Assessing Released Inmates for Substance-Abuse-Related Service Needs

Steven Belenko

High rates of substance abuse and recidivism and limited in-prison and postrelease treatment access and transitional planning complicate community reintegration. Moreover, drug-related health and social problems are related to treatment outcomes. In the framework of risk-responsivity theory and structured, integrated reentry models, this article argues for new, psychometrically sound assessment tools that are multidimensional, facilitate risk management and service linkages, and combine static and dynamic factors and multiple time frames. The organizational complexity of reentry increases the urgency to develop tools to accurately identify parolee service needs. Such tools will increase knowledge about factors determining or mediating postrelease outcomes.

Keywords: *reentry; assessment tool; service linkages; parolees*

SUBSTANCE ABUSE AND THE CORRECTIONAL POPULATION

The connections between the abuse of illegal drugs and crime have been well documented (Bradford, Greenberg, & Motayne, 1992; Goldstein, 1985; Tonry & Wilson, 1990). Recent data from the Arrestee Drug Abuse Monitoring program indicate that a range of 42% to 86% (median 67%) of adult male arrestees (39 sites) and 52% to 82% (median 68%) of female arrestees (25 sites) tested positive for marijuana, cocaine, opiates, methamphetamine, or phencyclidine (Zhang, 2004). Among male arrestees, a range of 24% to 50% was at risk for drug dependence (31% to 63% of females). Sixty-nine percent of state prison inmates report regular lifetime illicit drug use (Belenko, 2002a); 42% of state prison inmates have used cocaine, 27% crack, and 21% heroin. More than 80% of state prison inmates have indications of serious drug or alcohol involvement (Belenko & Peugh, 2005).

STEVEN BELENKO, Ph.D., is a senior scientist at the Treatment Research Institute at the University of Pennsylvania and is adjunct professor of psychology in the School of Medicine at the University of Pennsylvania. His primary research interests are the impact of drug offenders on the criminal justice system, substance abuse treatment for adult and juvenile offenders, treatment and HIV services access, and drug courts.

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Between 1980 and 2003, the number of inmates in the United States quadrupled from 501,886 to 2,212,475, with the state prison population increasing by more than 300% to 1,226,175 (Harrison & Beck, 2004). These increases have been fueled mainly by drug-related crime as well as more arrests, convictions, and incarcerative sentences for drug crimes (Belenko, 2000; Belenko & Peugh, 1999). Inmates who regularly use drugs or alcohol have higher recidivism rates than other inmates. National inmate survey data indicate that the more prior sentences, the more likely that the inmate is a regular drug user (Belenko, 2002a). Within 3 years, about 95% of released state inmates with drug use histories return to drug use (Martin, Butzin, Saum, & Inciardi, 1999), 68% are rearrested, 47% are reconvicted, and 25% are sentenced to prison for a new crime (Langan & Levin, 2002).

The high rates of drug involvement and recidivism among arrestees and inmates raise multiple challenges for supervising offenders following release. At the end of 2003, there were 4,848,575 offenders under community supervision (including 4,073,987 on probation and 774,588 on parole), more than twice the number of inmates in correctional facilities (Glaze & Palla, 2004). Some two thirds have a history of illegal drug use, including 31% who have used cocaine or crack (Mumola, 1998). More than 630,000 prison inmates were released to the community in 2002 after completing their sentences or being released to parole supervision (Harrison & Karberg, 2004); 80% were released to parole. Rates of technical violations of parole conditions are high (Beck & Mumola, 1999; Langan & Levin, 2002; Petersilia, 2001; Travis, 2000). In 1998, 37% of state prison commitments were for violations of parole or other conditional release (Bureau of Justice Statistics, 2002). Repeated recycling of offenders into secure custody—particularly adult males from neighborhoods and families already affected by poverty, instability, and in many cases substance abuse—can have devastating consequences (Clear & Corbett, 1999). Inmates are separated from the mainstream community and confront greater challenges to integration, including having to create reliable ties with new support networks (Clear & Rose, 1999) and addressing health and social needs (Travis, Solomon, & Waul, 2001).

