# Mapping the Innovation in Correctional Health Care Service Delivery in New York City

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This report is available at http://www.jjay.cuny.edu/centersinstitutes/pri/publications.asp

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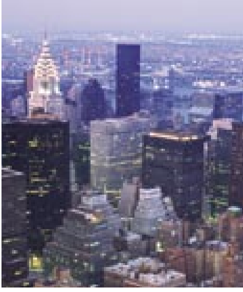

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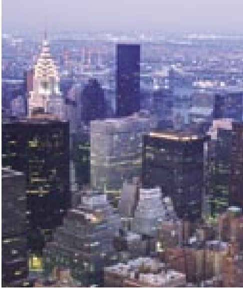

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# Executive Summary

This study profiles New York City's adoption of a community-based public health model that makes use of periods of incarceration to identify the chronic health and mental health needs of inmates. The goal of the model is to provide continuity of care and to facilitate the containment of communicable disease through community health care providers. The study is unique in that it combines multiple data sources previously unavailable for such a purpose.

New York City has reallocated funding from short-term treatment to discharge planning for a number of reasons. These include the need to increase the probability of effective outcomes as a result of the relatively brief and unpredictable length of inmate stays, the complexity of inmate needs, and current research demonstrating that the effectiveness of health and human services programs for inmates should be measured over a period of months, not days. As a result of litigation, new statutory requirements, and court orders, the New York City Department of Correction has joined forces with several partners to develop, implement, and evaluate the efficacy of innovative approaches to facilitate the successful reentry of these special needs populations.

The discharge-planning process begins at intake in a New York City Department of Correction facility. All inmates, within the first 24 hours of admission, have a comprehensive medical history taken and receive a physical examination. Routine, voluntary testing also is performed for tuberculosis, HIV/AIDS, sexually-transmitted infections, substance abuse, and mental illness.

Transitional Health Care Coordination, operated by the New York City Department of Health and Mental Hygiene, coordinates health education and service delivery from incarceration to release. Inside the facilities, health educators and patient care coordinators disseminate written health education materials to inmates and their families and provide prescriptive discharge planning services for those with chronic illness. Field staff are located in neighborhoods of high inmate return to facilitate referrals to primary care physicians, substance abuse counselors, and, since 2006, more than 170 community-based service providers. Regardless of their health care needs, city-sentenced inmates have the option of volunteering for the Rikers Island Discharge Planning Enhancement Project, which provides

direct transportation to community services at discharge and 90 days of post-release case management in the community.

### What is the Extent of Unmet Need?

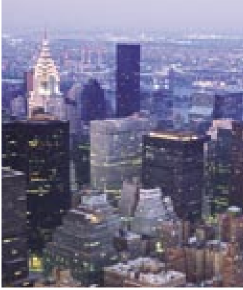
The most common way to measure unmet need is to determine the geographic availability and accessibility of services compared to the number of inmates released to a particular geographic area. A disproportionate share of inmates is released to specific communities within New York City's five boroughs. This report will describe some of the mismatch between released inmates and services. For example, six of 59 community districts are home to 26 percent of the inmate population released in 2005. In Brooklyn, two community districts in particular demonstrate the mismatch between returning inmates and the availability of services. There is a serious geographic mismatch in the Bronx, where the majority of available services are clustered in four community districts, even as four different community districts have fewer available services but are home to a greater number of returning inmates. While inmates returning to Manhattan benefit from a higher rate of availability and accessibility of service than inmates released to the Bronx and Brooklyn, these services are clustered in communities with fewer released inmates.

Mapping available services in Queens against the number of returning inmates demonstrates a disparity in access to and availability of services between neighborhoods and communities. On the other hand, Staten Island shows a more even distribution of services in the communities where the majority of returning inmates live.

### Has the New Service Delivery Model Fostered Increased Inter-Agency Collaboration?

The preponderance of providers who have worked on reentry in the past agree that there is a "culture of organizations in New York City working together to reintegrate former inmates back into their communities." These providers characterize the current political climate as supportive of organizational alliances with policies that facilitate collaborative relationships. A few, however, still cling to an often-repeated theme that competitive funding is a barrier to greater collaboration. While most agencies gave credit to the Department of Correction for its leadership, there was mild criticism of the quality of communication and the agency's ability to engage in collaborative decision-making with organizations working on reentry.

Agencies working on reentry face their own barriers to providing needed services. For example, though not a policy issue, housing barriers and Medicaid issues seem bureaucratically intractable to many service providers. A large group felt that this could be addressed if the Department of Correction would resolve these issues prior to inmate release. Despite the few issues that were identified by providers, it is clear that, while coordination among service providers and correction authorities remains in the early stages of development, stakeholders are positively disposed toward new policies and practices.

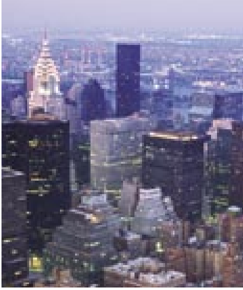


### What Potential Future Research Can Do to Build Upon This Study's Findings

The findings suggest a mismatch between the needs of inmates returning to the community and access to providers. Building upon this study, future research should study the significance of the availability and accessibility of service location for inmates' post-release service utilization. How far the formerly incarcerated will travel to services, and if the service type is a factor in their utilization, is still an open question in New York City. Descriptive studies will need to be implemented to help answer these questions.

Although this research identifies a lack of community support for reentry services as one problem, little is known at the community level about how key institutions, community characteristics, and the shape and direction of criminal justice agencies and social policies enhance or hinder reentry success. For example, it has yet to be determined to what extent policies and procedures relative to contracting with outside agencies locates or shapes availability and content of programs intended to provide health, vocational, or other needs for the returning population. Another area of uncertainty is the degree to which eligibility rules that govern an array of entitlement benefits might, in fact, create reentry obstacles in communities of high inmate return. A next step is an exploratory assessment of the level of state and city agencies and programs capacity for flexible and blended health and human services support, coordination, and accountable in several communities of high inmate return.

In sum, mapping the innovation in correctional health care service delivery in New York City is only the beginning in understanding the challenges and opportunities that lie ahead in reentering inmates back to the community. This portrait of inmate and service characteristics lays the foundation to bring stakeholders together to visually orientate themselves to the resources in communities of high inmate return and to understand how to build upon the innovative continuity of care and community linkages with which New York City has so actively engaged.



# Introduction:

This is a profile of the current pattern (as of 2005) of inmate reentry in New York City, with particular focus on: a) the health and human service policies and practices of the city agencies most involved: the New York City Department of Correction (DOC) and the Department of Health and Mental Hygiene (DOHMH); b) the related needs of released City inmates; and c) the capacity of the communities to which these inmates overwhelmingly return to provide the services and support prescriptively included in the inmate's discharge plan. While the profile does not attempt to evaluate policies, agencies, or service providers, it does include qualitative data from interviews with service providers. This information allows for a more in-depth understanding of the perceptions of current policy and practice than is possible from data alone.

This project is concerned specifically with health care. It dovetails with a primary focus of reentry policy: the creation of social and professional networks that encourage existing community organizations to become partners working toward the successful integration of released inmates into their communities. While health care is just one of the many challenges that face inmates returning to their communities, it is nonetheless critical to successful reentry. The identification of health problems during incarceration, with appropriate referral to community-based services at reentry, is an approach that could have an important impact on both public health and on outcomes for inmates themselves.

It has been well documented that incarcerated populations have a high prevalence of chronic and communicable diseases and mental illness, conditions that significantly impact their lives and the lives of those around them. On average, 40 percent of the inmates in city jails access mental health services during their period of incarceration.[1] Twenty-nine percent are diagnosed as mentally ill. Seventy-five percent have a history of substance abuse; 20 percent require drug or alcohol withdrawal treatment after admission; and seven percent of male inmates and 20 percent of female inmates are HIV-infected.[2]

The population dynamics of New York City's jails help explain the challenge. The average length of incarceration is 48 days for detainees and 38 days for those serving a City sentence. Twenty-eight percent of the inmates are released within three days of their admis-

[1] City of New York, Department of City Planning, *2003 Annual Report on Social Indicators* (New York, NY: 2003).

[2] New York City Department of Corrections, *Official Plan as of 10/18/2005. Discharge Planning Action from May 2, 2005 Retreat* (New York, NY: 2005).

[3] Roger K. Parris, "Public Health Collaborations in a Correctional Setting: New York City's Model," *Corrections Today*, available at www.aca.org/publications/ctarchives.asp#oct04 (accessed on May 22, 2006).

sion and 79 percent within 60 days of admission.[3] Given the brief average length of stay in a DOC facility, the Department is severely limited in terms of what it can accomplish with individual inmates or in terms of addressing risks to public health in communities to which the inmates return. As a result, public health, like public safety, has become a public policy concern with regard to the return of inmates to their communities.

One of the goals of New York City reentry policy is long-term improvement in the health care of former inmates. The current belief is that this can best be achieved through three primary strategies: 1) the identification and education of inmates with health and mental health problems; 2) a well-coordinated system of health care connections to the community with effective discharge planning; and 3) accessible community-based services.

This project profiles these three strategies, beginning with a discussion of the efforts of DOC and its sister agency, DOHMH, to provide for the identification and education of inmates and the creation of a well-coordinated system of health care. The report then profiles the health, mental health, and criminal justice-related characteristics of the inmate population. In a first for a project of this kind, Section 3 combines several databases to geo-map the availability of services in communities expecting the return of a disproportionate share of formerly incarcerated individuals. This section also identifies gaps between returning inmate needs and service delivery capacity.

The structured survey of service providers relative to their perspective as to the efficacy of the collaborative efforts is discussed in Section 4. The report concludes with a discussion of the next steps in the collaboration between John Jay College of Criminal Justice and the Bellevue Hospital Center Department of Psychiatry.

# SECTION 1:

## The New York City Department of Correction Health- and Non-Health-Related Discharge Planning

In 2003, the New York City Department of Correction (DOC), under the leadership of Commissioner Martin Horn, conducted a reassessment of the process by which inmates are prepared for their return to the community. As part of this initiative, DOC began to create comprehensive and coordinated discharge planning services, primarily for sentenced inmates incarcerated between 30 days and one year. That year, DOC and the Department of Homeless Services (DHS), under Commissioner Linda Gibbs, organized a retreat of stakeholders, including government agencies, service providers, researchers, and advocacy organizations to focus on the discharge-planning process.[4] Now organized into the Discharge Planning Collaborative, this group's goal is to "address the complex issues surrounding jail reentry." [5] A wide range of New York City government agencies are involved in this collaboration, including DOC, DHS, DOHMH, the Human Resources Administration (HRA), and the Office of the New York City Criminal Justice Coordinator.

### Policy Concerns Underlying the Collaboration

The innovative new reentry focus was driven by four interrelated policy concerns as well as by external legal pressures. First, data indicated that annual readmission rates (i.e., the percent of inmates admitted to DOC custody two or more times within the same fiscal year) were consistently high, averaging 47 percent between 1999 and 2004 and increasing slightly in 2005 to 49 percent.[6] This high rate of readmission indicated that many inmates were not successfully being reintegrated into their communities.

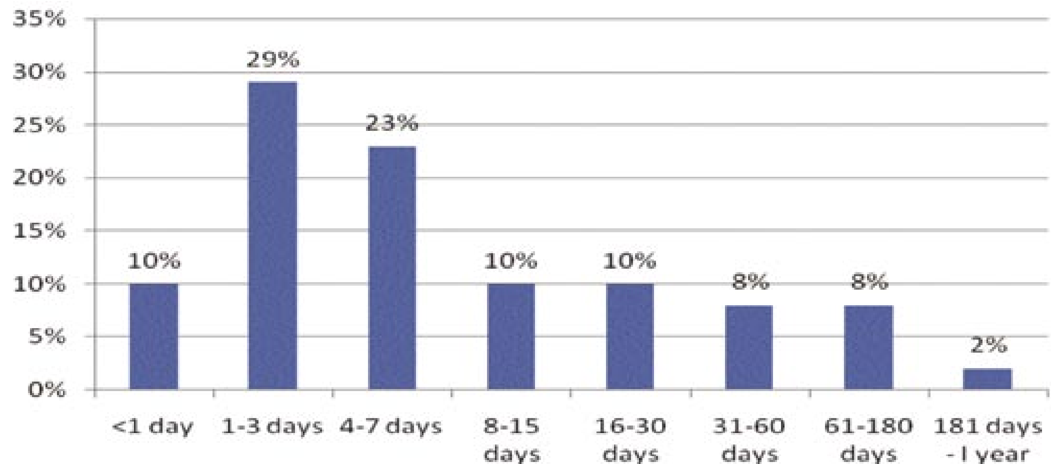
A second policy concern was that the unpredictable and short length of inmates' stays challenged the system's capacity to address their multiple needs. The average length of stay for those released in 2005 was 21 days, with nearly one-third (29 percent) incarcerated between just one and three days and more than 60 percent incarcerated for no more than seven days (Figure 1.1).

[4] New York City, *The Mayor's Management Report Fiscal 2005 Preliminary* (NY: 2005).

[5] Glen Martin, "Rikers Island Discharge Planning Initiative: A New York City Jail Reentry Model," *National HIRE Network News* 3 no. 8 (2005): 1-10.

[6] New York City, *The Mayor's Management Report Fiscal 2005 Preliminary* (New York, NY: 2005).

**Figure 1.1: DOC Inmates Length of Stay**




A third issue that gave impetus to the collaboration was that DOC facilities, like most urban jails, have become society's default mental institutions and addiction centers. Commissioner Horn has noted that "Rikers Island is the largest provider of acute mental health care services in the city of New York, bigger than Bellevue [Hospital] by an order of magnitude."[7] The question that Commissioner Horn and others pose is whether incarcerating the mentally ill and drug addicts for offenses driven by their mental illness or addiction is the most effective method of treatment. An alternative strategy is to develop a comprehensive post-release plan so that behavioral and health services in the community can become the front-line for managing these problems.

Fourth, public health concerns have come to the fore, particularly with regard to HIV/AIDS. In a study that compared male inmates discharged from DOC *with* community case management services to a control group with no community case management, the preliminary findings showed a reduction in sexual risk behaviors in the case-managed population.[8] Public health is affected when inmates with undiagnosed and/or untreated communicable and chronic diseases, mental illness, and substance abuse issues are released to the community without a transitional health care plan.[9] Released inmates are an important target population for outreach addressing communicable diseases, as they comprise a disproportionate share of known cases. For example, a 1999 DOHMH jail seropositivity survey of inmates found eight percent of men and 18 percent of women were HIV positive, significantly higher than the prevalence rates in New York City's general population. [10]

[7] The Drum Major Institute for Public Policy, *Marketplace of Idea Series: On the Power of Restorative Justice* (New York, NY: 2005): 26.

[8] Jeanne Moseley, Cynthia Gordon, Christopher Murrill, and Lucia Torian, *An Evaluation of Discharge Planning and Community Case Management Services for Incarcerated Adult Males at Rikers Island: Correction Case Management at Rikers Island (CCARI)* (paper presented at the 2005 National HIV Prevention Conference, Atlanta, Georgia, June, 13, 2005).

[9] New York City Commission on HIV/AIDS, *Report of the New York City Commission on HIV/AIDS* (New York, NY: 2005).

[10] Anne C. Spaulding, Kimberly R. Jacob Arriola, Theodore Hammett, Sofia Kennedy, and Giulia Norton, *Enhancing Linkage to HIV Primary Care in Jail Setting* (Cambridge, MA: Abt. Associates, 2007).

## Legal Pressures

A discussion of discharge planning would not be complete without a look at legal challenges that have materialized in the last decade, specifically statutory requirements and court orders that mandate discharge planning for specific DOC populations. In Brad H. *et al.* v. The City of New York, *et al.* (Brad H.), the courts required discharge planning as an essential component of mental health care delivered in accordance with the standard psychiatric practice.[11, 12, 13] The case cited several laws and regulations to support its argument: New York State Mental Hygiene Law 29.15, which mandates "providers of inpatient health services to provide discharge planning; a New York State regulation that requires providers of outpatient mental health services to provide discharge planning; and a provision of the New York State Constitution prohibiting cruel and unusual punishment."[14] New York State Mental Hygiene Law 29.15 specifically requires discharge planning to include a written service plan prepared by staff familiar with the person's case history.

According to Barr, the Brad H. case in New York City is noteworthy, not because it mandates discharge planning for the incarcerated who are mentally ill, but because it states that inmates are "entitled to discharge planning because they are the patients of a mental treatment provider and patients have a right to discharge planning."[15] Under a settlement with the plaintiffs, New York City agreed to provide comprehensive discharge planning support and access to treatment for the incarcerated who are seriously mentally ill.

In 2004, building on the Brad H. case, New York City passed an even more comprehensive discharge planning law.[16] The law goes beyond the Brad H. case in that it establishes a legal right to discharge planning for all inmates who serve a sentence of 30 days or more, and entitles them to enhanced post-release services, regardless of their health and behavioral needs.

## Current Discharge Planning Policies and Procedures

A primary goal of discharge planning is to link inmates with appropriate health and human service providers in the community to address their problems early on, before they might violate their conditions of community supervision or be arrested for a new offense. The overarching goal is to have a coordinated and collaborative effort to ensure a continuum of care and treatment during the reentry process, particularly with respect to health needs. To meet this goal, DOC adopted a strategy to reallocate funds from short-term behavioral treatment programs to discharge planning. As a result, the focus has shifted from inside the walls of Rikers Island to the development of reentry plans used by correctional officers, case managers, and service providers to ensure appropriate

[11] Brad H. et al. v. The City of New York, et al.(1999). Complaint, class action, Supreme Court of the State of New York, County of New York, Index No. 117882/99 (IAS Part 23), available at www.urbanjustice.org (accessed May 19, 2006).

[12] Brad H. et al. v. The City of New York, et al., order of the Supreme Court of the State of New York, 185 Misc. 2d 420; 712 N.Y.S. 2d 336 (July 12, 2000)

[13] Brad H. et al. v. The City of New York, et al 8 A.D.3d 142, 779 N.Y.S.2d 28, 2004 N.Y. App.Div. (N.Y. App. Div. 1st Dep't, 2004)

[14] Heather Barr, "Transinstitutionalization in the Courts: Brad H. v. City of New York, and the Fight for Discharge Planning for People with Psychiatric Disabilities Leaving Rikers Island," *Crime and Delinquency* 49 no 1 (2003, p. 101) 97-123.

[15] Ibid. p. 118.

[16] New York City Administrative Code, *Local law no. 54: To Amend the Administrative Code of the City of New York, in Relation to Discharge Planning Services,* available at www.nyccouncil.info/pdf_files/bills/law04054.pdf (accessed May 22, 2006).

supervision and case management once the inmate is released.[17, 18] For example, DOC reallocated resources previously used for substance abuse programs inside the facilities to discharge planning services, based on the assumption that effective substance abuse treatment cannot be achieved in the short time most inmates are in the custody of the DOC.[19] This shift is reflected in the diminishing number of inmates in substance abuse programs. In 1999, DOC's custodial substance abuse programs served 11,000 inmates. By 2003 that number had decreased 24.4 percent, to 8,840.[20] Research supports this reallocation of funds. Services (e.g., educational, substance abuse, and mental health programs) need to be long-term and provided over a period of months to increase the probability of change. A few days are not enough time to produce positive results.[21]

DOHMH provides treatment and transition services for inmates through various programs and bureaus (Figure 1.2). Under DOHMH's Division of Health Care Access and Improvement (HCAI), Correctional Health Services (CHS) is responsible for the medical, mental health, and dental services in the City's correctional facilities. The Bureau of Transitional Health Care Coordination (THCC) coordinates pre- and post-release connections to health care. The Bureau of Forensic Behavioral Health Services provides discharge planning services for mentally ill individuals released to the community from DOC facilities.

**Beginning the Discharge Process**

The discharge planning process begins at intake. Within the first 24 hours, all inmates are administered a four-page comprehensive medical screen and physical exam to identify their needs (see Appendix B) and the DOC Discharge Planning Questionnaire/Screening Form 983 (Appendix E), currently used for discharge planning for sentenced inmates. The medical screen focuses on the inmate's behavioral and health needs; each inmate is also given brochures on HIV-STD, health, and dental needs. Routine communicable disease testing is performed at intake, but is voluntary.

The type of discharge planning inmates receive depends on their behavioral and medical needs, reason for incarceration, length of stay in the facility, constraints in service delivery, and the availability of community-based resources.[22] As Black and Cho note, "discharge planning is more commonly provided to inmates with special needs such as mental illnesses or HIV/AIDS."[23] It stands to reason that a detainee released within 24 hours with no identified special needs will receive minimal services under this system.

[17] City of New York, Department of City Planning, *2003 Annual Report on Social Indicators.* (New York, NY: 2003).

[18] City of New York, *Fiscal 2005 Preliminary Budget Response: Part III Committee Reports Based on the Preliminary Budget Hearings* (New York, NY: March, 2004).

[19] City of New York, Department of City Planning, *2003 Annual Report on Social Indicators.* (New York, NY: 2003).

[20] Ibid.

[21] Douglas S. Lipton, *The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision,* National Institute of Justice (Washington, DC: 1995), NCJ 157642.

[22] Richard Cho, *Putting the Pieces Back Together: Overcoming Fragmentation to Prevent Post-Incarceration Homelessness* (paper submitted to Housing & Criminal Justice Policy in New York City, A Research and Practice Symposium Columbia University-Center for Urban Research and Poverty, 2004).

[23] K. Black and Richard Cho, *New Beginnings: The Need for Supportive Housing for Previously Incarcerated People* (New York, NY: Common Ground Community/Corporation for Supportive Housing, 2004) p. 26.

**Figure1.2: Department of Health and Mental Hygiene Table of Organization**

Legislative Body -- Board of Health
Advisory Boards:
-Health and Mental Hygiene Advisory Council
-Community Services Board/Mental Hygiene Advisory Board
-Federation for Mental Health, Mental Retardation and Alcoholism Services
-Local Early Intervention Coordinating Council
-HIV/AIDS Community Planning
-NYC Commission on HIV/AIDS
and others

**Department of Health and Mental Hygiene**
**Table of Organization**

Thomas R. Frieden, MD, MPH
Commissioner

Charles Hirsch, MD
Chief Medical Examiner

Christina Chang
Chief of Staff

Andrew S. Rein
Chief Operating Officer/
Executive Deputy Commissioner

Community Services Board
and
Federation for Mental Health, Mental Retardation and Alcoholism Services

Administration and Contracts
Chemical Dependency
Clinical Affairs
Consumer Affairs
Early Intervention
Mental Health
Mental Retardation & Developmental Disabilities
Policy & Planning

David Rosin, MD
Executive Deputy Commissioner
Mental Hygiene

Communicable Diseases
Emergency Management
HIV/AIDS
Immunization
Public Health Laboratory
STD Prevention & Control
Tuberculosis Control

Isaac Weisfuse, MD, MPH
Deputy Commissioner
Disease Control

Day Care
Environmental Disease Prevention
Environmental Emergency Preparedness & Response
Environmental Sciences & Engineering
Environmental Surveillance & Policy
Food Safety & Community Sanitation
Health Academy
Poison Control Center
Veterinary & Pest Control

Jessica Leighton, PhD
Deputy Commissioner
Environmental Health

Epidemiology Services
Public Health Training
Vital Statistics
World Trade Center Health Registry

Lorna Thorpe, PhD
Deputy Commissioner
Epidemiology

Correctional Health Services
Forensic and Behavioral Health Services
Health Insurance Programs
Oral Health
Primary Care Information Project
Take Care New York
Transitional Health Care Coordination

Louise Cohen, MPH
Deputy Commissioner
Health Care Access and Improvement

Chronic Disease Control
District Public Health Program
Maternal Infant & Reproductive Health
Minority Health
School Health
Tobacco Control

Mary T. Bassett, MD, MPH
Deputy Commissioner
Health Promotion and Disease Prevention

Administration and Operations

Scottie M. Owings-Leaks
Deputy Commissioner
Administration

ACCO/Procurement
Call Center
Facilities Planning & Plant Operations
Human Resources
Operations

Patricia Thomas
Agency Chief Contracting Officer

Dorothy Wright
Equal Employment Officer

Andrew S. Rein
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Financial & Strategic Management

Audit Services
Communications
Finance & Planning
Informatics & Information Technology
Intergovernmental Affairs

Geoffrey Cowley
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Source: NYC DOHMH website. http://www.nyc.gov/html/doh/downloads/pdf/public/dohmh-orgchart.pdf

## Health Screens and Discharge Services for Five Common Health Problems

### 1. Tuberculosis

Tuberculosis testing via tuberculin skin tests (TST) is offered to every incoming inmate, male and female, without a history of prior positive TST. In addition, symptom questionnaires for active TB (e.g., cough, fever, and sweats) are completed within the medical history of every inmate. Chest x-rays are ordered for anyone with a positive TST history and for anyone who is HIV positive or has another immunosuppressed condition. Those with new positive TST results after intake testing are sent for chest x-rays and offered INH/B6 treatment [24] if there are no contraindications (i.e., elevated liver enzymes from hepatitis C or alcohol use). If the history, physical, or a chest x-ray elicit suspicions of active TB, the patient is isolated to rule out TB via consecutive sputums. For active TB cases that are released and for those on INH/B6 treatment, follow-up care in the community is coordinated by the DOHMH Bureau of Tuberculosis Control.

### 2. HIV/AIDS

In 2004, the DOHMH implemented the 20-minute OraQuick HIV finger-stick test on a voluntary basis for all incoming male and female inmates. "From the public-health perspective, the OraQuick test is ideal for City inmates — who move quickly through the system — to find out their HIV status, and, if positive, enroll in treatment and stop infecting others."[25] Introduction of the OraQuick test has quadrupled the rate of inmate acceptance of HIV screening.[26] Between 2003 and 2005, inmates volunteering for the rapid test increased from 6,500 to 26,000, indicating that the rapid test is viewed more positively than the traditional test.[27] If the test result is positive, a confirmatory blood test is performed. Inmates have the option to take the HIV test anytime during incarceration.

HIV-related aftercare services are offered to all newly diagnosed HIV-infected inmates identified through voluntary rapid testing and to those who self-report or are known HIV-infected persons. Aftercare services are provided to both detainee and City-sentenced populations and consist of an evaluation performed by a discharge planning social worker or case manager, who refers the individual to appropriate services depending on the individual's preferences and place of residence. The inmate is provided with an aftercare letter that summarizes jail-based treatments, laboratory and radiology results, and medication regimens. While there are no aftercare clinics or centers specific to released HIV-infected persons in the manner of Brad H., HIV-infected persons are given instructions on how to access services in the community. Since March 2007, DOHMH's Health Care Access and Improvement (HCAI) team has put a new model in place for the HIV continuum of care. All HIV-infected inmates now have a minimum of one meeting with a DOHMH staff member prior to release, and they have the opportunity to be connected to community treatment clinics after release. See Appendix C for HCAI's new HIV continuum of care model.

[24] INH/B6 = isoniazid and vitamin B6, daily medications x 9 months of therapy for treatment of positive TB skin test.

[25] The Body, *NYC Inmates Being Screened With New 20-Minute HIV Test,* available at www.thebody.com/bp/jul04/newsline.html#1 (accessed on June 22, 2006).

[26] New York City Commission on HIV/AIDS, *Report of the New York City Commission on HIV/AIDS,* (New York, NY: October, 2005).

[27] Anne C. Spaulding, Kimberly R. Jacob Arriola, Theodore Hammett, Sofia Kennedy, and Giulia Norton, *Enhancing Linkage to HIV Primary Care in Jail Setting* (Cambridge, MA: Abt. Associates, 2007).

**3. Sexually Transmitted Diseases**

DOHMH's Correctional Health Services currently screens for gonorrhea and chlamydia using urine-based nucleic-acid testing in all male inmates less than 35 years of age and all female inmates regardless of age. They are also tested for syphilis. In addition, all female inmates are offered pelvic examinations and Pap smears at admission. Urine submitted at admission is analyzed by an outside laboratory within 48 hours of screening. If the individual is still incarcerated and the test is positive, they are called to clinic and offered treatment specific to gonorrhea, chlamydia, or both. At admission, the individual receives a pamphlet advising how to follow up on the tests at any DOHMH sexually transmitted disease clinic if the individual is released prior to an available result. In addition, women receive a pregnancy test and PAP smear.

**4. Serious Mental Illness**

The Bureau of Forensic Behavioral Health Services in DOHMH provides comprehensive discharge services to mentally ill individuals released from correctional facilities. At the time of the intake medical evaluation at Rikers Island, a determination is made as to whether a mental health assessment is necessary. When indicated, a mental health assessment is performed within three days. If this assessment reveals a need for follow-up for further assessment or treatment, a comprehensive discharge and treatment plan (CDTP) is completed. For those who are housed in one of the segregated mental health units, the CDTP is completed within seven days of the mental health assessment. If the inmate is housed in the general population, the CDTP is completed within 15 days of the initial screening.[28] Under New York City's settlement agreement in the Brad H. litigation, inmates become designated "class members" upon completion of the CDTP and are entitled to services pursuant to the settlement. In addition, inmates are designated as class members if they are prescribed certain psychotropic medications (antipsychotic medications or mood stabilizers), regardless of whether a CDTP is completed prior to release.

The Bureau of Forensic Behavioral Health Services established the Service Planning and Assistance Network (SPAN) to serve mentally ill inmates who did not receive services while incarcerated, either because they were released before services could be arranged, were released from courts unexpectedly, or because they refused services at Rikers Island. SPAN offices exist in four boroughs (the Staten Island SPAN office was closed in 2005), located near the court centers. The SPAN offices provide services to released inmates on a walk-in basis. Inmates who meet the New York State Office of Mental Health definition of being "Seriously and Persistently Mentally Ill" (SPMI) are entitled to a higher level of services, under the Brad H. settlement agreement. The determination of SPMI status may be made at the time of the initial mental health assessment or at any later time. In addition, inmates treated with a medication from the list of specified psychotropics (antipsychotic medications and mood stabilizers) are presumed to have

[28] Marcel Van Ooyen, *Mental Health Update on the Implementation of the Brad H. Settlement. Briefing Paper of the Human Service Division, Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse and Disability Services* (New York, NY: New York City Council, February 17, 2005).

SPMI status, unless otherwise documented following assessment. The Bureau of Forensic Behavioral Health Services provides an array of services as agreed to under the Brad H. settlement.[29]

**5. Substance Abuse**

The Key Extended Entry Program (KEEP) was established in 1987 and provides methadone maintenance to eligible opioid-dependent inmates in the jail, followed by referrals to participating community methadone programs at the time of release. About 4,000 inmates are admitted annually to KEEP. Of these, about 2,200 are convicted inmates serving sentences of less than one year, and 1,800 are detainees with charges that will not likely result in a sentence of more than one year of incarceration if they are found guilty. These restrictions ensure that KEEP patients will not be transferred to state prison at some point, where methadone maintenance is not available and opioid withdrawal protocols may differ from those of DOC.

