Growing a Recovery Generation:
A Case Management Model for Pregnant and Postpartum Women Experiencing Incarceration and Reentry
Planning Report and Implementation Guide
LETTER FROM GULLING CONSULTING

We are excited to share this Planning Report and Implementation Guide, which is the culmination of a year’s worth of planning, meeting, research, and collaboration among individuals who work in the reentry and recovery fields and women with first-hand experience of being incarcerated while pregnant or with children ages birth to three.

This project was designed to support the recovery of pregnant and postpartum women housed at the only women’s jail in Alaska, Hiland Mountain Correction Center in Eagle River, as they transitioned from prison back to their community by providing intensive case management services. We consider this Guide to be an introduction to the issues affecting pregnant and postpartum women as they work toward recovery and reentry. It is now up to the community of players to continue to build upon the foundation through ongoing collaboration and research and move the project forward.

The planning process was a truly a collaborative effort and we want to take a moment to thank the dedicated partners on this project:

To the Department of Corrections, the Alaska court system, CITC and the rest of the Project Steering Committee: Your forward-thinking and willingness to provide context on how related systems and programs could be included to offer true wraparound services was extraordinary. Thank you for continuously showing up despite your busy schedules and for your willingness to listen to one another and brainstorm solutions to obstacles.

To the Advisory Group members and Interviewees: Your vulnerability and courage in sharing your experience of incarceration, motherhood, addiction, and recovery, all in the name of helping women who may someday find themselves in a similar situation, is inspiring. Know that your wisdom is already making a difference.

And to my staff, contractors, TAs and the Circumpolar Health Studies at UAA Institute who worked alongside me on this project: You are all amazing.

Chelsea Gulling
Owner, Gulling Consulting
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EXECUTIVE SUMMARY

The number of women incarcerated in the United States increased almost 850% between 1980 and 2020, from 26,378 to 222,455.1 Two-thirds of these women have at least one minor child,2 with more than half never receiving visits from their children while incarcerated.3

Although we don’t have data on the number of incarcerated women who are mothers in Alaska, the vast majority are of childbearing age4. American Indian and Alaska Native women are among the most disproportionately incarcerated population in the state5. In 2019, though Alaska Natives comprised roughly 15% of Alaska’s total population, they represented 44% of the incarcerated female population6. In comparison, Caucasians comprised 65% of Alaska’s population, but only 44% of its incarcerated female population.7

With these numbers in mind, in 2017 Cook Inlet Tribal Council (CITC) applied for a Department of Justice, Bureau of Justice Assistance (BJA) grant. The awarded grant sought to support the recovery of pregnant and postpartum (up to 12 months) women housed at Hiland Mountain Correctional Center (Hiland) in Eagle River. BJA’s grant funding covered the planning stage of the project only. As a result, CITC hired Gulling Consulting to convene a Project Steering Committee (Steering Committee) to plan the future development of a project aimed at providing services to incarcerated pregnant or postpartum women with children ages birth to 3 who also have comorbid substance use and mental illness disorders (referred to throughout this Guide as co-occurring disorders, or CODs). Gulling Consulting worked with stakeholders to develop a project that could be funded by federal, state, and/or local funding sources, and

3 The Rebecca Project, Mothers Behind Bars, 13.
5 2019 Offender Profile.
7 2019 Offender Profile.
created a Planning Report and Implementation Guide (Guide) to serve as a resource for future projects.

Early in the project it became clear that the target population was under-resourced, underserved, and understudied. There was little national, state, or local data on the number of incarcerated women who had children ages birth to three and little research into the issues they faced upon reentry into their communities. Therefore, some of the work on this project was devoted to identifying data points that are missing from current state collection efforts. The data discussed throughout this Guide, then, does not paint an entirely accurate picture of the number of women who comprise the target population or of their needs. Instead, it paints the best picture possible given the data that exists.

The Steering Committee was comprised of three groups: the Core Team, Advisory Group, and Working Groups. The Core Team provided institutional knowledge of the target population and available resources. The Advisory Group was comprised of women with lived experience who met the criteria for program participation. The Working Groups were breakouts from the Core Team and included Core Team members and representatives from their respective agencies. The Core Team and Working Groups developed a proposed project mission, purpose, criteria for inclusion, goals and objectives, and a proposed project narrative. Although the Steering Committee anticipates that these may require revision, depending on future funding sources, they lay a framework for establishing baselines that will help determine whether the project’s goals are being met.