In particular, high rates of substance abuse and relapse and the difficulty of accessing effective treatment (both while in custody and in the community) greatly complicate reintegration. Failure to address postrelease substance abuse greatly reduces the likelihood that released inmates will be able to obtain and hold jobs, participate in training programs, reunify with families, or comply with parole supervision requirements (Taxman, Byrne, & Young, 2003).

Improving the Effectiveness of Treatment and Supervision for Parolees

The available evidence on inmate and other offender treatment suggests that reductions in postrelease relapse and recidivism are contingent on engaging offenders in continuing care following release (Butzin, Martin, & Inciardi, 2005; Inciardi, Martin, & Butzin, 2004; Prendergast, Hall, Wexler, Melnick, & Cao, 2004). Although there is increasing attention being paid to implementing "seamless systems of care" in the criminal justice system (Taxman, 1998), access to continuing care in the community that is linked to treatment services received in the prison remains relatively uncommon (Belenko & Peugh, 2005). Without aftercare or transitional services, inmates reentering the community face a difficult time even if they have received treatment while in custody (Hammett, Roberts, & Kennedy, 2001; Taxman, Byrne, et al., 2003).

An additional complicating factor for successful reentry and reintegration is that substance-abuse-related problems (i.e., psychiatric, employment, family-social) may be equally predictive of treatment outcome than the nature or severity of substance use; the addition of health and/or social services to standard addiction care can significantly improve treatment outcomes (McLellan, Arndt, Metzger, & O'Brien, 1993). Accordingly, there may be two key dimensions to consider in making appropriate service linkages for reentering inmates: drug use severity and the other service needs (Belenko & Peugh, 2005). Evidence that clients with a higher severity of drug use have better outcomes in more intensive or highly structured treatment comes from research on national samples of treatment clients (Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999), therapeutic communities (Melnick, De Leon, Thomas, & Kressel, 2001), outpatient settings (Rychtarik et al., 2000; Thornton, Gottheil, Weinstein, & Kerachsky, 1998), and Project MATCH (Project MATCH Research Group, 1998) for alcohol patients. Studies in various community treatment settings have found that matching services to specific client needs (e.g., psychological services, housing, employment) improves treatment outcomes (Gastfriend & McLellan, 1997; Hser, Polinsky, Maglione, & Anglin, 1999; Mattson et al., 1994; McLellan, Luborsky, Woody, O'Brien, & Druley, 1983; McLellan et al., 1993).

In addition, research has found that social and behavioral factors can be significant predictors of offender recidivism and persistent criminal behavior. These factors include employment (Belenko, Foltz, Lang, & Sung, 2004; Laub & Sampson, 2001; Sung, 2003), family status and family functioning (Gendreau, Little, & Goggin, 1996; Peters & Murrin, 2000), education

(Peters & Murrin, 2000; Sung, 2003), personality disorders (Gendreau et al., 1996), and social achievement (Gendreau et al., 1996).

These considerations suggest that making appropriate and effective referrals to substance abuse treatment for newly released inmates and parolees requires more than a simple assessment for drug abuse or dependence (Belenko & Peugh, 1999; Hammett, Gaiter, & Crawford, 1998; Hammett et al., 2001). For example, given the connections between crime, poverty, and poor health, many inmates enter prison in need of medical services (Anno, 1991; Hammett, Harmon, & Maruschak, 1999; Marquart, Merianos, Hebert, & Carroll, 1997). Findings from a public health-corrections model indicate that receiving continuity of health care at a central facility lowered recidivism for released inmates (Hammett et al., 2001). Health services of particular relevance for drug-involved inmates include treatment and prevention of HIV and other infectious diseases (Hammett et al., 1998). The large numbers of at-risk substance abusers in prisons suggests a need to educate inmates about reducing their risk behaviors and give them the tools to lower the incidence of HIV infection after they are released into the community (Belenko, Langley, Crimmins, & Chaple, 2004; Braithwaite & Arriola, 2003). Offenders under probation or parole supervision are also at high risk for HIV but receive few effective interventions to reduce risk (Belenko et al., 2004; Martin, O'Connell, Inciardi, Beard, & Surratt, 2003). Offenders also have high rates of mental health conditions and comorbid substance abuse and mental health disorders (Belenko, Lang, & O'Connor, 2003; Ditton, 1999; Lamb & Weinberger, 1998); 32% of inmates with a history of regular drug use and 28% of alcohol-involved inmates had indications of a mental health problem (Belenko, 2002a). But treating comorbid mental health and substance abuse presents substantial complications and special needs that are seldom addressed in practice (Belenko et al., 2003; Broner, Borum, & Gawley, 2002; Hoff & Rosenheck, 1999). Offender treatment retention studies have found that mental health disorders are predictive of early termination (Lang & Belenko, 2000) and that those with a comorbid psychiatric diagnosis are less likely to enter substance abuse treatment in the first place (Claus & Kendleberger, 2002).