Few inmates actually serve sentences that come close to a full year. KEEP patients receive methadone maintenance for an average of 30 days, and almost all patients serve sentences for periods that range from 10 to 90 days. A National Institute on Drug Abuse (NIDA)-sponsored evaluation of KEEP published in 1993 documented the relationship

[29] **Key elements of services for the seriously mentally ill pre- and post-release are as follows:**

1. Mentally ill inmates are released during daylight hours.
2. When release dates are known, discharge planning staff makes appointments at appropriate mental health programs in the community and advises inmates of the date, time, and place of the appointments.
3. Referral information is provided for inmates for whom release dates are not known.
4. Inmates who present themselves to SPAN offices within 30 days of release are to be provided with services to place them in appropriate mental health treatment programs.
5. On behalf of SPAN inmates, discharge planning staff make a follow up contact with mental health programs within three days of scheduled appointments. For inmates who failed to appear for their appointments, discharge planning staff makes efforts to contact them and arrange new appointments.
6. Inmates receiving medication for mental health purposes are supplied with a seven-day supply and prescriptions to cover an additional 21-day period.
7. Eligible inmates have Medicaid benefits activated or re-activated prior to release or have their Medicaid application submitted and have access to Medication Grant Program benefits.
8. For SPMI inmates, applications are made, as appropriate, for public assistance.
9. For SPMI inmates, there is assessment of housing needs and, where appropriate, placement in supportive or other housing, or Department of Homeless Services shelters.
10. For SPMI inmates, transportation from jail to the place of residence is provided.

between the treatment experience of KEEP patients and the likelihood that they would report for community treatment. The study found that 82 percent of KEEP patients who were on methadone maintenance therapy at entry to DOC reported to community methadone programs upon release, 52 percent of KEEP patients who were not in treatment at entry to Rikers Island reported for community treatment, and only 30 percent of patients who received methadone-assisted opioid withdrawal (detoxification) reported for community treatment.[30] Among those reporting for community maintenance treatment, 40 percent of the KEEP methadone maintenance sample was still in treatment five to six months after release compared to 25 percent of the opioid withdrawal sample. Being in methadone treatment at post-release follow-up was associated with less illicit drug use, drug injection, re-offending, and illegal income.[31] The KEEP program is currently implementing a pilot buprenorphine maintenance therapy program for opioid dependence that refers patients upon release to physicians in the community who are certified to prescribe buprenorphine.

**Transitional Health Care Coordination: An Emphasis on Chronic Conditions and Education**

The work of Transitional Health Care Coordination (THCC) is a particularly good example of the emphasis and resources DOHMH is committing to the facilitation of transitional health care. The mission of THCC is to coordinate "health education and service delivery from incarceration to the community for all [New York City] inmates" with an emphasis on chronic health conditions.[32] Actual policy, however, is more comprehensive and includes addressing the health conditions of the inmate's family and friends and other members of the community who have been involved in the criminal justice system. The three goals of THCC are to:

1. Intervene with visitors and families to promote better access to health care services by reaching out to those at greater risk by increasing personal health awareness;
2. Increase community referral of those with chronic disease (e.g., heart disease, hypertension, diabetes, and uncontrolled asthma) as well as HIV/AIDS and STDs;
3. Improve screening, education activities, and follow-up consistent with Take Care New York (the health policy agenda of DOHMH).[33]

To accomplish these goals, THCC has more than 40 employees (e.g., health educators, patient care coordinators) who work in the jails and in community locations where

[30] Stephen Magura, Andrew Rosenblum, Carla Lewis and Herman Joseph, "The Effectiveness of In-jail Methadone Maintenance," *Journal of Druq Issues 23* (1993): 75-99.

[31] Ibid.

[32] New York City Department of Health and Mental Hygiene, *Transitional Health Care Coordination-2006*, available at www.nyc.gov/html/doh/html/hca/thcc.shtml (accessed November 9, 2007).

[33] New York City Department of Health and Mental Hygiene, *Take Care New York*, available at nyc.gov/html/doh/html/tcny/index.shtml (accessed November 9, 2007).

inmates and former inmates are likely to end up. These locations include Rikers Island, Manhattan House of Detention (The Tombs), Vernon C. Baines Center (The Barge), the Rikers Island Central Visitor Center, Queensboro Correctional Facility, New York City probation offices, two state parole offices, two courts, homeless shelters, and the DOHMH district health centers in Central Brooklyn and the South Bronx.

The THCC's main focus inside the facilities is to disseminate written health education materials to inmates and their families and to provide transitional health care planning for those with chronic health conditions. For the visitors and families of the inmates, THCC provides staff at the Central Visitor Center Health Station at Rikers Island. In 2006, approximately 200,000 visitors were provided with health information and materials. Nearly 9,000 of the visitors also received health screening, including nicotine replacement therapy, body mass index, blood pressure testing, and referrals to community programs.

The agency's post-release care coordination work falls under the umbrella of their Correction-Community Linkage Program where THCC field staff are located in the neighborhoods of high inmate return to provide follow-up on inmates who received THCC services while incarcerated or criminal justice-involved individuals who are likely to have been previously incarcerated. The activities of the Correction-Community Linkage Program centers around the following 10 core health issues promoted in *Take Care New York*, the health policy agenda of DOHMH:

1. Have a regular doctor or other health care provider
2. Be tobacco free
3. Keep your heart healthy
4. Know your HIV status
5. Get help for depression
6. Live free of dependence on alcohol and drugs
7. Get checked for cancer
8. Get the immunizations you need
9. Make your home safe and healthy
10. Have a healthy baby

A discharge kit in English and Spanish is available to all DOC inmates released from jail and contains the following: 1) a list of where to apply for free- or low-cost health insurance; 2) a threefold pamphlet listing DOHMH health clinics in all boroughs, with particular focus on areas of high inmate return, explaining that HIV and STD counseling and testing are free and confidential; 3) the *Take Care New York Passport to Your Health* brochure, which is a personal health record plan that fits in a wallet and can be used to chart medical care as well as to record the addresses of health care providers, medical information, and an emergency contract person (see Appendix D); 4) three latex male condoms with information on how to use them; and 5) a female condom, lubricant, and easy-to-read instructions on how to use it for the female inmate population.

**Community-Based Referrals to Medical Services**

THCC also coordinates health education and discharge-planning services for inmates with chronic diseases who are being released to the community. Referrals are made for diabetes, hypertension, and cardiovascular disease in particular, but any chronic disease or condition requiring longitudinal follow-up is appropriate for THCC involvement. Both detainee and sentenced inmates are eligible. THCC health educators receive many of their referrals electronically from the jail's computerized medical intake system and are first seen on day two of their incarceration. THCC provides the inmates with an orientation to citywide health facilities, an MTA MetroCard for transportation, a discharge medication prescription, and an aftercare letter for health services.

According to THCC Executive Director Alison Jordan, her bureau in 2006 had health education and discharge planning discussions with approximately 72,000 jail-based inmates. Of those, 2,081 inmates with chronic health conditions received a discharge plan with an appointment made for them in the community. Of that number, 872 were released from jail and seen by a community provider for medical care, substance abuse treatment, or other health-related services. THCC has developed both formal and informal relationships with health and human service agencies to meet the health needs of the inmates. THCC staff members make referrals to primary care physicians at Federally Qualified Health Centers and to substance abuse counselors and clinics that provide HIV and STD testing. In 2006, nearly 2,000 criminal justice-involved individuals (i.e., individuals with a history of incarceration) in the community received a health service assessment from THCC. Of these, 63 percent kept an appointment in the community for medical or health-related care, including substance abuse treatment, housing for people with HIV/AIDS, health insurance, and HIV testing.

**Referrals to Community-Based Non-Profits**

An important part of THCC's programs is the development of formal linkages with non-profit agencies providing reentry services. In 2006, more than 170 agencies had partnered to work with THCC, with nearly half signing memorandum of agreements (MOA) with THCC. The MOA formalizes what is expected of all partnering agencies that receive and work with incarcerated persons referred to them by THCC. Additionally, service providers under the MOA are required to refer former inmates to the HCAI's Bureau of Health Insurance Services to get them enrolled in managed care. Referrals made by the service providers must be confirmed to ensure the appointment was kept.

**Non Health-Related Discharge Planning**

At intake, all inmates complete the *New York City Department of Correction Discharge Planning Questionnaire,* which was developed and pilot tested by the Vera Institute of Justice and identifies employment, family, benefits, housing, health care, and substance abuse needs.[34] This screen allows discharge planners to determine the appropriate reentry strategies and follow-up services in the community for the inmates, even for those with short length of stays (see Appendix E).

**The Rikers Island Discharge Enhancement Project**

The Rikers Island Discharge Enhancement Project (RIDE) provides a comprehensive discharge plan to individuals who have a City sentence, regardless of their health needs. The main asset of this voluntary program is that it provides direct transportation to community services at discharge and 90 days of case management in the community after release. No more than 14 days prior to the date of discharge, a discharge plan is completed (see Appendix F). The following are the main components of RIDE:[35]

- Early screening assessments to determine the employment, substance abuse, housing needs, and history of the incarcerated person;
- Immediate access to transitional employment programs;
- Streamlined procedures for obtaining birth certificates and social security cards;
- Completion of Medicaid application before release; and
- Immediate connection to case management in the community.

The discharge plan categories include identification, treatment plan/needs, discharge planning needs/referrals made for substance abuse, housing assistance, family reunification assistance, education/employment, and provider information. Community-based service providers located at Rikers Island work with the inmates to encourage them to continue treatment and physically take them to their services in the community. The individualized discharge planning process includes the completion of a discharge planning screening form, gathering identification information, transportation from Rikers Island, referrals to service providers, and 90 days of after-jail case management related to addiction treatment, employment, and housing.[36] In fiscal year 2006, 4,764 inmates participated in the RIDE project,[37] representing a 73 percent increase in participation since 2004. Agencies working with these inmates are Samaritan Village Rikers Island Discharge Planning Project, the Osborne Association, Fortune Society, Women's Prison Association, Vera Institute of Justice, and the Center for Employment Opportunities.

[34] New York City Department of Corrections. *Discharge Planning Update* (New York, NY: 2005).

[35] Glen Martin, "Rikers Island Discharge Planning Initiative: A New York City Jail Reentry Model," *National HIRE Network News* 3 no. 8 (2005): 1-10.

[36] New York City Department of Corrections. *Discharge Planning Update* (New York, NY: 2005).

[37] New York City Council, *Fiscal Year 2007 Executive Budget Hearings, Committee on Finance jointly with Committee on Fire and Criminal Justice Services,* (New York, NY: May 2006).

These providers work under performance-based contracts in which full payment is only obtained when continual engagement for 90 days after release is achieved.

### Discharge Planning Support Centers

In addition to the RIDE project, the Rikers Island Discharge Planning Support Center at the Rose M. Singer Center for females and the Eric M. Taylor Center for sentenced males were established in 2006. The goal of the Centers is to connect inmates to public benefits to help facilitate their transition back to the community. Representatives of DOC, DOHMH, and DHS all have offices at the Centers. The Centers are open to all inmates and offer a variety of discharge services. For example, interviews for public benefits such as SSI/SSDI can be done in person, and Medicaid services are authorized before inmates are discharged.

In 2007, the Center for Urban Community Services (CUCS), with funding from the Robin Hood Foundation, opened two Single Stop sites on Rikers Island that operate within the Support Centers. The number of Single Stop sites has since grown to approximately 40, located throughout New York City. The sites offer low-income families individual legal and financial counseling. Inmates can request a Single Stop referral by asking their RIDE provider or a DOC staff member, by completing a referral form located in the law library or in their housing area, or by stopping by the Discharge Planning Support Center to request a referral form. The Single Stop sites include confidential benefits counseling, assistance in applying for public benefits electronically, legal advice on civil matters, rap sheet clean-up and counseling, and financial and credit counseling. Besides CUCS, the Legal Action Center, The Legal Aid Society, and Credit Where Credit is Due, Inc. provide staff for the Single Stop sites.

### Additional Discharge Planning Services

#### *Frequent Users*

New York City Administrative Code now mandates the identification of frequent users of city services. DOC defines frequent users as having at least four stays in DOC and four in Department of Homeless Services (DHS) shelters in the last five years. In 2004, an estimated 1,725 individuals were classified as frequent users, with 221 presently in the shelters and another 257 incarcerated at DOC.[38] Of that population, 331 were affiliated with Brad H. and another 1,377 had been served by Office of Alcohol and Substance Abuse Services (OASAS)-licensed facilities. This population is identified through an integrated electronic system in coordination with DHS. DOC and DHS electronically match their populations on a bi-monthly basis.[39]

[38] New York City Department of Corrections, *Official Plan as of 10/18/2005. Discharge Planning Action from May 2, 2005 Retreat* (New York, NY: 2005).

The Frequent User Service Enhancement (FUSE) program provides subsidized housing units and services to approximately 100 frequent user clients in an effort to provide this population stable housing.[40,41] The New York City Housing Authority provides Section 8 housing vouchers.[42] Bowery Residents Committee, Common Ground, Palladia/Samaritan, and Women's Prison Association have contracted with the FUSE clients to provide services to those receiving vouchers.[43]

### *Short Stayers*

The Center for Alternative Sentencing and Employment Services (CASES) operates a day custody program for offenders who have "three or more prior misdemeanor convictions and are not classified as Operation Spotlight defendants."[44] The object of the Day Custody Program is to provide ex-inmates "with the supportive services they need while eliminating the enormous expense to taxpayers for transporting these individuals to Rikers Island only to have them released a few days later."[45] Individuals are "sentenced to a ten-day term of intermittent imprisonment to be served during three eight-hour daytime periods."[46] The CASES day custody program is located at the Manhattan House of Detention. Inmates work and participate in programming during the day and go home at night.

## Day Custody Program

- Community Service: Participants perform community service within the DOC facility.
- Needs Assessment: Participants engage in a comprehensive needs assessment in the areas of substance abuse, mental health, health care, entitlements, employment, and housing.
- Treatment Readiness Counseling: For three days, participants receive onsite presentations by representatives from treatment programs in New York City. Program representatives offer immediate enrollment to interested participants.
- Barriers to Arrest & Convictions: Program addresses the barriers that participants with criminal histories face and how to successfully address these barriers.
- Discharge Plan & CASES Referral Network: Each participant receives a discharge plan that includes linkages to community-based treatment programs and employment, housing, mental health, and health care assistance. Two social service agencies have representatives working onsite with participants.

CASES (2006a). Day Custody Program. NY: Criminal Courts Programs.

[39] New York City Department of Corrections, *Discharge Planning Administrative Code 9* 127, 9-128, 9-129 Mandates and Operationalization (New York, NY: 2005).

[40] Cassi Feldman, "Frequent Fliers Grounded: New Housing for Homeless," *City Limits Weekly*, (December 19, 2005): 515.

[41] New York City Department of Corrections, *Official Plan as of 10/18/2005. Discharge Planning Action from May 2, 2005 Retreat* (New York, NY: 2005).

[42] New York City Department of Corrections. *Discharge Planning Update* (New York,. NY: 2005).

[43] New York City Department of Corrections, *Official Plan as of 10/18/2005. Discharge Planning Action from May 2, 2005 Retreat* (New York, NY: 2005).

[44] CASES, *Criminal Court/Community Service Programs: Day Custody Program,* available at www.cases.org/cssp_sub2.html (accessed on June 12, 2006); Operation Spotlight defendants, those who have at least three misdemeanor arrests within a 12-month period, are eligible for adjudication in specialized court hearing only Operation Spotlight cases.

[45] Ibid.

[46] Ibid.

[47] Ibid.

During the day they engage in "community service (within DOC facilities), treatment readiness counseling, discharge planning, and referrals to community and government service agencies."[47] This program enjoys a 90 percent completion rate.[48]

### *All Inmates*

All inmates have access to the 20 benefits boards located in the law libraries and counseling offices of each DOC facility. The boards provide written discharge-planning materials, including informational pamphlets and applications from the Human Resource Administration, Social Security Administration, Departments of Health and Mental Hygiene, Education, and Motor Vehicles, Veterans Administration, and Immigration and Naturalization. Flyers and palm cards for the city's telephone 311 system are also provided. A phone call to 311 will connect inmates post-release with discharge planning services. The 311 system is also used by family and friends of those incarcerated. The palm cards are available in English and Spanish, written in easy-to-understand language, and instruct the inmates to say "Jail Release Services" when the 311 operator answers the phone (see Appendix G).[49]

The following two sections of this report map the spatial distribution of inmates' residence in the five boroughs of the City and the geographic location of post-release service providers to help identify the availability and accessibility of services in communities of high inmate return.[50]

[48] New York City Department of Corrections, *Official Plan as of 10/18/2005. Discharge Planning Action from May 2, 2005, Retreat* (New York, NY: 2005).

[49] Ibid.

[50] The most common way to measure unmet needs according to Queralt and Witt is by determining the spatial availability and accessibility of services to a client, otherwise referred to as location. For this profile, the service availability is determined by the total number of services listed in separate health and human service databases at the borough and community district level. Service accessibility; the distance from point A (home address of released NYC DOC inmates) to point B (service provider) is measured using density maps. A density map uses shades of color to portray locations of heavier concentrations of services and or inmates; Magaly Queralt and Ann Dryden Witte Queralt, "Estimating the Unmet Need for Services: A Middling Approach," *Social Service Review* (December 1999): 522-559.

# SECTION 2:

## Inmates Released by the New York City Department of Correction in 2005

In order to aid in the analysis of the living arrangements of released inmates, DOC provided individual case data on the 77,735 inmates discharged from DOC in calendar year 2005. Of that total, 50,974 inmates returned to the City's boroughs in 2005. A sample of 40,684 inmates (80 percent) was geocoded and analyzed. The sample was selected based on the following criteria: 1) inmate had a known home address at the time of incarceration; 2) inmate was released to one of the City's five boroughs (i.e., Brooklyn, Bronx, Manhattan, Queens, or Staten Island); and 3) only the inmate's last discharge from DOC in 2005 was counted to avoid double-counting inmates. Among the 10,230 cases that were not geocoded, 2,584 cases were identified as homeless or living in an institution (Table 2.1).[51]

[51] The address to which an inmate expects to return is not available in NYC DOC's electronic data. Understanding the limitations, the address at admission is used as a proxy for released address. Other research has adopted this method, and studies have shown that neighborhood at admission is a reliable proxy for neighborhood of return. Available at www.urban.org/publications/311213.html - "Returning Home Illinois Policy Brief: Prisoner Reentry and Residential Mobility."

**Table 2.1: Living Arrangement of DOC-Released Inmates by Borough**

| | Brooklyn | % | Bronx | % | Manhattan | % | Queens | % | Staten Island | % | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total (after duplicates removed) | 16,716 | 100.0 | 13,147 | 100.0 | 10,627 | 100.0 | 8,773 | 100 | 1,711 | 100.0 | 50,974 |
| Matched Address | 13,445 | 80.4 | 10,435 | 79.4 | 8,458 | 79.6 | 7,000 | 79.8 | 1,346 | 78.7 | 40,684 |
| Unmatched Addess | 3,271 | 19.6 | 2,712 | 20.6 | 2,169 | 20.4 | 1,773 | 20.2 | 365 | 21.3 | 10,290 |
| Invalid Address | 2,827 | 16.9 | 2,208 | 16.8 | 717 | 6.7 | 1,559 | 17.8 | 303 | 17.7 | 7,614 |
| Homeless | 414 | 2.5 | 478 | 3.6 | 1,250 | 11.8 | 194 | 2.2 | 61 | 3.6 | 2,397 |
| Group Home | 0 | 0.0 | 2 | 0.0 | 1 | 0.0 | 0 | 0.0 | 0 | 0.0 | 3 |
| Psych Center | 0 | 0.0 | 0 | 0.0 | 58 | 0.5 | 0 | 0.0 | 0 | 0.0 | 58 |
| YMCA | 0 | 0.0 | 0 | 0.0 | 1 | 0.0 | 1 | 0.0 | 0 | 0.0 | 2 |
| HOTEL | 1 | 0.0 | 1 | 0.0 | 2 | 0.0 | 0 | 0.0 | 1 | 0.1 | 5 |
| Shelter | 21 | 0.1 | 12 | 0.1 | 63 | 0.6 | 4 | 0.0 | 0 | 0.0 | 100 |
| Correctional Facility | 0 | 0.0 | 1 | 0.0 | 11 | 0.1 | 0 | 0.0 | 0 | 0.0 | 12 |
| Salvation Army | 1 | 0.0 | 0 | 0.0 | 6 | 0.1 | 0 | 0.0 | 0 | 0.0 | 7 |
| Missing | 7 | 0.0 | 10 | 0.1 | 60 | 0.6 | 15 | 0.2 | 0 | 0.0 | 92 |

The dynamics that explain why some inmates use post-release services and others do not are complex. Mapping service needs against the availability and accessibility of services taps only one dimension of the reentry challenge.[52] Individuals can be geographically near a service and still not have their needs met due to a host of factors including space availability, service affordability, service quality, days and hours of service operation, the lack of culturally competent staff, and service restrictions based on gender, age, mental health status, or type of felony conviction. Nevertheless, service location does matter. According to Anderson, "more enabling resources (in the community) provide the means for use, and increase the likelihood that use will take place."[53]

This profile is intended to provide a visual tool for developing, assessing, and recommending post-release programs and services. For the first time, discharge planners will have access to maps that show where released inmates can go within their communities for medical and mental health needs. Ideally, in the near future, a discharge planner working with an HIV-infected inmate, for example, with computerized access to GIS maps of the five boroughs and all available services, could enter the released inmate's address, generate an on-screen map of the HIV/AIDS services nearest to where the inmate lives, identify the transportation routes to the service, and make this information available to the individual.

## Sources for Mapping Data

In order to determine the location and the degree to which post-release health and human services are available in the areas where former inmates live, it was necessary to compile information from a variety of sources, which are described below.

### *Mapping Health and Human Service Providers*

For an individual health and human service provider to be part of the mapping database, the service had to be listed in one of the following databases: 1) New York City prisoner reentry guidebooks published in 2005, 2) the directory of mental hygiene programs and services contracted with DOHMH, 3) the DOHMH Transitional Health Care Coordination Partner, or 4) the primary Rikers Island Discharge Enhancement (RIDE) service providers or a service provider that the RIDE partners use for referrals.

DOC discharge planners, correctional officers, and parole and probation officers typically rely on printed resource directories or "word of mouth" when referring inmates to post-release services. DOC discharge planners are trained to use Lopez's 2005 reentry guide, which provides information on community services.[54] In addition, the analysis included

[52] Anderson's behavioral health service utilization model identifies three characteristics that influence the use of services: (1) a person's predisposition to use of services based on demographic and socio-economic factors; (2) enabling factors that focus on the logistical aspect of service utilization, e.g. the availability and accessibility of service; and (3) the perceived or real need for services, which is typically articulated by the individual or a health care provider.

[53] Ronald M. Anderson, "Revisiting the Behavioral Model and Access to Medical Care: Does it Matter?" *Journal of Health and Social Behavior 36*, no. 1, (1995, p. 4): 1-10.

[54] New York City Department of Corrections, *Official Plan as of 10/18/2005. Discharge Planning Action from May 2, 2005 Retreat* (New York, NY: 2005).

the services listed in two other well-known New York City reentry guides: Likosky's *Connections* (2005), a published 167-page directory that is available at no charge to discharged inmates and is available in the Rikers Island Visit Center and at various New York public libraries, and the City's Commission on Human Rights' *Making it Happen & Staying Home* (Whitaker, 2005, 91 pages), which has been distributed throughout New York State correctional facilities, parole and probation offices, and various service organizations.[55]

**Figure 2.1: New York City Inmate Reentry Handbook Covers**

The listings of services from all three reentry guides were included because many DOC inmates are discharged without any post-release planning, and one of these three reentry guides may serve as their primary source of information as they return home. In addition, the reentry guides specifically target the inmate population, so any agency, organization, or program listed in these guides, one would assume, has acknowledged a willingness to work with former inmates. There is, however, a lack of continuity in the reentry services listed in the three reentry guidebooks. Only 28 of 277 agencies are listed in all three guides, suggesting that a discharge planner's knowledge of services may be only as good as the quality of the referral list he or she is using. As a result, the use of different service directories could contribute to the type and quality of services to which released inmates are referred.

Apart from the above reentry guides, the Transitional Health Care Coordination Partner List and the RIDE service provider list were compiled for the present project. Unlike the services listed in the reentry guidebooks, all service providers listed on the THCC partner list have been vetted to work with the released population and are used by THCC staff members when referring inmates to health services in the community. The RIDE service provider list was included to identify the primary referral services used by RIDE

[55] *Making it Happen & Staying Home* can also be obtained in English or Spanish by contacting 311, NYC's Government Services and Information Center.

providers as of October 2007. The list focuses on the following service types: housing, education, clothing, employment, and substance abuse treatment.

Although this project was interested in analyzing the geographic location of agencies that discharge planners and DOC staff use to refer the reentry population, an important aspect of the project was to map as many New York City health and human service agencies as possible. To that end, a database of all mental hygiene programs and services (i.e., chemical dependency, mental health, mental retardation services) in contract with the DOHMH during fiscal year 2004 was developed and analyzed as part of this project.

### *The DOHMH Medical Registry Database*

DOHMH is in the process of conducting an analysis of the health conditions of individuals who have cycled through DOC custody in recent years. To accomplish this, researchers will identify inmates and former inmates who appear on one or more of the various health and behavioral DOHMH registries (e.g., HIV/AIDS, STD, Hepatitis B, Hepatitis C, Tuberculosis, and Seriously and Persistently Mentally Ill), and in vital statistics (death) data. DOHMH has agreed to parse the results for inmates who were discharged from the DOC in calendar year 2005 and to share the results, which will then be used to supplement this report.[56] This data will be available for future analysis of this project.

## Analysis of Released Inmates and the Availability and Accessibility of Services

In addition to analyzing information on the availability and accessibility of service providers, this profile includes a map of the neighborhoods to which the released inmates in the sample would return. In 2005, 40,684 unique inmates were discharged from DOC to one of the City's boroughs. The released inmates were predominately male (89 percent); only 11 percent were female (see Table 2.8 in Appendix H). The mean age of the inmates was 34 and the median age was 33 (Table 2.8). Fifty-nine percent of the inmates identified their race as black, 20 percent other, 14 percent white, 6 percent unknown, 1 percent Asian and 0.2 percent American Indian (Figure 2.2, Map 2.2, and Table 2.8). Thirty-three percent identified their ethnicity as Hispanic. From prior research on inmate populations, one can infer that the majority of those who self-identified as other are Hispanic (Figure 2.3, Map 2.3, and Table 2.8).

[56] To comply with the HIPAA regulations protecting the confidentiality of health information, all data provided to us by the NYC DOHMH will be stripped of all identifiers more specific than United Hospital Fund's (UHF) zip code cluster level. There are 42 UHF neighborhoods in New York City compared to NYC's 59 community districts, 179 zip codes and 2, 216 Census Tracts. Each UHF is comprised of multiple zip codes, making it impossible to identify the diagnoses of an individual from these data.

**Figure 2.2: Race of DOC-Released Inmates by Borough**

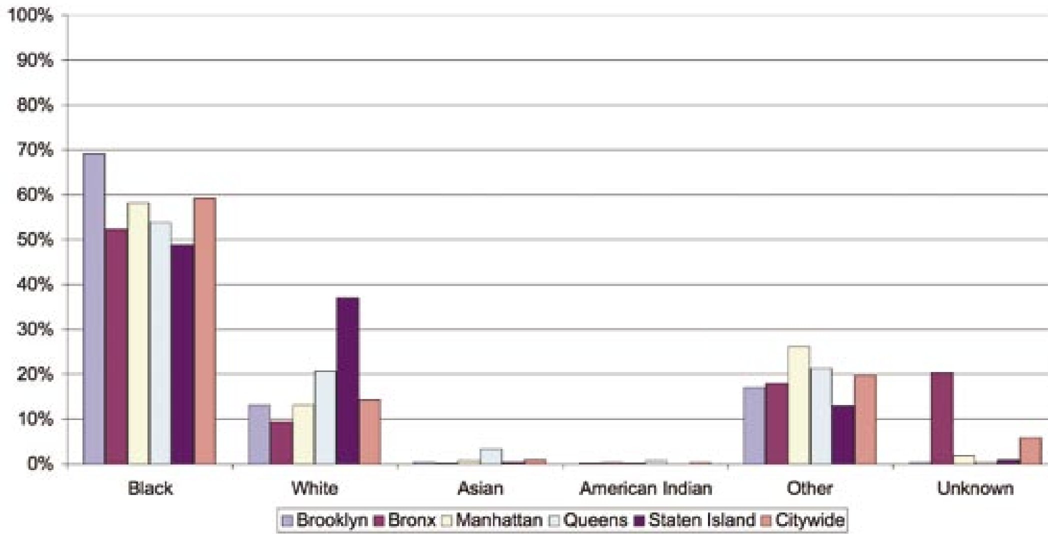
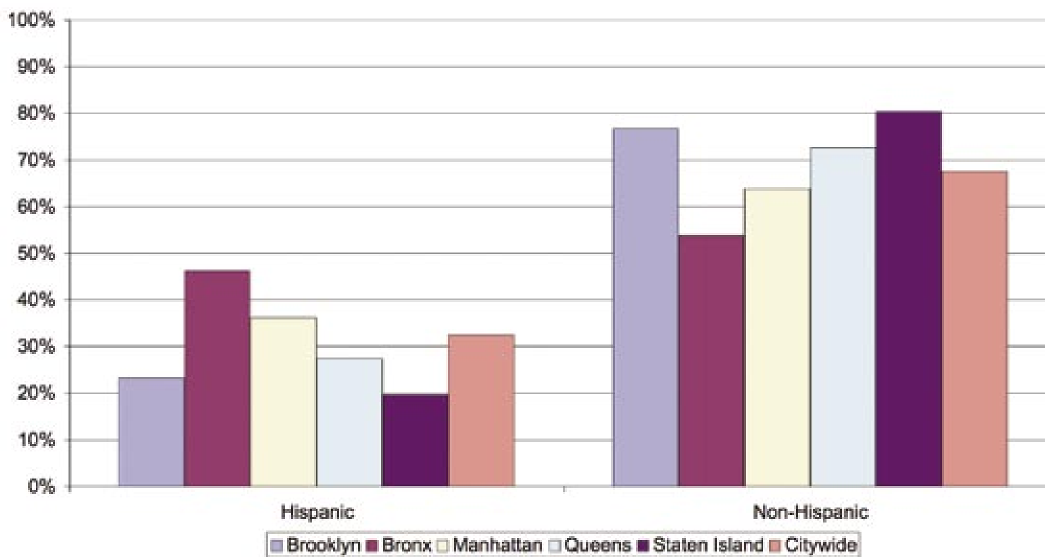
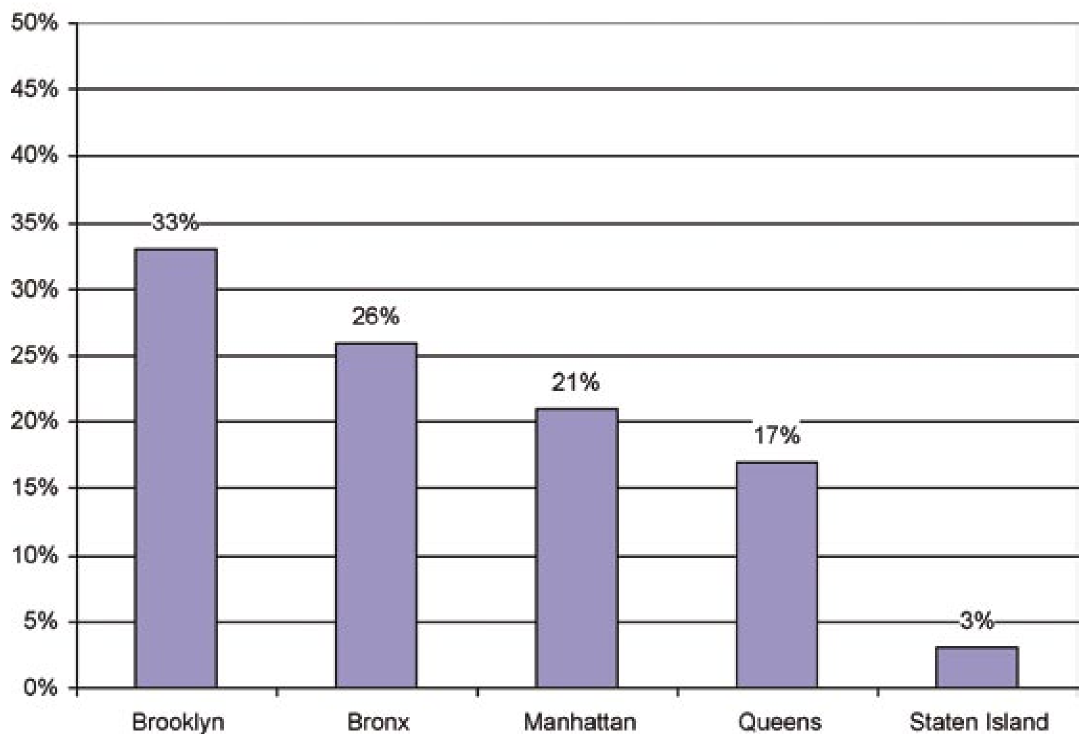



**Figure 2.3: Ethnicity of DOC-Released Inmates by Borough**



More than half (59 percent) of the inmates released identified living in Brooklyn or the Bronx at the time of intake (Figure 2.4).

