desire for retribution is understandable; unquestionably, rape and sexual assault inflict serious and lasting trauma. But our criminal justice system does a poor job of providing survivors of rape, sexual assault, and other violent crimes what they really want. In a 2016 survey of crime survivors, the Alliance for Safety and Justice found that, "Survivors of violent crime — including victims of the most serious crimes such as rape or murder of a family member — widely support reducing incarceration to invest in prevention and rehabilitation and strongly believe that prison does more harm than good." But more prison time is the default response: those released after serving sentences for rape and sexual assault served longer sentences, with a median sentence of 5 years (compared to 3 years for all others combined) and over a quarter serving 10 years or more before release.

And for many people convicted of sex offenses, confinement doesn't end when their prison sentence does. Twenty states continue to impose indefinite periods of involuntary confinement under civil commitment laws – *after* individuals have completed a sentence (or, in some cases, before they are even convicted). Proponents justify the practice as "treatment," but conditions of civil commitment are punitive and prison-like, and this confinement is hard to justify with the recidivism data we have. The likelihood of post-release arrest for another rape or sexual assault for this group is less than 2% in the first year out of prison, and after 9 years, less than 8% have been rearrested for a similar offense. Those who are released at age 40 or older are even less likely to be rearrested for another sex offense, with re-arrest rates about half those of people who are released at age 24 or younger.

After prison, a number of other special restrictions make reentry especially challenging for those who have served sentences for sex offenses, including registration, public notification, and restrictions to residence and employment. A current proposal suggests banning them from using New York City mass transit. (Even before release, some restrictions make it difficult for some people to leave prison when they would otherwise be paroled.) But these restrictions tend to cause more problems than they

solve. Residence restrictions in particular have contributed to homelessness and other problems in cities where they leave little room for returning citizens. According to a 2015 U.S. Department of Justice brief, "residence restrictions may actually increase offender risk by undermining offender stability and the ability of the offender to obtain housing, work, and family support."

In another recent academic article, Hanson et al. agree that these additional restrictions are "justified on the grounds of public protection," even though the underlying assumptions may be wrong: "Individuals are targeted because policy-makers believe they are likely to do it again. This is a testable assumption, and, as it turns out, not entirely true." Their analysis shows that individual recidivism risk varies widely, can be low enough to be indistinguishable from that of people convicted of non-sex offenses, and drops predictably over time. The data published by BJS track with those findings.

Collectively, the research seems fairly clear: our responses to people convicted of sex offenses do not reflect the actual – generally low – risks they present. Instead of panicking about the small portion who reoffend after release, it's time we talk more rationally about responses that effectively support desistence from crime – and serve the actual needs of victims of violence.

Footnotes

Strategies for Post-release Housing for People with a Sex Offense Conviction

Elianne Paley

Many states and communities have residency restrictions for where in the community people with sex offense convictions may live. Additionally, federal law prohibits anyone on a state sex offender registry from living in public housing. While these laws are intended to increase public safety, they often make community reentry especially challenging for those with sex offense convictions. These restrictions can make finding a legal place to live virtually impossible for individuals on the sex offender registry. This, in turn, pushes some individuals into homelessness, a known contributor to recidivism after reentry. Ongoing behavioral health treatment helps reduce recidivism; however, housing instability contributes to individuals' inability to maintain treatment.

Barriers to housing and employment leave individuals with a sex offense conviction vulnerable to rearrest for non-sex-offense-related charges. Research shows that individuals convicted of sex offenses are at highest risk of rearrest shortly after release from prison. This leaves community leaders with the conundrum: How can they help these individuals access stable housing, thereby maintaining ongoing treatment and reducing recidivism, within the context of existing state, county, or local residency restrictions and public opinion? Read on to learn how an interagency collaborative in Connecticut has developed its own solution to housing individuals convicted of sex offenses on parole or probation.

Connecticut's Model for Housing Individuals Convicted of Sex Offenses

In Connecticut, both the Department of Correction (DOC) and the Judicial Branch have roles in managing and supervising housing for people convicted of sex offenses after their release. The DOC has jurisdiction over individuals on parole, while the Judicial Branch oversees those on probation.

The DOC provides housing assistance for individuals on parole for sex offenses via its Sex Offender Supervision Model. This program provides participants with individualized case management, cognitive behavioral treatment, employment services, and monitoring and supervision activities. Housing is managed through contracts with several community-based housing programs. The DOC also works with the Connecticut Department of Mental Health and Addiction Services (DMHAS) to provide behavioral health services for individuals with additional mental health conditions.

On the other hand, the Judicial Branch offers a rapid re-housing program for individuals convicted of sex offenses who are released on probation. For the first 4 months of an individual's release, the

program subsidizes up to 100 percent of the participant's rent. When the participant becomes able to pay (once they get a job, for instance), they typically begin paying 0 to 60 percent of their income toward rent. "Our goal is to stabilize them, get them into specialized treatment, and help them get into a financial position that they can take on housing expenses on their own," says Deanna L. Dorkins, chief probation officer II, Sex Offender Supervision & Special Projects, Connecticut Judicial Branch. "This contributes to reduced risk of recidivism and increased community and victim safety, which are of utmost importance to us and our community." The Judicial Branch's housing program includes REACH (Reentry Assisted Community Housing), which offers scattered site, subsidized housing, along with intensive case management and vocational support, educational opportunities, transportation assistance, and referrals to mental health treatment. Additionally, the DOC and the Judicial Branch jointly contract with The Connection, Inc., to provide a 24-bed residential facility, the January Center, dedicated to higher-risk individuals.

"Having to register as a sex offender is a known barrier to reintegration because it restricts opportunities and supports for the offenders," says Natalie DuMont, PhD, LPC, regional manager, Community Services Division, DMHAS. "These individuals are often stigmatized in ways that have negative implications when seeking housing, employment, and social services." Connecticut's Sex Offender Supervision Model helps address these barriers for individuals convicted of sex offenses while ensuring the community feels safe and supported.

Scattered-Site, Transitional Housing Model

Within Connecticut's model, the state secures a contract with multiple outside housing providers that manage housing leases, usually an apartment, for people with sex offenses on their records. This allows the supervising agency to maintain contact more successfully with and monitor these individuals than if they were transient, experiencing homelessness, or otherwise housing insecure. In fact, the Connecticut DOC's reentry model has allowed the agency to avoid placing people convicted of sex offenses in homeless shelters for more than 10 years, according to a state report.

The model focuses on placing individuals in areas proximate to their communities of origin (when appropriate) and near their jobs, public transportation, and needed services and away from their victims. Additionally, because it is a scattered site model, no single community ends up with a high concentration of this population.

"This model helps develop equitable access to treatment, employment, and housing in areas that make sense for them and is not specific to a particular ZIP code," says DuMont. "This allows that individual to have improved quality of life, and thereby, lower rates of re-offense." Contracts and providers change over time but often include elements such as time-limited scattered site reentry housing, vocational supports, and transportation services.

In conjunction with housing support, other services available to individuals convicted of sex offenses through Connecticut DMHAS, the DOC, and the Judicial Branch include the Advanced Supervision and Intervention Support Team (ASIST) for defendants with moderate to severe mental illness to receive case management, treatment, and medication management upon reentry, alongside supervision. The Judicial Branch refers individuals convicted of sex offenses under its supervision to contracted Alternative in the Community programs, which provide job-readiness programming. They are also allowed to attend other residential services on a case-by-case basis.

Importance of Relationship Building for Success

A key element of Connecticut's program is building relationships with other partners in the state and community. These partners include public and private agencies, faith-based organizations, and community leaders.

There is regular collaboration between the DOC, DMHAS, and the Judicial Branch to ensure that people reentering the community from incarceration receive the behavioral health services they need to succeed. Additionally, the DOC notifies Connecticut State Police (CSP) and local law enforcement upon the placement of an individual on the sex offender registry in the community. The DOC also collaborates with the CSP Sex Offender Registry to ensure registry requirements have been fulfilled upon release.

The DOC also works closely with the Judicial Branch. When these two groups collaborated to open the January Center, a 24-bed residential treatment facility for individuals convicted of sex offenses, they held community forums and conducted other outreach to engage with the community and share information on safety and programming.

The voices and perspectives of victims are always an important part of the reentry process. The Judicial Branch and the DOC work closely with the Connecticut Alliance to End Sexual Violence and other victims' advocates. Victim impact, awareness, and community safety are built into treatment and housing plans. "Ongoing conversation and dialogue with communities are important to gaining trust and reducing fears," says DuMont.

Partnering for Positive Outcomes

The state's cross-agency collaboration helps to secure all needed services for people convicted of sex offenses, helping to address many social determinants of health (SDOH) and factors that may increase the risk of recidivism or other negative outcomes. "Many individuals with sex offenses may experience multiple severe disparities—insecure housing, family discord, justice involvement, mental illness, and stigma, which affect their ability to gain employment and meet their basic needs," says DuMont. "With a secure home and related case management, now they have somewhere to keep their

medication, an address to put on job applications; they are able to meet the requirements of their probation or parole, and their risk of returning to criminal behavior is greatly reduced."

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Protecting the Public's Health Through Successful Reentry for Sex Offender After Incarceration

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Abstract

This paper describes the post-incarceration reintegration experiences of military veterans convicted of sex offenses and identify potential interventions to ease reintegration for this population. Participants were a convenience sample of 14 veterans who were on sex offender (SO) registries and 21 community stakeholders involved in supporting persons during re-entry. Subjects were identified purposively and through snowball sampling, in Massachusetts. We employed semi-structured qualitative interviews of participants, followed by analysis including process mapping to identify barrier and facilitation points. We used both a grounded thematic approach and *a priori* codes, guided by the Behavioral Model for Vulnerable Populations. We found re-entry barriers include older age, stigma, lack of social support, inadequate information about sexual offense levels, limited housing options and access to mental health treatment to reduce sexual impulses, and re-entry information tailored to SOs. Re-entry facilitators include access to SO treatment, knowledge about services, self-efficacy, ability to self-advocate, and social support. Interventions to aid successful re-entry include pre-release counseling and classes tailored to SO needs, re-entry planning including housing resources, sexual deviance treatment, and referral to legal counseling to assist with altering assigned SO level. Specific needs and resources unique to veterans should be integrated into reentry plans. Convicted SOs often lack information and assistance to prepare for life after release, putting them at increased risk of

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homelessness, emotional difficulties, and financial hardship. Failure to recognize the unique needs of this population, and to leverage resources, creates a public health risk as it increases the likelihood that SOs will recidivate. Veterans who are SOs have unique resources available to them through the Veterans Administration such as SO treatment and peer-support specialists. Nevertheless there are additional steps that could be beneficial, such as timely provision of information, creating more opportunities for treatment, and providing more housing options.