Employment problems can also affect long-term recovery and complicate community transition (Belenko & Peugh, 2005; Finn, 1999; Leukefeld, McDonald, Staton, & Mateyoke-Scrivner, 2004; Reif, Horgan, Ritter, & Tompkins, 2004). Released inmates with few marketable skills and limited job opportunities are more susceptible to relapse and resumption of illegal activity (Laub & Sampson, 2001; Platt, 1995; Travis et al., 2001). Furthermore, for many inmates, their physical or mental health problems make it difficult for them to sustain employment or successfully complete educational

programs (Belenko, 2002a). Accordingly, an important goal of an effective reentry strategy is to identify employment and training needs to provide the skills training to enable the offender to be reintegrated into the legitimate labor market or to provide basic literacy skills, GED certification, and life skills (Martin & Inciardi, 1993). Parolees who receive vocational training or have higher employment rates and earnings have lower risk of reoffending (Finn, 1999; Needels, 1996; Seiter & Kadela, 2003). In addition, lack of access to health insurance or other benefits limits released inmates' access to housing, health care, and treatment (Hammett et al., 2001; Nelson & Trone, 2000). Inmates also have poor education: 39% of regular drug users in prison have completed less than 4 years of high school and have no GED (Belenko, 2002a), and only 38% of all inmates received some academic education within prison since their admission (Belenko, 2002a).

In 1999, 1.3 million children had a parent in state prison (Mumola, 2000), with 22% younger than the age of 5. Yet little is known about what happens to the children of incarcerated, substance-involved parents (either while the parent is serving time or subsequent to the parent's reentry into the community). Although there is little research on the causal impact of parental incarceration on a child, family drug use and criminal activity and low levels of parental involvement are risk factors for juvenile substance abuse and delinquency (Loeber & Farrington, 1998) and entry into the juvenile justice system (Farrington, 1998; Sampson & Laub, 1993). Furthermore, communities with high concentrations of incarcerated persons experience damaging losses to overall community social capital, severely affecting stability for children (Clear, Rose, & Ryder, 2001). However, prisons offer few programs to prepare parents to reintegrate with their children, families, or community or improve parenting skills (Petersilia, 2001). Taxman, Young, Byrne, Holsinger, and Anspach (2003) also point to the importance of strengthening family and community support mechanisms for released inmates (Beckerman, 1998), and such support may be a core component of effective drug treatment (National Institute on Drug Abuse [NIDA], 1999).

Substance-involved inmates have social networks comprising peers with high rates of drug use and criminal behavior (Belenko & Peugh, 1999; Friedman, Curtis, Neaigus, Jose, & Des Jarlais, 1999). Peer behavior is an important risk factor for initiation into and maintenance of substance abuse and criminal behavior (Keenan, Loeber, Zhang, Stouthamer-Loeber, & Van Kammen, 1995; Wills & Cleary, 1999). Conversely, association with prosocial peer norms may protect substance-involved offenders from relapse and recidivism (Carvajal et al., 1999; Hoge, Andrews, & Leschied, 1996); social networks must be considered in designing effective parole supervision and service plans. Given that at-risk parolees are likely to belong to a peer

group with lower social status, simply changing peer groups may be difficult (La Greca, Prinstein, & Fetter, 2001). Educating parolees about the risk of peer groups on substance use and criminal behavior may be important, but helping them to gain more positive friendships may be equally critical to sustain treatment effects (McBride, VanderWaal, Terry, & VanBuren, 1999; Prinstein, Boergers, & Spirito, 2001).