**Figure 2.4: DOC-Released Inmates by Borough at Arrest**




A disproportionate number of inmates were released to specific communities within boroughs, defined as community districts for this profile, with six of 59 community districts housing 26 percent of the released inmates (see Table 2.2 in text and Tables 2.9 and 2.10 in Appendix H).[57] The darkest area in Map 2.1 identifies the 13 community districts with DOC inmate returns of 1,036 or more in 2005. Community districts with high inmate return typically also face other challenges including high rates of poverty and unemployment. Four

[57] The six community districts with the highest inmate return were districts 303 and 305 in Brooklyn; district 205 in the Bronx; district 412 in Queens; districts 110 and 111 in Manhattan.

community districts in New York City were identified as having the highest concentration of released inmates. The extreme deprivation of these communities is described below.

1. **Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights in Brooklyn**
   In 2005, 2,076 DOC inmates returned to Community District 303, which includes the neighborhoods of Bedford Stuyvesant, Tompkins Park North, and Stuyvesant Heights in Brooklyn. Community District 303, with a total population of 143,867, has a rate of 14 inmates per 1,000 residents. This community district has multiple challenges. Thirty-five percent of the residents live below the poverty line (less than $19,350 for a family of four), and 46 percent are on some form of public assistance (e.g., Temporary Assistance for Needy Families, SSI, Medicaid). The unemployment rate is 18 percent; 37 percent of the households are headed by females, and 19 percent of the population is foreign-born. It is certainly not uncommon for a neighborhood with limited resources such as this to experience high rates of released inmates.[58]

2. **Jamaica, South Jamaica, Hollis, St. Albans in Queens**
   In 2005, 1,774 DOC inmates returned to Community District 412 in Queens. Community District 412 has a rate of eight inmates per 1,000 residents and a total population of 223,602 residents. Thirty-five percent of its residents are foreign-born. Seventeen percent of the population live below the poverty line, 34 percent receive public assistance, 29 percent of the households are headed by females, and 11 percent of the residents are unemployed.

3. **Central Harlem in Manhattan**
   In 2005, 1,772 DOC inmates returned to Community District 110 in Central Harlem. Central Harlem has the highest rate of inmates per population (17 per 1,000 residents). Thirty-seven percent of its 107,109 residents live below the poverty line, and 45 percent receive public assistance. Females head 30 percent of the households, 18 percent of the residents are unemployed, and 18 percent are foreign-born.

4. **Morris Heights, University Heights, Fordham, Mt. Hope in Bronx**
   In 2005, 1,515 DOC inmates returned to Community District 205 in the Bronx. With a total population of 128,313 (35 percent of whom are foreign-born), the rate of released inmates is high at 12 per 1,000 residents. Forty-one percent of the residents of the district are impoverished, 58 percent receive public assistance, and 40 percent of the households are headed by females.

[58] Eric Cadora, Mannix Gordon, and Charles Swartz, *Criminal Justice and Health and Human Services: An Exploration of Overlapping Needs, Resources, and Interests in Brooklyn Neighborhood* (Washington, DC: The Urban Institute, 2002).

**Table 2.2: Top Quartile of Community Districts with Highest Number of DOC-Released Inmates**

| Inmate Return by Community District in Descending Order of Frequency | Frequency | % | Cumulative % | Percent Persons Below Poverty Level | Unemployment Rate 16 years and older |
|---|---|---|---|---|---|
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights (BK) | 2,076 | 5.1 | 5.1 | 35.1 | 18.0 |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (QN) | 1,774 | 4.4 | 9.5 | 16.7 | 10.8 |
| 110 Central Harlem (MHN) | 1,772 | 4.4 | 13.8 | 36.6 | 18.4 |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 1,768 | 4.3 | 18.2 | 33.2 | 16.3 |
| 111 East Harlem (MHN) | 1,617 | 4.0 | 22.1 | 36.9 | 17.1 |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 1,515 | 3.7 | 25.9 | 41.4 | 20.1 |

Thirteen community districts have rates higher than 10 inmates per 1,000 residents; six of these districts are located in the Bronx, five in Brooklyn, and two in Manhattan (Table 2.3). Community District 412 in Queens was the only location with a high number of inmates that did not have a rate of 10 inmates or more per 1,000 residents. This is attributed to the high population base in Community District 412.

**Table 2.3: Community Districts with the Highest Rate of DOC-Released Inmates**

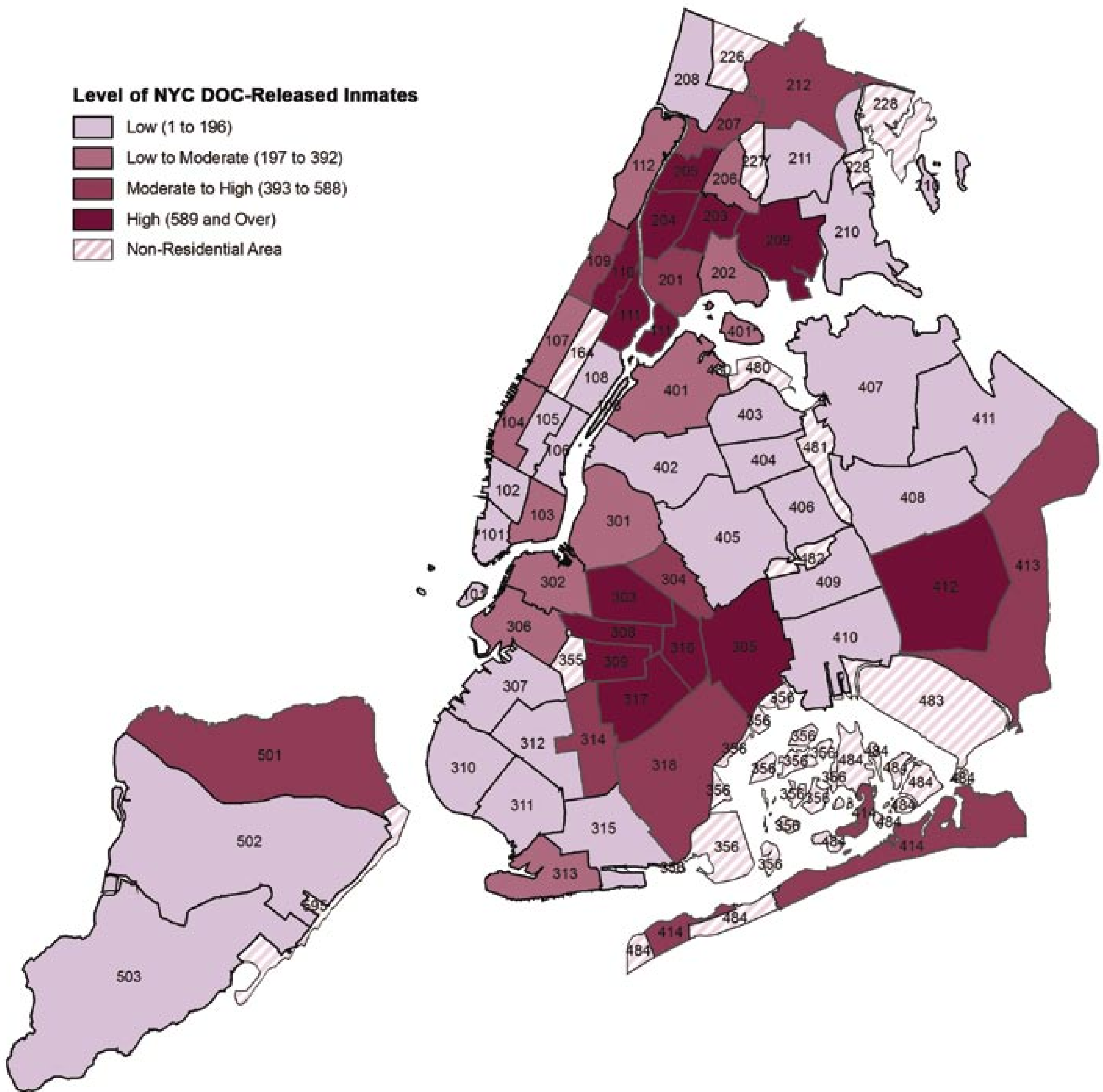
| Community Districts | Inmate Population | Rate per 1,000 |
|---|---|---|
| 110 Central Harlem (MHN) | 1,772 | 17 |
| 316 Ocean Hill, Brownsville (BK) | 1,338 | 16 |
| 111 East Harlem (MHN) | 1,617 | 14 |
| 201 Mott Haven, Melrose, Port Morris (BX) | 1,110 | 14 |
| 202 Hunts Point, Longwood (BX) | 660 | 14 |
| 203 Melrose, Morrisania, Claremont, Crotona Park East (BX) | 982 | 14 |
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights (BK) | 2,076 | 14 |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 1,515 | 12 |
| 206 East Tremont, Bathgate, Belmont, West Farms (BX) | 813 | 11 |
| 304 Bushwick (BK) | 1,166 | 11 |
| 308 Crown Heights, Prospect Heights, Weeksville (BK) | 1,040 | 11 |
| 204 Highbridge, Concourse (BX) | 1,392 | 10 |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 1,768 | 10 |

## Map 2.1: DOC-Released Inmates by Community District

**Level of NYC DOC-Released Inmates**

- Low (1 to 345)
- Low to Moderate (346 to 690)
- Moderate to High (691 to 1,035)
- High (1,036 and Over)
- Non-Residential Area

**Map 2.2: DOC-Released Non-Hispanic, Black Inmates by Community District**



**Map 2.3: DOC-Released Hispanic Inmates by Community District**

**Level of NYC DOC-Released Inmates**

- Low (1 to 112)
- Low to Moderate (113 to 224)
- Moderate to High (225 to 336)
- High (337 and Over)
- Non-Residential Area

### Criminal Justice Characteristics of the Released Inmates

Sixty-one percent of the DOC inmates in our sample were pretrial detainees, 37 percent were individuals with misdemeanor or felony convictions sentenced to one year or less in a DOC facility, and two percent were parole violators awaiting revocation hearings (see Table 2.5 in Appendix H).[59] Thirty-two percent of the inmates' top charges were for drug-related offenses (see Table 2.4).

The length of stay ranged from less than one day to 336 days in 2005. The average length of stay was 21 days, with 29 percent discharged within three days, 43 percent released between four and 30 days, and 18 percent incarcerated for more than 31 days (see Table 2.5 in Appendix H and Figure 1.1 in Section I). Detainees had the shortest length of stay at 14 days, followed by sentenced inmates (30 days) and parole violators (44 days) respectively. For those inmates with a classification score[60] (i.e., one or greater), the mean score for sentenced inmates was 5.61, compared to 6.43 for detainees and 11.1 for parole violators. Citywide, 82 percent of the inmates were classified in the low-risk range (<11 points) with 18 percent classified as high-risk offenders. Compared to the citywide average, high-risk offenders are overrepresented among inmates released to the Bronx, Manhattan, and Brooklyn (see Table 2.5 in Appendix H and Figure 2.7).

**Table 2.4: Top Count Charges of DOC-Released Inmates**

| Top Count Charge | % of total |
|---|---|
| (N=77,736) | |
| Drug Misdemeanor | 16% |
| Drug Felony Sale | 10% |
| Misdemeanor Larceny | 7% |
| Other Felonies | 6% |
| Misdemeanor Assault | 6% |
| Drug Felony Possession | 6% |
| Robbery | 5% |
| Warrants/Holds | 4% |
| Vehicular | 3% |
| Weapons | 3% |
| Violations | 3% |
| Assault | 3% |
| Loiter/Prostitution | 2% |
| Grand Larceny | 2% |
| Burglary | 2% |
| Other Sexual Offenses | 1% |
| Murder/Attempted Murder/ Manslaughter | 1% |
| Rape/Attempted Rape | 1% |
| Other Misdemeanor | 18% |

[59] This data did not include the number of inmates who were state prisoners with court appearances in NYC or newly sentenced felons awaiting transportation to New York state correctional facilities. To safeguard privacy, we report aggregate level data on the highest conviction charge at admission for those discharged in 2005. The top count charge data includes all inmates released from DOC in 2005.

[60] Classification scores are based on criminal justice characteristics (e.g., severity of current charge, history of prior convictions and history of escape) and inmate's age. The total scores are grouped into four risk categories: low (0-5), low-medium (6-10), high-medium (11-16) and high (+17).

**Figure 2.5: DOC Inmate Status at Release**

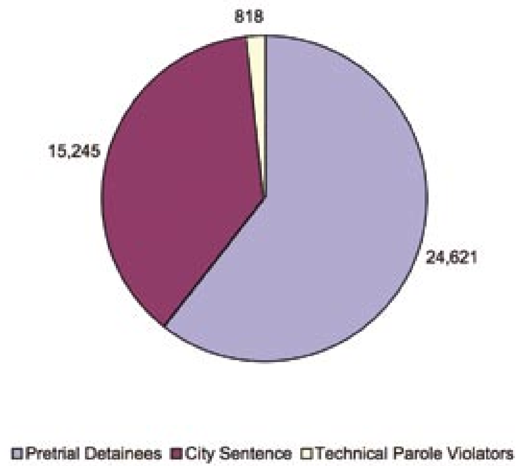
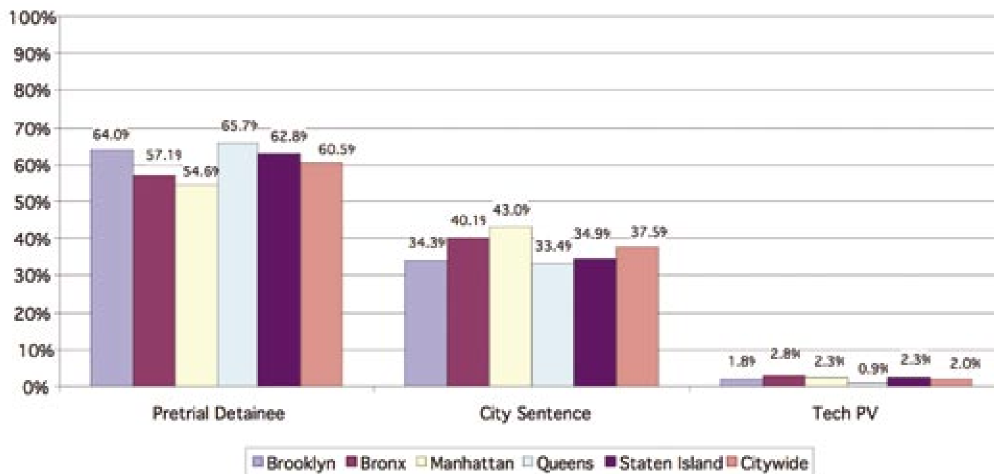
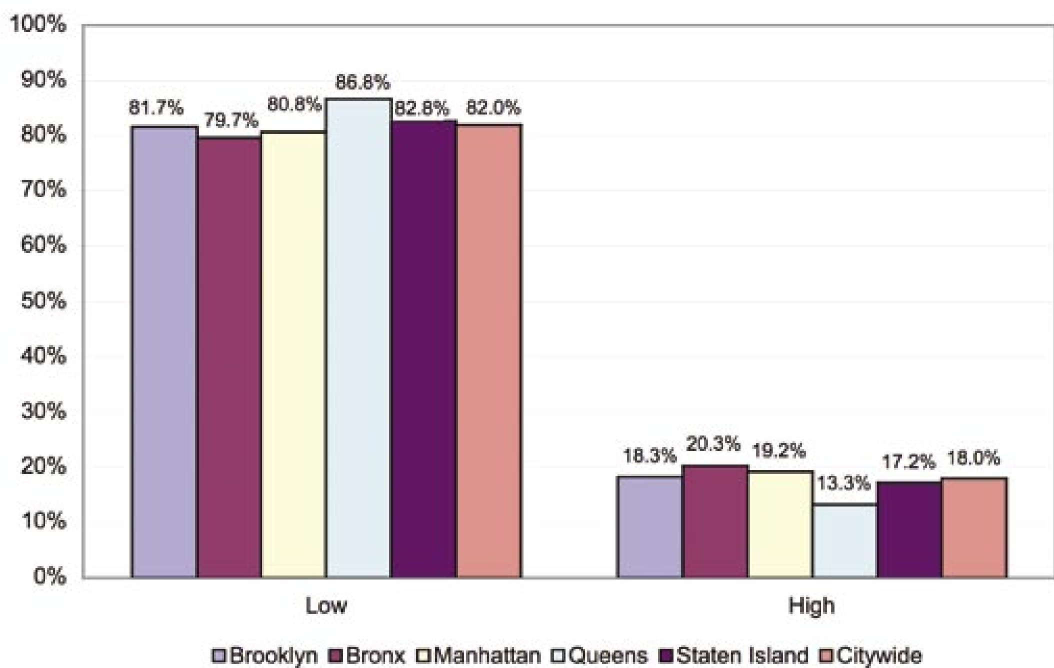



**Figure 2.6: DOC Inmate Status at Release by Borough**



Inmates who have a city sentence are the largest group who are provided a comprehensive discharge plan. This is because the process of discharge planning is time consuming and not easily accomplished without resources devoted to it and a predictable length of stay. The need for discharge planning is no less for pretrial detainees, however. Sixty-one percent of the inmates discharged in 2005 were pretrial detainees with demographic and criminal justice characteristics similar to the city sentence and technical violating discharges (see Table 2.6 in Appendix H). Pretrial detainees' self-reported drug use was 10 percent lower than the city-sentenced inmates, but their classification scores were significantly higher. Twenty-eight percent of the detainees were incarcerated for more than seven days, allowing for some, if limited, discharge planning.[61]

**Figure 2.7: DOC-Released Inmates and Their Classification Scores**




[61] We recognize, however, that discharge planning for pre-trial detainees is more difficult than working with a sentenced population because of their unpredictable length of stay in the facility.

**Health and Related Needs of Released Population: 2005**

Only 20 percent (7,991) of the inmates self-identified as drug users at intake.[62] DOC data indicate that between 70 and 80 percent of the inmates are defined as substance abusers, so the data clearly underreport inmate drug use. The median age of self-reported drug users was 39, with more of the females (33 percent) self-reporting drug use than the males (18 percent). Of those who self-reported drug use at admission, 44 percent were black. A smaller percentage of drug users — 21 percent — were white. One should note, however, that only 15 percent of black inmates self-reported drug use, compared to 29 percent of white inmates. American Indians (five percent) and Asians (six percent) had the lowest rates of self-reported drug use. Two thirds of the drug users lived in Brooklyn (33 percent) or the Bronx (32 percent) at the time of intake; 19 percent had a Manhattan address, with 14 percent and three percent in Queens and Staten Island respectively. Map 2.4 and Table 2.7 in Appendix H clearly identify how certain community districts have higher rates of self-reported drug users than other areas.

Parole violators had the lowest rate of self-reported substance abuse (3.1 percent), compared to 49 percent of sentenced inmates and 48 percent of detainees. The difficulty of providing effective substance abuse treatment during incarceration is understandable given that 26 percent of the drug users were discharged within three days, another 50 percent were released between four and 30 days, and just 24 percent were incarcerated for more than 31 days.

[62] Self-reported drug use is written on the Inmate Detention Record (Form #239). The drug use questions are as follows:

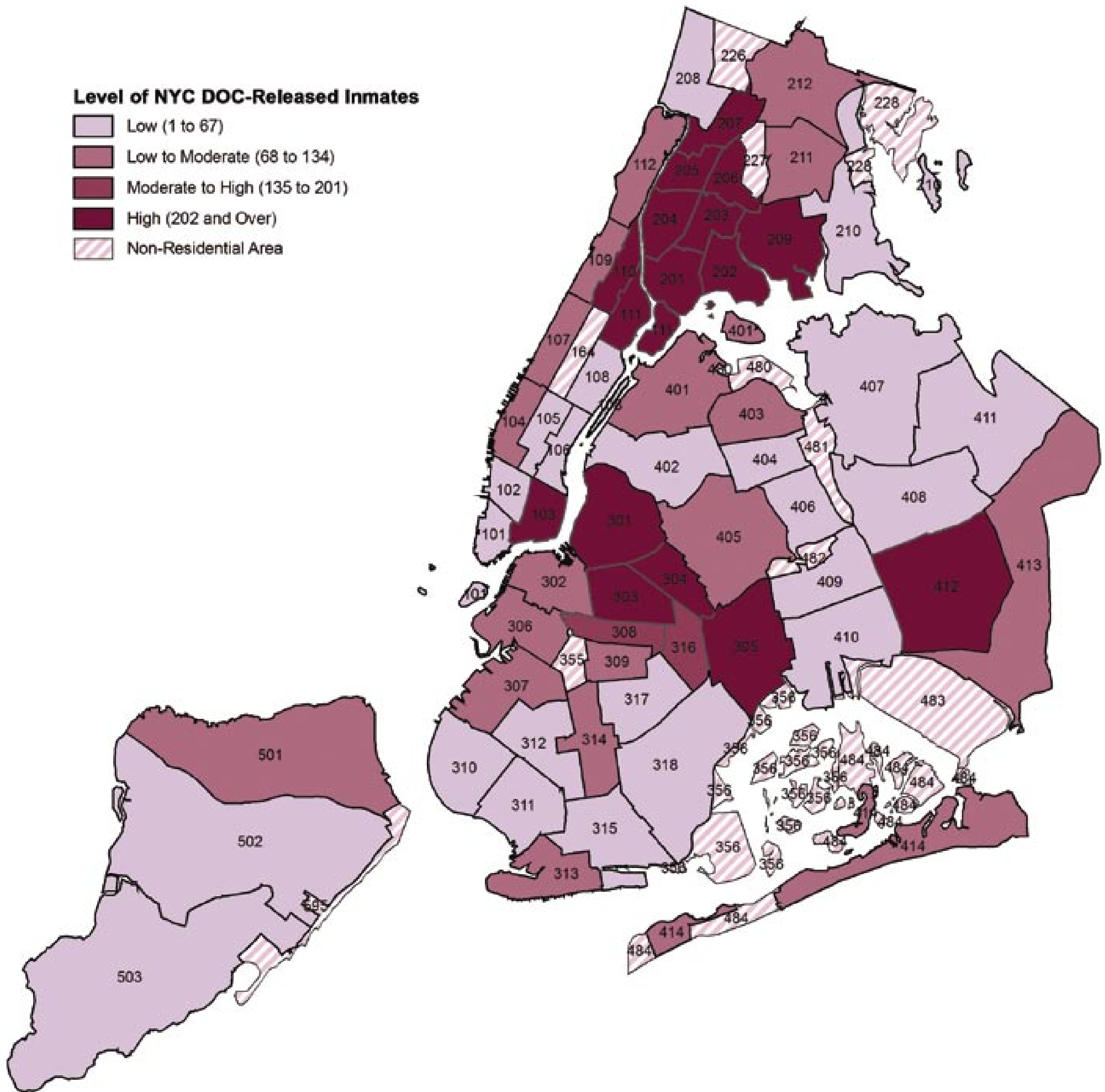
Drug Abuser?
(If Yes, specify):
Yes/No _____________

Alcohol Abuser: Yes/No

Detox: Yes/No

There is a section on Form # 239 where the Officer is asked to make note of any signs of the following; dilated pupils, needle tracks, staggering, tattoos, puncture marks, scars, signs of trauma, other ____

**Map 2.4: DOC-Released Drug-Using Inmates by Community District**



# SECTION 3:

## Mapping Existing Service Providers: Where Spatial Gaps Exist

This section maps the distribution of service providers that released inmates are likely to use in each borough and community district. It does not purport to be a census of all health and human service providers in each borough or community district. No single database of addresses identifying all services for residents, or specifically for released inmates, is known to exist. Therefore, services in the four database lists used in this report (DOHMH, THCCP, RIDE and Reentry Guidebooks) function as a proxy measure of the availability and accessibility of services in each community.

**Distribution of Services for Released Inmates**

Map 3.1 identifies the location of services from all the directories: Rikers Island Discharge Enhancement (RIDE) services are identified as purple triangles, Transitional Health Care Coordination Partner (THCC) services are green diamonds, reentry guidebook services are red squares, and New York City Department of Health and Mental Hygiene (DOHMH) services are marked as blue circles. Maps 3.2 thru 3.5 represent the four individual service directories with special attention on Map 3.2 to identifying the three types of mental hygiene categories of services contracted with DOHMH. Mental health services contracted with DOHMH are identified as green stars, mental retardation and developmental disabilities are blue squares and chemical dependency programs and services are red circles. Green diamonds represent THCC services (Map 3.3), and red squares are services listed in the reentry guidebooks (Map 3.4). There are five RIDE service categories (Map 3.5): red star for clothing, purple square for education, blue star for employment, green pentagon for housing, and red circle for substance abuse.

Disparities can be observed at the community district level (see Tables 3.1 through 3.4 in Appendix I for the number of services listed in each database by community district), where it becomes apparent that there is a disproportionate number of available services in certain districts. Two Manhattan community districts (105, 102), another on Staten Island (501), and one in Brooklyn (302) account for approximately 25 percent of the mental hygiene services contracted with DOHMH. Four community districts (105, 110,

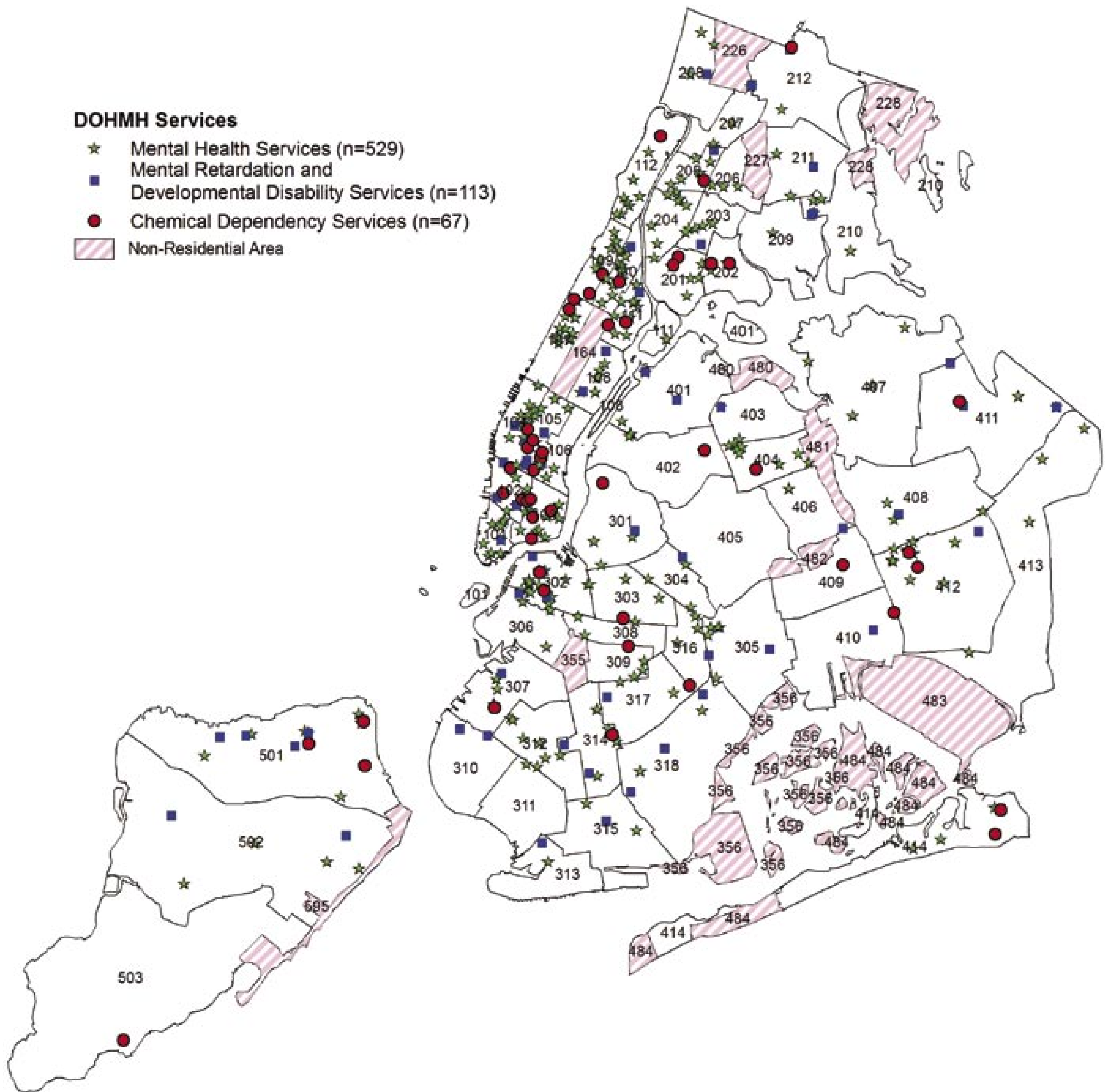
111, and 412) also account for 25 percent of the services on the THCC partner referral list and the same Manhattan community districts (105, 110, 111) account for 30 percent of services listed in the reentry guidebooks. Services located in community districts 111, 105, 201, 412, and 302 account for 27 percent of the RIDE services. For further visual clarification, the following maps identify the address locations separately for services and programs identified in each of the four databases. Without exception, the majority of available services are located in Manhattan.