The Steering Committee also worked to identify service gaps, current data and explored best practices for working with the target population. It settled on utilizing an Intensive Case Management Model for future projects, with preparation for reentry beginning a minimum of six months prior to a woman’s release when possible. These services should be provided in-person at the facility and continue upon the woman’s release with providers or agencies that can provide a trauma-focused, gender responsive continuum of care.

In addition to outlining a plan for an Intensive Case Management Model, the Steering Committee explored numerous obstacles that incarcerated mothers face upon reentry. Without adequate services or supports, these obstacles often cause women to return to substance use or prior patterns and individuals not conducive to their recovery. The result is a return to prison
and repeat separation from their children. For each of these issues, this report explores the obstacles to reentry, available services, best practices, and makes recommendations for improvements and implementation of future projects.
PLANNING PROCESS INTRODUCTION

Cook Inlet Tribal Council and the Alaska Department of Corrections (DOC) collaborated to initiate this proposal under a Department of Justice, Bureau of Justice Assistance grant. CITC hired Gulling Consulting to convene a Project Steering Committee to plan the future development of a program to serve women with comorbid substance use and mental health disorders (referred to throughout this document as co-occurring disorders, or CODs) incarcerated at Hiland Mountain Correctional Center (Hiland) in Eagle River, Alaska.

Although the BJA funded the planning stage of this grant, no implementation funds were attached. As a result, Gulling Consulting and stakeholders worked to develop a project that could be funded by federal, state, and/or local funding sources. This Planning Report and Implementation Guide serves as a resource to implement and secure funding for future projects.

The purpose of this Guide is to:

1. Report on the Steering Committee’s activities and document the actions taken to develop elements of this project.

2. Document relevant data collected from DOC and partner agencies.

3. Share best practices surrounding provision of holistic care and case management of mothers and pregnant women who are incarcerated and make recommendations for their local implementation.

Planning Process Limitations

Restrictions due to the COVID-19 pandemic meant that project planning meetings and data collection efforts were conducted virtually. This made consensus building and relationship development more challenging and limited to the tools available, perhaps limiting the depth and breadth of interagency agreements.

To our knowledge, there is no state-specific research into the target population’s needs. The Project Steering Committee therefore had to start from scratch when it came to identifying
available resources and collecting data relevant to the population. As a result, it is possible that resources beyond what are identified in this Guide are available.

**Alaska Data Collection**

During the early phases of this project, it became evident that the target population is under-resourced, underserved, and understudied. The lack of relevant data thus made it difficult for the Steering Committee to get a complete picture of the target population and to adequately identify their needs. For instance, it was difficult to establish baselines, which are necessary to evaluate whether services and/or other interventions are having the desired impact (e.g., reducing recidivism, preventing substance use relapse, etc.).

Specifically, data is limited or unavailable in the following areas:

- When the Office of Children’s Services (OCS) takes a child into custody, it doesn’t specify which of their parents is incarcerated or the length of the sentence; it simply notes that a parent is incarcerated.

- The Department of Corrections (DOC) does not currently collect data on:
  - Whether incarcerated women have children or the age and placement of their children
  - Whether an incarcerated mother’s goal is to reunify with her children upon release or how many of them meet that goal, or
  - The number of women who become pregnant and/or find stable housing and jobs within 12 months of release.
Table 1: Department of Corrections Data on Pregnant Women

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women Pregnant While Incarcerated</td>
<td>84</td>
<td>44</td>
<td>52</td>
</tr>
<tr>
<td>Women Who Delivered While Incarcerated</td>
<td>8</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The Number of Incarcerated Alaskan Women is Rising Exponentially

Available data shows that from 2003-2019, the number of Alaskan women incarcerated increased 53%, compared to only a 3% increase for males (See Table 2).

Table 2: Total Admissions into State Custody by Year

<table>
<thead>
<tr>
<th>Admissions</th>
<th>2003(^\text{10})</th>
<th>2019(^\text{11})</th>
<th>Change (2003-2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>6,678</td>
<td>10,186</td>
<td>53%</td>
</tr>
<tr>
<td>Male</td>
<td>23,727</td>
<td>24,557</td>
<td>3%</td>
</tr>
</tbody>
</table>

Although we could not identify any clear reasons why female admissions more than doubled from 2003-2009, or why the increase was so much more than males, we can theorize based on national data and anecdotal evidence from Project Steering Committee and Advisory Group members.