Keywords

sex offenders; re-entry; veterans; homelessness; public health

Introduction

Individuals convicted of a sex crime have an increased likelihood of experiencing homelessness and emotional and financial hardship (Levenson, 2008; Levenson & Cotter, 2005). This presents a public health risk as it increases the likelihood that these citizens returning to the community from jails and prisons will commit another sex crime. Levenson et al. found that those persons convicted of a sexual offense who have social support and stable employment are less likely to recidivate (Levenson, 2008). Additionally, while rates of recidivism are low among people convicted of a sexual offense (5%–14%), a meta-analysis by Hanson and Bussiere (1998) demonstrated that with mental health treatment designed to control sexual impulses, the likelihood of recidivism is reduced by half. But, many of the policies intended to keep the public safe from those who have committed sexual offenses have an unintended consequence of making an individual more likely to reoffend due to social isolation (Freeman-Longo, 1997; Gavrilets et al., 2016; Hanson & Bussiere, 1998; Levenson, 2008).

Addressing the needs of persons convicted of a sexual offense has special importance for the Department of Veterans Affairs (VA) because veterans are disproportionately more likely to be convicted of a sex crime than the general population. Veterans make up 8% of the incarcerated population and there is a lower rate of incarceration among veterans than nonveterans (855 per 100,000 compared to 968 per 100,000) (Bronson et al., 2015). However, within the incarcerated population, veterans who are sex offenders (SOs) are overrepresented. Nationally veterans convicted of a sexual offense (VCSO) make up about 35% of incarcerated veterans in prisons and 12% of incarcerated veterans in jails compared to 23% of nonveterans in prison and 5% of nonveterans in jails who have been convicted of a sexual offense (Bronson et al., 2015). Veterans have 1.35 greater odds of being convicted of a sexual offense than a nonveteran (Finlay et al., 2019). Veterans convicted of a sex offense are also more likely to experience housing instability (OR 1.81, 95% confidence interval [CI] 1.46–2.25), homelessness (OR 2.97, 95% CI 1.67–5.17) (Byrne et al., 2020) and to have been forced to have had sex (OR 4.43, 95% CI 3.55–5.54) (Finlay et al., 2019). And men among the military more generally are more likely to have been a victim of sexual abuse before the age of 18 (OR 2.19, 95% CI, 1.34–3.57) among other adverse childhood experiences (Blosnich et al., 2014).

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Veterans are also an especially vulnerable population. Veterans leaving incarceration generally are more likely to be older and sicker than their civilian counterparts (Eibner et al., 2016). They are also more likely to have mental health problems, traumatic brain injury, substance use disorder and are more likely to commit suicide (Olenick et al.,2015). Despite this, they have services available through the VA that other populations do not.

When veterans return to the community after incarceration, they need to be engaged in services upon release in order to reduce their risk of homelessness and reoffending, as well as address other mental and physical health problems common to veterans. There are unique services for veterans leaving incarceration: within the VA, reentry planning for all veterans leaving incarceration, including those who are required to register as an individual convicted of a sexual offense, is primarily the responsibility of counselors within the national Health Care for Reentry Veterans (HCRV) program (VHA Health Care for Reentry Veterans (HCRV) Program Handbook, 2014). A 2015 national survey of these HCRV providers found that housing for SOs is the number one unmet need among reentry veterans (Office of Public Affairs and Media Relations, 2015). However, despite the high level of need, the unique vulnerability and resources specific to this population, and the positive impact successful reintegration can have both for the veteran and for public safety, there is little literature specifically on veteran experiences in the first months after release from incarceration. While there has been qualitative research on reentry with those convicted of a sexual offense among the general population, there is scant literature on the barriers to, and facilitators of, successful reintegration into the community for veterans specifically. Our research aimed to better understand for veterans what unmet needs exist in the reentry process. We were guided by the following research questions:

1. What are the most significant barriers to housing, employment and health care that are specific to reentry VCSO?

2. What are some of the facilitators in use by the VA, state, and community organizations to overcome the barriers faced by VCSO?

This work was conducted in the context of a VA initiative to improve support and linkage to services for reentry veterans, and as such was designed to identify potential best practices that would improve reentry processes and outcomes for VCSOs. The larger VA initiative has been described elsewhere (Simmons et al., 2017).

Methods

Overview

We used qualitative semistructured interviews because of the strength of this method in the early exploration of a topic (Yin, 2015). The qualitative approach gives “permission” to respondents to guide the discussion to areas that are of high importance, which may not have been specifically mentioned in an interview question. We conducted interviews with VA HCRV counselors and staff, state officials and reentry program managers, community care providers, and veterans who were convicted of a sex offense to more fully understand barriers and facilitators to community reintegration after incarceration, including such issues as housing, behavioral health, and access to treatment in this subgroup of reentry veterans.

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In addition to analyzing data to identify major themes, we also used these interviews to construct a process map (Figure 1) for veterans on an SO registry leaving incarceration to depict the common pathways that VCSOs follow during the first 4 to 6 months postrelease. The study was designed to identify areas in which the VA could improve services to address the needs of veterans who had been incarcerated, including veterans with sex offenses. It was submitted to the Institutional Review Board (IRB) at the Edith Nourse Rogers Memorial Veterans Hospital (Bedford, Massachusetts, USA), which determined it was a quality improvement project as per VA handbook 1200.05. The need for continued IRB review was waived. Verbal informed consent was obtained from all participants.

Interview Guide

When developing our interview guide, we drew on the behavioral model for vulnerable populations (BMVPs), developed by Gelberg et al. The BMVP describes the barriers and facilitators of service utilization by highly vulnerable groups such as persons who are homeless, persons with substance use and mental health disorders, as well as persons with a history of incarceration (Gelberg et al., 2000). We chose this model because our research questions are designed to help develop interventions to improve the health of veterans who are in an environment in which frayed social structures may engender unstable housing and homelessness, high crime rates, and high prevalence of mental illness, substance use disorders, and infectious diseases. Our interview guide encompassed questions about the process of leaving incarceration, experiences of individuals leaving incarceration and an opportunity to recommend steps that would have eased the transition.

Interviews

The interviews were conducted October 2016 to July 2017. Stakeholders and veterans were interviewed once and interviews lasted 30–90 minutes. We achieved data saturation which means that additional interviews yielded no new relevant information. It is used to strengthen the validity of our results (Yin, 2015). Interviews were audio recorded and transcribed.

Setting and Study Sample

This project was conducted in Massachusetts, with interviews seeking to gain perspectives from a wide variety of agencies and organizations involved in policies, programming, and service delivery for veterans undergoing reentry. We chose this sample because we were seeking to identify resources specific to veterans.

We first used purposeful sampling, a method in which participants are identified based on their knowledge or role in an organization (Yin, 2015), to identify and interview persons who were most knowledgeable about VCSOs, and especially with knowledge of the processes and experiences of VCSOs. There are six main categories from which we sampled: VA entities, state agencies (e.g., Department of Corrections, Department of Veterans Services), community organizations (e.g., transitional housing and shelter programs targeting veterans, and similar programs targeting the general homeless and reentry population), peer support specialists, VCSOs, and leadership of the national HCRV office. We then used snowball sampling (Yin, 2015) to identify veterans and additional

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stakeholders. Veterans in particular were only suggested for inclusion by stakeholders specifically. Snowball sampling can be especially useful for research into socially sensitive topics. Veterans were given a $25 CVS gift card for their time, while other interview participants were not compensated.

For veterans inclusion/exclusion criteria are having been released from a Massachusetts state prison, or jail, being on the SO registry, and eligible for Veterans Health Administration (VHA) services. We did not restrict our sample by SO level. There are three SO levels in Massachusetts: Level 1 includes individuals who “have a low risk of reoffending, pose a low degree of danger to the public.” Level 2 includes individuals who “have a moderate risk of reoffending, pose a moderate degree of danger to the public.” Level 3 includes individuals who “have a high risk of reoffending, pose a high degree of danger to the public.” For level 1, information about the offender can only be accessed by law enforcement agencies and state social service agencies and not the public. For level 2, information on anyone classified after July 12, 2013 is publicly available on the online registry, while for level 3, information is available through local police departments and the online registry. History of dementia and other serious cognitive impairment were exclusionary criteria.

Analysis

Interview audio-recordings were transcribed verbatim by a professional transcription service and analyzed using NVivo, a qualitative data analysis software (QSR International Pty Ltd., 2014). A codebook was developed iteratively by two members of our research team (MS, KR), with two levels of coding beginning with open coding. Open codes capture recurring relevant information and are closely related to source data. We then conducted categorical coding, which is a higher conceptual level of coding that takes into account similarities across codes (Yin, 2015). Codes were both deductive and inductive. The former were *a priori* codes based on interview questions, while the latter codes emerged from the data. *A priori* codes based on interview questions were drawn from BVMP constructs and literature relating to vulnerable populations’ housing issues, needs, services, and engagement (Gelberg et al., 2000; Stein et al., 2007). Within this coding scheme, we considered veterans status specifically and included an *a priori* code to reflect this. Three members of the project team coded the data (MS, KR, TL). The process started with 5 of the transcripts being separately coded by each of the three team members and then discussed in a team meeting to identify and resolve discrepant approaches to coding. This resulted in a consensus on the use of the codes and helped to improve consistency in coding across coders. The remaining transcripts were then divided among the three coders for completion of coding. After coding was completed, the team met to develop themes from the categorical codes, a process in which the codes were arranged hierarchically (Yin, 2015) (grouping open codes under one or more categorical codes), and then conceptually similar categorical codes were grouped into themes.