**Map 3.1: Type of Services in New York City by Community District**

**Type of Services**

- RIDE Services (n=411)
- Transitional Health Care Services (n=280)
- Services in Reentry Guidebooks (n=465)
- Department of Health and Mental Hygiene Services (n=709)
- Non-Residential Area

**Map 3.2: DOHMH Services by Community District**



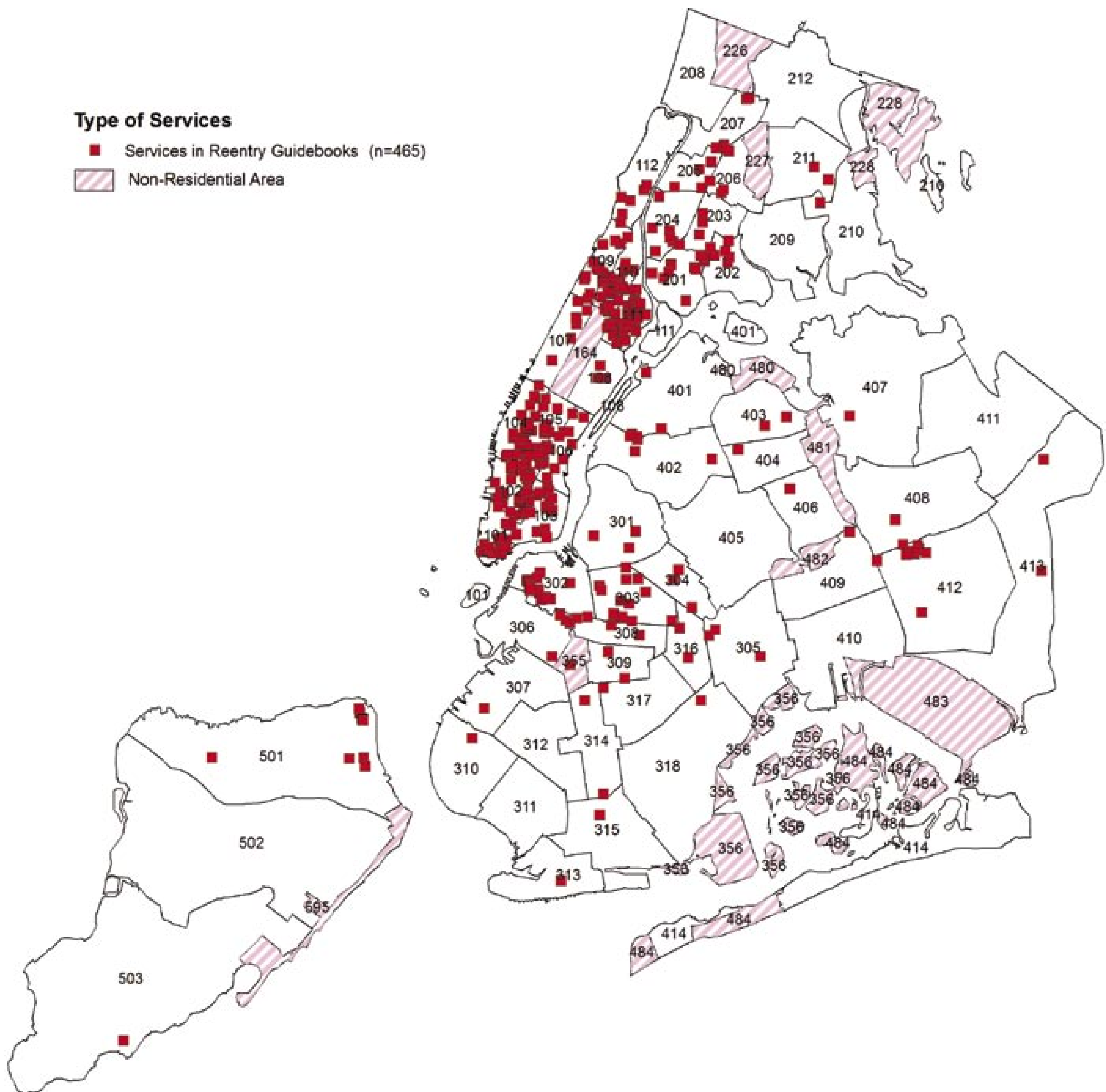
## Map 3.3: Transitional Health Care Services by Community District

**Type of Services**

Transitional Health Care Services (n=280)

Non-Residential Area

**Map 3.4: Reentry Guidebook Services by Community District**



**Map 3.5: Rikers Island Discharge Enhancement Services by Community District**

**Type of Services**

- Clothing (n=1)
- Education (n=3)
- Employment (n=2)
- Housing (n=37)
- Substance Abuse (n=368)
- Non-Residential Area

## Gaps in Post-Release Services

The maps reveal that not all returning inmates have equal access to services. Health and human services appear to be available for inmates released to Manhattan, though this may be a function of the quality of each database (Table 3.5). Meanwhile, services listed in Brooklyn, the Bronx, and, at times, in Queens are underrepresented, based on the percent of released inmates to those boroughs.

The findings also support recent data from DOHMH on the unmet chemical dependency service needs in the city. According to DOHMH, unmet needs are the "ratio of current service capacity to estimated needed service capacity."[63] According to DOHMH, Manhattan and the Bronx are the only two boroughs with an over-capacity of outpatient chemical dependency services. Methadone treatment services are at under-capacity levels in all five boroughs, though Manhattan has the greatest capacity of methadone treatment needs met at 82 percent, compared to the Bronx (63 percent), Brooklyn (45 percent), Staten Island (40 percent), and Queens (30 percent).

**Table 3.5:
The Number of Health and Human Services in New York City by Borough**

| Services by Borough | Released Inmates | | Mental Hygiene Services Contracted with DOHMH | | THCC Partner Listings | | Reentry Guidebook Listings | | RIDE Primary Referral Sources | |
|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % |
| Brooklyn | 13445 | 33.0% | 146 | 21.5% | 57 | 20.4% | 78 | 16.8% | 104 | 25.3% |
| Bronx | 10435 | 25.6% | 92 | 13.5% | 61 | 21.8% | 50 | 10.8% | 80 | 19.5% |
| Manhattan | 8458 | 20.8% | 257 | 37.8% | 116 | 41.4% | 291 | 62.6% | 154 | 37.5% |
| Queens | 7000 | 17.2% | 126 | 18.6% | 32 | 11.4% | 34 | 7.3% | 51 | 12.4% |
| Staten Island | 1346 | 3.3% | 58 | 8.5% | 14 | 5.0% | 12 | 2.6% | 22 | 5.4% |
| Total | 40684 | 100.0% | 679 | 100.0% | 280 | 100.0% | 465 | 100.0% | 411 | 100.0% |

[63] New York City Department of Health and Mental Hygiene, *Local Governmental Plan Chemical Dependency Services-2007*, available at www.nyc.gov/html/doh/downloads/pdf/basas/basas-localgovt-plan-2007.pdf (accessed on November 9, 2007).

The spatial mismatch of services listed in the directories becomes more apparent in the individual community district level analysis (Maps 3.7, 3.9, 3.11, 3.13, 3.15 in this section and Table 3.7 in Appendix I). For example, only 26 percent of the mental hygiene services contracted with DOHMH are located in the 14 community districts where approximately half the inmates return. This is in comparison to 38 percent of the reentry guidebook listings, 45 percent of the THCC partner listings, and 38 percent of the RIDE listings. Additionally, some community districts have very few services listed in the databases, and the services that are listed are not consistent in each database.

The profile of borough locations for mental hygiene services contracted with DOHMH shows that 46 percent of the community districts with high rates of released inmates self-reporting drug use do not have access to city-contracted chemical dependency services (see Tables 3.6 below and 3.9 in Appendix I). One limitation of the DOHMH data is that it does not include programs and services funded and/or operated by New York State.[64] Nevertheless, discharge planners rely primarily on these databases to connect inmates with substance abuse services, so it is reasonable to assume that they are the exclusive source of information used when making referrals.

**Table 3.6: Chemical Dependency, Mental Health, and Mental Retardation Programs and Services Contracted with DOHMH by Borough**

| Services by Borough | Released Inmates | | DOHMH Chemical Dependency Service Addresses | | Mental Health | | Mental Retardation and Developmental Disabilities | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| Brooklyn | 13445 | 33.0% | 8 | 12.1% | 115 | 22.7% | 23 | 21.7% |
| Bronx | 10435 | 25.6% | 7 | 10.6% | 70 | 13.8% | 15 | 14.2% |
| Manhattan | 8458 | 20.8% | 32 | 48.5% | 194 | 38.3% | 31 | 29.2% |
| Queens | 7000 | 17.2% | 11 | 16.7% | 95 | 18.7% | 20 | 18.9% |
| Staten Island | 1346 | 3.3% | 8 | 12.1% | 33 | 6.5% | 17 | 16.0% |
| Total | 40684 | 100.0% | 66 | 100.0% | 507 | 100.0% | 106 | 100.0% |

[64] A preliminary analysis of the 374 Substance Abuse and Mental Health Services Administration (SAMHSA) drug and alcohol abuse treatment programs in New York City and licensed by the New York State Office of Alcoholism and Substance Abuse Services confirms that Manhattan has the highest concentration of services (40 percent), followed by the Bronx and Brooklyn (each at 21 percent), Queens (13 percent), and Staten Island (6 percent).

**Density of Inmates and Services in Brooklyn**

Maps 3.6 (previous page) and 3.7 (page 46) display areas of released inmates and social services where density values for each are the greatest compared to other areas in Brooklyn. While inmates, for example, may live in any community district in Brooklyn, the majority are concentrated in the shaded purple areas of the maps. The same is true of social services identified by zones of black, blue, orange, and green in map 3.7. The map identifies areas of accessibility and inaccessibility of services for inmates released to Brooklyn. Community District 304 (Bushwick) in Brooklyn is an example of the mismatch of services: a high concentration of inmates live there, but there are few available services. For District 304, the THCC partner lists three services: Damon House (providing residential treatment), DOHMH's TB Evaluation & Treatment Clinic, and Builders for the Family and Youth (offering recreation programs). The reentry guidebooks also list DOHMH's TB Evaluation & Treatment Clinic, as well as Family Services Network of New York and Make the Road for Walking (a legal services program). The DOHMH mental hygiene directory lists three mental health services: Coalition for Hispanic Family Services (adult clinic treatment), Institute for Community Living (case management) and St. Christopher-Tillie (respite care). The primary referral resources for RIDE list seven services in district 304: five housing (Bernard's House, Alta House [three locations], and Today is a Good Day) and two substance abuse services (Addiction Research and Treatment and Damon House).

Another problem area is Community District 303 (Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights) in Brooklyn, which accounts for five percent of the known drug users. The primary referral list for RIDE lists three substance abuse services (New York Therapeutic Communities, Woodhull Medical/Mental Health Center, and Kingsboro Addiction Treatment Center). According to the DOHMH directory, the Brooklyn USA Athletic Association, which focuses on youth education intervention/information and referrals, is the only chemical dependency service contracted by the DOHMH. Both the THCC and reentry guidebooks list Serendipity, a community-based residential program for men and women, primarily for individuals in the criminal justice system who have a substance abuse problem, in District 303.

**Map 3.6: Borough of Brooklyn – Density of DOC-Released Inmates**

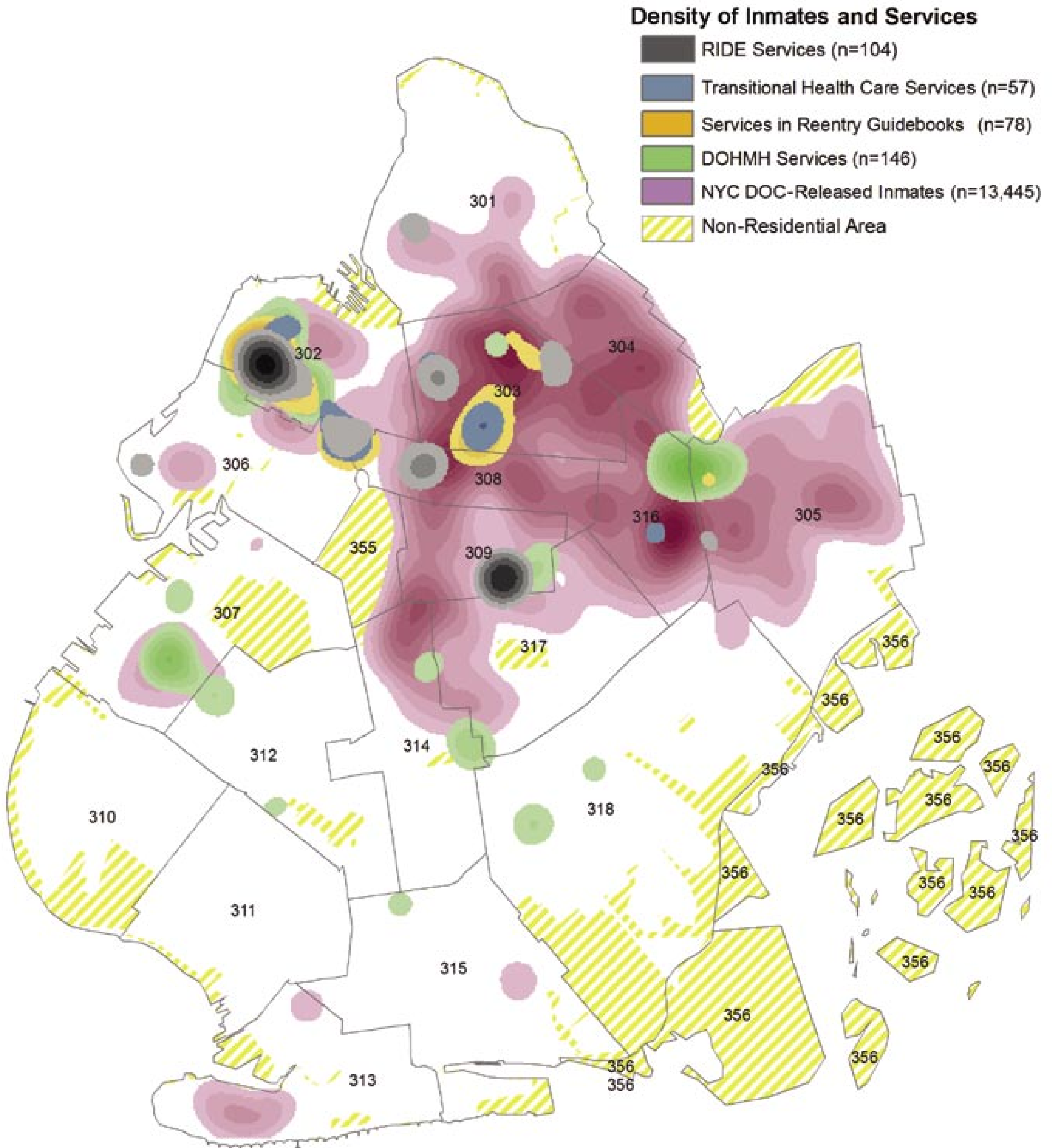
Density of Inmates

NYC DOC-Released Inmates (n=13,445)

Non-Residential Area

301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
355
356

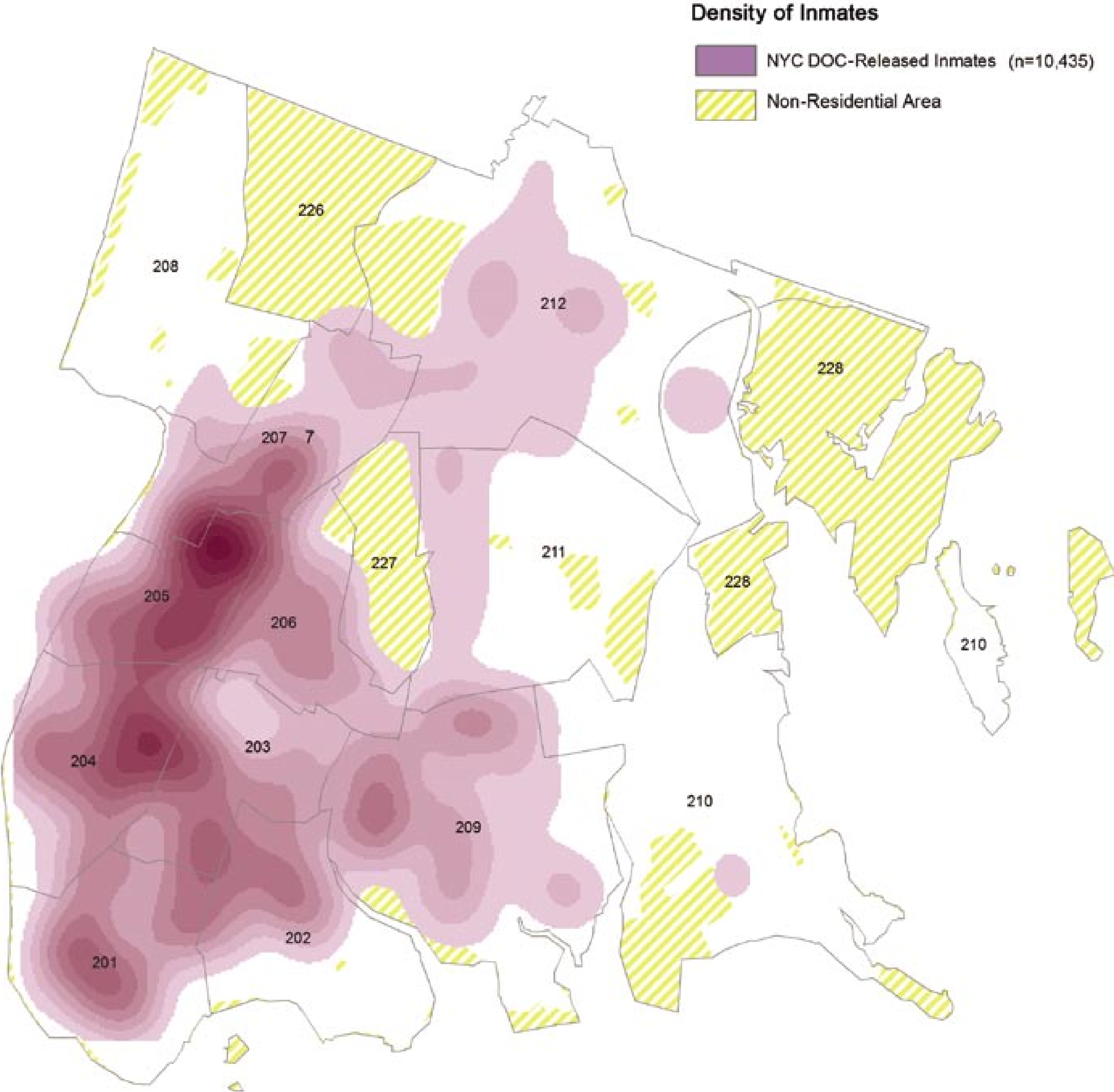
**Map 3.7: Borough of Brooklyn – Density of DOC-Released Inmates and Four Services by Community District**



### Density of Inmates and Services in the Bronx

The spatial mismatch of services is also apparent in the Bronx. Maps 3.8 and 3.9 reveal that the majority of services are clustered in Community Districts 201 through 205. Yet inmates released to Districts 207, 209, 211, and 212 live in areas where social services are not readily available. Another example of this disparity is Community District 209 (Soundview, Castle Hill, Union Port, Parkchester) in the Bronx, where 1,355 DOC inmate returned in 2005. Community District 209 has only one mental health service listed in th DOHMH database (New Era Veterans), one primary care service in the THCC partner list (Soundview Community Health Service), and one substance abuse service in the RIDE referral list (Albert Einstein College of Medicine of Yeshiva University). The reentry guidebooks list no services at all in this high inmate return community district.

**Map 3.8: Borough of Bronx – Density of DOC-Released Inmates**



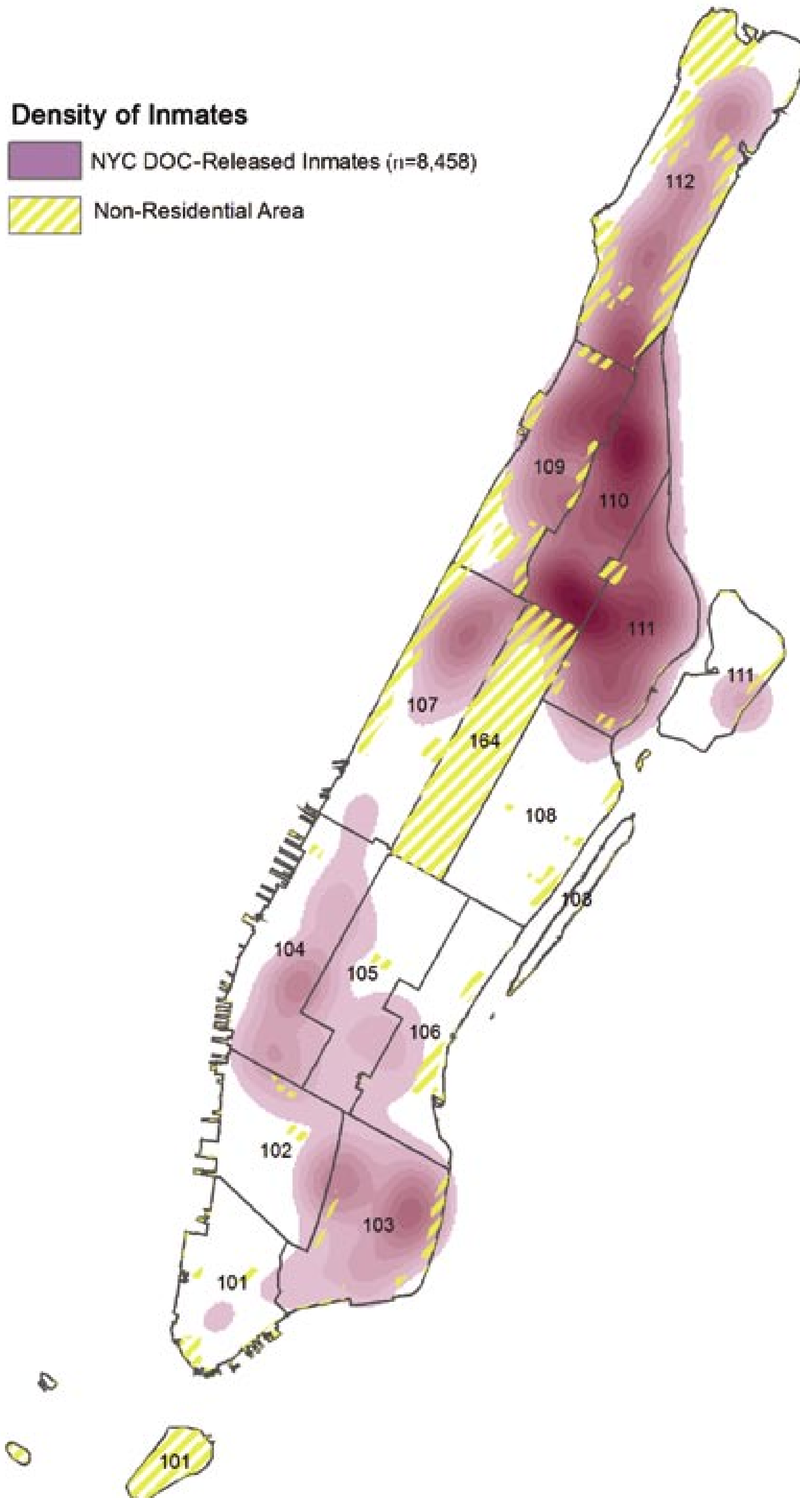
**Map 3.9: Borough of Bronx — Density of DOC-Released Inmates and Four Services by Community District**

Density of Inmates and Services

- RIDE Services (n=80)
- Transitional Health Care Services (n=61)
- Services in Reentry Guidebooks (n=50)
- DOHMH Services (n=92)
- NYC DOC-Released Inmates (n=10,435)
- Non-Residential Area

226
208
212
228
207
7
227
211
205
206
226
210
204
203
209
210
202
201

**Map 3.10: Borough of Manhattan – Density of DOC-Released Inmates**




## Density of Inmates and Services in Manhattan

Maps 3.10 and 3.11 confirm that the location of social services is more evenly distributed throughout Manhattan. Inmates released to Manhattan have a higher rate of availability and accessibility of services compared to those released in the Bronx and Brooklyn. Even in Manhattan, however, the clustering of services is apparent in certain community districts that are not necessarily where the highest number of inmates are released. For example, services located in Community District 102 (Greenwich Village, Noho, Soho, Little Italy) are overrepresented in each database compared to the 0.5 percent of inmates (n=209) who in 2005 returned to the district. Seven percent of services listed in the reentry guidebooks (n=32) have a 102 community district address, compared to six, four, and two percent respectively for services listed in the DOHMH mental hygiene (n=43), THCC (n=11), and RIDE (n=7) databases.

**Map 3.11: Borough of Manhattan – Density of DOC-Released Inmates and Four Services by Community District**

Density of Inmates and Services

- RIDE Services (n=154)
- Transitional Health Care Services (n=116)
- Services in Reentry Guidebooks (n=291)
- DOHMH Services (n=257)
- NYC DOC-Released Inmates (n=8,458)
- Non-Residential Area

112 109 110 111 111 107 164 108 108 104 105 106 102 103 101 101

### Density of Inmates and Services in Queens

Maps 3.12 and 3.13 of Queens highlight again the disparity of access to services in different communities. Community District 412 (Jamaica, South Jamaica, Hollis, St. Albans) has a high concentration of services to meet the inmates' needs. On the other hand, District 414 (Rockaways, Broach Channel) is potentially underserved. It is evident from Map 3.4 that certain social service databases used during the reentry process do not have agencies listed in certain community districts. For Queens, the guidebooks do not list any services in districts 405, 410, 411, or 414 even though, in 2005, four percent (n=1,573) of all inmates returned to those four districts and services are known to exist in these community districts. For example, Community District 405 (Maspeth, Middle Village, Ridgewood, Glendale) has a residential drug abuse facility, a non-residential mental health clinic, and several food program and drop-in centers for adults and families, but these are not listed in the guidebooks.

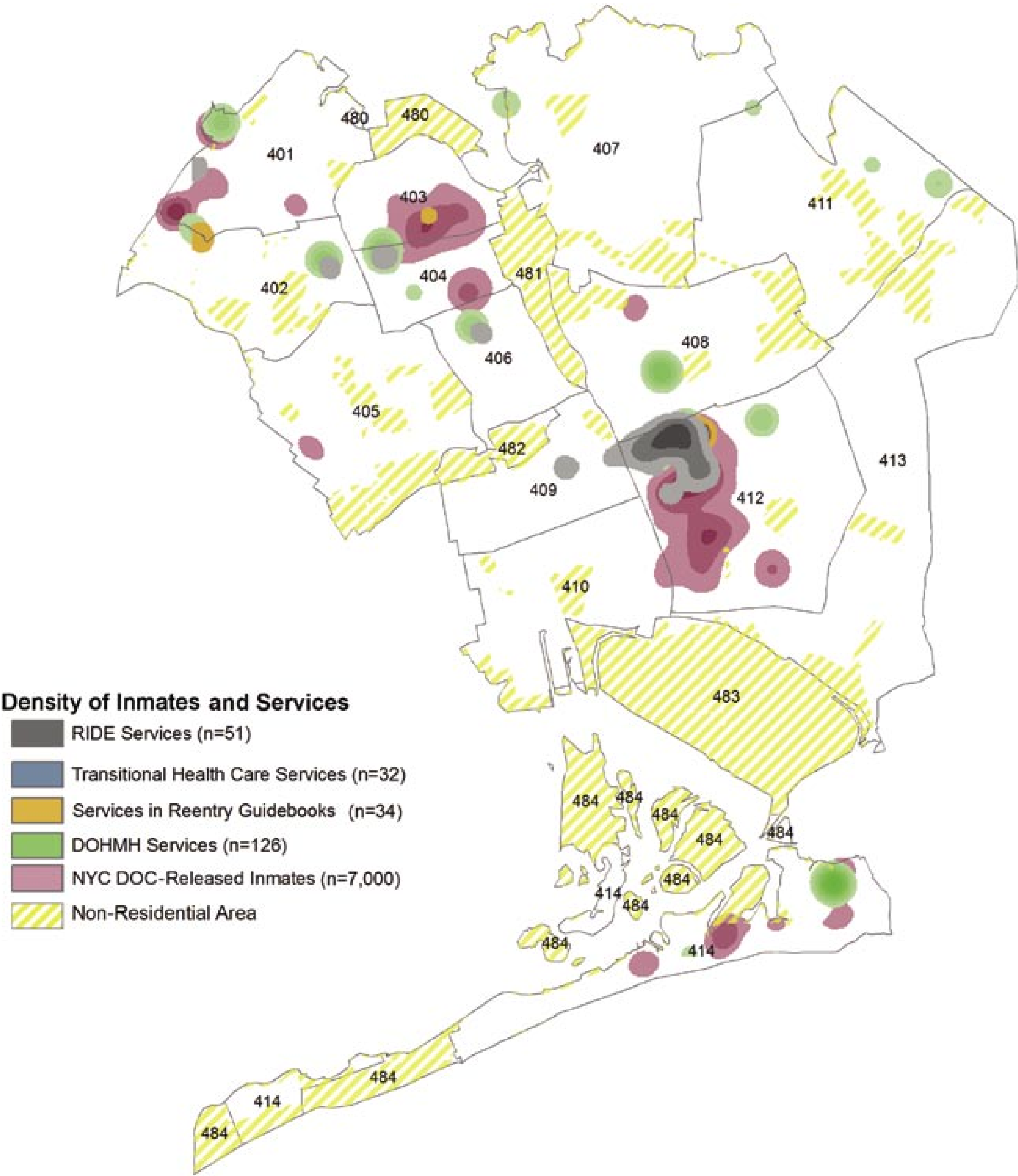
**Map 3.12: Borough of Queens – Density of DOC-Released Inmates**

Density of Inmates

NYC DOC-Released Inmates (n=7,000)

Non-Residential Area

**Map 3.13: Borough of Queens – Density of DOC-Released Inmates and Four Services by Community District**



### Density of Inmates and Services in Staten Island

Maps 3.14 and 3.15 of Staten Island show a more even distribution of services compared to the residential location of returning inmates in Staten Island. In 2005, 71 percent (n=959) of the released inmates on Staten Island lived in Community District 501 (North Island), with 16 (n=215) and 13 percent (n=171) of the inmates respectively living in districts 502 (Mid-Island) and 503 (South Island). As shown on the map, however, the number of services in district 503 is low. RIDE lists four substance abuse programs while DOHMH and the guidebooks each list one service in this area.