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\(^8\) DOC reported in March 2021 that the actual number of women who are pregnant while incarcerated is possibly higher than indicated. This is because while it is DOC policy to administer a pregnancy test to every woman who enters its facilities within 14 days of admission, women whose stay is less than 14 days may not have been tested prior to release. In addition, DOC indicated that the accuracy of these numbers depends on whether staff accurately inputted the data, so there is the possibility that some data was not entered or entered incorrectly.

\(^9\) Total admissions are the total number of admissions to an institution over the course of the year, not the total number of individuals admitted. For example, one woman we interviewed had been admitted to Hiland 13 times in one year; this is reflected in the data as 13 separate admissions.


• Project Steering Committee members indicated that the rise in incarceration rates may be tied to the high rates of trauma among Alaskan women. Many women who experience trauma turn first to opioids to numb the pain and then to criminal activity to support their addiction.

• There are few substance abuse treatment centers in Alaska that allow women to enter with their children. Therefore, it is assumed that some women who want help with their addiction forego treatment because they do not want to leave their children or have no one to help care for them. For many, the result is arrest for a drug-related crime.

• Female offenders are generally poorer than male offenders and therefore far less likely to be able to post bail. Nationally, 1 in 4 women are incarcerated because they cannot post bail; that same statistic likely applies in Alaska. One Advisory Group member shared that she spent seven months at the men’s jail in Juneau because she could not post her $15,000 bail and could not be transported to Hiland until she was sentenced. The table below underscores this reality.

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A closer examination of the numbers, which was beyond the scope of this project, would likely show an even higher proportion of unsentenced, incarcerated women housed at ALL DOC facilities. Figure 1 only accounts for unsentenced women incarcerated at Hiland; it does not include unsentenced women incarcerated at other DOC facilities. It is therefore estimated that the actual percentage of ALL incarcerated, unsentenced women is closer to 72%. This estimate is based on the fact that there are approximately 400 women in DOC custody on any given day, and the percentages in Figure 1 represent 319 women housed at Hiland (i.e., 204 pre-trial/unsentenced and 115 post-trial/sentenced). That leaves 80 women unaccounted for; since women arrested in communities outside Anchorage and the Mat-Su are only transported to Hiland once they are sentenced, it is safe to assume that these 80 women are unsentenced, most likely because they cannot post bail.

It would also be interesting to compare the numbers in Figure 1 to the numbers of sentenced and unsentenced men incarcerated in Alaska and attempt to determine how many of the unsentenced women are incarcerated as a result of their inability to post bail.
Alaskan Women are Largely Incarcerated for Nonviolent Crimes

The FBI definition of a non-violent crime is anything other than murder, nonnegligent manslaughter, forcible rape, robbery, and aggravated assault.\(^\text{13}\) For the purposes of this Guide, non-violent crimes are any crime other than sex offenses, weapons offenses, or offenses against persons.

While Figure 2, below, shows that over 70% of Alaskan women are incarcerated for non-violent crimes, a deeper dive into the data would likely reveal that many of the offenses included in the violent crime category would be classified as non-violent crimes per the FBI definition. Based on the research conducted and recommendations made as part of this project, the ideal scenario would be for most of the women charged and/or sentenced for non-violent crimes to be diverted to a treatment program that allows them to remain with their children.

Women Quickly Cycle Through the Facilities

Nationwide, women generally receive shorter sentences than men. Possible reasons for this include:

- Women are typically convicted of lesser crimes, which equate to shorter sentences.
- As discussed previously, many women are housed in pre-trial facilities due to an inability to post bail. Thus, their sentences are adjusted accordingly to account for the time already served.
- The “chivalry hypothesis,” which posits that women receive more lenient treatment in the criminal justice system, particularly at sentencing, because they are considered “weaker,” “helpless,” “less likely to be dangerous,” etc., and therefore seen as needing to be protected and not punished as harshly as men.