Analysis of qualitative data contributed to the first aim, which was the creation of a process map which helped to identify where in the reentry process there were bottlenecks, confusing steps, or other barriers in the way that VCSOs transition back into the community, and, consequently, opportunities for improvement or intervention (Simmons et al., 2017). To

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create the process map, the timing, sequence, and duration of Veterans' contacts with individuals and organizations were diagrammed to show the whole network of reentry-related contacts made (Lyalin & Williams, 2005), services used, and barriers encountered, by VCSOs. Such maps may also reveal unproductive steps or contacts, long waiting periods between contacts, and useful but infrequently tapped resources (Kim et al., 2019). Team members met and developed the process map together in a consensus building and collaborative process (Gavrilets et al., 2016) facilitated by one member with experience in this technique, using sticky-notes flipcharts to create "draft" versions, and then revisions, of the process map. This map was intended as a tool for the research team to identify specific intervention points.

Results

Description of the Sample

We completed interviews with 14 veterans and 21 stakeholders. Among stakeholders were VA employees, and the rest were affiliated with state and local organizations. Approximately half of the interviewed stakeholders served in supervisory roles at their organizations, with the other half serving more front-line program delivery roles. Approximately half of the interviewed stakeholders were female. Among VCSO participants, all were male and ages ranged from 50 to 70 years. We included more stakeholders than veterans due to the diverse roles of the stakeholders.

Themes

We grouped major themes into two categories: barriers to reintegration and facilitators to reintegreation. In barriers, major themes were older age, stigma, lack of knowledge about resources and services, limited housing options, lack of social support, lack of treatment programs to address sexual impulses, confusion, and lack of information about the process of assigning a sexual offense level to an offender. Themes categorized as facilitators were access to SO treatment (especially services offered through the VA), knowledge about services, self-efficacy and ability to self-advocate, and social support (especially in the form of other veterans). These are described in more detail below.

Barriers to reintegration

Age.—All but two of the veterans in our sample had been incarcerated for years or decades due to the nature of their crimes. This meant that they were of advanced age when leaving incarceration. This exacerbated many of the challenges of leaving incarceration. For instance, several participants explained how they did not know how to use a smart phone or automated banking systems. Many also discussed their age in relation to their potential for employment, with some deciding not to participate in the workforce at all and others wondering what kinds of jobs they might be able to secure given the combination of their age, offense, and general lack of work history.

Stigma.—Stigma runs through many aspects of the VCSO experience and is a consistent barrier to successful reentry throughout the process. This stigma can be subtle and overt. For instance, one caseworker described a subtle experience with stigma:

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> I think families want to be able to do that, [provide social support] and want to be able to embrace folks [veteran sex offenders], but they are leery. I mean, it may be as specific as being very supportive and helpful but being nervous about them being around the young cousins or whatever. And then the other part is, people obviously have their visceral reaction to thinking about whatever the crime or the allegation was. And so, I think that that level of support, that often we get from families or friends or whatever, can be really compromised or confusing, I think, with this population.

This stigma can also be more overt. For instance, VCSOs described having houses and cars vandalized and being harassed in shelters. One veteran described how he was hired for a job and then the offer was rescinded when he disclosed that he was on the SO registry for previous crimes. The stigma also can distort the way other people view the crime. Here a level 1 (lowest risk level) VCSO described the ostracism and vilification he felt. It should be noted he was not describing his own sexual offense in the following quote:

> We committed a crime. A horrible crime, pled guilty, we're sentenced, and we're punished for that crime. Now when we get out, we're on probation, a continuance of that punishment. We have to register, another continuance, we wear a GPS monitor, the stigma, the family, isolation, all of these things. And then on top of that you got people that are just going to hate you because the second you say, "I'm a sex offender," they automatically assume you held some little three-year child down and brutally raped them and killed them. That's in their minds automatically. When it could have been something as simple as you got drunk on the way home, you're walking; you stopped behind a bush to urinate and happened to be in front of a school at nighttime. And it's closed but a cop sees you and [snapping fingers] you're a sex offender.

While stigma is a consistent issue throughout the reentry process, there are also specific points when it is particularly crippling, such as when trying to access housing and treatment, and its contribution to social isolation, as described in the sections below.

Lack of knowledge.—This is another theme that cuts through many aspects of the VCSO experience and is a consistent barrier. While lack of knowledge of resources is a near-universal problem for those who have been incarcerated, the stakes are higher for persons who have a criminal history that includes a sexual offense and they also have unique needs – thus generic resource packets for ex-offenders may be less helpful for them. Especially for veterans, there are resources for VCSOs that can be particularly helpful that are not available in generic reentry planning. Also, knowledge and skills to secure resources are also a barrier that reentry veterans encounter upon release. There are several programs designed to help people leaving incarceration but veterans often discussed they did not know about programs when they were released. For instance, one VCSO was in transitional housing and during that time the caseworker he met there told him about how he qualified for food stamps. Another described how he learned how to procure donated clothes and furniture. VCSOs reported that knowing this information at the time of release would be helpful.

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It is unclear from our sample if this lack of knowledge was due to a lack of communication or because individuals were overwhelmed by the information they were given. Additionally, some participants reported that the counselors at the VA and the Department of Correction (DOC) did not always fully communicate with each other, which meant they were given information twice, contributing to feeling overwhelmed by the amount of information provided upon reentry. Veterans in our sample recommended that having a short packet of information tailored specifically for VCSOs might be helpful to mitigate this.

Lack of social support.—While lack of social support is prevalent among all types of offenders, it appears to be particularly acute among VCSOs as compared to other justice involved veterans. This is likely due to the stigma and fear that the SO label brings with it in society. Some veterans reported feeling rejected by family members, while others reported being taken advantage of by family members. For instance, this veteran described reaching out to a cousin he had been close to his entire life:

> So, I called [from prison] and the telephone says, "this phone call is originating from a penal institution" or something like that, and I heard his wife answer the phone and after it said that, "click." So, that was a kick in the head.

He went on to describe the isolation that he felt after that call and how it was a setback for him. This isolation can also cause a situation where family members take advantage of the reentry veteran. One caseworker told us about one VCSO who lost over $100,000 to family members to whom he had given control over his finances while he was incarcerated. Other veterans described similar disappearance of their money at the hands of family members.

Housing.—Limited access to housing is another major barrier for VCSOs especially as compared to other justice involved veterans. While some of the veterans we interviewed were fortunate to own a home, or have family that was willing to take them in, the majority struggled to secure safe housing. Adequate housing is pivotal to successful reintegration as described by a caseworker:

> if they don't have a place to go, if they're gonna go underground and they're not gonna register, they're gonna be floating from place to place, and if they reoffend then there's gonna be public outcry. But if there were places to have people like that go to have a fair chance at starting their lives back over again…

Respondents noted that homeless shelters generally would accept those on SO registries, but that few long-term low-income housing programs would. In Massachusetts, stakeholder respondents reported there are only three temporary housing facilities that can house persons required to be on the SO registry. They also noted that cannot live in public housing while on the registry and cannot receive federal housing assistance while on the registry. Veterans and stakeholders also reported that at the local level, municipalities often have different rules about where an individual who is on a SO registry may live and work, making it difficult to abide by all rules. Participants noted that localities prohibit registered individuals from living near schools, parks, and public buildings but that there is not a consistent state-wide law that governs this. Respondents indicated that some veterans choose to flout the rules because the limited availability of housing left them with no other option. But respondents

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reported these municipal regulations can severely limit housing options for SOs. Participants who were able to find housing in the private rental market reported that because of their limited financial resources they often could only afford shared living arrangements and often the housing was substandard including poorly maintained or rodent infested.

Stakeholders reported that one of the most significant barriers to housing was the federal prohibition on using federal housing funds, such as Section 8 vouchers, for individuals who were required to be life-time registrants on the SO list. In Massachusetts this is level 3 SOs. However, municipality specific housing authorities may have additional prohibitions for anyone on a SO list, further complicating this issue. The VA does not have any long-term or transitional housing for VCSOs, though they do have residential SUD treatment facilities that will accept VCSOs. Caseworkers also reported that nursing homes in Massachusetts will not take individuals with a criminal history of sexual offenses which is particularly problematic because many of them have been incarcerated for many years, are old and often frail.

Finally, stigma and societal fear can also contribute to housing barriers for individuals who have been convicted of a sexual offense. Respondents described private landlords being wary of the liability and the potential backlash from neighbors who find out about VCSOs living in their neighborhood. One caseworker explained how an initial housing placement success turned to failure. Five VCSOs were housed in a private rental property when a newspaper reported on it:

> "The neighbors," according to the caseworker, were, "all ashamed and they want them [the veterans] to leave that place, but before that happened, we were like, what a success, we actually housed five sex offenders which is so hard to do.

Access to sex offender treatment.—Limited access to treatment for sexual impulses was also an issue, beginning with the incarceration period, even though there is limited programming within the VA specific to sexual offenses. It was reported that treatment was often not available while incarcerated or, when it was, stigma made attending the groups difficult. One veteran explained that there was a therapy group he could participate in while incarcerated but people were reluctant to go. This was because they were required to leave their IDs outside of the door and other inmates would look through them to see who was required to be on the sex-offender registry. This participant reported that this opened him up to harassment by other inmates. He also described how the guards would give them a hard time for even holding the group, at one point telling them, "you don't even deserve coffee."

Stakeholders also reported a lack of mental health services to manage SO treatment following incarceration. Stakeholders reported that the VA runs two small groups in Massachusetts (8–10 people) that are treating VCSOs but these groups are hard to get into because of their limited size (this was corroborated by one of the stakeholders, a mental health clinician, who himself ran one of the groups). New group members were only permitted if an existing member left, which happened infrequently. Veterans involved in these groups reported they were very pleased with their therapy.