Finally, access to affordable, stable, drug-free housing is important for released inmates (Rossi, 1989; Travis et al., 2001). Many inmates face obstacles to finding adequate housing following release because of poor family ties, lack of financial resources for a rental deposit, ineligibility for public housing, or discrimination by landlords (Hammett et al., 2001). Public housing may be denied because of their criminal records or history of drug involvement. Inmates also tend to come from low socioeconomic strata and have relatively high rates of prior homelessness. Among state inmates, 15% of regular drug users were homeless or had no stable housing at the time of their arrest (Belenko, 2002a).

Special needs of female inmates. Although women only make up about 6% of inmates, the number of women in prison has risen by 336% since 1980, compared to a 189% rise for men (Peugh & Belenko, 1999). Although substance-involved women and men in prison share some of the same treatment needs, the manifestations and severity of these needs differ, particularly related to mental and physical health, vocational training, employment, family issues, prenatal and postnatal care, risk of HIV and other infectious diseases, and treatment design (Mahan, 1996; Miller & Downs, 1993; Peugh & Belenko, 1999; Prendergast, Wellisch, & Falkin, 1995; Teplin, Abram, & McClelland, 1996; Wellisch, Prendergast, & Anglin, 1994; Wells & Jackson, 1992). Employment issues have become even more important since the passage of the Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which limits the length of time an individual is eligible for welfare benefits, requires employment in many cases, and denies benefits to drug-addicted felons. Mental health problems are more likely and distinct for drug-involved female than male inmates (Helzer & Pryzbeck, 1988; Wilcox & Yates, 1993; Windle, Windle, Scheidt, & Miller, 1995). Women who abuse substances often suffer more intense emotional distress, psychosomatic symptoms, depression, and self-esteem problems than males (De Leon & Jainchill, 1982; Falkin et al., 1994; McClellan, Farabee, & Crouch, 1997; Ransom, Schneider, & Robinson-Sanford, 1996). Responsibility for parenting may undermine a woman's ability to participate in postrelease treatment and other services (Richie, Freudenberg, & Page, 2001). Finally, there has been little use of discharge planning or continuity of care for female inmates

(Prendergast et al., 1995), contributing to high rates of recidivism and relapse (Hammett et al., 1998; Veysey, Steadman, Morrissey, & Johnsen, 1997).

Facilitating Successful Reentry and Service Linkages

The preceding discussion suggests that by addressing substance abuse and related problems more effectively by providing evidence-based interventions, public safety, risk management, and treatment outcomes for released inmates would be improved. Considering the multiple risks and service needs for substance-involved inmates, risk-responsivity theory (Andrews & Bonta, 1998; Marlowe, 2003; Thanner & Taxman, 2003) offers a useful framework for understanding the types of assessment mechanisms needed for reentering inmates. This theory includes two key constructs: (a) Outcomes will be improved by identifying risk levels and targeting services specific to those risks, and (2) services need to be targeted to those needs in a way that recognizes the client's current cognitive abilities and learning styles (Thanner & Taxman, 2003). Higher risk clients need a greater intensity of services, and moderate- or low-risk clients need less intensive or comprehensive services (Festinger et al., 2002; Marlowe et al., 2003). In an era of declining resources, strategies to more accurately target scarce services have intuitive and practical appeal. In a direct test of this theory, Thanner and Taxman (2003) found that targeting high-risk probationers with integrated intensive treatment and other services reduced relapse and recidivism and increased employment. The benefits of intensive treatment were much lower for moderate-risk offenders.

Ideally, reentry and reintegration for inmates can be defined as processes that specify appropriate roles and responsibilities for key agencies that house, supervise, and treat the offender before and after release (Travis, 2000). Altschuler, Armstrong, and MacKenzie (1999) identified several factors that improve successful reintegration of adolescent offenders: (a) Agencies responsible for community supervision and service provision must team with corrections to assess needs and risks and facilitate discharge planning; (b) released offenders must have the resources minimally necessary to sustain a livelihood in the community, including housing, employment, and substance abuse services; and (c) community supervision must provide support to facilitate reintegration, including linkage to needed services as well as sufficient external control (monitoring) and compliance management to enforce public safety goals. All of these issues are also quite pertinent for adult substance-involved inmates being released to the community.