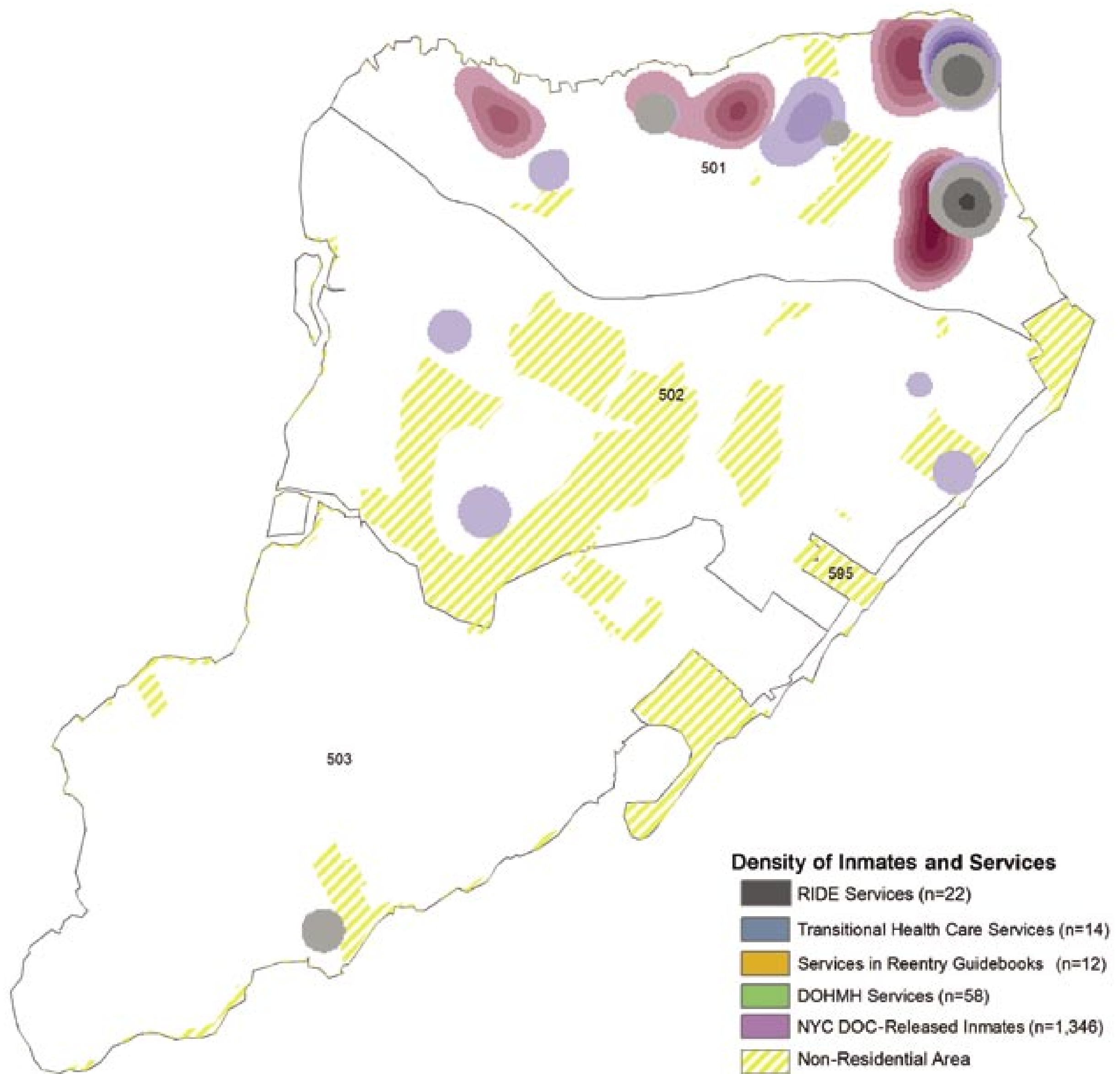
**Map 3.14: Borough of Staten Island – Density of DOC-Released Inmates**

Density of Inmates

NYC DOC-Released Inmates (n=1,346)

Non-Residential Area

**Map 3.15: Borough of Staten Island – Density of DOC-Released Inmates and Four Services by Community District**



# SECTION 4:

## Service Providers' Perception of Inter-Agency Collaboration

Experts increasingly agree that successful reintegration into the community is most successful when there is a collaborative and coordinated effort by all stakeholders who work with returning inmates. To further overall understanding of this process, interviews were conducted with the director or a senior staff member of 13 health and human service providers who work with inmates returning from New York City jails or who work with the director of the provider's reentry program.[65,66] Topics of interest included agency and client characteristics, collaboration among individual service providers and government and other non-government agencies, and overall community relations.

### Characteristics of Surveyed Service Providers and Their Clients

#### *Organizational characteristics*

Service providers addressed a wide range of inmate reentry needs, describing their priorities as substance abuse treatment (three programs), homeless services (one), employment programs (three), legal assistance (one), alternatives to incarceration programs (two), multi-tiered services for reentry populations (one), family services (one), and mental health treatment (one). (See Table 4.1.) Slightly more than half of the providers offer 24/7 access to at least one aspect of their operations, with all keeping regular Monday through Friday business hours.

The surveyed agencies offer a mean of seven distinct reentry services, and there is wide overlap among providers regarding the types of services offered. The most frequently listed services were employment and job training (92 percent), case management (85 percent), drug and alcohol counseling (77 percent), alternative to incarceration programs (69 percent), and mental health assistance and/or treatment (69 percent).

[65] The criterion for an agency to be included in this survey was that the agency be mentioned in each of the following NYC inmate reentry handbooks published in 2005: 1). Stephan Likosky, *Connections 2005-2006 and The Job Search* (New York, NY: The New York Public Library, 2005); 2). Gerald Lopez, *The Center for Community Problem Solving Reentry Guide: A Handbook for People Coming Out of Jails and Prisons and for their Families and Communities* (New York, NY: The Center for Community Problem Solving Press, 2005); and 3). William Whitaker, *Making it Happen & Staying Home* (New York, NY: Commission on Human Rights, 2005); Thirteen of 28 agencies contacted participated in the survey.

[66] Meetings were scheduled with each agency where the agency representative answered a closed- and open-ended 56-item questionnaire. The questionnaire was adapted from an Institutional and Collaborative Relationship survey produced in 1998 by the Center on Urban Poverty and Social Change, Case Western Reserve University, Cleveland, Ohio, and from a reentry offender survey developed in 1994 by Department of Human Services, Allegheny County, Pennsylvania.

## Table 4.1: Organization Characteristics

| | N | % |
|---|---|---|
| **Total programs surveyed** | 13 | 100 |
| **Agency priority** | | |
| Alternative to incarceration (ATI) | 2 | 15 |
| Employment and training | 3 | 23 |
| Ex-Offender services | 1 | 8 |
| Family service/counseling | 1 | 8 |
| Health – Mental | 1 | 8 |
| Homeless service | 1 | 8 |
| Legal aid counseling/service | 1 | 8 |
| Substance abuse prevention & treatment | 3 | 23 |
| **Hours of Operation** | | |
| 24/7 | 7 | 54 |
| 7 days, 9-5 | 4 | 31 |
| M-F, 9-5 | 2 | 15 |
| **Services Offered** | | |
| Alternative to incarceration (ATI) | 9 | 69 |
| Anger management | 9 | 69 |
| Case management | 11 | 85 |
| Child care and development | 1 | 08 |
| Child welfare | 1 | 08 |
| Community organization/advocacy | 8 | 62 |
| Culture and arts | 3 | 23 |
| Drug and alcohol counseling | 10 | 77 |
| Drug and alcohol treatment | 6 | 46 |
| Education/literacy assistance | 7 | 54 |
| Emergency food/clothing/shelter | 6 | 46 |
| Employment & training services | 12 | 92 |
| Financial planning | 7 | 54 |
| Housing referral/assistance | 9 | 7 |
| Information & referral | 11 | 85 |
| Legal assistance | 5 | 38 |
| Life-skills training | 11 | 85 |
| Medical treatment and/or assistance | 8 | 62 |
| Mental health treatment and/or assistance | 9 | 69 |
| Mentoring | 7 | 54 |
| Offender support | 9 | 69 |
| Parent/family counseling | 8 | 62 |
| Psychological assistance | 4 | 31 |
| Religious ministry | 11 | 8 |
| Self-help support group | 4 | 31 |
| Violence prevention/conflict resolution training | 8 | 62 |
| Other | 4 | 31 |

### *Client characteristics*

All of the service providers interviewed offer services to reentry populations, with four of 13 explicitly *limiting* services to individuals with a criminal history (Table 4.2). Most agencies "strongly agreed" (77 percent) that released prisoners needed specialized services. Seventy-seven percent market their services to reentry populations, and 92 percent receive funding targeted toward reentry. A mean of 23 percent of clients per agency were court-ordered to obtain the agency's services. Only one of 13 agencies serve clients from outside of New York City's five boroughs. The majority of clients for all 13 agencies were drawn from Brooklyn, the Bronx, and Manhattan.

**Table 4.2: Client Characteristics**

| | N | % |
|---|---|---|
| **Programs surveyed** | 13 | 100 |
| **Do you serve returning prisoners? (Yes)** | 13 | 100 |
| **Do you explicitly limit your services to individuals with a criminal history? (Yes)** | 4 | 31 |
| **Do you identify/classify returning prisoners as such in your records? (Yes)** | 7 | 54 |
| **To what extent do you agree or disagree that returning prisoners need specialized services which differ from the services given to your other clients:** | | |
| Strongly agree | 10 | 77 |
| Somewhat agree | 2 | 15 |
| Somewhat disagree | 1 | 8 |
| Strongly disagree | 0 | 0 |
| **Approximately what percentage of our clients are returning prisoners? (mean)** | 9 | 7 |
| **Do you market your services to returning prisoners? (Yes)** | 10 | 77 |
| **What percent of your clients are court-ordered to obtain your services? (mean)** *12 of 13 programs responding, 1 of 13 = Don't Know) | 0.23 | 0.23 |
| **From what geographic areas do you draw your clients?** | | |
| Brooklyn | 13 | 100 |
| Bronx | 11 | 85 |
| Queens | 7 | 54 |
| Manhattan | 12 | 92 |
| Staten Island | 6 | 46 |
| Other | 1 | 8 |
| **To what extent do you agree or disagree that returning prisoners come from the same geographic areas as the majority of your other clients:** | | |
| Strongly agree | 11 | 85 |
| Somewhat agree | 1 | 8 |
| Somewhat disagree | 0 | 0 |
| Strongly disagree | 0 | 0 |
| No opinion | 1 | 8 |
| **Do you receive monies targeted toward serving returning prisoners?** | 12 | 92 |
| **What skills or training does your staff need to be most effective when working with prisoners returning to the community?** | Various | Various |

### Assessment of Inter-Agency Collaboration

Ninety-two percent of providers had worked with other agencies on reentry issues and 77 percent agreed that there exists a “culture of organizations in New York City working together to reintegrate prisoners back to their communities.” Further, 92 percent characterized the current political atmosphere as “supportive” of organizational alliances (Table 4.3). Examples given of organizational collaboration included recent DOC discharge planning initiatives involving multi-agency collaboration (cited by 54 percent of respondents), agencies sharing staff for training and programmatic purposes (31 percent), and cooperation among agencies in lobbying and funding efforts (23 percent). Barriers to collaboration include scarce funding and competition among agencies for the same clients.

Respondents listed a mean of 4.5 other agencies with which they collaborate (when asked to list up to five). The purpose for developing these relationships included coordination of discharge planning and substance abuse services, lobbying/advocacy, and transitional housing. Most of the relationships cited had existed for more than five years, and many were established 15-20 years prior. Respondents considered these relationships successful if client-level outcomes improved, the inter-organizational relationships continued, and if joint funding was maintained or improved.

## Table 4.3: Organizational Collaboration

| | N | % |
|---|---|---|
| **Programs surveyed** | 13 | 100 |
| **Is there a culture of agencies in New York City working together to reintegrate prisoners back to their communities? (Yes)** | 10 | 77 |
| **Can you name and describe some recent examples of your agency working together to reintegrate prisoners back into the community?** | | |
| New York City DOC reentry/discharge planning initiative | 7 | 54 |
| Coordinated lobbying among NGOs | 3 | 23 |
| Shared staff training efforts | 4 | 31 |
| **What discourages effective cooperation between agencies working to reintegrate prisoners back into the community?** | | |
| Lack of funding | 6 | 46 |
| Competition among NGOs for clients | 4 | 31 |
| **Do you believe the political atmosphere in the community where your agency works is supportive of organizational alliances, or not supportive? (Supportive)** | 12 | 92 |
| **Follow up: What do you see that supports this belief?** | | |
| New York City government support of reentry reforms | 8 | 62 |
| **Has your agency ever worked together with other agencies relating to prisoner reentry issues? (Yes)** | 12 | 92 |
| Number of other agencies with which your agency has collaborated (mean) | 4.5 | 4.5 |
| **What was the purpose or goal of each relationship and how long has each relationship lasted?** | | |
| Coordinating discharge planning and re-entry services | 8 | 62 |
| Substance abuse services | 6 | 46 |
| Lobbying/advocacy | 5 | 38 |
| Transitional Housing | 2 | 15 |
| **On what basis or by what criteria do you decide whether working relationships between agencies have been successful or unsuccessful?** | | |
| Client-centered outcomes are obtained | 8 | 62 |
| Discharge planning processes are improved | 3 | 23 |
| Programs' outcomes are obtained | 7 | 54 |
| Intra-agency relationships continue | 4 | 31 |
| Continued funding | 1 | 8 |
| **Are you aware of any problems that generally result from agencies working together on prisoner reentry issues? (Yes)** | 4 | 31 |
| **What problems have you noticed, and how should they be addressed?** | | |
| Competition among agencies for clients and funding | 3 | 23 |

**Assessment of Collaboration with Government Agencies**

All respondents reported either an ongoing or planned relationship with the DOC, and 77 percent expected the relationship to last five or more years (Table 4.4). The motivation for cultivating the relationship was described as coming from a desire to improve discharge planning and case management. Advantages afforded by or expected from working with DOC included better access to clients, better client outcomes, a bolstered organizational mission, and improved funding. The majority of respondents described interactions with DOC as being defined by clear strategies for goal attainment, documented protocols (e.g., memoranda or contracts), and a decision-making process of negotiation and discussion.

Generally, respondents agreed that their agency and DOC "share a common vision" (mean score 8.0), work together in an "atmosphere of mutual trust" (8.7), and had "communicated fully" with DOC the purpose of the relationship (8.3).[67] Most felt the relationship between their agency and DOC "will result in positive change in how we reenter people back into the community" (8.9), and that DOC was an "important force for change" (8.3). Reaction was more neutral to these statements: "Influence is shared equally" (6.1), and "I am satisfied with the current relationship between my agency and DOC" (7.1).

When asked about changes needed in their agency's relationship with DOC, the most common response was that no changes are needed (46 percent of respondents). Other suggestions were for better communication and more collaborative decision making on the part of DOC. When asked what policy changes would help the service providers be more effective in reintegrating inmates back into the community, 62 percent of respondents felt that various government agencies and benefits could be much better coordinated (e.g., housing and Medicaid benefits for reentry clients) and that government "silos" prevent such coordination. Increasing access to benefits prior to release from jail was mentioned by 11 of 13 (84 percent) respondents when asked what DOC must do next to improve reentry. In addition, six of 13, or 54 percent, of respondents cited the importance of DOC continuing current efforts to improve discharge planning for sentenced jail inmates in the near term as well as during subsequent administrations.

When asked for summary comments, respondents commended the current DOC leadership for addressing many traditional barriers in order to improve reentry services, but also described a need for improved reentry funding and better reentry service coordination between New York State Department of Corrections, NYS Division of Parole, and DOC.

[67] Seven Likert-scale questions were used to assess agencies' attitudes toward DOC. Responses were along a 10-point scale ranging from, "1–strongly disagree," to, "10–strongly agree."

## Table 4.4: Collaboration with Governmental Agencies

| | N | % |
|---|---|---|
| **Programs surveyed** | 13 | 100 |
| **Are you familiar with any DOC reentry initiatives? (Yes)** | 10 | 77 |
| **Has your agency established a relationship with DOC? (Yes)** | 12 | 92 |
| **With which component at DOC?** | | |
| Discharge planning (DOC Commissioner's office) | 8 | 62 |
| **What is the person's name and title of the DOC person you work with?** | | |
| **What is the purpose of the relationship your agency has developed with DOC?** | | |
| Discharge planning | 8 | 62 |
| Case management | 4 | 31 |
| Supportive housing | 1 | 8 |
| **What is the current status of your organization's relationship with DOC?** | | |
| Planned | 2 | 15 |
| Ongoing | 11 | 84 |
| Complete | 0 | 0 |
| **In what ways do you believe it will be advantageous for your organization to work with the DOC?** | | |
| Improved access to clients | 6 | 46 |
| Congruent with our organization's mission | 10 | 77 |
| **Is your organization's relationship with DOC defined by ways of organization documents, memos, or written agreements, etc.?** (Yes) *12 of 13 respondents (1 of 13 = not applicable) | 8 | 67 |
| **Have clear strategies for goal attainment been created? (Yes)** *11 of 13 respondents (2 of 13 = not applicable) | 8 | 73 |
| **Is there a written agenda describing these goals and objectives? (Yes)** *10 of 13 respondents (3 of 13 = not applicable) | 8 | 80 |
| **In pursuing the relationship we are discussing here, does your organization and DOC share responsibility for specific tasks? (Yes)** *12 of 13 respondents (1 of 13 = not applicable) | 8 | 67 |
| **Are the responsibilities documented in writing (memos, agreements, contracts, other)? (Yes)** *9 of 13 respondents (4 of 13 = not applicable) | 8 | 89 |
| **What is the process by which DOC and your organization make decisions in this relationship?** | | |
| Collaboration & negotiation | 8 | 62 |
| DOC mandates policy | 1 | 08 |
| **What specific benefits do you anticipate as a result working with DOC?** | | |
| Improved client access | 8 | 62 |
| Improved outcomes | 10 | 77 |
| Collaboration among NGOs | 1 | 8 |
| Increased funding | 3 | 23 |
| **Do you expect your organization and DOC to share equally in the benefits? (Yes)** | 12 | 92 |
| **Do you expect this relationship to endure? (Yes)** | 12 | 82 |

### Table 4.4: Collaboration with Governmental Agencies *(cont.)*

| | | |
|---|---|---|
| **How long do you expect this relationship to continue?** *12 of 13 respondents | | |
| *(1 of 13 = not applicable) | | |
| 6 months or less | 1 | 8 |
| 6 months to one year | 0 | 0 |
| 1 year to 2 years | 0 | 0 |
| 2 years to 3 years | 1 | 8 |
| 3 years to 4 years | 0 | 0 |
| 5 years or more | 10 | 77 |
| **What policy changes in how bureaucracies work would help you be more effective in reintegrating prisoners back into the community?** | | |
| Improving coordination of benefits / dissolving government 'silos' | 8 | 62 |
| **With regard to the purpose of our relationship, my organization and DOC share a common vision** (mean score, 1-10 Likert scale; 1=strongly disagree, 10=strongly agree) | 8 | |
| **The atmosphere between my organization and DOC is characterized by mutual trust** (mean score, 1-10 Likert scale; 1=strongly disagree, 10=strongly agree) | 8.67 | |
| **My organization and DOC have communicated fully our reasons for participating in this relationship** (mean score, 1-10 Likert scale; 1=strongly disagree, 10=strongly agree) | 8.33 | |
| **Influence is shared equally among the participants in this relationship** (mean score, 1-10 Likert scale; 1=strongly disagree, 10=strongly agree) | 6.11 | |
| **I believe the relationship between my organization and DOC will result in positive change in how we reenter people back into the community** (mean score, 1-10 Likert scale; 1=strongly disagree, 10=strongly agree) | 8.92 | |
| **DOC is an important force for change in this community** (mean score, 1-10 Likert scale; 1=strongly disagree, 10=strongly agree) | 8.27 | |
| **I am satisfied with the current relationship between my organization and DOC** (mean score, 1-10 Likert scale; 1=strongly disagree, 10=strongly agree) | 7.08 | |
| **If you could, what would you change about your relationship with DOC?** | | |
| No changes are needed | 6 | 46 |
| Better communication, more collaborative decisions | 5 | 38 |
| Improved access to DOC facilities | 1 | 8 |
| **What incentives would make it more likely that your organization would form a working relationship with DOC?** | | |
| Continuation of current programs and relationships | 9 | 69 |
| **What do you believe DOC must do next in order to be more successful in reentering prisoners back into the community?** | | |
| Continue w/ discharge planning initiatives (e.g., RIDE center) | 7 | 54 |
| Increase pre-discharge benefit coordination | 11 | 84 |
| Housing and treatment referrals | 2 | 15 |
| **Are there other agencies in the community that presently work with DOC? (Yes)** | 1 | 1 |
| **Do they have similar activities working with the same people? (Yes)** *11 of 13 responding (2 of 13 = no answer) | 5 | 64 |
| **Is this a source of conflict? (Yes)** *12 of 13 responding (1 of 13 = no answer) | 1 | 9) |

**Assessment of Community Relations**

Most respondents described a lack of community support for reentry populations as well as a lack of support for locating reentry services in the organization's community (Table 4.5). When asked to name members of the community that could help the agency's reentry efforts, the New York City Housing Authority was the entity most often listed (31 percent of respondents), followed by other city agencies and officials, community boards, and various community-based agencies. It was noted that most of the community-based agencies mentioned were part of the survey's target sample.

**Table 4.5: Community Relations**

| | N | % |
|---|---|---|
| **Programs surveyed** | 13 | 100 |
| **What attitudes or circumstances in the community your agency works in harms the success of reentering prisoners back into the community?** | | |
| Lack of community support for hosting reentry services and populations | 12 | 92 |
| Lack of community support for hosting re-entry housing | 7 | 53 |
| **Can you list the names of two individuals and/or agencies in your community who are or could be successful in helping your agency reintegrating prisoners back to the community?** | | |
| New York City Housing Authority | 4 | 31 |
| New York City agencies and officials (various) | 9 | 69 |
| Community-based agencies (various) | 3 | 23 |
| Local philanthropic agencies | 1 | 8 |
| **Are there further comments you would like to make about this survey, about DOC,** | | |
| **or about working within inter-organizational collaboration in general?** | | |
| **Is there anything else you would like to say about your organization and connections with other entities or agencies within and outside the community that work with people returning home from prison?** | | |
| City and State CJS bodies should better coordinate re-entry services | 6 | 46 |
| Despite advances in New York City reentry services more resources are needed | 2 | 15 |
| Current DOC leadership has broken many traditional barriers to improving re-entry services | 3 | 23 |

## Discussion

Representatives of the 13 New York City service agencies who were interviewed described relationships with the DOC as largely collaborative, productive, well-established, and projected to be long in duration. The most frequently cited obstacles to reentry work were limited funds and limited clients sought by multiple agencies (e.g., employment agencies and inpatient drug treatment centers recruiting the same soon-to-be-released individual). Other barriers to improved reentry services include a lack of pre-release benefit coordination and access (e.g., housing support and Medicaid), and a general lack of support by the agencies' home communities for hosting reentry services such as transitional housing within these same communities.

Although just over half (54 percent) of the target service providers were reached for the survey, it was notable that the service priorities of the 13 responding agencies were representative of core reentry needs, including housing, employment and job training, substance abuse and mental health treatment, and family and legal support. A comparison of agencies based on publicly available information found that agencies that did not respond were similar in terms of size and services offered to those that did respond. Many of the respondents were also participants in recent citywide reentry improvement efforts led by DOC and likely represent the largest "players" within New York City reentry services.

Among the 13 responding agencies, there was a mix of programs. Some were designed for clients whether or not they were reentering the community from a period of incarceration while others were restricted to reentering clients. While 12 of the 13 programs agreed that reentry clients have the same geographic origins as other clientele, most agencies stated that reentry clients need "specialized services" compared to non-reentry clients. Four of the 13 limit their programs to reentry clients. These findings indicate that both "blended" and "specialty" approaches to reentry programs are common and active models among New York City agencies.

While competition for clients and limited funding was readily acknowledged, a more prevalent assessment of these relationships was that they were long-standing, included multiple agencies, and served to enhance lobbying and advocacy, staff training, and the coordination of complementary services (e.g., mental health and transitional housing services). Generally, the service providers described the expected outcomes from these efforts as improved client services, successful programs, and the continuation of the inter-organizational relationships. Overall, these interviews indicated a healthy culture of support, interaction, and collaboration among reentry agencies in New York City.

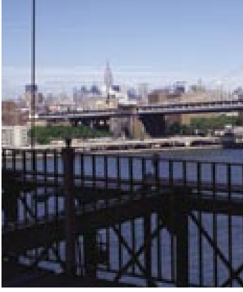
Most agencies also described well-established, usually formally defined, working relationships (via contracts or other written documents) with the DOC, predominantly

involving discharge planning and post-release case management. DOC was viewed as sharing their organization's vision, establishing mutual trust, "communicating fully," and partnering for "positive change" with the responding agencies, attitudes that may indicate a broad approval of current DOC reentry policies.

However, while DOC was seen as "an important force for change," there were no perceived guarantees that currently successful reentry initiatives involving discharge planning would last beyond the tenure of current DOC leadership. Whether or not DOC's present commitment and enthusiasm for such efforts would extend over the long-term was a common and recurring concern. Respondents were largely neutral on the statement that influence was shared equally with DOC. Given that many of the agencies depend on DOC as contractors and for access to clients, overall favorable attitudes toward DOC may reflect unequal relationships with a powerful government body.

These interviews documented a climate of active collaboration between agencies and strong approval of DOC reentry efforts, albeit among a limited sample of reentry service agencies. The importance of sustained efforts to improve reentry was seen as a challenge for future leaders of both the community agencies and government entities. Communities that are home to persons leaving jail and prison are often unsupportive of hosting important reentry components such as transitional housing. Gaps in health insurance coverage and other entitlements related to incarceration are viewed as crucial barriers to successful reentry. These have persisted despite recent discharge planning improvements at New York City jails, suggesting a need to continue and strengthen such reforms.

Coordination between service providers and correctional authorities remains at an early stage; providers are not yet confident that the city's commitment to partnering in reentry efforts is stable and long-term. Specific barriers to partnering, from the perspective of service agencies, include inconsistencies in benefit status and stability for re-entering individuals, issues with overlapping services, and coordination of services across settings. Broader community support, relationships with community boards, and local advocacy to define and establish the roles of service providers' reentry efforts were also felt to be important by responding agencies.



# SECTION 5:

## Conclusions and Recommendations for Future Work

As with other major cities, New York City faces complex challenges related to the community reentry of inmates released from jail. A large proportion of the inmates who are released each year from the New York City Department of Correction (DOC) have significant medical or mental health conditions that require ongoing management in the community. DOC and the New York City Department of Health and Mental Hygiene (DOHMH) have implemented reentry strategies that help to address these needs, including discharge planning, case management, and working with community-based service providers. These strategies are intended to leverage improved public health outcomes overall (as the inmate population has such a high incidence of health issues) and may also provide benefit through lower rates of recidivism.

However, inmates return in disproportionate numbers to impoverished, disorganized communities, with 26 percent returning to just six community districts. These communities appear to be less well-prepared for inmate reentry, as evidenced by an under-allocation of service locations at the borough and community district level. Even when services are available, awareness of these services and how to access them appears to be dependent upon printed resource directories used by discharge planners, none of which are comprehensive. As noted in Section 3, the different directories often list different service providers, so a returning inmate or a discharge planner is limited in knowing what services are available by the particular directory being used. In certain instances, services do exist in a community district, but they are not identified in the reentry guidebooks.

Service providers interviewed for this profile report problems resulting from limited funds, poor pre-release coordination, difficulties accessing benefits, and a lack of community support for reentry services. Despite the large numbers of inmates returning to these communities, providers report that there are few clients for their services, suggesting that there are other, underlying reasons why inmates do not seek out or continue to utilize the community services that do exist.

**Future Study Possibilities**

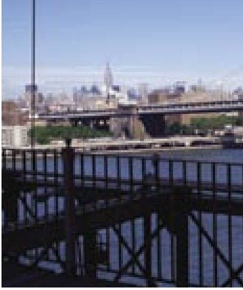
These findings raise some important questions related to the behavior, needs, and preferences of reentering inmates and their communities. Suggestions for further study are identified below. These result from the findings contained in this report, input from the 13 surveyed agency representatives, and comments recorded at a roundtable of 21 public health officials and scholars (including the authors of this report) in April 2007, which focused on the roles and applicability of public health paradigms in public policy (in particular, policy regarding the reentry of individuals into their communities from jail).

- **Descriptive studies regarding inmates' post-release utilization of health care services.** At present, it is not known how reentering inmates actually use medical and mental health services. This profile suggests a mismatch between the needs of returning inmates and access to providers. Data regarding actual utilization will better inform policy makers.

- **Descriptive studies to help stakeholders understand the nature and extent of barriers reentering inmates face in obtaining health care.** Stakeholders need to understand whether returning inmates, or segments of this population, are motivated to seek medical and psychiatric care in the community, and what resources they use to locate these services. It would be useful to know if reentering inmates are seeking treatment outside their local communities and, if so, why. For example, it is possible that reentering inmates may seek treatment in other neighborhoods due to the stigma attached to a number of the common medical conditions found in the inmate population. Alternatively, some may believe that they can obtain higher quality services in more affluent communities. Studies about service utilization and preferences would also help to inform policy decisions regarding how best to provide transition services.

  It is important to understand why service providers interviewed for this profile report a scarcity of clients in the face of large numbers of reentering inmates. Results of descriptive studies could inform decisions as to whether inmates need incentives or coercion to obtain care in the community. For example, if incompetent, seriously mentally ill inmates are repeatedly failing to obtain outpatient care, programs such as Assisted Outpatient Treatment may be useful.

- **Evaluation of community support problems.** Service providers who were interviewed report a lack of community support for reentry services. Policy makers need a better understanding of the sources of support and opposition to reentry within communities. Models of mobilizing community advocates, educating other entities in the community, and minimizing stigma associated with incarceration could be developed. Descriptive studies might be undertaken



to ascertain any sources of opposition, the level of understanding about the importance of reentry, and the intensity of current feelings on the issue.

As part of the effort to lay the groundwork for engaging the community in the planning and implementation of reentry, a planning initiative funded by the Langeloth Foundation will be implemented collaboratively between New York University School of Medicine and the John Jay College of Criminal Justice of the City University of New York. Working with DOC and DOHMH, this effort will be a preliminary effectiveness study of high impact communities and will also evaluate the communities' interest and readiness for a larger demonstration pilot. The pilot study will use local planning and mobilization resources to design more responsive health links for individuals reentering the community. In addition, city agencies and university partners will evaluate behavior and barriers in relation to service use and will work toward changes in the discharge planning process based on some of the suggestions contained in this report.