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Sex offender classification and classification process.: There are also several legal barriers to reintegration that can be navigated with appropriate assistance and knowledge, but often Veterans do not know how or when to do that. One of these barriers that occurs during incarceration is SO level assignment. Assignment happens when an incarcerated person is getting ready for release. Level assignment can greatly impact the restrictions that are placed on a veteran once they have left incarceration and thus their ability to reintegrate. Participants reported that, seemingly by default, most with a criminal history of sexual offenses were assigned level 3. According to stakeholders, that assignment can be appealed, something many people may not know. Veteran participants in our sample who did appeal their decision successfully had it lowered to a level 1. Participants noted that it was commonly through speaking with other fellow veteran inmates that they made their decision to appeal. Stakeholders reported that generally, inmates do not have legal counsel while incarcerated so they do not have formal advice when appealing their level decision. Once they initiate an appeal, however, they are appointed a lawyer who will help with the remainder of the appeals process. One stakeholder noted that if an individual decides to appeal their level after leaving incarceration it can be more difficult because they need a lawyer, and many cannot afford legal counsel.

Another classification issue that was reported by HCRV staff was the process of civil commitment. Civil commitment means being committed to a state psychiatric hospital for no defined amount of time (Massachusetts Legislature). Participants reported that not every reentry veteran may know that they can appeal the decision to have this hearing or, they may not appeal because participants reported that they felt that appealing was a hopeless endeavor. HCRV counselors reported that the civil commitment process made it difficult to make a reentry plan for these individuals because the counselor may have secured housing only to find out on the day the veteran is supposed to be released that they are being committed. Or, the date that the individual is supposed to get released gets pushed back so there can be a civil commitment hearing or to hear an appeal.

Facilitators to Reintegration

Identifying facilitators to reintegration may lead to development of interventions. The themes related to facilitators included access to care, knowledge about services, the ability to self-advocate, and strong social support (often provided by other veterans).

Access to sexual impulse treatment and other health care.

Access to health care (medical and behavioral) while still in prison or jail was noted as having advantages over receiving care after release only. Some of this care was to address issues with their sexual offense and some of it was to assist with other mental health or medical problems. VCSOs described how in-facility treatment helped them to see themselves differently and gave them skills, such as understanding boundaries, to navigate life outside of incarceration and reducing the likelihood of reoffending with a sex offense. Veterans also described how having Alcoholics and Narcotics Anonymous groups inside prison and jail was “fantastic” and helped with recovery.

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After release, access to SO treatment was equally important. While not every veteran described a positive experience with postincarceration therapy, all except two described therapy as a necessary outlet where they were able to discuss the issues they were facing and learn coping skills and the importance of the comradery of the VSCO group they attend. One veteran explained the benefits of SO therapy:

> they offer you some positive, constructive feedback in a way that's not saying that you shouldn't feel that way, no, it's healthy for you feel that way and then, they ask you how are you going to work through it? Instead of telling you how you are going to work through it.

While many were court mandated to attend sexual impulse therapy as part of a probation agreement, one of the stakeholders (a VA behavioral health provider) reported that VCSOs attending SO groups offered by the VA often continued therapy longer than what was required by courts.

Knowledge, self-advocacy, and hope.

Having knowledge of the legal process and the ability to self-advocate was important for persons with all types of offenses, but it was particularly important for VCSOs to understand the significance of their SO level assignment and how to navigate the appeals process. In the months prior to leaving incarceration an individual convicted of a sexual offense receives a letter with their level assignment, including a form to appeal that level. Not every VCSO took advantage of this appeals process or necessarily understood what the form was for – even though getting a lower level can greatly ease reentry. The decision to appeal a SO level assignment was, for some veterans, attributed to self-advocacy. As one veteran described,

> I felt under the new law, I had grounds for a lower number, and you should always appeal it…. You know you could win and say, even though it looks like you don't have a shot in hell…. So, that's what I live by, I don't look at the top number; like eighty percent chance it's not going to happen, I look at twenty percent that it is going to happen or one percent chance or whatever. Why can't I fall in that category?

The concepts of self-advocacy and hope were important facilitators which we saw repeatedly eased the transition.

Upon release, a veteran has multiple, nearly simultaneous, needs, including securing housing and food, obtaining identification, enrolling in benefits, and opening a bank account. Having the ability and motivation to try to get help securing these essentials was a major facilitator to a successful reentry. As one veteran described,

> When I get out, there was nobody gonna be standing there outside the gate of your jail waiting to pick me up, drive me home. "Oh we missed you!" It wasn't happening. I'm on my own. What am I gonna do? Am I gonna wait? And then see what happens or am I gonna start taking advantage and start asking questions and reaching out. And I was like, I really don't like sleeping on the street so I gotta really start getting involved in this and from the get-go.

Another veteran pointed out,

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> there are some food pantries and there are churches that give meals and so, but you got to do the foot work. You can't sit on a park bench, downtown, and expect people to give you everything you need. You gotta be willing to you know, get a bus pass. That's important and go places and be told, no, but if you are doing it right, you won't be told no.

Other veterans discussed the importance of learning about where one was living (or going to live) and making sure the important resources were available. For example, they recommended living in a place that was on a bus line and near social/medical/mental health services so that they could have all the essential ingredients for a successful reentry. VCSO also described being advocates for their friends who were fellow reentry veterans who were also VCSOs. This helped them to form social networks, another important facilitator to reentry, described below. Many were involved with the National Association for Incarcerated Veterans and described this group as important for making social connections while incarcerated and, that these friendships were a source of knowledge that sometimes continued after incarceration.

Social support.

Social support, both formal and informal, can be a facilitator to successful reintegration. In the formal area, several veterans described how HCRV counselors helped with housing and medical appointments. Almost all veterans in our sample indicated they had met with an HCRV counselor while still incarcerated. These counselors often knew landlords who were more flexible and would take someone with a sex offense. Veterans and HCRV counselors also reported that one of the counselor's roles prior to the veteran's release was to help the veteran secure benefits and make medical appointments (that would take place after release).

Another formalized social support which was seen as facilitating reintegration was reentry class held in prisons and jails. Some of the class material (e.g., how to secure housing) was not very relevant to VCSOs because they face considerable restrictions on where they can live, but other aspects of the class were described positively. For instance, veterans reported learning how to make a budget, what things should cost at the grocery store, how to write a resume, how to conduct one's self in an interview, and other life skills that assist with the transition. One criticism of the class however was the focus on employment. Many of the veterans in our sample were at or above retirement age and did not plan to work after release. The skills learned in reentry classes are intended to help veteran help themselves, reinforcing the importance of self-advocacy and hope.

Informal social support usually came from friends and family. Levels of informal social support varied, but all veterans described at least one social connection who was an important facilitator to successful reentry. These included family members, friends, fellow reentry veterans, religious organizations, and caseworkers. Several of these participants also lived with others VCSOs or formed friendships and support networks through in-patient and out-patient therapy. Veterans in our sample described how this support system had given them not only moral support but also helped them find housing, transportation, and employment.

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Discussion

To our knowledge, this is one of the first qualitative efforts to describe the reentry experience for VCSOs. Our qualitative approach allowed us insights into the considerable barriers to community reintegration that are faced by VCSOs specifically. It was important to study this population specifically not only because they have unique characteristics but also because the VA can potentially target resources towards this population if their needs are better understood. Staff commented that they often felt ill-equipped to manage this population.

Consistent with the BVMP (Gelberg et al., 2000), we saw that predisposing characteristics such as age, combined with enabling characteristics, such as social support impacted the outcome of the reentry process. The most prominent barriers are stigma and limited housing options, both of which increase vulnerability in getting reestablished safely and productively. This is congruent with literature on the topic which shows that reentry planning is critical to community integration and reducing recidivism (Gwenda & Randolph, 2009; Zamble & Quinsey, 2001). These veterans carry a double burden upon release: having a criminal record and being registered as a SO. In addition to pervasive stigma and significant challenges to finding housing, other barriers faced by this sample of VCSOs included lack of social support, access to sexual impulse treatment, information about the sexual offense level assignment process and opportunities to appeal, and knowledge about resources and services. Below we describe opportunities for intervening, suggested by our data, to enhance the reintegration for those registered as a SO.

We found that stigma in particular was an overarching issue that permeated each step in the reentry process and contributed greatly to the limited housing options and dearth of social supports. While all justice involved individuals potentially experience stigma, even among this population those convicted of a sexual offense are particularly stigmatized (Tewksbury, 2012). Literature on the topic has shown that public fear those on the SO registry returning to communities and this has resulted in pickets, vigils, and evictions (Petrunik & Deutschmann, 2008). In the initial weeks and months after release the interrelated barriers of social isolation and stigma can impede community reintegration and lead to recidivism (Freeman-Longo, 1997; Gavrilets et al., 2016; Hanson & Bussiere, 1998; Levenson, 2008). This is demonstrated throughout the process map (Figure 1). Researchers at the VA recently deployed a peer supported intervention, which has the potential to help ameliorate social isolation and provide reentry veterans with practical support (Simmons et al., 2017). Peers are well positioned to assist veterans who require trauma informed care and improve outcomes among justice involved persons (Aos et al., 2006; Bagnall et al., 2015; Prendergast, 2009). Trauma informed care is needed among this population, which has a high likelihood of having been exposed to trauma both in childhood and the military (Blosnich et al., 2014; Finlay et al., 2019). Peers also develop relationships within the community which have potential to help in finding housing for VCSOs when none is available through the VA, due to restrictions on Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) vouchers (HUD-VASH vouchers are part of a supportive housing program jointly run by the Department of Housing and Urban Development and the VA). This is intervention points 3 and 4 in Figure 1.