The Structured Reentry Model, now being tested in a number of jurisdictions, suggests that two periods are crucial for successful reintegration

(Taxman, Young, & Byrne, 2004). Prior to scheduled release, it is important for a reentry plan to be put in place. Taxman, Byrne, et al. (2003) note that this must involve a comprehensive assessment of treatment, health, housing, family, educational, and vocational needs; the identification of potential community supports (e.g., family members, other community members, organizations, program services); and a supervision plan. Comprehensive and integrated services are needed to achieve long-term success for parolees (Taxman, Young, et al., 2003). Inmates with histories of drug abuse leaving prison with little money, social capital, or community supports face a high likelihood of early relapse and recidivism (Petersilia, 2001; Taxman, Byrne, et al., 2003). An effective reentry supervision plan must provide intensive services and close supervision during this early release period. In this phase, crucial referrals and linkages to treatment and other services must occur, housing must be stabilized, and treatment and supervision plans must be finalized.

This conceptual framework also suggests that proximal factors may be important to consider in understanding the mediators and moderators of reintegration. In addition, intentions and plans (e.g., peer and family supports, housing options) are likely to interact with the management of risk, the impact of service referrals, and parole outcomes. Unfortunately, to date, there are few data to determine the relative importance of proximal versus distal factors for postrelease outcomes.

However, there remain important organizational challenges for facilitating service linkages and agency collaborations. Parole officers have high caseloads that limit their ability to assess for and manage service delivery. Doctrines of retribution, deterrence, and social control have become the dominant models for parole supervision, resulting in an emphasis on monitoring and public safety and low tolerance for violations of supervision conditions. Incentives for parole officers to refer to health and social services are limited, and they often lack training about substance abuse, treatment, and other health services. Given limited resources, parole officers may not have access to computer systems, service directories, or training that can improve their ability to identify community resources and service linkages in an effective and efficient manner. Consequently, service linkages for parolees are likely to be haphazard and inconsistent at best and inappropriate and iatrogenic at worst. Carise, Gurel, Kendig, and McLellan (2002) found that service referrals increase and are more effective when treatment counselors are provided computerized provider directories linked to specific services. Thus, there is a need to create tools that will facilitate access to appropriate and effective services following release. Finally, recent literature on the impacts of legal coercion on treatment retention and outcomes (e.g., Farabee,

Prendergast, & Anglin, 1998; Hiller, Knight, Broome, & Simpson, 1998; Marlowe, 2001; Young & Belenko, 2002) suggest that parole officer involvement in monitoring treatment attendance, accountability structures, and better matched referrals may lead to improved outcomes.

New Approaches Are Beginning to Emerge

Recent attention to prisoner reentry and reintegration and therapeutic jurisprudence models, such as drug courts (Belenko, 2002b; Hora, Schma, & Rosenthal, 1999), has created a new climate that may be more accepting of rehabilitative ideals and the role of health and social services in managing offenders in the community, especially related to substance abuse problems and consequences (Winick, 1999). Unfortunately, much less attention has been paid to prerelease or transitional planning for inmates or the implementation of comprehensive, multidimensional, validated assessment tools to assist in identifying service and supervision needs (Taxman, Byrne, et al., 2003).

Under support from the Office of Justice Programs (OJP) of the Department of Justice, the Reentry Partnership Initiative (RPI) established community-based models for inmate reintegration into the community with the goal of reducing recidivism (Taxman et al., 2004). The model, implemented in eight sites, involved collaborative partnerships among community service providers (e.g., treatment programs, housing agencies) and public agencies responsible for supervising and monitoring offenders (e.g., corrections, parole agencies). The RPI model incorporates a conceptual framework for a reentry process that includes institutional, structured reentry and community reintegration, supported by integrated case management (Taxman et al., 2004). Underlying much of this process is a need for ongoing, individualized assessment of offender risks and needs. However, a recent process analysis of the implementation of the eight RPI sites found that the sites had made little progress in implementing risk and needs assessment protocols (Taxman et al., 2004).