Regardless of the reason for shorter sentences, for the purpose of this project, two important things should be noted. First, catching women quickly, particularly if they are in the early stages of their pregnancy, means they receive needed medical care they may not have received prior to incarceration and connects them with the case management model for support prior to their reentry. Second, research suggests that women are more likely to make positive life changes during pregnancy and/or the postpartum stage, so this is an ideal time for intervention with the potential to prevent recidivism.

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Alaska Native Women are Incarcerated at Staggering Rates

Alaska Natives/American Indians comprise an estimated 15.6% of Alaska’s total population,\(^{16}\) yet in 2019 comprised 44% of Alaska’s total incarcerated female population.\(^{17}\)

Furthermore, the overall proportion of Alaska Native women who are incarcerated is much higher, in comparison to their distribution in the total population, than the proportion of Caucasian women who are incarcerated:

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Note: This number represents those reporting one race only. The available Census data doesn’t provide a further breakdown of races for individuals identifying as one or more races.

\(^{17}\) State of Alaska, 2019 Offender Profile.
The Steering Committee proposed several possible reasons for these disproportionately higher numbers:

- Implicit racial bias and/or racism may lead to assumptions of an individual’s guilt, resulting in increased arrests, charges, convictions, plea deals that lead to sentencing versus diversion/probation, failure to suspend sentences, and/or imposition of longer sentences compared to non-Native women.

- Increased analysis and examination of policies and practices in both the criminal justice system and other fields that serve the target population has shown that implicit bias, racism, and/or sexism has created fewer options and choices in many life domains, which can lead to criminal activity.

- A history of oppressive practices against Alaska Natives, including retraction of their tribal rights and sovereignty, created historical trauma and economic deprivation that has caused
them to rank at or near the bottom of nearly every social, health, and economic indicator. Thus, some Alaska Natives lack the same level of resources as non-Natives, making it more difficult to hire a private attorney or post bail.

- Less access to culturally responsive, trauma-informed, and equitable resources.
- Rural Alaska Native women who are unable to return to their home community when released from prison lack the natural and cultural support their communities provide. Anecdotally, Project Steering Committee members said the inability to go back home and lack of support causes many women, Native and non-Native alike, to return to their often-unhealthy local support system, making them more likely to reoffend.

Data Collection

Recommendations for Implementation

» Establish a baseline for evaluation (See Appendix E - Complete Project Goals, Objectives and Key Indicators). [Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding]

» Reestablish a workgroup that includes, at minimum, the project evaluation team, OCS, and DOC to determine which additional data points agencies should collect moving forward. If relevant, a data collection and information sharing agreement should be developed between entities that work with the target population. [Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding]
Data Collection (cont.)

Recommendations for Implementation

» Potential ideas for improved data collection:
  
  o Focused data-sharing project between DOC, Division of Public Health (DPH), the Department of Health and Human Services (DHSS), and vital records. Determine the number of women admitted to DOC within a particular timeframe. These names are then cross-checked with Medicaid records or live birth data to determine how many women admitted had children under age 3 and/or became pregnant within 12 months of release.
  
  o Obtain funding to hire contractors to conduct intake screenings to improve consistency. (Note: This is also a recommendation for Screening & Assessments)

» Focus a discussion on prosecution and conviction data, including number of prosecution referrals to Therapeutic Court, to determine why therapeutic court is operating at two-thirds capacity when two-thirds of incarcerated women at Hiland have pre-sentence status. [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

» Develop a workgroup to further analyze the data presented in the Planning Report and Implementation Guide and/or host community conversations to examine the following questions and discuss which potential policies, practices, interagency cooperation, or resources should be developed or reviewed to improve the landscape for the target population. [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]
  
  o Why are women being incarcerated at a much higher rate than men?
  
  o Why are so many more women than men awaiting sentencing (pre-trial vs. post-trial)?
  
  o Why is Therapeutic Court operating at only two-thirds capacity when more than two-thirds of incarcerated women have not been sentenced?
  
  o Why are Alaska Native women of childbearing age possibly the most disproportionality incarcerated population in the state?
PROJECT STEERING COMMITTEE

Overview

The Project Steering Committee was composed of three groups: the Core Team, the Advisory Group, and Working Groups. Over the life of the project, the Core Team and Advisory Group each met seven times, and various working groups comprised of Core Team members and/or their colleagues met 17 times.\(^{20}\)