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Our data also show that psychological treatment is essential to help the veterans in our sample learn to navigate stigma, which in turn will lead to less social isolation and lower chances of recidivism. This is especially important for veterans because they are more likely to additionally suffer from mental illness, traumatic brain injury and substance use disorder (Olenick et al., 2015). In the postrelease period, health care settings provide an opportunity for intervention, especially when they provide opportunities for sexual offender treatment that can address underlying contributors that led to the individual committing a sexual offense. From our stakeholder interviews we identified 2 therapy groups in Massachusetts specifically for VCSOs. Participants in these groups reported that therapy had the additional benefit of helping them to navigate the stigma and social isolation of their SO status. Hanson and Bussiere (1998) demonstrated that this type of therapy is effective at reducing recidivism and therefore may be essential for those with pathologic impulse to commit crimes of a sexual nature. Increasing the availability of this type of treatment at VA medical centers would likely contribute to reducing recidivism. Due to the single payer health care status of the VA, this is a unique opportunity for veterans specifically. Some of the veterans in our sample also struggled with substance use disorder, and often substance use contributed to the sexual incident for which they were convicted. This would suggest that access to substance use disorder treatment is also an important component of initiatives to assist reentry VCSOs. Access to these services is important at intervention points 3 and 4 (Figure 1).

SO level assignment can also have a critical impact on reentry and more attention to this designation is needed. Being assigned a level 3 SO designation (which is a common default designation in Massachusetts often when not warranted, according to respondents) can make the attainment of housing, and many other aspects of reintegration more difficult. As respondents noted, those with a level 3 designation are placed on the life time SO list and cannot ever receive federal housing assistance (US Department of Housing and Urban Development, Office of Housing, Office of Public and Indian Housing, 2012). The public notification associated with this higher level assignment (e.g., a level 2 and 3) such as public online registries, may increase social isolation, depression, and anxiety, which can contribute to recidivism (Edwards & Hensley, 2001; Freeman-Longo, 1997; Hanson & Bussiere, 1998). Consistent with literature on the topic, respondents reported that some localities also have restrictions on where those on SO registries can live, for example not near schools or parks for level 2 or 3 offenders (Levenson, 2008; Levenson & Cotter, 2005). The veterans in our sample who appealed their level decision had it lowered. HCRV providers – who have contact with the veteran while he or she is incarcerated – would potentially be best suited to advise the reentry veteran about the appeals process (intervention point 1 on Figure 1). However, HCRV and the VA are prohibited from providing legal advice nationally (Department of Veterans Affairs, 2019). They are however allowed to refer the reentry veteran to pro-bono legal services. Appealing a decision post incarceration has traditionally been more difficult because the VCSO is responsible for their own legal fees and many cannot afford the process. However, a recent court case in Massachusetts overturned this restriction but it is unclear how this will impact how many people request an appeal.

Consistent with the literature (Petrunik & Deutschmann, 2008), our data show that housing is also a major barrier to successfully reentry that must be addressed (intervention point 3 on Figure 1). This may require state or federal intervention to either provide funding

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for housing assistance or to change regulations to open up more VA or state transitional housing to VCSOs. Additionally, while many municipalities in Massachusetts do not have prohibitions on VCSOs using housing vouchers for nonlifetime registrants, there are locations where this is not the case. Expanding access to these vouchers nationally may help to address some of the issues related to housing. Changes in housing policy have also been suggested by several studies which have looked specifically at residency restrictions for those on a SO registry (Mercado et al., 2008; Zgoba et al., 2008). A potential intermediary step is to provide education to housing providers so they better understand the low risk of housing individuals registered as SOs and the benefit providing housing may have. The VA has engaged in similar community development programs in the past (Department of Veterans Affairs, 2020). Research would be needed to determine if this might have an impact on housing availability for VCSOs specifically. VA hospital campuses which have housing should consider making more units open to VCSOs, especially when there are sexual offender treatment resources on site.

Another opportunity for intervention (intervention point 2 in Figure 1) is more targeted dissemination of information to veterans while still incarcerated. For example, this information may be provided during prerelease classes and during visits with HCRV and DOC counselors. Access to HCRV counselors, and the resources these counselors have access to, is unique for veterans. Most health care systems do not provide assistance tailored to the unique needs of persons recently released from incarceration as is done in the VA.

HCRV counselors can assist with creating a comprehensive reentry plan, which is critical to reducing recidivism (Gwenda & Randolph, 2009). This specifically addresses the barrier associated with lack of knowledge. Our data showed that there are some specific issues related to those on the SO list which are not covered in prerelease classes, such as appealing one’s SO level assignment or finding sexual impulse treatment groups. Likewise, some information presented in the typical prerelease classes is not useful for those who are on the SO registry, such as much of the content around securing housing – since the rules are so different for those on the SO list. For example, the information provided to the general inmate population about federal housing assistance was largely not suited for those who are registered SOs because they are often not eligible for that type of assistance. At the same time, veteran study participants reported feeling overwhelmed by the amount of information they were given in the release process. So, better-targeted information related to those who have to register as a SO might help with this reentry planning, and is concordant with literature demonstrating that poor reintegration planning can increase recidivism, thus decreasing public safety (Gwenda & Randolph, 2009). Veterans in our sample suggested an information packet specifically for this population might help address current knowledge gaps that those on a SO registry experience.

Strengths and Limitations

It should first be noted that the findings we produced should be taken in context of us as researchers with individual personal characteristics. Our interest in the well-being of veterans may encourage participants to be open and honest during interviews. At the same time participant responses may be tempered by the knowledge that we are researchers that

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work for the VA, despite assurances that data collected are private and confidential and that VA services were not contingent on participation in our study, nor would they be affected by any responses the participants gave.

This was a small qualitative study focused on male VCSOs, all White except for one Black, in a single Northeast state; thus, the findings may not generalize to females, Blacks, persons in other states, or to nonveterans. Although there are limitations to the generalizability of our findings, we believe there are likely to be commonalities in the reentry experience for many individuals (veterans and nonveterans) on a SO list. For instance, while state laws governing the management of those on the SO registry may vary, the experience of stigma and the need for social support at reentry are unlikely to change by state. As previously mentioned, our sample of VCSO was also all White except for one Black participant. While this one participant's experience mirrored that of his white counterparts, there are potentially additional barriers other races may encounter that have not been fully explored in this study. There may be some differences in experience between veterans and nonveterans on the SO registry. For example, there are specific resources that support reentry for veterans that are not always available to nonveterans. However, there were significant barriers experienced by our study participants, meaning nonveterans have an even more difficult time reintegrating following incarceration.

The qualitative methods we employed have the benefit of producing a deep and rich understanding of the facilitators and barriers faced by this population. This allowed for unexpected information to be included in our data and gave us a richer context for understanding of our results. We also triangulated findings through multiple participants and collected information until data saturation was reached.

Conclusion

A greater understanding of the barriers and facilitators for VCSOs at each stage of the reentry process is essential to providing appropriate services to this population. Veterans have specific resources and needs so research on this population specifically was needed. The knowledge gained through this study can contribute to leveraging interventions to deliver the most appropriate assistance. This includes social support, access to housing, referral to legal services and treatment options targeted towards the needs of VCSOs. This not only improves the lives of those on SO registries but is also essential from a public health perspective. Communities are safer and healthier if those who have a history of sexual crimes live in stable housing, are employed, receive the medical and mental health care they need and are integrated into a social network (Hanson & Bussiere, 1998; Levenson, 2008).

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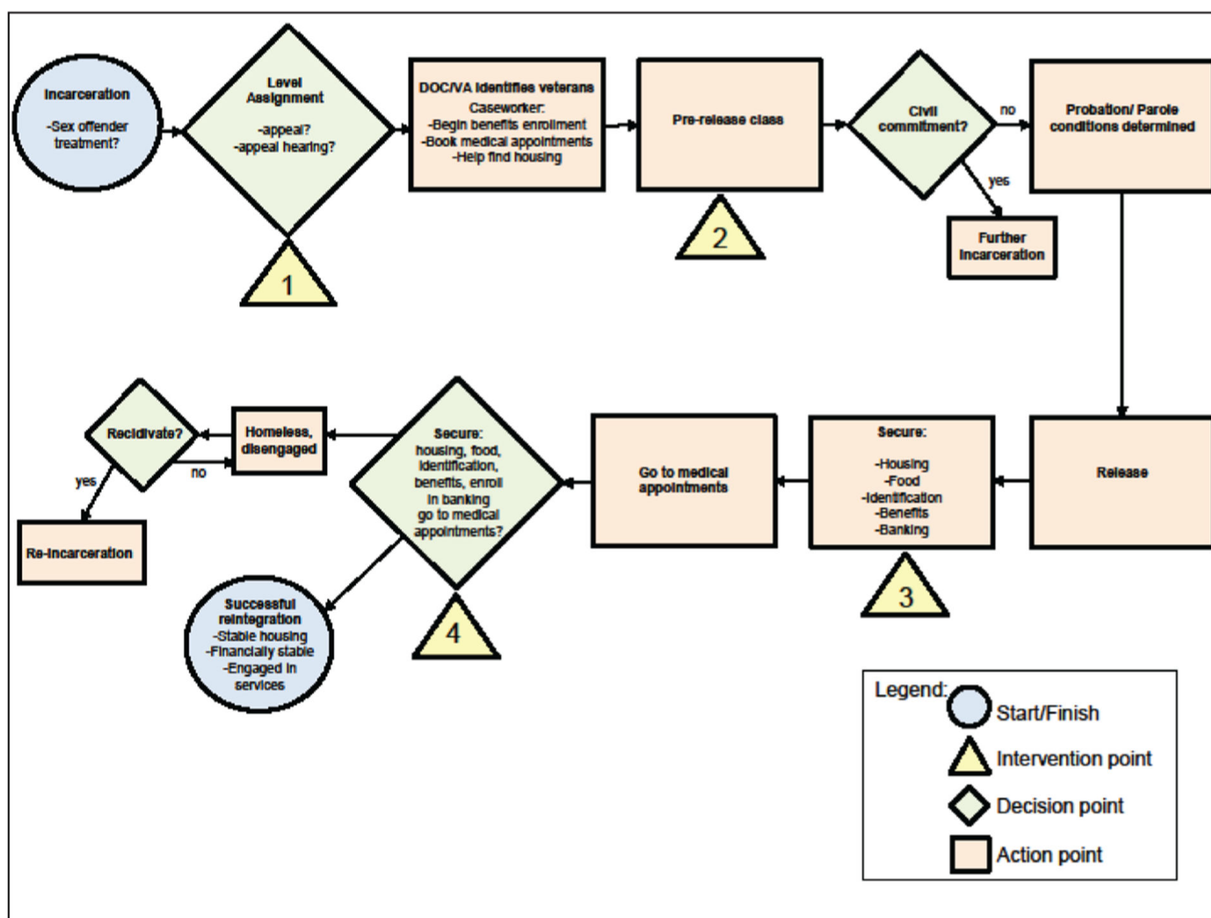


Figure 1.
Process map of VSOs leaving incarceration. The map includes a start and finish for the process (indicated by blue circles), potential intervention points (indicated by yellow triangles), decision points (indicated by green diamonds) and action points indicated by red rectangles.