The Serious and Violent Offender Reentry Initiative (SVORI) began in 2002 and was designed to develop inmate reentry processes that are focused on public safety. OJP and the National Institute of Corrections, through a collaboration with and support from other federal agencies, funded 68 sites in 49 states. The goals of the SVORI are to

> increase public safety by reducing recidivism and noncompliance; to improve health by addressing substance abuse and physical and mental health; to improve self-sufficiency through employment, housing, family, and commu-

> nity involvement; and to achieve systems change through multi-agency collaboration and case management. (Lattimore et al., 2004, p. 2)

The SVORI applicants were required to form partnerships between correctional agencies and a local agency, including community- and faith-based organizations (Roman, 2004). Programs were to include phases that addressed (a) institutionally based programs, (b) community-based transition programs, and (c) community-based long-term support. States were provided guidelines for the structure of the three phases; the service delivery systems, including case management, risk and need assessment, preparation of reentry plans, and provision of services; a continuum of supervision and continuity of services; and terms and conditions of the reentry plan. This new initiative suggests that many correctional and parole agencies are beginning to pay increased attention to other service and supervision needs for reentering inmates.

Finally, the NIDA established the Criminal Justice Drug Abuse Treatment Studies (CJDATS) collaborative research program to explore the issues related to the complex system of offender treatment services (www.cjdats.org). Nine research centers and a coordinating center were created in partnership with researchers, criminal justice professionals, and drug abuse treatment practitioners to form a national research infrastructure. CJDATS is intended to spur the development and testing of models for integrated approaches to the treatment of incarcerated individuals with substance use disorders, including treatment in jail or prison, and as a component of reentry into the community.

Better Assessments for Reentry and Service Linkage Are Needed

The research and practice findings discussed above, in the context of risk-responsivity theory, suggest that additional dimensions of drug abuse and its effects need to be assessed for and considered in making clinically appropriate estimates of treatment need (McLellan et al., 1983), in determining intensity of treatment (McLellan & Alterman, 1991), and in crafting appropriate treatment plans (Carise et al., 2002). As Hammett et al. (2001) state, there is an "overarching need for correctional facilities to improve programs for discharge planning, community linkages, and continuity of care for all inmates" (p. 392). The American Society of Addiction Medicine patient placement criteria indicate that behavioral conditions and consequences of drug use (e.g., educational and vocational problems, anger management problems, or motor vehicle accidents) should be taken into account in determining the level of care (Mee-Lee, Shulman, Fishman, Gastfriend, & Griffith, 2001).

Current assessment tools commonly used in correctional settings have limitations for identifying multiple clinical, supervision, and social service needs for this population. Common examples are the Addiction Severity Index (McLellan et al., 1985), the Offender Profile Index (Inciardi, McBride, & Weinman, 1993), the Global Assessment of Individual Needs (Dennis, Titus, White, Unsicker, & Hodgkins, 2002), and the Level of Service Inventory–Revised (Andrews & Bonta, 1995). New assessment tools are needed that

- are validated with inmate populations released to parole;
- include multiple domains tied specifically to the behavioral, health, organizational, and social issues most likely to affect relapse and recidivism in the community;
- have good psychometric properties;
- are designed to serve as risk management and service linkage tools for parole officers; and
- combine static and dynamic factors, covering different time periods, which are important for postrelease success and adjustment (Simourd, 2004).

Typical assessment instrument domains center on specific timeframes (e.g., lifetime versus recent). However, given that incarceration limits an inmate's ability to engage in many behaviors and may alter the antecedents and determinants of risk behaviors, it may be important to incorporate multiple time frames in new assessment tools. Examples are (a) first initiation into behavior and childhood problems or behaviors, (b) behavior just prior to incarceration (e.g., 6 months before admission to prison), (c) behaviors and experiences during incarceration (e.g., mental and physical health, infractions, training and education, treatment and services received), and (d) postrelease plans and intentions (e.g., having a place to live, likelihood of obtaining a job, reunification with family). Experiences while incarcerated may exacerbate prior conditions, so there may be a need to assess for the effects of incarceration itself on health and social functioning and the inmate's ability to successfully reenter society. Recent data indicate that inmates with misconduct infractions have higher recidivism rates after release; parolees in Pennsylvania with one or more misconducts in the year prior to release had a higher rate of return to prison than inmates without infractions (44% vs. 33%; Flaherty, 2004).

In addition, research on reentry and recidivism suggests that additional items are needed in new domains beyond those covered in most existing instruments, such as issues related to intentions, plans, strengths and protective factors, peer supports, and family and community resources (Taxman, Byrne, et al., 2003). Moreover, attributes and behaviors may cluster across

unidimensional domains into higher order factors that are better predictors of postrelease relapse and recidivism. For example, items related to family, peer networks, employment, community supports, and housing might fall into a general social support factor. A personal health domain might incorporate items from medical and psychiatric domains, including psychopathy.