Core Team

The Core Team provided institutional knowledge of the needs of the proposed target population and available resources. The team consisted of members from the following agencies:

- Alaska Court System
- Alaska Native Justice Center
- Alaska Native Medical Center / Southcentral Foundation
- Alaska Network on Domestic Violence and Sexual Assault
- Alaska Youth and Family Network
- Anchorage Reentry Coalition
- Cook Inlet Housing Authority
- Cook Inlet Tribal Council
- State of Alaska, Department of Corrections
- University of Alaska Anchorage (UAA), Institute of Circumpolar Health Studies

\(^{20}\) Notes from meetings are available from Gulling Consulting upon request.
Advisory Group

The original intent of the Advisory Group was to allow the Project Steering Committee to conduct focus groups with women currently housed at Hiland; however, that plan had to be revised due to COVID-19 restrictions at DOC facilities. Instead, women who met the target population criteria participated in nine semi-structured interviews and were offered a $20 gift card for their participation. (See Appendix G - Report on Semi-Structured Interviews)

Five women who participated in the initial interviews participated in the Advisory Group and were nominally compensated for their time. They shared that their motivation to participate wasn’t the compensation, but rather a desire to help other women who may find themselves in a similar situation in the future.

“I am here to help make the situation better for others, so that they don’t have to go through what we had to go through,” one member shared. “I want to see people succeed because of more resources.”

Another Advisory Group member, who served time at Hiland alongside her mother, said she also hoped her participation would help end the cycle of trauma, addiction, and incarceration.

“Addiction and co-occurring disorders are very much generational, and we need to do everything in our power to not let our kids follow in our footsteps,” she said.

PROJECT DEVELOPMENT

The Project Steering Committee created a proposed mission, purpose, participant criteria, and goals and objectives for any future project.

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21 We suggest that the Implementation Steering Committee revisit this area and conduct focus groups of women within the target population once DOC lifts COVID-19 safety protocols.
Proposed Mission

To generate lasting change in the region’s reentry and recovery systems of care to improve outcomes related to key life domains among pregnant and postpartum women with co-occurring disorders (CODs) who are involved with the Alaska criminal justice system.

Proposed Purpose

To improve access to, and the delivery of, services to women [with co-occurring substance abuse and mental illness] when they reenter the community following incarceration.

Proposed Goals and Objectives

Gulling Consulting prepared draft goals and objectives based on discussions at Project Steering Committee meetings. A working group then revised the goals and objectives over the course of three meetings and with input from the Advisory Group. The goals are listed below, objectives for each goal, including a rationale and key indicators for project evaluation can be found in Appendix D: Complete Project Planning Goals, Objectives and Key Indicators.

Goal 1: Implement [Project Name] to improve outcomes and well-being among pregnant and postpartum women with CODs who are involved with the Alaska criminal justice system and increase knowledge of, and reduce stigma surrounding, CODs among program participants and partner agencies.

Goal 2: Implement integrated COD care and comprehensive case management services targeted to the recovery and reentry needs of pregnant and/or postpartum women who are involved with the Alaska criminal justice system. Addressing root causes of substance abuse disorder, depression, anxiety, and other mental health conditions, such as history of trauma, will be prioritized.

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22 Depending on the funding source, co-occurring disorders may not have to be a criterion for participation.
23 The Project Steering Committee should choose a name for its project in the implementation phase to aid in developing community ownership.
Goal 3: Improve life domains among pregnant and postpartum women with CODs who are involved with the Alaska criminal justice system and reentering the community.

Goal 4: Improve public safety in Alaska by reducing the criminal exposure of program participants and reducing the risk of criminal exposure to their children.

**Goals and Objectives**

**Recommendations for Implementation**

» Review DOC policies and procedures and other laws related to the target population and advocate for any changes. [**Responsible entities: Case management agency/Project Steering Committee; Timeframe: Upon identification of funding source**]
  
  o Convene a workgroup to review relevant policies, procedures, and laws that relate to target population and discuss any changes that need to be made.

  o Review and possibly revise the goals and objectives before submitting grant application to add goal related to Project Steering Committee conducting policy reviews and advocating additions, revisions, and/or deletions.