ISSUE BRIEF | AUGUST 2022

BIG IDEAS

ENDING THE HIV EPIDEMIC —
SUPPORTING ALL PEOPLE LIVING WITH HIV AND REDUCING NEW TRANSMISSIONS

STRATEGIC CHANGES ARE NEEDED TO STRENGTHEN LINKAGE AND ENGAGEMENT IN HIV CARE

DIAGNOSING, CONNECTING TO CARE, AND PROVIDING A RANGE OF SOCIAL AND CLINICAL SUPPORTS to facilitate continued engagement in care for all people living with HIV is complex, yet achievable. When the Centers for Disease Control and Prevention (CDC) first published a national estimate of the HIV care continuum (previously called the HIV treatment cascade) in 2010, a little more than a quarter of people with HIV in the U.S. had reached HIV viral suppression.[1] As of 2020, this estimate has more than doubled to 64.6%.[2,3] Viral suppression in 2020 was much higher, however, for persons who received at least one outpatient medical service (i.e., a physician visit, prescription drugs, etc.) through the Ryan White HIV/AIDS Program, reaching 89.4%, approximately 25% higher than the nation as a whole.[4]

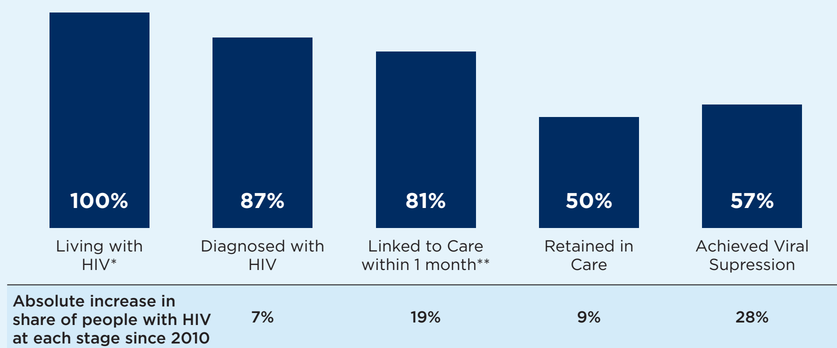
This trajectory of progress, however, belies large disparities in access and outcomes, with varying progress and challenges across the continuum. Three steps that pose especially complex challenges are: 1) linkage to care immediately after diagnosis; 2) sustaining engagement in HIV care over the life course, through major life events and changes in personal and public resources; and 3) monitoring missed clinic visits and

IMPROVING ONGOING ENGAGEMENT IN CARE REQUIRES NEW THINKING

Despite population-level improvements in HIV clinical outcomes, the following new approaches can fuel continued progress:

- **Facilitate adoption of differentiated care models that include low-barrier services for specific sub-populations.**
- **Implement syndemic approaches that can improve HIV outcomes and extend the impact of existing resources.**
- **Develop monitoring strategies that accommodate differing models of care and evolving clinical practices.**

UNITED STATES HIV CARE CONTINUUM, 2019



	Living with HIV*	Diagnosed with HIV	Linked to Care within 1 month**	Retained in Care	Achieved Viral Supression
Absolute increase in share of people with HIV at each stage since 2010		7%	19%	9%	28%

SOURCE: *HIV Surveillance Supplemental Report: Monitoring Selected National HIV Prevention and Care Objectives by Using Surveillance Data – United States and 6 Dependent Areas, 2019*, 26 Ctrs. for Disease Control and Prevention (May 2021); *Vital Signs: HIV Prevention Through Care and Treatment – United States*, 60 Morbidity and Mortality Weekly Report – Ctrs. for Disease Control and Prevention 1618-23 (Dec. 2, 2011).

Notes: *In 2010, it was estimated that 1,178,350 people 13+ were living with HIV in the United States. In 2019, it was estimated that 1,189,700 people 13+ were living with HIV. **This comparison understates the improvement in linkage to care that has occurred: in 2010, 62% were linked within 3-4 months, and in 2019, 81% were linked within 1 month.

other interruptions in care in order to rapidly address barriers to engagement. There are many reasons why people living with HIV may experience interruptions or barriers to care, including due to unreliable and expensive transportation, housing instability, lack of childcare, and other competing life activities, such as employment. Further, stigma and discrimination are additional barriers and can even act to compound other barriers. While there are interventions proven to be effective at engaging and retaining people living with HIV in care, scaling up interventions remains a challenge. Action in three areas can have a large impact:

1. CLIENT-CENTERED SUPPORTS ARE NEEDED TO SUSTAIN ENGAGEMENT IN CARE

The population of people living with HIV in the U.S. is diverse, yet certain populations are more impacted. This is oftentimes attributed to various unmet needs and can impede ongoing engagement in care. Therefore, varying levels of supports are needed to maintain an effective relationship with a system of care. Some people have been living with HIV for a long time, have been durably virally suppressed, and do not require extensive services to maintain engagement. Others, however, may enter care unfamiliar with or wary of healthcare systems (whether it is because of past negative experiences or because they are from a community that has experienced racism or unequal treatment when accessing health services), thus making it difficult to engage with and trust their providers. Some may require a variety of services (and at varying levels of need), such as assistance with transportation to get to care and access to healthy and nutritious food and other social services, including housing, childcare, and treatment for mental health and substance abuse disorders (SUD). Too frequently, however, a one-size-fits-all approach produces strain on the system and does not match the needs of people who require either more or less support. Looking to strategies initially adopted to scale-up access to antiretroviral therapy (ART) globally can offer insights into how to adapt the U.S. HIV care system in ways that can lead to better outcomes. This approach, called differentiated care, incorporates concepts such as simplification, task shifting, decentralization (i.e., community-based care), and, when appropriate, rededicating saved resources to patients who are in the greatest need for them.[5] Differentiating among groups and between individuals and matching service models to specific needs could result in a more efficient and responsive system. Those who stand to benefit the most from differentiated care services are populations who have been historically underserved and those that do not receive clinical care on a routine basis.[6]

Innovative programs are being developed in the U.S. that move in this direction. People with a strong relationship with a clinical team and have sustained viral suppression may be best served with only an annual visit with their HIV care provider. Other related services that require lab work [e.g., viral load and sexually transmitted infection (STI) testing and vaccinations] could be accomplished remotely via self-swab or mail-in, or via drop-in services that do not require seeing a provider. Indeed, prominent HIV treating physicians at a high-burden clinic in Atlanta have called for such an approach.[7] For such individuals, this has the advantage of reducing the burden of attending medical appointments, creating more opportunities to address non-HIV-related health concerns, and allowing HIV status to recede in prominence in a person's life in a way that can foster well-being. For the health system, it may offer a way to conserve health care resources and staff time that could be redirected to persons with more extensive needs. Current guidelines, however, call for viral load testing every six months,[8] which typically leads to an in-person provider visit. Efforts to simplify clinical requirements and reduce the frequency of physician

DISPARITIES IN OUTCOMES PERSIST ALONG THE CONTINUUM

Despite progress for all groups, large disparities and inequities continue to produce unequal results:

- **People living in high poverty census tracks** have the highest HIV diagnosis rates, the lowest percentages of adults linked to HIV medical care after receiving a diagnosis, and the lowest percentages of adults with suppressed viral load within 6 months of receiving an HIV diagnosis.[1]
- **Rural Black persons** received a higher percentage of late-stage HIV diagnoses than did those in urban and metropolitan areas. Viral suppression within 6 months of diagnoses was highest in metropolitan areas.[2]
- **Hispanic/Latino MSM** have lower adherence to ART when affected by poverty, SUD, depression, or unmet ancillary service needs.[3]

Sources: [1] *HIV Surveillance Supplemental Report: Social determinants of health among adults with diagnosed HIV infection, 2019,* 27 Ctrs. for Disease Control and Prevention (2022).

[2] Shacara Johnson Lyons et al., *Care Outcomes Among Black or African American Persons with Diagnosed HIV in Rural, Urban, and Metropolitan Statistical Areas – 42 U.S. Jurisdictions, 2018,* 70 Morbidity and Mortality Weekly Report – Ctrs. for Disease Control and Prevention 229–35 (2021).

[3] Stacy M. Crim et al., *Barriers to Antiretroviral Therapy Adherence Among HIV-Positive Hispanic and Latino Men Who Have Sex with Men – United States, 2015 – 2019,* 69 Morbidity and Mortality Weekly Report – Ctrs. for Disease Control and Prevention 1437–42 (2020).

visits, however, could be contributing to low rates of STI testing and insufficient attention being given to other co-morbid conditions, such as diabetes and hypertension. To illustrate this point, in 2019, fewer than half of all sexually active people with HIV were screened for syphilis, gonorrhea, and chlamydia every three months,[9] which is the standard recommendation for sexually active gay and bisexual men (the largest share of people living with HIV in the U.S.). Therefore, alternative approaches to STI testing in ways that minimize patient and provider burden without sacrificing the optimal level of care for individual patients should be explored.