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# APPENDIX B

## New York City Correctional Health Services Intake History and Physical Exam

DIVISION OF HEALTH CARE ACCESS & IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

**INTAKE**
**HISTORY AND PHYSICAL EXAM**

PLACE MEDICAL LABEL HERE

| Patient's Last Name | First Name |
|---|---|
| Book & Case Number | NYSID Number |

| DATE | TIME ☐ AM ☐ PM | FACILITY | HAVE YOU PREVIOUSLY BEEN INCARCERATED? ☐ YES ☐ NO<br>If yes, where? ☐ RIKERS ☐ ELSEWHERE: ______<br>If yes, when? | DO YOU HAVE MEDICAID OR ANY HEALTH INSURANCE? ☐ YES ☐ NO<br>WHERE DO YOU CURRENTLY GET MEDICAL CARE? |
|---|---|---|---|---|

| 1. DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO | Reaction Type<br>☐ HIVES ☐ RASH ☐ SOB<br>☐ ANAPHYLAXIS ☐ DON'T KNOW | ALLERGIES TO MEDICATIONS? | OTHER |
|---|---|---|---|

| 2. HAVE YOU EVER HAD HIGH BLOOD SUGAR OR DIABETES? ☐ YES ☐ NO<br>IF YES, ☐ TYPE-1 ☐ TYPE-2 | FINGER STICK (ON ADMISSION) | 3. HAVE YOU EVER HAD TB? ☐ YES ☐ NO<br>Where diagnosed? | Do you have?<br>Weight loss ☐ YES ☐ NO<br>Night Sweats ☐ YES ☐ NO<br>Fever ☐ YES ☐ NO<br>Cough > 2 Wks ☐ YES ☐ NO | Chest X-ray done? ☐ YES ☐ NO<br>If yes, ☐ Normal ☐ Abnormal<br>When? __/__/__ | Current and Past TB Medications Taken? | How long taken? |
|---|---|---|---|---|---|---|

| 4. HAVE YOU EVER HAD: | HAVE YOU EVER HAD: | Did you watch the HIV Video? | Do you have HIV Infection or AIDS? |
|---|---|---|---|
| • Multiple Sex partners? ☐ YES ☐ NO<br>• Unprotected sex? ☐ YES ☐ NO<br>• Sex with substance abusers? ☐ YES ☐ NO<br>• Same sex relationship? ☐ YES ☐ NO<br>• I.V. Drug Use? ☐ YES ☐ NO | • Syphilis? ☐ YES ☐ NO • Gonorrhea? ☐ YES ☐ NO<br>• Chlamydia? ☐ YES ☐ NO • Hepatitis A? ☐ YES ☐ NO<br>• Hepatitis B? ☐ YES ☐ NO • Hepatitis C? ☐ YES ☐ NO<br>• Any current tx ? ☐ YES ☐ NO | ☐ YES ☐ NO<br>Did you read the HIV Brochure?<br>☐ YES ☐ NO | ☐ YES ☐ NO<br>*(If yes, complete HIV Flow Sheet)* |

| 5. RAPID HIV TEST | REASONS FOR DECLINING RAPID HIV TEST | HIV Ab Testing done? | Viral Load ☐ YES ☐ NO |
|---|---|---|---|
| ☐ Wants Rapid HIV Test<br>☐ Declines HIV Testing<br>☐ Undecided<br>☐ Confirmatory<br>☐ Retest | ☐ Known HIV Positive<br>☐ Prefer Conventional Test<br>☐ Had Negative HIV Result ,< 3 months ago<br>☐ Not Ready to get test results today<br>☐ Don't want test now/today<br>☐ Other | ☐ YES ☐ NO<br>When? | #______<br>When?<br>Latest T-Cell (CD4)<br>#______<br>When? |

| 6. EVER HAD ASTHMA? ☐ YES ☐ NO | Last ER Visit?<br>Last Attack?<br>Ever Admitted? ☐ YES ☐ NO | Ever Intubated? ☐ YES ☐ NO<br>When? __/__/__ | 7. EVER HAD HYPERTENSION? ☐ YES ☐ NO |
|---|---|---|---|

| 8. DO YOU HAVE:<br>☐ PND ☐ SOB<br>☐ Palpitations ☐ DOE<br>☐ Pedal Edema | Chest Pain? ☐ YES ☐ NO<br>When? __/__/__ | Syncope? ☐ YES ☐ NO<br>When? __/__/__ | Family history of sudden death under age 55? ☐ YES ☐ NO | Ever had Heart Disease? ☐ YES ☐ NO | Ever had a heart attack? ☐ YES ☐ NO<br>When? __/__/__ |
|---|---|---|---|---|---|

| 9. HAVE YOU HAD A PAP SMEAR IN THE LAST 12 MONTHS? ☐ YES ☐ NO ☐ N/A<br>If yes, When? __/__/__ | 10. DO YOU USE DRUGS ☐ YES ☐ NO<br>DRUG AMOUNT: | *If yes, check drugs, and complete the "Opiod Withdrawal Assessment Form"*<br>Drugs used: ☐ HEROIN ☐ BARBITUATES ☐ MARIJUANA<br>☐ CRACK ☐ COCAINE ☐ CRYSTAL METH ☐ METHADONE<br>☐ OTHER: |
|---|---|---|

**If you have answered "YES" to any question and require additional space, please use the Additional Comments area on Page 4.**

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| 11. ARE YOU CURRENTLY IN A METHADONE PROGRAM? ☐ YES ☐ NO | Where? Dose ____ | 12. DO YOU USE ALCOHOL? ☐ YES ☐ NO AMOUNT: | Have you considered cutting down drinking? ☐ YES ☐ NO<br>Annoyed by people asking about your drinking? ☐ YES ☐ NO<br>Ever had guilty feelings about your drinking? ☐ YES ☐ NO<br>Ever needed a drink as an "eye opener"? ☐ YES ☐ NO | When last drink or drug use? |
|---|---|---|---|---|

| 13. ANY ADDITIONAL MEDICAL PROBLEMS? ☐ YES ☐ NO | List |
|---|---|

| 14. TREATED OR HOSPITALIZED FOR NERVOUS / MENTAL PROBLEMS? ☐ YES ☐ NO When? | Where? Why? | 15. ARE YOU TAKING MEDICATION FOR NERVES/MENTAL PROBLEMS? ☐ YES ☐ NO | Medications / Dosage: |
|---|---|---|---|

| 16. HAVE YOU TRIED TO HURT OR KILL YOURSELF? ☐ YES ☐ NO When? | How? Why? | 17. HAVE YOU EVER BEEN ASSAULTED (SEXUALLY/PHYSICALLY)? ☐ YES ☐ NO | 18. HAVE YOU BEEN CHARGED WITH A VIOLENT ACT (RAPE, ASSAULT)? ☐ YES ☐ NO |
|---|---|---|---|

| 19. HAVE YOU HURT ANYONE WHEN YOU WERE ANGRY OR UPSET? ☐ YES ☐ NO | When? Who? | How? Why? |
|---|---|---|

| 20. HAVE YOU EXPERIENCED ANY RECENT LOSSES? (i.e., death, employment, relationships, etc) ☐ YES ☐ NO | Explain |
|---|---|

**SUMMARY OF CURRENT MEDICATIONS** *(Please List)*

21. CHARGES REVIEWED?

☐ YES ☐ NO

COMPLETED BY (*Print Name*) ____________________ REVIEWED BY: ____________________

| Signature of person completing form | Title | Date | Time |
|---|---|---|---|
| | | | |

If you have answered "YES" to any question and require additional space, please use the Additional Comments area on Page 4.



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DIVISION OF HEALTH CARE ACCESS & IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

# PHYSICAL EXAMINATION

| Last Name | | First Name | | Temp |
|---|---|---|---|---|
| Snellen | w/o correction R ______ L ______ | w correction R ______ L ______ | Ht | Pulse / RR |
| VSS Taken by *(Full Name)* | | | Wt | Peak Flow |
| Signature | | | | BP |

## GENERAL APPEARANCE: *(Include body habitus, nutritional status, and state of distress.)*

**HEENT**
- ❑ NL ❑ Traumatic ❑ Lacerations ❑ Icteric
- ❑ Scalp lesions ❑ Abnormal Pupils ❑ Conjunctivitis ❑ Pale sclera ❑ Other

**SKIN** *Describe*
- ❑ NL ❑ Rash ❑ Pallor ❑ Scars
- ❑ Jaundice ❑ Tattoos ❑ Tracks ❑ Other

**ORAL CAVITY** *Describe*
- ❑ NL ❑ Lesions ❑ Swellings
- ❑ Filled cavities ❑ Dentures loose ❑ Missing teeth ❑ Other

**BREASTS** *Describe*
- ❑ NL ❑ Discharge
- ❑ Masses ❑ Other

**CHEST** *Describe*
- ❑ NL ❑ Wheezing ❑ Rales
- ❑ Rubs ❑ Rhonchi ❑ Other

**HEART** *Describe*
- ❑ NL / RRR
- ❑ Murmur ❑ Gallop
- ❑ Rub ❑ Other

**FUNDUS**
- ❑ Normal ❑ Not Visualized ❑ Other

**OTOSCOPIC**

**LYMPH NODES**

**NECK THYROID**
- ❑ NL ❑ Carotid Bruit
- ❑ Thyroid enlargement/mass

**ABDOMEN** *Describe*
- ❑ NL ❑ Ascites
- ❑ Tenderness ❑ Other
- ❑ Hypo/Hyperactive Bowel sounds
- ❑ Organomegaly

**GENITALIA** *Describe*
- ❑ Lesions
- ❑ Sores ❑ Warts
- ❑ Discharge ❑ Other

**PELVIC EXAM** *(Adnexa, Uterus)* *Describe*
- ❑ N/A ❑ Refused
- ❑ NL ❑ Adnexal Mass
- ❑ Discharge from Cervix ❑ Tenderness
- ❑ Uterine Mass ❑ Other

**PAP SMEAR** *Describe*
- ❑ Performed ❑ Refused
- ❑ Chlamydia/Gonorrhea Test ❑ Deferred
- ❑ Culture
- ❑ Other *(Describe)*

**RECTAL**
- ❑ NL ❑ Not Indicated PT less than 40 yrs old
- ❑ Hemorrhoids ❑ Sores
- ❑ Fissures ❑ Refused
- ❑ Warts ❑ Other

**EXTREMITIES**
- ❑ NL ❑ Pulse
- ❑ Edema ❑ Clubbing
- ❑ Cyanosis ❑ Other

## MENTAL STATUS

**ORIENTATION TO**
- ❑ Time ❑ Place ❑ Person

**PSYCHOMOTOR**
- ❑ WNL ❑ Retardation ❑ Agitation

**SPEECH**
- ❑ Coherent ❑ Incoherent ❑ Normal Rate ❑ Pressured ❑ Spontaneous

**MOOD**
- ❑ Euthymic ❑ Irritable
- ❑ Anxious ❑ Elated
- ❑ Depressed ❑ Angry
- ❑ Embarrassed/Humiliated

**AFFECT**
- ❑ Appropriate to mood ❑ Inappropriate to mood ❑ Labile

**THOUGHT PROCESS**
- ❑ Logical ❑ Illogical ❑ Relevant ❑ Irrelevant

**ANY PROBLEMS WITH SLEEP OR APPETITE OR ANY FEELINGS OF HOPELESSNESS OR BEING WORTHLESS?** ❑ YES ❑ NO

**SUICIDAL IDEATION?** ❑ YES ❑ NO

**HOMICIDAL IDEATION?** ❑ YES ❑ NO

**DELUSIONS**
- ❑ None ❑ Grandiose (Do you have special abilities or features?)
- ❑ Persecution (Do you feel anyone is plotting against you?)
- ❑ Somatic ❑ Other

**HALLUCINATIONS** Does patient exhibit any?
- ❑ None ❑ Auditory ❑ Visual

**DOES PT EXHIBIT ANY SIGNS OF GROSS MENTAL RETARDATION?** ❑ YES ❑ NO

**NEUROLOGIC** *(Sensory, Motor, DTR, Gait, Cerebellar, Cranial Nerves)* **DESCRIBE** *(If abnormal, give details in assessment)*

**If you have answered "YES" to any question and require additional space, please use the Additional Comments area on Page 4.**

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**ADDITIONAL COMMENTS** *(Please include Question Number with each Additional Comments Section)*

| ASSESSMENT | PLAN |
|---|---|
| | |

| URINE PREGNANCY | DISPOSITION | HOUSING |
|---|---|---|
| ☐ N/A<br>☐ Positive<br>☐ Negative | ☐ Medical Isolation Reason: | HOUSING : ☐ GP ☐ CDU<br>☐ INFIRMARY ☐ C-71 ☐ MO<br>☐ OTHER: |
| URINE DIP/KETONES *(ON ADMISSION)*<br>☐ YES ☐ NO | ☐ Detox | CONSULTS: ☐ URGICARE<br>☐ ER/HOSPITAL ☐ MH EMERGENCY<br>☐ MH ROUTINE ☐ OTHER:<br>BROCHURES GIVEN?<br>REACH HIV-STD ☐ YES ☐ NO<br>Health Information ☐ YES ☐ NO<br>Dental Brochure ☐ YES ☐ NO |

| SIGNATURE | DATE/TIME |
|---|---|
| PRINT NAME | TITLE |

REVIEWED BY:

| PRINT NAME | SIGNATURE | DATE/TIME |
|---|---|---|

Please use the Additional Comments area on the top of this page for any "YES" question requiring additional space.



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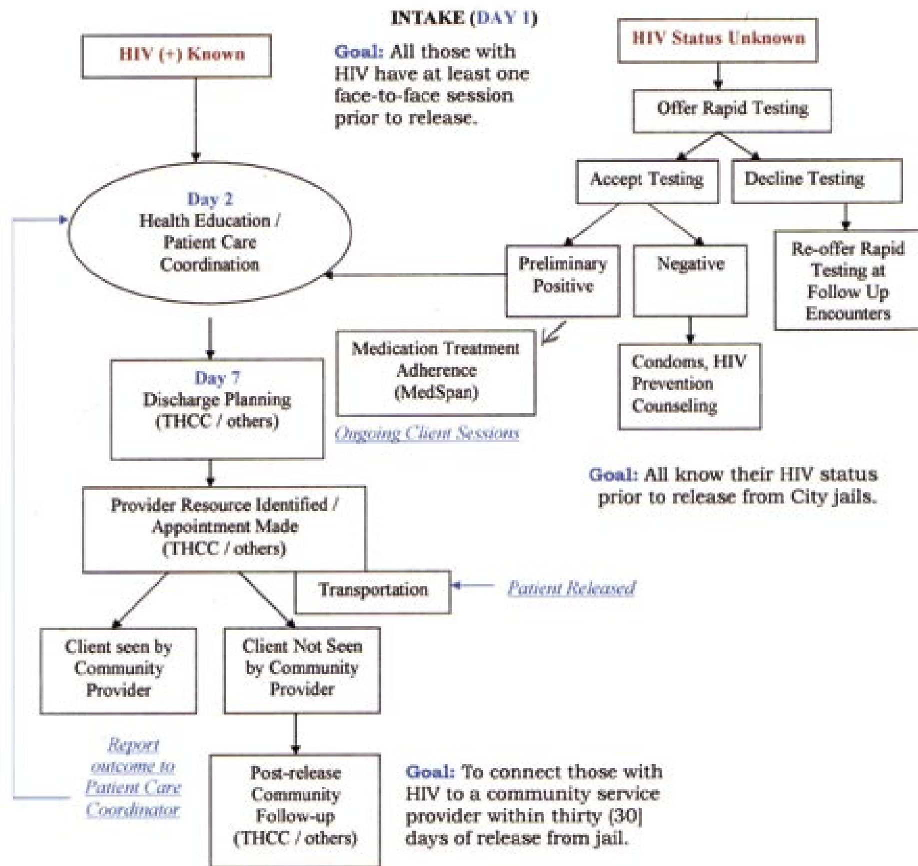
# APPENDIX C

## HIV Continuum of Care Model



# APPENDIX D

## Take Care New York Passport to Your Health

# APPENDIX E

## New York City Department of Correction Discharge Planning Questionnaire

## NEW YORK CITY DEPARTMENT OF CORRECTION
## DISCHARGE PLANNING QUESTIONNAIRE – FORM 983

Revised 10/20/04

INMATE'S LAST NAME:______________________ FIRST NAME:______________________

NYSID #:______________ BOOK & CASE #:______________ DATE OF ADMISSION:____/____/____

### EMPLOYMENT RELATED

INMATE'S PHONE NUMBER: (______)________-________ SOCIAL SECURITY #:______-______-______

HOW LONG AGO WERE YOU LAST EMPLOYED? 1☐ AT ARREST ______ (#) MONTHS AGO ______ (#) YEARS AGO 2☐ NEVER

WAS THIS WORK: 1☐ FULL TIME 2☐ PART TIME 3☐ ODD JOBS 0☐ N/A ARE YOU: 1☐ STUDENT 2☐ DISABLED 3☐ RETIRED 0☐ N/A

WILL YOU HAVE A JOB WHEN YOU LEAVE JAIL? 1☐ YES 2☐ NO 9☐ NOT SURE 0☐ D/A (DIDN'T ANSWER)

DO YOU WANT ASSISTANCE WITH: 1☐ JOB TRAINING 2☐ FINDING A JOB 3☐ CONTINUING YOUR EDUCATION 0☐ N/A

NUMBER OF CHILDREN UNDER 18:____ NUMBER YOU HAVE CUSTODY OF:____ NUMBER IN FOSTER CARE:____ 0☐ D/A

DO YOU WANT ASSISTANCE WITH: 1☐ CHILD CUSTODY 2☐ FAMILY COUNSELING 0☐ N/A

| OF THE BENEFITS LISTED BELOW: | WHICH ARE YOU NOW RECEIVING? | WHICH DO YOU WANT TO RECEIVE? |
|---|---|---|
| CASH ASSISTANCE (WELFARE, P.A.) | 1☐ YES ☐ NO | 1☐ YES ☐ NO |
| FOOD STAMPS | 2☐ YES ☐ NO | 2☐ YES ☐ NO |
| S.S.I. (DISABILITY) | 3☐ YES ☐ NO | 3☐ YES ☐ NO |
| UNEMPLOYMENT | 4☐ YES ☐ NO | 4☐ YES ☐ NO |
| VETERANS' BENEFITS | 5☐ YES ☐ NO | 5☐ YES ☐ NO |
| NONE OF THE ABOVE | 0☐ YES ☐ NO | 0☐ YES ☐ NO |

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING HEALTH INSURANCE? (PLEASE CHECK ALL THAT APPLY)

| | |
|---|---|
| PRIVATE INSURANCE | 1☐ YES ☐ NO |
| MEDICAID | 2☐ YES ☐ NO |
| OTHER | 3☐ YES ☐ NO |
| NONE | 4☐ YES ☐ NO |

### HOUSING RELATED

JUST BEFORE YOUR ARREST, WHERE OR WITH WHOM WERE YOU LIVING? 1☐ ALONE 2☐ FAMILY 3☐ FRIEND(S) 4☐ GROUP HOME 5☐ HOSPITAL 6☐ JAIL/PRISON 7☐ SHELTER 8☐ HOMELESS, NOT IN SHELTER 0☐ OTHER:______________ 0☐ D/A

ARE YOU RECEIVING HOUSING BENEFITS, SUCH AS PUBLIC HOUSING, "NYCHA", OR SECTION 8? 1☐ YES 2☐ NO 0☐ D/A

AFTER YOU LEAVE JAIL, WHERE OR WITH WHOM WILL YOU LIVE? 1☐ ALONE 2☐ FAMILY 3☐ FRIEND(S) 4☐ GROUP HOME 5☐ HOSPITAL 6☐ JAIL/PRISON 7☐ SHELTER 8☐ HOMELESS, NOT IN SHELTER 9☐ NOT SURE 0☐ OTHER:________ 0☐ D/A

HAVE YOU EVER BEEN HOMELESS? 1☐ YES 2☐ NO 0☐ D/A IF YES, DO YOU HAVE AN "H. A. NUMBER" (HOMELESS ASSISTANCE #) FROM A NEW YORK CITY SHELTER? 1☐ YES:____________ 2☐ NO 0☐ N/A

DO YOU WANT ASSISTANCE WITH YOUR HOUSING SITUATION? 1☐ YES 2☐ NO 0☐ D/A

### TREATMENT RELATED

DO YOU HAVE A REGULAR HEALTH CARE PROVIDER OR DOCTOR? 1☐ YES 2☐ NO 9☐ NOT SURE 0☐ D/A
IF YES, HOW LONG AGO WERE YOU LAST SEEN? 1☐ IN THE LAST 12 MONTHS 4☐ MORE THAN A YEAR AGO 9☐ NOT SURE 0☐ N/A
OFFICE NAME:______________ DOCTOR:______________ PHONE NUMBER: (______)______-______

IN THE LAST 12 MONTHS, HOW OFTEN DID YOU USE ALCOHOL? 0☐ NEVER 1☐ ONLY A FEW TIMES 2☐ 1-3 TIMES A MONTH 3☐ 1-5 TIMES A WEEK 4☐ ABOUT EVERY DAY 0☐ D/A

IN THE LAST 12 MONTHS, HOW OFTEN DID YOU USE DRUGS? 0☐ NEVER 1☐ ONLY A FEW TIMES 2☐ 1-3 TIMES A MONTH 3☐ 1-5 TIMES A WEEK 4☐ ABOUT EVERY DAY 0☐ D/A

HAVE YOU EVER BEEN IN A PROGRAM FOR ALCOHOL OR DRUG ABUSE? 1☐ YES 2☐ NO 0☐ D/A
IF YES, HOW LONG AGO? 1☐ AT TIME OF ARREST 2☐ LAST 6 MONTHS 3☐ 6 MONTHS TO A YEAR 4☐ MORE THAN A YEAR AGO 0☐ N/A
PROGRAM NAME:______________ COUNSELOR:______________ PHONE NUMBER: (______)______-______

DO YOU WANT HELP FOR ALCOHOL ABUSE? 1☐ YES 2☐ NO 0☐ D/A DO YOU WANT HELP FOR DRUG ABUSE? 1☐ YES 2☐ NO 0☐ D/A

INMATE'S SIGNATURE:______________________________ DATE:____/____/____

OFFICER'S NAME (PLEASE PRINT):______________________ OFFICER'S SHIELD NUMBER:______________

OFFICER'S SIGNATURE:______________________________ DATE:____/____/____

D/A= DIDN'T ANSWER

# APPENDIX F

## New York City Department of Correction Rikers Island Discharge Enhancement Plan

# NYC DEPARTMENT OF CORRECTION
# RIKERS ISLAND DISCHARGE ENHANCEMENT (R. I. D. E.)

## DISCHARGE PLAN

PROVIDER: ____________________________________________

## PART A: IDENTIFICATION

**Inmate's Name:** ____________________________________________
(Last Name) (First Name) (MI)

Date of Birth: ____/____/______ Expected Date of Release: ______/_____/_________

Book & Case No.: ____________________ NYSID No.: __________ ______________

SS#: _____–_____–_________ Verified: Yes ____ No ____

Birth Certificate: Yes ____ No ____ U.S. Citizen: Yes ____ No ____

Veteran: Yes ____ No ____ Registered Alien: Yes ____ No ____

**Inmate's Address:** ***(Write "none" if there is no residence, but include last shelter address if one is known)***

____________________________________________
(Address) (Apt #)

____________________________________________
(Borough) (State) (Zip code)

Does the inmate expect to be released to known housing: Yes ___ No ___

Does the inmate expect to be released to a homeless shelter: Yes ___ No ___

Are any identification documents in inmate's property: Yes ___ No ____

If yes, specify type of documentation:

____________________________________________

If no, explain how identification is being obtained:

____________________________________________

____________________________________________

____________________________________________

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## PART B. TREATMENT PLAN/NEEDS:

**(An assessment is to be given for each category, "Yes" or "No". A "Yes" response indicates that a referral is to be included as part of the Discharge Plan)**

Was the Discharge Planning Screening Questionnaire reviewed? Yes ___ No ___

1. Substance Abuse Treatment: Yes___ No ___

Level of Care Required: Outpatient ____ Residential ____ Methadone Maint. ____

2. Housing Assistance: Yes ___ No ___

Type of Housing Required: ______________________________

3. Custody of Children: Yes ___ No ____ If yes: How many ___ Ages ____, ____, ______

Need for Family Reunification Services: Yes ___ No ___

If yes, what type: ______________________________

______________________________

______________________________

4. Educational/Employment Skills: GED: Yes ___ No ___ High School Diploma: Yes__ No___

Job Skills Training: Yes ___ No ___ Area of interest: ______________________

Job Placement: Yes ___ No ___ Special Skills: (specify) ____________________

5. HRA – Benefits Information (check all that apply)

Public Assistance ___ Food Stamps ___Medicaid ___ SSI ___ SSD ___ Veteran____

**PART C: DISCUSS ALL MITIGATING FACTORS THAT IMPACTED ON THE DEVELOPMENT OF THE DISCHARGE PLAN: (Ex: While treatment for substance abuse was indicated, inmate refused.)**

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

(Attach additional sheets if more space is needed)

## PART D. DISCHARGE PLANNING NEEDS/REFERRALS MADE

EACH AREA OF SECTION B MUST BE ADDRESSED AND A PLACEMENT REFERRAL MUST BE INICATED FOR EACH CATEGORY A NEED WAS DETERMINED, UNLESS AS DISCUSSED ABOVE. SPECIFY IF PLACEMENTS ARE TO BE CONCURRENT OR SEQUENTIAL.

### REFERRALS:

### I. SUBSTANCE ABUSE:

Program Name: ______________________________

Address: ______________________________

______________________________
(Borough) (State) (Zip Code)

Phone #: (___)______________

Proposed admission date: ____/_____/_________

Comments: ______________________________

______________________________

______________________________

### II. HOUSING ASSISTANCE:

Program Name: ______________________________

Address: ______________________________

______________________________
(Borough) (State) (Zip Code)

Phone #: (_____)______________

Proposed admission date: _____/______/________

Comments: ______________________________

______________________________

______________________________

______________________________

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## III. FAMILY REUNIFICATION ASSISTANCE

Program Name: ____________________________________________

Address: ____________________________________________

____________________________________________
(Borough) (State) (Zip Code)

Phone #: (___)______________

Proposed admission date: _____/______/__________

Comments: ____________________________________________

____________________________________________

____________________________________________

## IV. EDUCATION/EMPLOYMENT

Program Name: ____________________________________________

Address: ____________________________________________

____________________________________________
(Borough) (State) (Zip Code)

Phone #: (____)______________

Proposed admission date: _____/_______/____________

Comments: ____________________________________________

____________________________________________

____________________________________________

____________________________________________

**ADDITIONAL COMMENTS: (Include any supplementary services recommended to the client where referrals have been made. List program and other information as asked for above.)**

____________________________________________

____________________________________________

____________________________________________

____________________________________________

**(Attach additional sheets if more space is needed.)**

## PART E. PROVIDER INFORMATION

Name of Provider: ______________________________________________

Facility: ________________Inmate's Housing Area: (specify if other facility)____________________

Date MOA signed: _____/_______/_______ Date Discharge Plan Completed: _____/_______/________

Aftercare Case Manager ______________________________ Phone #: (__)______________
(Signature)

Primary Counselor (provider): ___________________________ Phone #: (__)______________
(Signature)

**Supervisor: ___________________________________ Phone #: (__)______________
(Signature)

## PART F. **INMATE AGREEMENT

I AGREE WITH AND HAVE RECEIVED A COPY OF THIS DISCHARGE PLAN DEVELOPED FOR ME

BY ____________________________________________________________________________
**(Provider name)**

**Inmate's Name:** ___________________________________ **Date:** ________/________/__________

**Date Copy Received:** _____/_____/______ **(Inmate's signature)** ______________________________

**Provider signature:** ________________________________ **Date:** ________/_________/__________

****Required before submission**

***THE DISCHARGE PLAN IS TO BE SUBMITTED NO MORE THAN 14 DAYS PRIOR TO THE DATE OF DISCHARGE, AFTER A FINAL REVIEW BY THE INMATE AND PROVIDER***

*ANY QUESTIONS OR CONCERNS WITH THIS DISCHARGE PLAN WILL BE BROUGHT TO YOUR ATTENTION WITHIN14 DAYS OF RECEIPT BY THE PROGRAM MONITORING UNIT.*

# APPENDIX G

## Dial 311 Palm Card

**Figure 1.6: Dial 311**

TELL THE OPERATOR IF YOU ARE INTERESTED IN: DRUG/ALCOHOL PROGRAMS, EMPLOYMENT, TRAINING, LEGAL SERVICES OR HOUSING, AND YOU WILL BE CONNECTED TO THE ORGANIZATION (S) THAT CAN PROVIDE YOU WITH ASSISTANCE.