» Any revisions should focus on maintaining simple objectives to ensure the project doesn’t stall during periods of staff turnover.
Proposed Participant Criteria

The Steering Committee chose to develop a project to serve women involved with the Alaskan criminal justice system who have co-occurring substance use and mental health disorders and who meet **at least one** of the following criteria:

- Are pregnant when entering the criminal justice system
- Discover they are pregnant any time from initial entry into the criminal justice system through one year of release while on probation or parole
- Have children ages birth to 3 when entering the criminal justice system, provided their parental rights have not been terminated

Although future projects can alter these criteria - for example, allowing participation if the woman has either a substance misuse or mental health disorder, rather than both - the Steering Committee chose this specific population for two reasons. First, limited services are available to help these women during the reentry process. Second, it is believed that **women who are pregnant or have young children are more motivated to make positive life changes.** A mother’s concern for the well-being of her unborn baby, a desire to care for her children, and/or a desire to be reunited with them are major factors that motivate women to seek out substance abuse treatment and work to maintain their sobriety.\(^\text{24}\) Programs designed using a gender-responsive approach offer women a safe environment where they can develop supportive relationships which can help them work on their recovery.\(^\text{25}\)

In addition, children ages birth to three have a limited ability to understand why their mother is absent or when she is expected to return. Because of this, **maternal absence during this age period is thought to be particularly stressful for the child.** One study, for example, found that children ages birth to 3 who were separated from their mother for even one week displayed

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increased levels of aggression and negativity by age 3.\textsuperscript{26} The strength of the parent-child bond is a significant factor in a child’s later ability to overcome challenges and become successful in life.\textsuperscript{27} Therefore, it is thought that providing targeted services to this population has the greatest potential to impart lasting change to the mother, her children, and the community.

Women who meet the entry criteria and who express a willingness to participate will be assessed for their readiness to change. Priority for participation will be given to women who exhibit a higher readiness to change and have higher criminogenic risk factors. Participants who choose to reside with a sex offender or otherwise put their child in harm’s way will


be reported to OCS and may be asked to leave the program. These decisions will be made on a case-by-case basis.

The Steering Committee proposed serving 56 women over a three-year timeframe. This number was chosen based on the assumption that two full-time case managers would be assigned to the project, with a combined caseload of 15-25 clients at any given time.

Proposed Grant Narrative

In the 1970’s, roughly 340,000 Americans were incarcerated. Today, that number has increased 600% to more than two million.²⁸ For women, it has risen even more – between 1980 and 2019, the number of women incarcerated increased nearly 850%, from 26,378 to 222,455.²⁹ Nationally, two-thirds of these women have at least one minor child,³⁰ and more than half of them never see their children while in prison.³¹

“The U.S. criminal justice system is not designed for females and is progressively less responsive to the needs of mothers - even less so for pregnant and postpartum women.”

- Jonathan Pistonik, Anchorage Reentry Coalition, Core Team member

Although we don’t have data on the number of incarcerated women who are mothers in Alaska, the vast majority are of childbearing age³². American Indian and Alaska Native women are among the most disproportionately incarcerated population in the state³³. In 2019, though

²⁹ The Sentencing Project, Incarcerated Women and Girls.
³⁰ The Rebecca Project, Mothers Behind Bars, 12.
³¹ The Rebecca Project, Mothers Behind Bars, 13.
³³ 2019 Offender Profile.
Children of incarcerated mothers had even higher incarceration rates later in life, as well as earlier and more frequent arrests, compared to children whose fathers were incarcerated.\(^{39}\)

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\(^{35}\) 2019 Offender Profile.


\(^{37}\) Turney, Kristin. “Stress Proliferation Across Generations?”


They are also at an increased risk of being placed in foster care, in part because their mother’s inability to participate in reunification plans can lead to termination of her parental rights.40

Recidivism is linked to a failure to provide women with economic, health, and psychological supports.41 For pregnant or postpartum women, a lack of affordable childcare is another obstacle that can set them up for relapse and/or recidivism.42 Therefore, it’s unsurprising that research has shown that rehabilitation programs work when they take into consideration the risks and needs of reentrants, including healthcare, housing, education or vocational training, mental health services, substance abuse counseling, and other social services. Data also reveal that women are most likely to make positive, permanent life changes when they are pregnant or have young children, making the period when a woman’s children are between ages birth to 3 the best period for intervention.