For persons not optimally engaged in care, some jurisdictions have developed models of low-barrier services, often for people who are unhoused, transitionally housed, and/or those with a SUD and have not sustained HIV viral suppression. The low-barrier concept means that services are available often on a walk-in basis, so persons are not held to a standard of reporting for a scheduled appointment. The Maximum Assistance Clinic (Max Clinic) in Seattle-King County is available only to persons who are not virally suppressed and/or are no longer taking ART and did not experience improvements in viral suppression after lower intensity outreach and support.[10] Key components include walk-in access to primary care in public health sexually transmitted diseases (STD) clinics, walk-in access to intensive coordinated case management, food vouchers, no-cost bus passes, cell phones, and financial incentives for visits with blood draws and for achieving and maintaining viral suppression. An initial evaluation of the Max Clinic showed that clients were more likely to reach viral suppression than clients in a more traditional HIV clinic.[11] Subsequent qualitative research has shown that clients reported that walk-in services lowered experiences of shame and stigma associated with missing scheduled appointments.[12] Adolescent health experts in the Bronx, NY also propose the adoption of differentiated care models for adolescents and young adults, citing the importance of specific practices and needs: frequent and informal communications via text and social media; support services beyond medical care by interdisciplinary staff like mental health and harm reduction services and assistance with housing, transportation, and job training; an LGBTQ-friendly and culturally appropriate service environment; and proactive interventions for adolescents and young adults at-risk for or who have stopped engaging in care.[13] During the COVID-19 pandemic, people who are transitionally housed likely faced greater barriers to engagement in care than others. The Ward 86 HIV clinic at San Francisco General Hospital, however, compared outcomes for people who were transitionally housed and served by the 'POP-UP' low-barrier, high-intensity HIV primary care program with the general Ward 86 client population. Among the 85 clients assessed, care engagement and viral suppression remained comparable across both groups.[14]

POLICY ACTION: FACILITATE ADOPTION OF DIFFERENTIATED CARE MODELS THAT INCLUDE LOW-BARRIER SERVICES FOR SPECIFIC SUB-POPULATIONS.

The Ryan White HIV/AIDS Program can be a central locus of efforts to adopt differentiated care models, but the Health Resources and Services Administration HIV/AIDS Bureau (HRSA/HAB), which administers the program, cannot achieve all necessary policy actions alone:

- **Grantees and Jurisdictions:** Not every clinic should seek to operate a resource-intensive, low-barrier clinic. Therefore, jurisdictions need to be encouraged and supported in planning to adapt their services system to offer more flexibility and support for differentiated care based on current and ongoing needs assessments. Some clinics may primarily serve well-established patients and to simplify their care regimens, should provide them with the option of reducing their own frequency of routine clinical care visits. They also should be supported to expand access to telehealth services (building on experiences gained during the COVID-19 clinic closures) and walk-in services or home-based testing for routine laboratory services and STI testing, which can simplify care seeking for clients and reduce staffing burdens, all while recognizing that this involves overcoming current regulatory and other policy barriers. For low-barrier clinics, having adequate clinical staff available without the predictability achieved by scheduled appointments can be a challenge and must be supported through a trial-and-error process. Health departments and planning councils must play a role in providing an overall vision for how different entities within the community can work together to establish a cohesive system of care. This includes considering ways to ensure adequate revenue for clinics serving clients with various levels of need. Differentiated care models should seek to minimize incentives to provide services that may be only marginally beneficial simply to maintain clinic revenue.

- **HRSA/HAB:** A positive aspect of the Ryan White HIV/AIDS Program is the flexibility in the use of funds and the ability to prioritize services in response to local needs. This can be in tension, however, with the policy goal of achieving a uniform standard for high quality HIV services nationwide. HRSA/HAB should develop policy guidance that affirmatively encourages the adoption of differentiated care models and that identifies strategies and tools jurisdictions can use to move toward greater differentiation. Further, they should consider ways to use the Special Projects of National Significance (SPNS) Program to help jurisdictions and clinics adapt payment models and deploy the use of technology to move toward greater differentiated care.

TOOLS AND CHALLENGES IN ADOPTING DIFFERENTIATED CARE

The vision of an HIV healthcare system able to respond to the individual needs of people living with HIV is simple, but adapting our current delivery and financing systems to more flexible approaches is more complex. Critical tools that can enable jurisdictions and clinics to move to differentiated care models include:

Rapid Start of ART: Evidence supporting the significance of the initial clinical interaction at the time of diagnosis is mounting, and starting ART as soon as possible after receiving an HIV diagnosis also may lead to higher rates of viral suppression among some populations.[1] Developing and maintaining capacity to ensure that qualified, culturally-competent, and linguistically appropriate providers are available as needed to provide information and discuss treatment options at the time of diagnosis and ensuring payment for initial ART before insurance or safety-net program eligibility is established, however, is challenging.

Expanding the Dynamic HIV Care Team: Physicians and other clinical providers are often stretched too thin, and people with HIV tend to come to care with a variety of socioeconomic challenges and comorbidities. This calls for renewed efforts and funding to task shift and use nurses, social workers, case managers, and other non-physician providers to the greatest extent feasible.

Self-Sample Collection: Research has shown that individuals are able to reliably collect their own samples for STI testing.[2] The ability to self-collect laboratory samples at home or in the clinic may be an important way to increase STI testing among all populations, especially sexually active individuals, while minimizing clinic burdens.

Extended Prescription Drug Refills: The response to COVID-19 has shown that it is possible to fill prescriptions for 90 days in place of the prior standard of once every one month. By facilitating better adherence to ART and simplifying the demands of remaining engaged in care, this may be beneficial both for individual and population health. It is welcomed by many clients and can reduce costs and staff time. Many commercial and public payors, however, do not offer this option, and if patients lose their supply, replacement costs are even higher.

Telehealth Services: The COVID-19 pandemic revealed the essential role of telehealth and its acceptability and preference for these services by many patient populations. By facilitating the options of telephone visits or full clinical visits by videoconference, telehealth can serve a critical role in overcoming transportation and time barriers to care engagement. Providers also should embrace timely/current modes of communicating with clients, the use of web/app services to schedule and confirm appointments, and texting to reach clients who have fallen out of care.[3]

Social Services: Differentiated care models should not stop within the clinical setting. For example, pilot programs utilizing rideshare services have proven to be effective for patients in areas that lack public transportation, and a variety of innovative models have been developed to overcome non-medical barriers to engagement in care.[4]

INNOVATION IS NEEDED: Moving from small innovative projects to widespread adoption across various settings is challenging. More work is needed with engagement from federal program leadership, health department staff, clinical providers, and community members to tackle complex issues, including developing **payment models** to create more flexibility for providers and patients. New efforts are needed to address **administrative simplification** to make it easier for grantees to comply with competing requirements for different grant programs. Further, new consideration must be given to take successful models and achieve **sufficient scale** across a jurisdiction.

Sources: [1] Jeffrey S. Crowley & Sean E. Bland, *Big Ideas: Leveraging the Ryan White Program to Make Rapid Start of HIV Therapy Standard Practice*, O'Neill Inst. for Nat'l & Glob. Health Law (Dec. 2018); [2] Carole Lunny et al., *Self-Collected versus Clinician-Collected Sampling for Chlamydia and Gonorrhea Screening: A Systemic Review and Meta-Analysis*, 10 PLoSONE (July 13, 2015); [3] Jeffrey S. Crowley & Sean E. Bland, *Big Ideas: Integrating Telehealth Into HIV Services Systems Can Help to Sustain Improved Outcomes*, O'Neill Inst. for Nat'l & Glob. Health Law (Oct. 9, 2020); [4] Nicole Rapfogel & Jill Rosenthal, *How North Carolina Is Using Medicaid To Address Social Determinants of Health*, Ctr. for Am. Progress (Feb. 3, 2022).

- **Medicaid:** Medicaid is the largest payer for HIV health care services in the U.S. and should be encouraged to develop tailored programs to better meet the needs of beneficiaries with HIV. While states operate their own programs, the Centers for Medicare and Medicaid Services (CMS), which administers the program at the federal level, has an important role in describing barriers to linkage and retention, emphasizing Medicaid services options that can be used, and highlighting innovative state initiatives. One option that may offer a promising mechanism for increasing HIV outcomes is the Medicaid Health Home State Plan Option that was authorized under the Affordable Care Act (ACA) and allows states to establish health homes that will coordinate care for people with chronic conditions, including for people living with HIV.[15] As of March 2022, 19 states and the District of Columbia had submitted state plan amendments to create health home programs. At least four of those states (Michigan, New York, Washington, and Wisconsin) have created health homes that offer services to beneficiaries with HIV/AIDS. Michigan, New York, and Washington include HIV among other qualifying chronic conditions for enrollment into the health home.[16] Wisconsin is the only state that has created a distinct category of health homes that are solely dedicated to people living with HIV.[17] New York found success in its Supportive Housing Health Homes Pilot, which from 2012-2018, provided a number of services to chronically homeless people living with HIV.[18] Care coordination; comprehensive transitional care (including appropriate follow-up, from inpatient to other settings); and the facilitation and referral to individual, family support, community, and social support services resulted in decreased likelihood of emergency department visits and hospitalizations and an increased likelihood in the utilization of outpatient services. Other Medicaid options, such as the rehabilitation services option or existing waiver authorities, also may create avenues for state experimentation to strengthen linkage and retention in care.

SUCCESSFUL INTERVENTIONS FOR IMPROVING RETENTION SHOULD BE SCALED UP

To reduce disparities across populations, evidence-informed interventions for populations disproportionately impacted by HIV need to be developed and evaluated at the local level. The following are illustrative examples of interventions that have been shown to work for Black gay and bisexual men.

Acceptance-based behavior therapy: Newly diagnosed patients receiving therapy had 6.7% disengagement from care compared to 26.7% percent for those not receiving tailored therapy.

Project Identify, Navigate, Connect, Access, Retain, and Evaluate (IN-CARE): Out of care clients were identified through case finding, outreach, and referral partnerships and then provided six to nine months of peer health navigation, peer-led group education focused on retention, and access to primary care, laboratory services, and medication. At follow-up, linkage to care increased from 0% to 90%, and retention increased from 0% to 73%.