# APPENDIX H

## Tables Profiling DOC Inmates Released to Communities in New York City

### Table 2.5: Criminal Justice Background Characteristics of DOC-Released Inmates by Borough

| Variable | Brooklyn | | Bronx | | Manhattan | | Queens | | Staten Island | | Citywide | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Status at Release** | N | % | N | % | N | % | N | % | N | % | N | % |
| Pretrial Detainee | 8,597 | 63.9% | 5,958 | 57.1% | 4,621 | 54.6% | 4,600 | 65.7% | 845 | 62.8% | 2,4621 | 60.5% |
| City Sentence | 4,608 | 34.3% | 4,188 | 40.1% | 3,640 | 43.0% | 2,339 | 33.4% | 470 | 34.9% | 15,245 | 37.5% |
| Tech PV | 240 | 1.8% | 289 | 2.8% | 197 | 2.3% | 61 | 0.9% | 31 | 2.3% | 818 | 2.0% |
| **Length of Stay** | | | | | | | | | | | | |
| < 1 day | 1,060 | 7.9% | 1,129 | 10.8% | 999 | 11.8% | 852 | 12.2% | 100 | 7.4% | 4,140 | 10.2% |
| 1-3 days | 3,865 | 28.7% | 2,778 | 26.6% | 2,381 | 28.2% | 2,363 | 33.8% | 380 | 28.2% | 11,767 | 28.9% |
| 4-7 days | 3,359 | 25.0% | 2,645 | 25.3% | 1,922 | 22.7% | 1,278 | 18.3% | 351 | 26.1% | 9,555 | 23.5% |
| 8-15 days | 1,443 | 10.7% | 1,055 | 10.1% | 774 | 9.2% | 705 | 10.1% | 123 | 9.1% | 4,100 | 10.1% |
| 16-30 days | 1,410 | 10.5% | 984 | 9.4% | 775 | 9.2% | 661 | 9.4% | 123 | 9.1% | 3,953 | 9.7% |
| 31-60 days | 1,087 | 8.1% | 861 | 8.3% | 671 | 7.9% | 544 | 7.8% | 133 | 9.9% | 3,296 | 8.1% |
| 61-180 days | 988 | 7.3% | 788 | 7.6% | 735 | 8.7% | 491 | 7.0% | 103 | 7.7% | 3,105 | 7.6% |
| 181-360 days | 233 | 1.7% | 195 | 1.9% | 201 | 2.4% | 106 | 1.5% | 33 | 2.5% | 768 | 1.9% |
| **Self-Reported Drug Use** | 2,666 | 19.8% | 2,523 | 24.2% | 1,510 | 17.9% | 1,090 | 15.6% | 202 | 15.0% | 7,991 | 19.6% |
| **Classification Points** | | | | | | | | | | | | |
| 0-5 low score | 6,806 | 50.6% | 4,717 | 45.2% | 4,053 | 47.9% | 4,117 | 58.9% | 670 | 49.8% | 20,363 | 50.1% |
| 6-10 low medium score | 4,181 | 31.1% | 3,597 | 34.5% | 2,783 | 32.9% | 1,956 | 27.9% | 444 | 33.0% | 12,961 | 31.9% |
| 11-16 high medium score | 1,857 | 13.8% | 1,659 | 15.9% | 1,262 | 14.9% | 718 | 10.3% | 178 | 13.2% | 5,674 | 13.9% |
| 17+ high score | 601 | 4.5% | 462 | 4.4% | 360 | 4.3% | 209 | 3.0% | 54 | 4.0% | 1,686 | 4.1% |

## Table 2.6: Criminal Justice Background Characteristics of DOC-Released Inmates by Status at Release

| Variable | Pretrial Detainees (N=24,621) | | City Sentence (N=15,245) | | Technical Parole Violators N=818 | |
|---|---|---|---|---|---|---|
| **Mean age at arrest** | 31.9 | | 36.1 | | 35.8 | |
| **Length of Stay** | N | % | N | % | N | % |
| < 1 day | 2,395 | 9.7% | 1,745 | 11.4% | 0 | 0.0% |
| 1-3 days | 8,546 | 34.7% | 3,211 | 21.1% | 10 | 1.2% |
| 4-7 days | 6,877 | 27.9% | 2,658 | 17.4% | 20 | 2.4% |
| 8-15 days | 2,176 | 8.8% | 1,792 | 11.8% | 132 | 16.1% |
| 16-30 days | 1,710 | 6.9% | 2,025 | 13.3% | 218 | 26.7% |
| 31-60 days | 1,412 | 5.7% | 1,650 | 10.8% | 234 | 28.6% |
| 61-180 days | 1,316 | 5.3% | 1,587 | 10.4% | 202 | 24.7% |
| 181-360 days | 189 | 0.8% | 577 | 3.8% | 2 | 0.2% |
| **Self-Reported Drug Use** | 3,837 | 15.6% | 3,904 | 25.6% | 250 | 30.6% |
| **Classification Points** | | | | | | |
| 0-5 low score | 12,056 | 48.9% | 8,237 | 54.1% | 70 | 8.5% |
| 6-10 low medium score | 7,670 | 31.2% | 5,007 | 32.8% | 284 | 34.7% |
| 11-16 high medium score | 3,683 | 15.0% | 1,646 | 10.8% | 345 | 42.2% |
| 17+ high score | 1,212 | 4.9% | 355 | 2.3% | 119 | 14.5% |

## Table 2.7: Community Districts in the Top Two Quartiles of DOC-Released Drug-Using Inmates

| Community Districts | Frequency | Percent |
|---|---|---|
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights (BK) | 422 | 5.3% |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 422 | 4.4% |
| 111 East Harlem (MHN) | 340 | 4.3% |
| 304 Bushwick (BK) | 339 | 4.2% |
| 209 Soundview, Castle Hill, Union Port, Parkchester (BX) | 337 | 4.2% |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 329 | 4.1% |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (QN) | 325 | 4.1% |
| 204 Highbridge, Concourse (BX) | 323 | 4.0% |
| 201 Mott Haven, Melrose, Port Morris (BX) | 320 | 4.0% |
| 110 Central Harlem (MHN) | 267 | 3.3% |
| 206 East Tremont, Bathgate, Belmont, West Farms (BX) | 247 | 3.1% |
| 202 Hunts Point, Longwood (BX) | 233 | 2.9% |
| 203 Melrose, Morrisania, Claremont, Crotona Park East (BX) | 229 | 2.9% |
| **Total** | **4,133** | **50.8%** |

## Table 2.8: Baseline Demographic Characteristics of DOC-Released Inmates by Borough

| Variable | Brooklyn | | Bronx | | Manhattan | | Queens | | Staten Island | | Citywide | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| **Number of released inmates (%)** | 13,445 | 33.0% | 10,435 | 25.6% | 8,458 | 20.8 | 7,000 | 17.2% | 1,346 | 3.3% | 40,684 | 100.0% |
| Mean Age at Arrest | 33.49 | | 33.27 | | 35.01 | | 32.42 | | 33.04 | | 33.55 | |
| **Age** | N | % | N | % | N | % | N | % | N | % | N | % |
| <18 | 466 | 3.5% | 356 | 3.4% | 228 | 2.7% | 309 | 4.4% | 30 | 2.2% | 1389 | 3.4% |
| 18-25 | 3,783 | 28.1% | 3,037 | 29.1% | 2,097 | 24.8% | 2,253 | 32.2% | 410 | 30.5% | 11,580 | 28.5% |
| 26-36 | 3,589 | 26.7% | 2,799 | 26.8% | 2,215 | 26.2% | 1,823 | 26.0% | 381 | 28.3% | 10,807 | 26.6% |
| 37-47 | 4,044 | 30.1% | 3,112 | 29.8% | 2,649 | 31.3% | 1,873 | 26.8% | 383 | 28.5% | 12,061 | 29.6% |
| 48-65 | 1,529 | 11.4% | 1,099 | 10.5% | 1,215 | 14.4% | 715 | 10.2% | 139 | 10.3% | 4,697 | 11.5% |
| 66 < | 34 | 0.3% | 32 9 | 0.3% | 54 | 0.6% | 27 | 0.4% | 3 | 0.2% | 150 | 0.4% |
| **Sex** | | | | | | | | | | | | |
| Male | 11,888 | 88.4% | 9,207 | 88.2% | 7,437 | 87.9% | 6,297 | 90% | 1,181 | 87.7% | 36,010 | 88.5% |
| Female | 1,557 | 11.6% | 1,228 | 11.8% | 1,021 | 12.1% | 703 | 10% | 165 | 12.3% | 4,674 | 11.5% |
| **Race** | | | | | | | | | | | | |
| Black | 9,294 | 69.1% | 5,456 | 52.3% | 4,916 | 58.1% | 3,776 | 53.9% | 658 | 48.9% | 24,100 | 59.2% |
| White | 1,765 | 13.1% | 967 | 9.3% | 1,108 | 13.1% | 1,439 | 20.6% | 498 | 37.0% | 5,777 | 14.2% |
| Asian | 57 | 0.4% | 15 | 0.1% | 59 | 0.7% | 221 | 3.2% | 5 | 0.4% | 357 | 0.9% |
| Am. Indian | 9 | 0.1% | 16 | 0.2% | 7 | 0.1% | 44 | 0.6% | 0 | 0.0% | 76 | 0.2% |
| Other | 2,275 | 16.9% | 1,869 | 17.9% | 2,217 | 26.2% | 1,491 | 21.3% | 173 | 12.9% | 8,025 | 19.7% |
| Unknown | 45 | 0.3% | 2,112 | 20.2% | 151 | 1.8% | 20 | 0.4% | 12 | 0.9% | 2349 | 5.8% |
| **Ethnicity** | | | | | | | | | | | | |
| Hispanic | 3,139 | 23.3% | 4,822 | 46.2% | 3,065 | 36.2% | 1,915 | 27.4% | 264 | 19.6% | 13,205 | 32.5% |

## Table 2.9: The Frequency and Rate of DOC-Released Inmates by Community Districts

| Released Inmates by Community District | Number of Released Inmates | % of Released Inmates in All Community Districts | Rate of Released Inmates per 1,000 People in the Community |
|---|---|---|---|
| **Manhattan** | | | |
| 101 Civic Center, Wall Street, Governors Island, Liberty Island (MHN) | 140 | 0.3% | 4.0 |
| 102 Greenwich Village, Noho, Soho, Little Italy (MHN) | 209 | 0.5% | 2.0 |
| 103 Lower East Side, Chinatown, Two Bridges (MHN) | 901 | 2.2% | 5.0 |
| 104 Chelsea, Clinton (MHN) | 567 | 1.4% | 6.0 |
| 105 Midtown, Times Square, Herald Square, Midtown South (MHN) | 250 | 0.6% | 6.0 |
| 106 Murray Hill, East Midtown, Stuyvesant Town (MHN) | 200 | 0.5% | 1.0 |
| 107 Lincoln Square, Upper West Side (MHN) | 644 | 1.6% | 3.0 |
| 108 Upper East Side, Lenox Hill, Yorkville, Roosevelt Island (MHN) | 186 | 0.5% | 1.0 |
| 109 West Harlem, Morningside Heights, Manhattanville, Hamilton Hgts (MHN) | 835 | 2.1% | 7.0 |
| 110 Central Harlem (MHN) | 1,772 | 4.4% | 17.0 |
| 111 East Harlem (MHN) | 1,617 | 4.0% | 14.0 |
| 112 Washington Heights, Inwood (MHN) | 1,135 | 2.8% | 5.0 |
| **Bronx** | | | |
| 201 Mott Haven, Melrose, Port Morris (BX) | 1,110 | 2.7% | 14.0 |
| 202 Hunts Point, Longwood (BX) | 660 | 1.6% | 14.0 |
| 203 Melrose, Morrisania, Claremont, Crotona Park East (BX) | 982 | 2.4% | 14.0 |
| 204 Highbridge, Concourse (BX) | 1,392 | 3.4% | 10.0 |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 1,515 | 3.7% | 12.0 |
| 206 East Tremont, Bathgate, Belmont, West Farms (BX) | 813 | 2.0% | 11.0 |
| 207 Kingsbridge Heights., Bedford Park, Fordham, University Heights (BX) | 1,000 | 2.5% | 7.0 |
| 208 Kingsbridge, Riverdale, Marble Hill, Fieldston (BX) | 173 | 0.4% | 2.0 |
| 209 Soundview, Castle Hill, Union Port, Parkchester (BX) | 1,355 | 3.3% | 8.0 |
| 210 Throgs Neck, Pelham Bay, Co-op City, Westchester Square, City Island (BX) | 282 | 0.7% | 2.0 |
| 211 Morris Park, Pelham Parkway, Bronxdale, Van Nest, Laconia (BX) | 374 | 0.9% | 3.0 |
| 212 Williamsbridge, Baychester, Woodlawn, Wakefield, Eastchester (BX) | 781 | 1.9% | 5.0 |

## Table 2.9: The Frequency and Rate of DOC-Released Inmates by Community Districts *(cont.)*

| Released Inmates by Community District | Number of Released Inmates | % of Released Inmates in all Community Districts | Rate of Released Inmates per 1,000 people in the community |
|---|---|---|---|
| **Brooklyn** | | | |
| 301 Greenpoint, Williamsburg (BK) | 683 | 1.7% | 4.0 |
| 302 Downtown Brooklyn, Fort Greene, Brooklyn Heights, Boerum Hill (BK) | 482 | 1.2% | 5.0 |
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights (BK) | 2,076 | 5.1% | 14.0 |
| 304 Bushwick (BK) | 1,166 | 2.9% | 11.0 |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 1,768 | 4.3% | 10.0 |
| 306 Red Hook, Park Slope, Gowanus, Carroll Gardens, Cobble Hill (BK) | 426 | 1.0% | 4.0 |
| 307 Sunset Park, Windsor Terrace (BK) | 453 | 1.1% | 4.0 |
| 308 Crown Heights, Prospect Heights, Weeksville (BK) | 1,040 | 2.6% | 11.0 |
| 309 Crown Heights South, Prospect Lefferts Gardens, Wingate (BK) | 729 | 1.8% | 7.0 |
| 310 Bay Ridge, Dyker Heights, Fort Hamilton (BK) | 173 | 0.4% | 1.0 |
| 311 Bensonhurst, Mapleton, Bath Beach, Gravesend (BK) | 262 | 0.6% | 2.0 |
| 312 Borough Park, Ocean Parkway, Kensington (BK) | 239 | 0.6% | 1.0 |
| 313 Coney Island, Brighton Beach, Gravesend, Homecrest, Seagate (BK) | 448 | 1.1% | 4.0 |
| 314 Flatbush, Ocean Parkway, Midwood (BK) | 642 | 1.6% | 4.0 |
| 315 Sheepshead Bay, Manhattan Beach, Kings Highway, Gravesend (BK) | 249 | 0.6% | 2.0 |
| 316 Ocean Hill, Brownsville (BK) | 1,338 | 3.3% | 16.0 |
| 317 Flatbush, Rugby, Farragut, Northeast Flatbush (BK) | 757 | 1.9% | 5.0 |
| 318 Canarsie, Flatlands, Marine Park, Mill Basin, Bergen Beach (BK) | 514 | 1.3% | 3.0 |
| **Queens** | | | |
| 401 Astoria, Long Island City (QN) | 700 | 1.7% | 3.0 |
| 402 Sunnyside , Woodside (QN) | 257 | 0.6% | 2.0 |
| 403 Jackson Heights, East Elmhurst, North Corona (QN) | 536 | 1.3% | 3.0 |
| 404 Elmhurst , Corona (QN) | 391 | 1.0% | 2.0 |
| 405 Maspeth, Middle Village, Ridgewood, Glendale (QN) | 355 | 0.9% | 2.0 |
| 406 Rego Park , Forest Hills (QN) | 97 | 0.2% | 1.0 |
| 407 Flushing, Whitestone, College Point (QN) | 377 | 0.9% | 2.0 |

## Table 2.9: The Frequency and Rate of DOC-Released Inmates by Community Districts *(cont.)*

| Released Inmates by Community District | Number of Released Inmates | % of Released Inmates in all Community Districts | Rate of Released Inmates per 1,000 people in the community |
|---|---|---|---|
| 408 Fresh Meadows, Kew Gardens Hills, Jamaica Hills (QN) | 293 | 0.7% | 2.0 |
| 409 Woodhaven, Richmond Hill, Kew Gardens (QN) | 302 | 0.7% | 2.0 |
| 410 Howard Beach, Ozone Park, South Ozone Park (QN) | 354 | 0.9% | 3.0 |
| 411 Bayside, Douglaston, Little Neck, Auburndale (QN) | 132 | 0.3% | 1.0 |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (QN) | 1,774 | 4.4% | 8.0 |
| 413 Laurelton, Cambria Heights, Queens Village, Glen Oaks (QN) | 700 | 1.7% | 4.0 |
| 414 The Rockaways, Broad Channel (QN) | 732 | 1.8% | 7.0 |
| **Staten Island** | | | |
| 501 North Island (SI) | 959 | 2.4% | 6.0 |
| 502 Mid-Island (SI) | 215 | 0.5% | 2.0 |
| 503 South Island (SI) | 171 | 0.4% | 1.0 |
| **Total** | **40,684** | **100.0%** | |

## Table 2.10: The Number of DOC-Released Inmates by Community District

| Community Districts | Number of Released Inmates | % of Released Inmates in All Community Districts | Cumulative % of Released Inmates |
|---|---|---|---|
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights (BK) | 2,076 | 5.1% | 5.1% |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (QN) | 1,774 | 4.4% | 9.5% |
| 110 Central Harlem (MHN) | 1,772 | 4.4% | 13.8% |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 1,768 | 4.3% | 18.2% |
| 111 East Harlem (MHN) | 1,617 | 4.0% | 22.1% |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 1,515 | 3.7% | 25.9% |
| 204 Highbridge, Concourse (BX) | 1,392 | 3.4% | 29.3% |
| 209 Soundview, Castle Hill, Union Port, Parkchester (BX) | 1,355 | 3.3% | 32.6% |
| 316 Ocean Hill, Brownsville (BK) | 1,338 | 3.3% | 35.9% |
| 304 Bushwick (BK) | 1,166 | 2.9% | 38.8% |
| 112 Washington Heights, Inwood (MHN) | 1,135 | 2.8% | 41.6% |
| 201 Mott Haven, Melrose, Port Morris (BX) | 1,110 | 2.7% | 44.3% |
| 308 Crown Heights, Prospect Heights, Weeksville (BK) | 1,040 | 2.6% | 46.8% |
| 207 Kingsbridge Heights., Bedford Park, Fordham, University Heights (BX) | 1,000 | 2.5% | 49.3% |
| 203 Melrose, Morrisania, Claremont, Crotona Park East (BX) | 982 | 2.4% | 51.7% |
| 501 North Island (SI) | 959 | 2.4% | 54.1% |
| 103 Lower East Side, Chinatown, Two Bridges (MHN) | 901 | 2.2% | 56.3% |
| 109 West Harlem, Morningside Heights, Manhattanville, Hamilton Hgts (MHN) | 835 | 2.1% | 58.3% |
| 206 East Tremont, Bathgate, Belmont, West Farms (BX) | 813 | 2.0% | 60.3% |
| 212 Williamsbridge, Baychester, Woodlawn, Wakefield, Eastchester (BX) | 781 | 1.9% | 62.3% |
| 317 Flatbush, Rugby, Farragut, Northeast Flatbush (BK) | 757 | 1.9% | 64.1% |
| 414 The Rockaways, Broad Channel (QN) | 732 | 1.8% | 65.9% |
| 309 Crown Heights South, Prospect Lefferts Gardens, Wingate (BK) | 729 | 1.8% | 67.7% |
| 401 Astoria , Long Island City (QN) | 700 | 1.7% | 69.4% |
| 413 Laurelton, Cambria Heights, Queens Village, Glen Oaks (QN) | 700 | 1.7% | 71.2% |
| 301 Greenpoint, Williamsburg (BK) | 683 | 1.7% | 72.8% |
| 202 Hunts Point, Longwood (BX) | 660 | 1.6% | 74.5% |

### Table 2.10: The Number of DOC-Released Inmates by Community District *(cont.)*

| Community Districts | Number of Released Inmates | % of Released Inmates in All Community Districts | Cumulative % of Released Inmates |
|---|---|---|---|
| 107 Lincoln Square, Upper West Side (MHN) | 644 | 1.6% | 76.0% |
| 314 Flatbush, Ocean Parkway, Midwood (BK) | 642 | 1.6% | 77.6% |
| 104 Chelsea, Clinton (MHN) | 567 | 1.4% | 79.0% |
| 403 Jackson Heights, East Elmhurst, North Corona (QN) | 536 | 1.3% | 80.3% |
| 318 Canarsie, Flatlands, Marine Park, Mill Basin, Bergen Beach (BK) | 514 | 1.3% | 81.6% |
| 302 Downtown Brooklyn, Fort Greene, Brooklyn Heights, Boerum Hill (BK) | 482 | 1.2% | 82.8% |
| 307 Sunset Park, Windsor Terrace (BK) | 453 | 1.1% | 83.9% |
| 313 Coney Island, Brighton Beach, Gravesend, Homecrest, Seagate (BK) | 448 | 1.1% | 85.0% |
| 306 Red Hook, Park Slope, Gowanus, Carroll Gardens, Cobble Hill (BK) | 426 | 1.0% | 86.0% |
| 404 Elmhurst , Corona (QN) | 391 | 1.0% | 87.0% |
| 407 Flushing, Whitestone, College Point (QN) | 377 | 0.9% | 87.9% |
| 211 Morris Park, Pelham Parkway, Bronxdale, Van Nest, Laconia (BX) | 374 | 0.9% | 88.8% |
| 405 Maspeth, Middle Village, Ridgewood, Glendale (QN) | 355 | 0.9% | 89.7% |
| 410 Howard Beach, Ozone Park, South Ozone Park (QN) | 354 | 0.9% | 90.6% |
| 409 Woodhaven, Richmond Hill, Kew Gardens (QN) | 302 | 0.7% | 91.3% |
| 408 Fresh Meadows, Kew Gardens Hills, Jamaica Hills (QN) | 293 | 0.7% | 92.0% |
| 210 Throgs Neck, Pelham Bay, Co-op City, Westchester Square, City Island (BX) | 282 | 0.7% | 92.7% |
| 311 Bensonhurst, Mapleton, Bath Beach, Gravesend (BK) | 262 | 0.6% | 93.4% |
| 402 Sunnyside , Woodside (QN) | 257 | 0.6% | 94.0% |
| 105 Midtown, Times Square, Herald Square, Midtown South (MHN) | 250 | 0.6% | 94.6% |
| 315 Sheepshead Bay, Manhattan Beach, Kings Highway, Gravesend (BK) | 249 | 0.6% | 95.2% |
| 312 Borough Park, Ocean Parkway, Kensington (BK) | 239 | 0.6% | 95.8% |
| 502 Mid-Island (SI) | 215 | 0.5% | 96.4% |
| 102 Greenwich Village, Noho, Soho, Little Italy (MHN) | 209 | 0.5% | 96.9% |
| 106 Murray Hill, East Midtown, Stuyvesant Town (MHN) | 200 | 0.5% | 97.4% |
| 108 Upper East Side, Lenox Hill, Yorkville, Roosevelt Island (MHN) | 186 | 0.5% | 97.8% |
| 208 Kingsbridge, Riverdale, Marble Hill, Fieldston (BX) | 173 | 0.4% | 98.2% |
| 310 Bay Ridge, Dyker Heights, Fort Hamilton (BK) | 173 | 0.4% | 98.7% |

### Table 2.10: The Number of DOC-Released Inmates by Community District *(cont.)*

| Community Districts | Number of Released Inmates | % of Released Inmates in All Community Districts | Cumulative % of Released Inmates |
|---|---|---|---|
| 503 South Island (SI) | 171 | 0.4% | 99.1% |
| 101 Civic Center, Wall Street, Governors Island, Liberty Island (MHN) | 140 | 0.3% | 99.4% |
| 411 Bayside, Douglaston, Little Neck, Auburndale (QN) | 132 | 0.3% | 99.8% |
| 406 Rego Park , Forest Hills (QN) | 97 | 0.2% | 100.0% |
| **Total** | **40,684** | **100.0%** | |

## Table 2.11: The Rate of DOC-Released Inmates by Community District

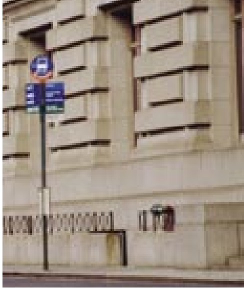
| Community Districts | Number of Released Inmates | Rate of Released Inmates per 1,000 |
|---|---|---|
| 110 Central Harlem (MHN) | 1,772 | 16.5 |
| 316 Ocean Hill, Brownsville (BK) | 1,338 | 15.7 |
| 111 East Harlem (MHN) | 1,617 | 13.7 |
| 201 Mott Haven, Melrose, Port Morris (BX) | 1,110 | 13.5 |
| 202 Hunts Point, Longwood (BX) | 660 | 14.1 |
| 203 Melrose, Morrisania, Claremont, Crotona Park East (BX) | 982 | 14.3 |
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights (BK) | 2,076 | 14.4 |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 1,515 | 11.8 |
| 206 East Tremont, Bathgate, Belmont, West Farms (BX) | 813 | 10.7 |
| 304 Bushwick (BK) | 1,166 | 11.2 |
| 308 Crown Heights, Prospect Heights, Weeksville (BK) | 1,040 | 10.8 |
| 204 Highbridge, Concourse (BX) | 1,392 | 10.0 |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 1,768 | 10.2 |
| 209 Soundview, Castle Hill, Union Port, Parkchester (BX) | 1,355 | 8.1 |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (QN) | 1,774 | 7.9 |
| 109 West Harlem, Morningside Heights, Manhattanville, Hamilton Hgts (MHN) | 835 | 7.5 |
| 207 Kingsbridge Heights., Bedford Park, Fordham, University Heights (BX) | 1,000 | 7.1 |
| 309 Crown Heights South, Prospect Lefferts Gardens, Wingate (BK) | 729 | 7.0 |
| 414 The Rockaways, Broad Channel (QN) | 732 | 6.9 |
| 104 Chelsea, Clinton (MHN) | 567 | 6.5 |
| 105 Midtown, Times Square, Herald Square, Midtown South (MHN) | 250 | 5.7 |
| 501 North Island (SI) | 959 | 5.9 |
| 103 Lower East Side, Chinatown, Two Bridges (MHN) | 901 | 5.5 |
| 112 Washington Heights, Inwood (MHN) | 1,135 | 5.4 |
| 212 Williamsbridge, Baychester, Woodlawn, Wakefield, Eastchester (BX) | 781 | 5.2 |
| 302 Downtown Brooklyn, Fort Greene, Brooklyn Heights, Boerum Hill (BK) | 482 | 4.9 |
| 317 Flatbush, Rugby, Farragut, Northeast Flatbush (BK) | 757 | 4.6 |

### Table 2.11: The Rate of DOC-Released Inmates by Community District *(cont.)*

| Community Districts | Number of Released Inmates | Rate of Released Inmates per 1,000 |
|---|---|---|
| 101 Civic Center, Wall Street, Governors Island, Liberty Island (MHN) | 140 | 4.1 |
| 301 Greenpoint, Williamsburg (BK) | 683 | 4.3 |
| 306 Red Hook, Park Slope, Gowanus, Carroll Gardens, Cobble Hill (BK) | 426 | 4.1 |
| 307 Sunset Park, Windsor Terrace (BK) | 453 | 3.8 |
| 313 Coney Island, Brighton Beach, Gravesend, Homecrest, Seagate (BK) | 448 | 4.2 |
| 314 Flatbush, Ocean Parkway, Midwood (BK) | 642 | 3.8 |
| 413 Laurelton, Cambria Heights, Queens Village, Glen Oaks (QN) | 700 | 3.6 |
| 107 Lincoln Square, Upper West Side (MHN) | 644 | 3.1 |
| 211 Morris Park, Pelham Parkway, Bronxdale, Van Nest, Laconia (BX) | 374 | 3.4 |
| 318 Canarsie, Flatlands, Marine Park, Mill Basin, Bergen Beach (BK) | 514 | 2.6 |
| 401 Astoria , Long Island City (QN) | 700 | 3.3 |
| 403 Jackson Heights, East Elmhurst, North Corona (QN) | 536 | 3.2 |
| 410 Howard Beach, Ozone Park, South Ozone Park (QN) | 354 | 2.8 |
| 102 Greenwich Village, Noho, Soho, Little Italy (MHN) | 209 | 2.2 |
| 208 Kingsbridge, Riverdale, Marble Hill, Fieldston (BX) | 173 | 1.7 |
| 210 Throgs Neck, Pelham Bay, Co-op City, Westchester Square, City Island (BX) | 282 | 2.4 |
| 311 Bensonhurst, Mapleton, Bath Beach, Gravesend (BK) | 262 | 1.5 |
| 315 Sheepshead Bay, Manhattan Beach, Kings Highway, Gravesend (BK) | 249 | 1.6 |
| 402 Sunnyside , Woodside (QN) | 257 | 2.3 |
| 404 Elmhurst , Corona (QN) | 391 | 2.3 |
| 405 Maspeth, Middle Village, Ridgewood, Glendale (QN) | 355 | 2.1 |
| 407 Flushing, Whitestone, College Point (QN) | 377 | 1.6 |
| 408 Fresh Meadows, Kew Gardens Hills, Jamaica Hills (QN) | 293 | 2.0 |
| 409 Woodhaven, Richmond Hill, Kew Gardens (QN) | 302 | 2.1 |
| 502 Mid-Island (SI) | 215 | 1.7 |
| 106 Murray Hill, East Midtown, Stuyvesant Town (MHN) | 200 | 1.5 |
| 108 Upper East Side, Lenox Hill, Yorkville, Roosevelt Island (MHN) | 186 | 0.9 |

## Table 2.11: The Rate of DOC-Released Inmates by Community District *(cont.)*

| Community Districts | Number of Released Inmates | Rate of Released Inmates per 1,000 |
|---|---|---|
| 310 Bay Ridge, Dyker Heights, Fort Hamilton (BK) | 173 | 1.4 |
| 312 Borough Park, Ocean Parkway, Kensington (BK) | 239 | 1.3 |
| 406 Rego Park , Forest Hills (QN) | 97 | 0.8 |
| 411 Bayside, Douglaston, Little Neck, Auburndale (QN) | 132 | 1.1 |
| 503 South Island (SI) | 171 | 1.1 |



# APPENDIX I

## Tables Profiling the Distribution of Services for Released Inmates

### Table 3.1: The Number of Mental Hygiene Programs and Services Contracted with DOHMH in 2004 by Community District

| Community Districts | Number of DOHMH Services | Percent of Total Services | Cumulative Percent |
|---|---|---|---|
| 105 Midtown, Times Square, Herald Square, Midtown South (MHN) | 46 | 6.8% | 6.8% |
| 102 Greenwich Village, Noho, Soho, Little Italy (MHN) | 43 | 6.3% | 13.1% |
| 501 North Island (SI) | 40 | 5.9% | 19.0% |
| 302 Downtown Brooklyn, Fort Greene, Brooklyn Heights, Boerum Hill (BK) | 31 | 4.6% | 23.6% |
| 111 East Harlem (MHN) | 27 | 4.0% | 27.5% |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (QN) | 27 | 4.0% | 31.5% |
| 110 Central Harlem (MHN) | 25 | 3.7% | 35.2% |
| 107 Lincoln Square, Upper West Side (MHN) | 22 | 3.2% | 38.4% |
| 101 Civic Center, Wall Street, Governors Island, Liberty Island, Ellis Island, Tribeca (MHN) | 18 | 2.7% | 41.1% |
| 104 Chelsea, Clinton (MHN) | 18 | 2.7% | 43.7% |
| 103 Lower East Side, Chinatown, Two Bridges (MHN) | 17 | 2.5% | 46.2% |
| 414 The Rockaways, Broad Channel (QN) | 17 | 2.5% | 48.7% |
| 502 Mid-Island (SI) | 17 | 2.5% | 51.3% |
| 112 Washington Heights, Inwood (MHN) | 16 | 2.4% | 53.6% |
| 404 Elmhurst , Corona (QN) | 14 | 2.1% | 55.7% |
| 201 Mott Haven, Melrose, Port Morris (BX) | 12 | 1.8% | 57.4% |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 12 | 1.8% | 59.2% |
| 211 Morris Park, Pelham Parkway, Bronxdale, Van Nest, Laconia (BX) | 12 | 1.8% | 61.0% |
| 307 Sunset Park, Windsor Terrace (BK) | 12 | 1.8% | 62.7% |
| 314 Flatbush, Ocean Parkway, Midwood (BK) | 12 | 1.8% | 64.5% |
| 411 Bayside, Douglaston, Little Neck, Auburndale (QN) | 12 | 1.8% | 66.3% |

## Table 3.1: The Number of Mental Hygiene Programs and Services Contracted with DOHMH in 2004 by Community District *(cont.)*

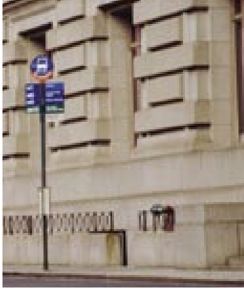
| Community Districts | Number of DOHMH Services | Percent of Total Services | Cumulative Percent |
|---|---|---|---|
| 109 West Harlem, Morningside Heights, Manhattanville, Hamilton Heights (MHN) | 11 | 1.6% | 67.9% |
| 203 Melrose, Morrisania, Claremont, Crotona Park East (BX) | 11 | 1.6% | 69.5% |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 11 | 1.6% | 71.1% |
| 316 Ocean Hill, Brownsville (BK) | 11 | 1.6% | 72.8% |
| 401 Astoria , Long Island City (QN) | 11 | 1.6% | 74.4% |
| 108 Upper East Side, Lenox Hill, Yorkville, Roosevelt Island (MHN) | 10 | 1.5% | 75.8% |
| 204 Highbridge, Concourse (BX) | 10 | 1.5% | 77.3% |
| 210 Throgs Neck, Pelham Bay, Co-op City, Westchester Square, City Island (BX) | 10 | 1.5% | 78.8% |
| 312 Borough Park, Ocean Parkway, Kensington (BK) | 10 | 1.5% | 80.3% |
| 318 Canarsie, Flatlands, Marine Park, Mill Basin, Bergen Beach (BK) | 10 | 1.5% | 81.7% |
| 408 Fresh Meadows, Kew Gardens Hills, Jamaica Hills (QN) | 10 | 1.5% | 83.2% |
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Height (BK) | 8 | 1.2% | 84.4% |
| 407 Flushing, Whitestone, College Point (QN) | 8 | 1.2% | 85.6% |
| 207 Kingsbridge Heights., Bedford Park, Fordham, University Heights (BX) | 7 | 1.0% | 86.6% |
| 309 Crown Heights South, Prospect Lefferts Gardens, Wingate (BK) | 7 | 1.0% | 87.6% |
| 402 Sunnyside , Woodside (QN) | 7 | 1.0% | 88.7% |
| 301 Greenpoint, Williamsburg (BK) | 6 | 0.9% | 89.5% |
| 315 Sheepshead Bay, Manhattan Beach, Kings Highway, Gravesend (BK) | 6 | 0.9% | 90.4% |
| 406 Rego Park , Forest Hills (QN) | 6 | 0.9% | 91.3% |
| 208 Kingsbridge, Riverdale, Marble Hill, Fieldston (BX) | 5 | 0.7% | 92.0% |
| 212 Williamsbridge, Baychester, Woodlawn, Wakefield, Eastchester (BX) | 5 | 0.7% | 92.8% |
| 306 Red Hook, Park Slope, Gowanus, Carroll Gardens, Cobble Hill (BK) | 5 | 0.7% | 93.5% |
| 403 Jackson Heights, East Elmhurst, North Corona (QN) | 5 | 0.7% | 94.3% |
| 413 Laurelton, Cambria Heights, Queens Village, Glen Oaks (QN) | 5 | 0.7% | 95.0% |
| 106 Murray Hill, East Midtown, Stuyvesant Town (MHN) | 4 | 0.6% | 95.6% |
| 202 Hunts Point, Longwood (BX) | 4 | 0.6% | 96.2% |
| 304 Bushwick (BK) | 4 | 0.6% | 96.8% |
| 206 East Tremont, Bathgate, Belmont, West Farms (BX) | 3 | 0.4% | 97.2% |