CONCLUSION

In sum, there are several key challenges for improving assessment and service linkages for reentering inmates and maximizing successful reentry for substance-involved inmates. First, prerelease or transitional planning is limited now and rarely based on adequate assessment using research-based instruments (Knight, Simpson, & Hiller, 2002). There is a need to improve transitional planning to identify effective services, to facilitate linkages to services, and to better manage risk in the community. The term *effective referrals* means services that are accessible; are relevant and appropriate to the offender's risk, need, and cognitive ability levels; and provide data and feedback to the parole officer on the offender's progress in meeting service goals. Second, parole officers faced with heavy caseloads and limited training in health and social services are ill equipped to provide appropriate referrals to such services and adequately monitor progress and compliance. The emphasis on control and monitoring means that high parole violation rates and reincarceration are consequences of relapse rather than adjustments of services or rereferral to another provider. Third, existing assessment tools have not been widely adopted; in a survey of correctional psychologists, Boothby and Clements (2000) found that the vast majority of clinicians in correctional facilities ignore risk assessment tools in assessing and treating inmates. Fourth, simply targeting substance abuse problems may be insufficient if other social, behavioral, and health problems mediate and moderate relapse and recidivism following release. Finally, the unique profiles and serious needs of female inmates have not been addressed in previous research or reentry program development.

There are several important reasons for assessing released inmates for current conditions, motivational levels, behavioral status, and beliefs and perceptions related to service needs and access. These include the need to target services that are appropriate to the offender's current cognitive and learning skills (indicated by risk-responsivity theory), the multiple health and social service needs of inmates, the importance of the early release period in a structured reentry model, and the importance of linkages to appropriate services to facilitate reintegration and community supports (Altschuler et al.,

1999). More recent dynamic factors may be more predictive of postrelease adjustment and risk than either static factors or more distal dynamic traits measured prior to incarceration (Simourd, 2004). For example, the Addiction Severity Index includes both the assessment of lifetime functioning and the assessment of recent (acute) problems and functioning. Lifetime information is designed to help the clinician evaluate problem severity and develop treatment plans; acute recent problems are also used for these purposes and are also used to monitor change. These are very different functions. Whereas assessment of lifetime functioning is conceptualized as typically applying to treatment intake and baseline, assessment of acute functioning needs to be applicable at intake and subsequent time points. Accordingly, new frameworks are needed to guide inmate assessment that

- identify areas of functioning and health that require interventions on release;
- assess multiple dimensions, including public safety risk, that have sound psychometric properties, are relatively compact and easy to administer and score, and have clinical utility and acceptability in real-world settings;
- assess for both static and dynamic factors and distinguish recent dynamic behaviors and conditions from more distal conditions;
- include higher order factors that may mediate or moderate postrelease behavior;
- are validated for the reentering inmate population (which have disproportionate percentages of African American, Hispanic, and socially disadvantaged persons);
- will be adopted and used by correctional and parole staff to expand and improve service linkages ("ecological validity");
- are sensitive to the dynamics of the reentry and reintegration processes; and
- include community resource or community strength assessments to determine the social ecology and social capital aspects of the inmate's reintegration (Laverack & Wallerstein, 2001; McKnight & Kretzmann, 1996; Putnam, 1995).

In addition to identifying areas that may require provision of services, a useful assessment instrument would move beyond current instruments and also identify domains and problems that might require additional or modified supervision levels or different conditions of parole and probation (e.g., housing, community supports, peer networks). The ideal assessment instrument should be a standardized tool that can provide data useful for research on postrelease behaviors and service delivery for released inmates and policy efforts to improve the reentry process for reentering inmates. The individual and organizational complexity of the reentry process, coupled with the high level of reoffending risk for substance-involved inmates and their multiple service needs, increases the urgency to develop new tools to help transitional planning staff and parole officers accurately identify service needs for inmates reentering the community. Such new tools are vital for generating a new set of research questions and hypotheses that will increase and deepen

our understanding of the array of factors that determine or mediate post-release outcomes for inmates.

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