Project nGage: This is a social support intervention delivered by social workers. At twelve months, the intervention group was three times more likely to have had at least three care visits and report high adherence to their medication.

Sources: Hilary Goldhammer et al., *HIV care continuum interventions for Black men who have sex with men in the USA*, 8 The Lancet HIV e776-86 (2021).

2. FUNDING, GRANT REQUIREMENTS, AND STAFFING PRACTICES MUST BETTER SUPPORT INTEGRATED AND COHESIVE SERVICES MODELS

Another proposed HIV policy solution is the adoption of a syndemic approach. Factors that increase risk for poor HIV-related outcomes also increase the risk for other infectious diseases and are often associated with mental health (or brain health) challenges and substance use disorders. Syndemics often arise in the context of inadequate health care access and social supports. A syndemic is characterized by two or more negative health outcomes and/or social factors interacting simultaneously, contributing to excess burden of disease in a population.[19] An ongoing policy obstacle to embracing syndemic strategies is the siloed nature of many federal and state funding initiatives, limited interoperability across federal/state data systems, and the complexity and volume of reporting requirements that have accrued over time to increase accountability and improve the monitoring of outcomes.

To maintain and improve outcomes along the care continuum in a manner that reduces inequities, it is important to consider the sustainability of the HIV response, including ways to better integrate with other public health and services programs serving the same communities. In prior briefs, we have highlighted the need for more federal funding both for the Ending the HIV Epidemic (EHE) Initiative and the broader HIV response.[20] Additionally, it is essential to conserve

HIV discretionary resources (i.e., funding for the Ryan White HIV/AIDS Program and other HIV programs) by maximizing public and private insurance coverage and demanding more accountability from these programs to better structure services to meet the needs of their enrollees. Investing now in services to maintain insurance enrollment, including assisting people living with HIV who may need to recertify their Medicaid eligibility as the public health emergency ends (as early as the fall of 2022), is critically important to minimize cost shifts onto the Ryan White Program. This also underscores the need for all states to adopt Medicaid expansion, as prior research has shown that insured individuals are more likely to be virally suppressed.[21]

POLICY ACTION: IMPLEMENT SYNDEMIC APPROACHES THAT CAN IMPROVE HIV OUTCOMES AND EXTEND THE IMPACT OF EXISTING RESOURCES.

- **HHS:** Clinics and grantees continually report their frustrations with being unable to operate a cohesive clinic to meet a variety of needs when each funding source (i.e., Ryan White Parts A, B, C, and D, the Minority HIV/AIDS Fund, supplemental EHE funding, etc.) has competing demands and reporting requirements. For many years, numerous stakeholders have proposed permitting blended or braided funding and streamlined reporting, with seemingly limited progress. The Office of Infectious Disease Policy should convene relevant HHS operating divisions (i.e., CDC, HRSA, SAMHSA, IHS, etc.) and HHS, HUD/HOPWA, the Departments of Interior, Labor, Education, and agency budget officials to discuss policy options, including potential legislative proposals, for blending funding and reducing reporting burden. They also should task the President's Advisory Council on HIV/AIDS (PACHA) with providing community and provider recommendations for consideration.

- **HRSA/HAB:** An element of differentiated care is reliance on task shifting to relieve the burden and staffing needs on physicians and relying more heavily on nurses and other health care professionals. While state laws vary, jurisdictions and clinics may need technical assistance to adapt their current service delivery models to expand the range of professionals that are part of the care team. A critical component of such efforts is to facilitate greater use of Community Health Workers (CHWs). Employing workers drawn from the communities in which they work also creates opportunities for more syndemic approaches as they may both better understand the overlapping and inter-related challenges that give rise to multiple adverse outcomes, and they may be better equipped to tap into a variety of community resources to improve health. Whether through hiring CHWs to work in clinics or establishing partnerships and funding community-based organizations (CBOs), federal and state policy leadership is needed to induce a much greater commitment to integrating CHWs to improve clinical and other outcomes and to ensure that CHWs are paid a living wage with benefits. HRSA/HAB should consider policy guidance, technical assistance, and other actions it can take to lead this change.

3. EFFECTIVE MONITORING CAN GUIDE POLICY INTERVENTIONS TO KEEP IMPROVING OUTCOMES

The HIV care continuum has been an effective framework because it is visually simple to understand and can guide policy action at the national, state, tribal, local, and clinic levels. An unresolved challenge in monitoring HIV outcomes, however, is the tension between simplifying clinical interactions and collecting comprehensive data. Providers have expressed the view that their primary focus in a clinic visit is addressing a client's immediate needs and ensuring that they have access to antiretroviral therapy (ART). This is especially challenging for those with the greatest health care needs or those who face housing instability, food insecurity, cognitive impairments, HIV-related stigma, and other needs not universally addressed by the HIV services systems. Some of the very innovations that allow the health system to simplify the care experience, such as more telehealth services and at-home testing, can lead to data loss. This has been powerfully illustrated with the widespread use of rapid antigen tests for COVID-19. Despite being urged to report results, including negative results, to public health authorities, the vast majority of the roughly 28 million antigen tests performed each week go unreported, thus contributing to the proliferation of a "data black hole."[22]

The metrics used for the care continuum have evolved over the past decade and will continue to evolve in the future, yet our ability to adapt metrics has fallen behind. For example, the linked to care metric in the 2010 continuum was based on linkage within 3-4 months, whereas in 2019 it is measured as linked within a month. This is still generally understood to be too long, and the ideal timeframe is linkage within 24-72 hours, so this standard may continue to change. The current definition of sustained engagement in care requires two viral load measurements in a year. As research seeks to evaluate the use of an annual viral load measurement, it is also easy to imagine more frequent viral load screening becoming the norm. In resource limited settings, dried blood spots (DBS) have been shown to be an effective way to measure HIV viral load.[23] Just as fitness trackers and other technology have led to near continuous monitoring of other health metrics that were once measured only periodically, it is easy to foresee a

future where the FDA has approved DBS or other tools that could allow for much more frequent viral load monitoring.

POLICY ACTION: DEVELOP MONITORING STRATEGIES THAT ACCOMMODATE DIFFERING MODELS OF CARE AND EVOLVING CLINICAL PRACTICES.

There are no simple solutions to the conflict between comprehensive data collection, standardization of metrics, and facilitating ease of clinical practice. Prior federal efforts have incorporated innovation and led to significant improvements. Continued leadership by various parts of HHS can drive the next phase of practice:

CDC: The Centers for Disease Control & Prevention is working with grantees to implement the Data Modernization Initiative. They should work with HRSA and other parts of the Department of HHS and consult with health department and clinical providers to develop strategies for the greater integration of clinical data sets as part of data modernization, including CAREWare, the electronic information management system supported by HAB and the Ryan White HIV/AIDS Program, or any subsequent systems used for Ryan White services data collection. Within the context of HIV prevention, CDC should continue to expand its investment in the Medical Monitoring Project (MMP). At present, the data set is nationally representative, but not all states participate in MMP. By expanding MMP to more states and jurisdictions, it can continue to build capacity at the state level for improved data monitoring and analysis.

NIH: The National Institutes of Health (NIH), through both the Office for AIDS Research (OAR) and the Centers for AIDS Research (CFAR) network, should conduct a broad stakeholder consultation that includes a diverse array of clinical providers, researchers, participants, and surveillance experts across federal data sets, including MMP, the North American AIDS Cohort Collaboration on Research and Design (NA-ACCORD), and others to consider the issues described. This includes evolving definitions of metrics as clinical standards change and addressing lost data or data gaps that may arise when serving specific patient populations or in specific settings. The NIH should be asked to qualitatively examine these assumptions, make recommendations for immediate policy actions, preview future challenges and opportunities that may arise with technological changes, and invest in research studies to evaluate and validate new or more flexible devices and metrics, like home-testing devices that can communicate with electronic medical records.

HRSA/HAB: Several grantees have reported that CAREWare, which is supported by the Ryan White Program, is a poor means of data management. Critiques have included that it has a clinic-level interface for some, but not all EHRs. It is also said that

PAST POLICY EFFORTS HAVE YIELDED IMPROVED MONITORING

For over ten years, efforts have been made to standardize and improve the monitoring of HIV clinical indicators. In 2010, the White House Office of National AIDS Policy (ONAP) commissioned the Institute of Medicine (now the National Academies of Sciences, Engineering, and Medicine, or NASEM) to conduct a consensus study to identify critical data and indicators related to continuous HIV care and access to supportive services, as well as to monitor the impact of the U.S. National HIV/AIDS Strategy and the Affordable Care Act (ACA) on improvements in HIV care. This led the committee to release two reports in 2012 with recommendations for:

(1) indicators and data systems[1] and,

(2) generating national estimates of HIV care and coverage.[2]

In response, HHS identified core indicators for federal programs, streamlined required metrics for grantee reporting, and established uniform definitions of terms.[3] CDC also made several changes to the Medical Monitoring Project (MMP), a surveillance data set of behaviors and the clinical care experience of people living with HIV in the U.S., to improve the reliability and ability to provide nationally representative data of all people with diagnosed HIV.[4] This included revising data collection methods to allow for the inclusion of persons with diagnosed HIV but not receiving regular HIV care.

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there is a need for greater harmonization of common data elements and that the tailoring of CAREWare for specific uses is often unduly challenging. Given that lack of interoperability is a problem across the health system, HRSA/HAB should work with the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHACHSPT) to continue gathering user perspectives and recommendations for short- and long-term strategies for improving CAREWare's utility as a data management system.

THE TIME IS NOW

The doubling of the share of people with HIV who are virally suppressed from 2010 to 2020 shows how the implementation of healthcare best practices and community-centered leadership can drive change. As stakeholders strive to strengthen linkage and sustained engagement in care, reduce inequities across populations, and improve quality of life, strategic refinements to make HIV programs better able to address client needs is necessary. By implementing treatment and care that is integrated with other health and social services and more responsive to differential outcomes across populations, we can continue improving outcomes along the HIV care continuum.

ENDNOTES

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