### Table 3.1: The Number of Mental Hygiene Programs and Services Contracted with DOHMH in 2004 by Community District *(cont.)*

| Community Districts | Number of DOHMH Services | Percent of Total Services | Cumulative Percent |
|---|---|---|---|
| 308 Crown Heights, Prospect Heights, Weeksville (BK) | 3 | 0.4% | 97.6% |
| 310 Bay Ridge, Dyker Heights, Fort Hamilton (BK) | 3 | 0.4% | 98.1% |
| 313 Coney Island, Brighton Beach, Gravesend, Homecrest, Seagate (BK) | 3 | 0.4% | 98.5% |
| 317 Flatbush, Rugby, Farragut, Northeast Flatbush (BK) | 3 | 0.4% | 99.0% |
| 409 Woodhaven, Richmond Hill, Kew Gardens (QN) | 2 | 0.3% | 99.3% |
| 410 Howard Beach, Ozone Park, South Ozone Park (QN) | 2 | 0.3% | 99.6% |
| 209 Soundview, Castle Hill, Union Port, Parkchester (BX) | 1 | 0.1% | 99.7% |
| 311 Bensonhurst, Mapleton, Bath Beach, Gravesend (BK) | 1 | 0.1% | 99.9% |
| 503 South Island (SI) | 1 | 0.1% | 100.0% |
| **Total** | **679** | **100.0%** | |

**Table 3.2: The Number of Services in Partnership with the Bureau of Transitional Health Care Coordination in 2006 by Community District**

| Community Districts | Number of THCC Services | Percent of Total Services | Cumulative Percent |
|---|---|---|---|
| 111 East Harlem (MHN) | 26 | 9.3% | 9.3% |
| 105 Midtown, Times Square, Herald Square, Midtown South (MHN) | 16 | 5.7% | 15.0% |
| 110 Central Harlem (MHN) | 14 | 5.0% | 20.0% |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (QN) | 14 | 5.0% | 25.0% |
| 104 Chelsea, Clinton (MHN) | 13 | 4.6% | 29.6% |
| 201 Mott Haven, Melrose, Port Morris (BX) | 13 | 4.6% | 34.3% |
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Height (BK) | 13 | 4.6% | 38.9% |
| 501 North Island (SI) | 12 | 4.3% | 43.2% |
| 102 Greenwich Village, Noho, Soho, Little Italy (MHN) | 11 | 3.9% | 47.1% |
| 204 Highbridge, Concourse (BX) | 11 | 3.9% | 51.1% |
| 103 Lower East Side, Chinatown, Two Bridges (MHN) | 10 | 3.6% | 54.6% |
| 101 Civic Center, Wall Street, Governors Island, Liberty Island, Ellis Island, Tribeca (MHN) | 9 | 3.2% | 57.9% |
| 302 Downtown Brooklyn, Fort Greene, Brooklyn Heights, Boerum Hill (BK) | 9 | 3.2% | 61.1% |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 7 | 2.5% | 63.6% |
| 202 Hunts Point, Longwood (BX) | 6 | 2.1% | 65.7% |
| 203 Melrose, Morrisania, Claremont, Crotona Park East (BX) | 6 | 2.1% | 67.9% |
| 308 Crown Heights, Prospect Heights, Weeksville (BK) | 6 | 2.1% | 70.0% |
| 109 West Harlem, Morningside Heights, Manhattanville, Hamilton Heights (MHN) | 5 | 1.8% | 71.8% |
| 207 Kingsbridge Heights., Bedford Park, Fordham, University Heights (BX) | 5 | 1.8% | 73.6% |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 5 | 1.8% | 75.4% |
| 107 Lincoln Square, Upper West Side (MHN) | 4 | 1.4% | 76.8% |
| 112 Washington Heights, Inwood (MHN) | 4 | 1.4% | 78.2% |
| 206 East Tremont, Bathgate, Belmont, West Farms (BX) | 4 | 1.4% | 79.6% |
| 301 Greenpoint, Williamsburg (BK) | 4 | 1.4% | 81.1% |
| 314 Flatbush, Ocean Parkway, Midwood (BK) | 4 | 1.4% | 82.5% |
| 106 Murray Hill, East Midtown, Stuyvesant Town (MHN) | 3 | 1.1% | 83.6% |
| 210 Throgs Neck, Pelham Bay, Co-op City, Westchester Square, City Island (BX) | 3 | 1.1% | 84.6% |
| 211 Morris Park, Pelham Parkway, Bronxdale, Van Nest, Laconia (BX) | 3 | 1.1% | 85.7% |

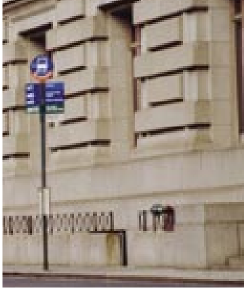


## Table 3.2: The Number of Services in Partnership with the Bureau of Transitional Health Care Coordination in 2006 by Community District *(cont.)*

| Community Districts | Number of THCC Services | Percent of Total Services | Cumulative Percent |
|---|---|---|---|
| 304 Bushwick (BK) | 3 | 1.1% | 86.8% |
| 315 Sheepshead Bay, Manhattan Beach, Kings Highway, Gravesend (BK) | 3 | 1.1% | 87.9% |
| 316 Ocean Hill, Brownsville (BK) | 3 | 1.1% | 88.9% |
| 401 Astoria , Long Island City (QN) | 3 | 1.1% | 90.0% |
| 208 Kingsbridge, Riverdale, Marble Hill, Fieldston (BX) | 2 | 0.7% | 90.7% |
| 306 Red Hook, Park Slope, Gowanus, Carroll Gardens, Cobble Hill (BK) | 2 | 0.7% | 91.4% |
| 402 Sunnyside , Woodside (QN) | 2 | 0.7% | 92.1% |
| 403 Jackson Heights, East Elmhurst, North Corona (QN) | 2 | 0.7% | 92.9% |
| 404 Elmhurst , Corona (QN) | 2 | 0.7% | 93.6% |
| 406 Rego Park , Forest Hills (QN) | 2 | 0.7% | 94.3% |
| 408 Fresh Meadows, Kew Gardens Hills, Jamaica Hills (QN) | 2 | 0.7% | 95.0% |
| 414 The Rockaways, Broad Channel (QN) | 2 | 0.7% | 95.7% |
| 502 Mid-Island (SI) | 2 | 0.7% | 96.4% |
| 108 Upper East Side, Lenox Hill, Yorkville, Roosevelt Island (MHN) | 1 | 0.4% | 96.8% |
| 209 Soundview, Castle Hill, Union Port, Parkchester (BX) | 1 | 0.4% | 97.1% |
| 307 Sunset Park, Windsor Terrace (BK) | 1 | 0.4% | 97.5% |
| 309 Crown Heights South, Prospect Lefferts Gardens, Wingate (BK) | 1 | 0.4% | 97.9% |
| 312 Borough Park, Ocean Parkway, Kensington (BK) | 1 | 0.4% | 98.2% |
| 317 Flatbush, Rugby, Farragut, Northeast Flatbush (BK) | 1 | 0.4% | 98.6% |
| 318 Canarsie, Flatlands, Marine Park, Mill Basin, Bergen Beach (BK) | 1 | 0.4% | 98.9% |
| 409 Woodhaven, Richmond Hill, Kew Gardens (QN) | 1 | 0.4% | 99.3% |
| 411 Bayside, Douglaston, Little Neck, Auburndale (QN) | 1 | 0.4% | 99.6% |
| 413 Laurelton, Cambria Heights, Queens Village, Glen Oaks (QN) | 1 | 0.4% | 100.0% |
| **Total** | **280** | **100.0%** | **90.0%** |

### Table 3.3: The Number of Services Listed in New York City Reentry Guidebooks by Community District

| Community Districts | Number of Guidebook Services | Percent of Total Services | Cumulative Percent |
|---|---|---|---|
| 111 East Harlem (MHN) | 59 | 12.7% | 12.7% |
| 105 Midtown, Times Square, Herald Square, Midtown South (MHN) | 44 | 9.5% | 22.2% |
| 110 Central Harlem (MHN) | 38 | 8.2% | 30.3% |
| 102 Greenwich Village, Noho, Soho, Little Italy (MHN) | 32 | 6.9% | 37.2% |
| 101 Civic Center, Wall Street, Governors Island, Liberty Island, Ellis Island, Tribect (MHN) | 26 | 5.6% | 42.8% |
| 104 Chelsea, Clinton (MHN) | 25 | 5.4% | 48.2% |
| 103 Lower East Side, Chinatown, Two Bridges (MHN) | 21 | 4.5% | 52.7% |
| 302 Downtown Brooklyn, Fort Greene, Brooklyn Heights, Boerum Hill (BK) | 21 | 4.5% | 57.2% |
| 109 West Harlem, Morningside Heights, Manhattanville, Hamilton Heights (MHN) | 20 | 4.3% | 61.5% |
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights (BK) | 19 | 4.1% | 65.6% |
| 201 Mott Haven, Melrose, Port Morris (BX) | 12 | 2.6% | 68.2% |
| 501 North Island (SI) | 11 | 2.4% | 70.5% |
| 106 Murray Hill, East Midtown, Stuyvesant Town (MHN) | 10 | 2.2% | 72.7% |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (QN) | 10 | 2.2% | 74.8% |
| 202 Hunts Point, Longwood (BX) | 8 | 1.7% | 76.6% |
| 308 Crown Heights, Prospect Heights, Weeksville (BK) | 8 | 1.7% | 78.3% |
| 112 Washington Heights, Inwood (MHN) | 7 | 1.5% | 79.8% |
| 204 Highbridge, Concourse (BX) | 7 | 1.5% | 81.3% |
| 107 Lincoln Square, Upper West Side (MHN) | 6 | 1.3% | 82.6% |
| 203 Melrose, Morrisania, Claremont, Crotona Park East (BX) | 6 | 1.3% | 83.9% |
| 206 East Tremont, Bathgate, Belmont, West Farms (BX) | 6 | 1.3% | 85.2% |
| 401 Astoria , Long Island City (QN) | 6 | 1.3% | 86.5% |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 5 | 1.1% | 87.5% |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 4 | 0.9% | 88.4% |
| 403 Jackson Heights, East Elmhurst, North Corona (QN) | 4 | 0.9% | 89.2% |
| 108 Upper East Side, Lenox Hill, Yorkville, Roosevelt Island (MHN) | 3 | 0.6% | 89.9% |
| 207 Kingsbridge Heights., Bedford Park, Fordham, University Heights (BX) | 3 | 0.6% | 90.5% |
| 301 Greenpoint, Williamsburg (BK) | 3 | 0.6% | 91.2% |

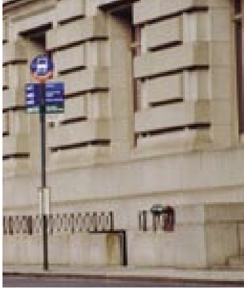


## Table 3.3: The Number of Services Listed in New York City Reentry Guidebooks by Community District *(cont.)*

| Community Districts | Number of Guidebook Services | Percent of Total Services | Cumulative Percent |
|---|---|---|---|
| 304 Bushwick (BK) | 3 | 0.6% | 91.8% |
| 306 Red Hook, Park Slope, Gowanus, Carroll Gardens, Cobble Hill (BK) | 3 | 0.6% | 92.5% |
| 309 Crown Heights South, Prospect Lefferts Gardens, Wingate (BK) | 3 | 0.6% | 93.1% |
| 314 Flatbush, Ocean Parkway, Midwood (BK) | 3 | 0.6% | 93.8% |
| 316 Ocean Hill, Brownsville (BK) | 3 | 0.6% | 94.4% |
| 402 Sunnyside , Woodside (QN) | 3 | 0.6% | 95.1% |
| 408 Fresh Meadows, Kew Gardens Hills, Jamaica Hills (QN) | 3 | 0.6% | 95.7% |
| 211 Morris Park, Pelham Parkway, Bronxdale, Van Nest, Laconia (BX) | 2 | 0.4% | 96.1% |
| 404 Elmhurst , Corona (QN) | 2 | 0.4% | 97.0% |
| 409 Woodhaven, Richmond Hill, Kew Gardens (QN) | 2 | 0.4% | 97.4% |
| 413 Laurelton, Cambria Heights, Queens Village, Glen Oaks (QN) | 2 | 0.4% | 97.8% |
| 210 Throgs Neck, Pelham Bay, Co-op City, Westchester Square, City Island (BX) | 1 | 0.2% | 98.1% |
| 307 Sunset Park, Windsor Terrace (BK) | 1 | 0.2% | 98.3% |
| 310 Bay Ridge, Dyker Heights, Fort Hamilton (BK) | 1 | 0.2% | 98.5% |
| 313 Coney Island, Brighton Beach, Gravesend, Homecrest, Seagate (BK) | 1 | 0.2% | 98.7% |
| 315 Sheepshead Bay, Manhattan Beach, Kings Highway, Gravesend (BK) | 1 | 0.2% | 98.9% |
| 317 Flatbush, Rugby, Farragut, Northeast Flatbush (BK) | 1 | 0.2% | 99.1% |
| 318 Canarsie, Flatlands, Marine Park, Mill Basin, Bergen Beach (BK) | 1 | 0.2% | 99.4% |
| 406 Rego Park , Forest Hills (QN) | 1 | 0.2% | 99.6% |
| 407 Flushing, Whitestone, College Point (QN) | 1 | 0.2% | 99.8% |
| 503 South Island (SI) | 1 | 0.2% | 100.0% |
| **Total** | **465** | **100.0%** | |

**Table 3.4: The Number of Rikers Island Discharge Enhancement Primary Referral Sources by Community District**

| Community Districts | RIDE Services | Percent of Total Services | Cumulative Percent |
|---|---|---|---|
| 111 East Harlem (MHN) | 30 | 7.3% | 7.3% |
| 105 Midtown, Times Square, Herald Square, Midtown South (MHN) | 24 | 5.8% | 13.1% |
| 201 Mott Haven, Melrose, Port Morris (BX) | 20 | 4.9% | 18.0% |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (QN) | 19 | 4.6% | 22.6% |
| 302 Downtown Brooklyn, Fort Greene, Brooklyn Heights, Boerum Hill (BK) | 18 | 4.4% | 27.0% |
| 104 Chelsea, Clinton (MHN) | 17 | 4.1% | 31.1% |
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights (BK) | 17 | 4.1% | 35.3% |
| 103 Lower East Side, Chinatown, Two Bridges (MHN) | 16 | 3.9% | 39.2% |
| 501 North Island (SI) | 16 | 3.9% | 43.1% |
| 106 Murray Hill, East Midtown, Stuyvesant Town (MHN) | 15 | 3.6% | 46.7% |
| 107 Lincoln Square, Upper West Side (MHN) | 11 | 2.7% | 49.4% |
| 308 Crown Heights, Prospect Heights, Weeksville (BK) | 11 | 2.7% | 52.1% |
| 110 Central Harlem (MHN) | 10 | 2.4% | 54.5% |
| 204 Highbridge, Concourse (BX) | 10 | 2.4% | 56.9% |
| 109 West Harlem, Morningside Heights, Manhattanville, Hamilton Heights (MHN) | 9 | 2.2% | 59.1% |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 9 | 2.2% | 61.3% |
| 206 East Tremont, Bathgate, Belmont, West Farms (BX) | 9 | 2.2% | 63.5% |
| 211 Morris Park, Pelham Parkway, Bronxdale, Van Nest, Laconia (BX) | 8 | 1.9% | 65.5% |
| 309 Crown Heights South, Prospect Lefferts Gardens, Wingate (BK) | 8 | 1.9% | 67.4% |
| 102 Greenwich Village, Noho, Soho, Little Italy (MHN) | 7 | 1.7% | 69.1% |
| 304 Bushwick (BK) | 7 | 1.7% | 70.8% |
| 101 Civic Center, Wall Street, Governors Island, Liberty Island, Ellis Island, Tribeca (MHN) | 6 | 1.5% | 72.3% |
| 202 Hunts Point, Longwood (BX) | 6 | 1.5% | 73.7% |
| 203 Melrose, Morrisania, Claremont, Crotona Park East (BX) | 6 | 1.5% | 75.2% |
| 301 Greenpoint, Williamsburg (BK) | 6 | 1.5% | 76.6% |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 6 | 1.5% | 78.1% |
| 314 Flatbush, Ocean Parkway, Midwood (BK) | 6 | 1.5% | 79.6% |
| 108 Upper East Side, Lenox Hill, Yorkville, Roosevelt Island (MHN) | 5 | 1.2% | 80.8% |
| 306 Red Hook, Park Slope, Gowanus, Carroll Gardens, Cobble Hill (BK) | 5 | 1.2% | 82.0% |

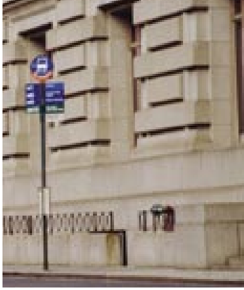


## Table 3.4: The Number of Rikers Island Discharge Enhancement Primary Referral Sources by Community District *(cont.)*

| Community Districts | RIDE Services | Percent of Total Services | Cumulative Percent |
|---|---|---|---|
| 316 Ocean Hill, Brownsville (BK) | 5 | 1.2% | 83.2% |
| 112 Washington Heights, Inwood (MHN) | 4 | 1.0% | 84.2% |
| 210 Throgs Neck, Pelham Bay, Co-op City, Westchester Square, City Island (BX) | 4 | 1.0% | 85.2% |
| 212 Williamsbridge, Baychester, Woodlawn, Wakefield, Eastchester (BX) | 4 | 1.0% | 86.1% |
| 307 Sunset Park, Windsor Terrace (BK) | 4 | 1.0% | 87.1% |
| 401 Astoria & Long Island City (QN) | 4 | 1.0% | 88.1% |
| 408 Fresh Meadows, Kew Gardens Hills, Jamaica Hills (QN) | 4 | 1.0% | 89.1% |
| 409 Woodhaven, Richmond Hill, Kew Gardens (QN) | 4 | 1.0% | 90.0% |
| 503 South Island (SI) | 4 | 1.0% | 91.0% |
| 310 Bay Ridge, Dyker Heights, Fort Hamilton (BK) | 3 | .7% | 91.7% |
| 313 Coney Island, Brighton Beach, Gravesend, Homecrest, Seagate (BK) | 3 | .7% | 92.5% |
| 402 Sunnyside & Woodside (QN) | 3 | .7% | 93.2% |
| 404 Elmhurst & Corona (QN) | 3 | .7% | 93.9% |
| 406 Rego Park & Forest Hills (QN) | 3 | .7% | 94.6% |
| 413 Laurelton, Cambria Heights, Queens Village, Glen Oaks (QN) | 3 | .7% | 95.4% |
| 414 The Rockaways, Broad Channel (QN) | 3 | .7% | 96.1% |
| 209 Soundview, Castle Hill, Union Port, Parkchester (BX) | 2 | .5% | 96.6% |
| 317 Flatbush, Rugby, Farragut, Northeast Flatbush (BK) | 2 | .5% | 97.1% |
| 318 Canarsie, Flatlands, Marine Park, Mill Basin, Bergen Beach (BK) | 2 | .5% | 97.6% |
| 410 Howard Beach, Ozone Park, South Ozone Park (QN) | 2 | .5% | 98.1% |
| 502 Mid-Island (SI) | 2 | .5% | 98.5% |
| 207 Kingsbridge Heights., Bedford Park, Fordham, University Heights (BX) | 1 | .2% | 98.8% |
| 208 Kingsbridge, Riverdale, Marble Hill, Fieldston (BX) | 1 | .2% | 99.0% |
| 312 Borough Park, Ocean Parkway, Kensington (BK) | 1 | .2% | 99.3% |
| 403 Jackson Heights, East Elmhurst, North Corona (QN) | 1 | .2% | 99.5% |
| 405 Maspeth, Middle Village, Ridgewood, Glendale (QN) | 1 | .2% | 99.8% |
| 407 Flushing, Whitestone, College Point (QN) | 1 | .2% | 100.0% |
| **Total** | **411** | **100.0**% | |

## Table 3.7: Health and Human Services Located in the Community Districts with the Highest Rate of DOC-Released Inmates

| Services Located in the Community Districts of Highest Inmate Return -- 49.3 percent of the released inmates live in these 14 community districts | NYC DOHMH Service Listings | | THCC Partners Listings | | Reentry Guide-book Listings | | RIDE Primary Referral Sources | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights (BK) | 8 | 1.2% | 13 | 4.6% | 19 | 4.1% | 17 | 4.1% |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (QN) | 27 | 4.0% | 14 | 5.0% | 10 | 2.2% | 19 | 4.6% |
| 110 Central Harlem (MHN) | 25 | 3.7% | 14 | 5.0% | 38 | 8.2% | 10 | 2.4% |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 11 | 1.6% | 5 | 1.8% | 4 | 0.9% | 6 | 1.5% |
| 111 East Harlem (MHN) | 27 | 4.0% | 26 | 9.3% | 59 | 12.7% | 30 | 7.3% |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 12 | 1.8% | 7 | 2.5% | 5 | 1.1% | 9 | 2.2% |
| 204 Highbridge, Concourse (BX) | 10 | 1.5% | 11 | 3.9% | 7 | 1.5% | 10 | 2.4% |
| 209 Soundview, Castle Hill, Union Port, Parkchester (BX) | 1 | 0.1% | 1 | 0.4% | 0 | 0.0% | 2 | 0.5% |
| 316 Ocean Hill, Brownsville (BK) | 11 | 1.6% | 3 | 1.1% | 3 | 0.6% | 5 | 1.2% |
| 304 Bushwick (BK) | 4 | 0.6% | 3 | 1.1% | 3 | 0.6% | 7 | 1.7% |
| 112 Washington Heights, Inwood (MHN) | 16 | 2.4% | 4 | 1.4% | 7 | 1.5% | 4 | 1.0% |
| 201 Mott Haven, Melrose, Port Morris (BX) | 12 | 1.8% | 13 | 4.6% | 12 | 2.6% | 20 | 4.9% |
| 308 Crown Heights, Prospect Heights, Weeksville (BK) | 3 | 0.4% | 6 | 2.1% | 8 | 1.7% | 11 | 2.7% |
| 207 Kingsbridge Heights., Bedford Park, Fordham, University Heights (BX) | 7 | 1.0% | 5 | 1.8% | 3 | 0.6% | 1 | 0.2% |
| **Total** | | **25.7%** | | **44.6%** | | **38.3%** | | **36.7%** |



## Table 3.8: Chemical Dependency, Mental Health, and Mental Retardation Programs and Services Contracted with DOHMH in 2004 by Borough

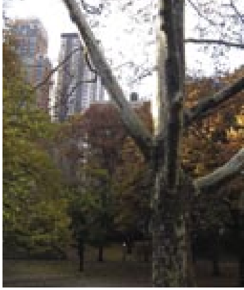
| Services by Borough | Released Inmates | | NYC DOHMH Chemical Dependency Service Addresses | | Mental Health | | Mental Retardation and Developmental Disabilities | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| Brooklyn | 13445 | 33.0% | 8 | 12.1% | 115 | 22.7% | 23 | 21.7% |
| Bronx | 10435 | 25.6% | 7 | 10.6% | 70 | 13.8% | 15 | 14.2% |
| Manhattan | 8458 | 20.8% | 32 | 48.5% | 194 | 38.3% | 31 | 29.2% |
| Queens | 7000 | 17.2% | 11 | 16.7% | 95 | 18.7% | 20 | 18.9% |
| Staten Island | 1346 | 3.3% | 8 | 12.1% | 33 | 6.5% | 17 | 16.0% |
| **Total** | **40684** | **100.0%** | **66** | **100.0%** | **507** | **100.0%** | **106** | **100.0%** |

## Table 3.9: Community Districts in the Top Two Quartiles of DOC-Released Drug-Using Inmates by Chemical Dependency Services

| Community Districts with the Highest Numbers of Self Reported Drug Use | Frequency of Drug Users | | NYC DOHMH Chemical Dependency Services | | RIDE Substance Abuse Treatment Services | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Hgts (BK) | 422 | 5.3% | 1 | 1.5% | 7 | 1.9% |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 422 | 4.4% | 0 | 0.0% | 3 | 0.8% |
| 111 East Harlem (MHN) | 340 | 4.3% | 3 | 4.5% | 29 | 7.9% |
| 304 Bushwick (BK) | 339 | 4.2% | 0 | 0.0% | 2 | 0.5% |
| 209 Soundview, Castle Hill, Union Port, Parkchester (BX) | 337 | 4.2% | 0 | 0.0% | 2 | 0.5% |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 329 | 4.1% | 1 | 1.5% | 8 | 2.2% |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (STN) | 325 | 4.1% | 2 | 3.0% | 16 | 4.3% |
| 204 Highbridge, Concourse (BX) | 323 | 4.0% | 0 | 0.0% | 10 | 2.7% |
| 201 Mott Haven, Melrose, Port Morris (BX) | 320 | 4.0% | 3 | 4.5% | 19 | 5.2% |
| 110 Central Harlem (MHN) | 267 | 3.3% | 1 | 1.5% | 10 | 2.7% |
| 206 East Tremont, Bathgate, Belmont, West Farms (BX) | 247 | 3.1% | 0 | 0.0% | 8 | 2.2% |
| 202 Hunts Point, Longwood (BX) | 233 | 2.9% | 2 | 3.0% | 4 | 1.1% |
| 203 Melrose, Morrisania, Claremont, Crotona Park East (BX) | 229 | 2.9% | 0 | 0.0% | 6 | 1.6% |
| | 4,133 | 50.8% | 13 | 19.5% | 124 | 33.6% |

## Table 3.10: Community Districts in the Top Two Quartiles of DOC-Released Inmates by Chemical Dependency, Mental Health, and Mental Retardation Services

| Highest Inmate Return by Community District | Frequency | | DOHMH Chemical Services | | Mental Health Services | | Mental Retardation Services | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| 303 Bedford Stuyvesant, Tompkins Park North, Stuyvesant Heights (BK) | 2,076 | 5.1% | 1 | 1.5% | 7 | 1.4% | 0 | 0.0% |
| 412 Jamaica, South Jamaica, Hollis, St. Albans (QN) | 1,774 | 4.4% | 2 | 3.0% | 24 | 4.7% | 1 | 0.9% |
| 110 Central Harlem (MHN) | 1,772 | 4.4% | 1 | 1.5% | 22 | 4.3% | 2 | 1.9% |
| 305 East New York, New Lots, City Line, Starrett City (BK) | 1,768 | 4.3% | 0 | 0.0% | 9 | 1.8% | 2 | 1.9% |
| 111 East Harlem (MHN) | 1,617 | 4.0% | 3 | 4.5% | 23 | 4.5% | 1 | 0.9% |
| 205 Morris Heights, University Heights, Fordham, Mt. Hope (BX) | 1,515 | 3.7% | 1 | 1.5% | 10 | 2.0% | 1 | 0.9% |
| 204 Highbridge, Concourse (BX) | 1,392 | 3.4% | 0 | 0.0% | 10 | 2.0% | 0 | 0.0% |
| 209 Soundview, Castle Hill, Union Port, Parkchester (BX) | 1,355 | 3.3% | 0 | 0.0% | 1 | 0.2% | 0 | 0.0% |
| 316 Ocean Hill, Brownsville (BK) | 1,338 | 3.3% | 1 | 1.5% | 10 | 2.0% | 0 | 0.0% |
| 304 Bushwick (BK) | 1,166 | 2.9% | 0 | 0.0% | 3 | 0.6% | 1 | 0.9% |
| 112 Washington Heights, Inwood (MHN) | 1,135 | 2.8% | 1 | 1.5% | 15 | 3.0% | 0 | 0.0% |
| 201 Mott Haven, Melrose, Port Morris (BX) | 1,110 | 2.7% | 3 | 4.5% | 9 | 1.8% | 0 | 0.0% |
| 308 Crown Heights, Prospect Heights, Weeksville (BK) | 1,040 | 2.6% | 0 | 0.0% | 3 | 0.6% | 0 | 0.0% |
| 207 Kingsbridge Heights., Bedford Park, Fordham, University Heights (BX) | 1,000 | 2.5% | 0 | 0.0% | 4 | 0.8% | 3 | 2.8% |
| **Total** | **20,058** | **49.3%** | **13** | **19.5%** | **150** | **29.7%** | **11** | **10.2%** |



APPENDIX J

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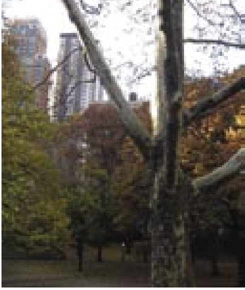

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# Pertinent Acronyms

| | |
|---|---|
| BK | Brooklyn |
| Brad H. | Brad H. et al. v. The City of New York, et. al. |
| BX | Bronx |
| CASES | Center for Alternative Sentencing and Employment Services |
| CDTP | Comprehensive Discharge and Treatment Plan |
| CHS | Correctional Health Services |
| DHS | Department of Homeless Services |
| DOC | New York City Department of Corrections |
| DOHMH | New York City Department of Health and Mental Hygiene |
| EMTC | Eric M. Taylor Center |
| FUSE | Frequent User Service Enhancement |
| GIS | Geographic Information Systems |
| HCAI | Health Care Access and Improvement |
| HHC | New York City Health and Hospitals Corporation |
| HIPPA | Health Insurance Portability & Accountability Act |
| KEEP | Key Extended Entry Program |
| MHN | Manhattan |
| MOA | Memorandum of Agreement |
| NIDA | National Institute on Drug Abuse |
| NYC | New York City |
| OASAS | Office of Alcohol and Substance Abuse Services |
| PHS | Prison Health Services |
| QN | Queens |
| RIDE | Rikers Island Discharge Enhancement Project |
| SI | Staten Island |
| SPAN | Service Planning and Assistance Network |
| SPMI | Seriously and Persistently Mentally Ill |
| SSDI | Social Security Disability Insurance |
| SSI | Supplemental Security Income |
| STD | Sexually Transmitted Disease |
| THCC | Transitional Health Care Coordination |
| UHF | United Hospital Fund |

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