Yet despite these well-documented risks and the research showing that the unique needs of the target population, serious gaps in the availability of services designed to help women remain connected to their children while incarcerated, to help them work toward reunification, or to set them up for a successful transition back into the community exist at the local, state, and national levels.

This project therefore seeks to reduce recidivism rates for pregnant and postpartum mothers with children ages birth to three who also have co-occurring disorders by providing services designed to support their successful reentry into the community. To accomplish this, the Steering Committee recommends that communities implement a case management model with a strong community handoff component that ensures continuity of care between in-jail and community-based programs and services.43

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41 Cowan, Incarcerated Women.  
43 Warwick, et. al., Case Management Strategies.
The National Association of State Mental Health Program Directors defines case management as “a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational and other services essential to successful daily living.” For the best chance of success, a case management plan must be developed prior to a woman’s release from prison.

Best practices for case management calls for a person-centered planning model. Person-centered planning originated in the disability realm but has expanded to encompass other areas. Person-centered case management planning focuses on what matters to the individual receiving services, their families, and their support staff. A person-centered approach is like a “toolbox” – the “tools” only work if the individual receiving the services and supports has developed the skills to use them. It lets individuals participate in decisions about the services they will receive and the support staff they will work with to achieve their goals. Examples of person-centered planning include talking with, rather than about, the person; planning with,

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rather than planning for, the person, or; focusing on the person’s strengths, abilities, and skills rather than their labels, diagnoses, and deficits.  

The case management plan should include referral, assessment, care planning, service coordination, monitoring and documentation. When developing a person-centered plan in the criminal justice setting, the case manager must develop a personal relationship with both the offender and her caregiver/s to successfully reenter society. They should be trained in how to identify criminogenic risk factors and conditions and know where to refer women for treatment. Some of the most important pieces of the person-centered case management plan include locating stable housing, jobs, benefits, and other community resources needed to address the individual’s physical health, behavioral health, and social and criminogenic needs.

Throughout this project the Steering Committee identified the following issues regarding intervention for the target population:

- **Data Limitations**: Lack of available national, state, and local data; lack of publicly available data to researchers and service agencies; lack of data-sharing agreements between state agencies and service providers; lack of data analysis by institutional stakeholders as it relates to the target population.

- **Lack of Resources**: Lack of community-based programs and other resources specific to women: no gender-responsive reentry case management services; no reentry housing that supports or permits women to bring their children; lack of trauma-based therapies, etc.

- **Lack of Well-defined Policies Related to the Target Population**: Lack of policies defining pre-natal, natal and post-natal care in the Alaska Department of Corrections.

- **No Evidence-based Guidelines**: Lack of evidence-based guidelines on providing trauma-informed care to adults in correctional settings; very few evidence-based practices or gender specific case management models identified.

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Current Resources Available at Hiland Correctional

The following are classes and resources that were available to women housed at Hiland prior to the COVID-19 pandemic; it is unclear whether these programs will continue post-pandemic, or in what capacity.48

- Parenting Classing: Two curriculums offered, Parenting Inside Out and Love & Logic.
- Transformational Living Community (TLC): Operated by Alaska Correctional Ministries, TLC is an intensive, multi-phase program designed to provide a spiritual-based approach to correctional rehabilitation. During the 12- to 18-month program, women live together in a supportive, community environment and are expected to embrace personal accountability, responsibility, and commitment to change in all aspects of their life.
- Reentry class and vocational training: These include computer skills training and apprenticeships.
- Assess, Plan, Identify, Coordinate (APIC): Provides re-entry planning and transitional services to inmates with mental illness or cognitive disabilities.
- Institutional Discharge Program, IDP*(Plus): IDP targets felony prisoners with a psychotic disorder who are being released to probation or parole in Anchorage communities. Two DOC mental health clinicians, in conjunction with a probation officer and other identified agency representatives, develop a treatment and monitoring plan for the released prisoner.
- Mental Health Treatments: Mental Health Release Planning Teams, mental health services offered by the Municipality of Anchorage, and access to staff psychiatrists for medication management.
- Probation/parole officers and one probation/parole supervisor on staff.
- Social worker to assist with placement of pregnant women’s children

48 The bullet points in this section came from contributions from the Alaska DOC and this document: State of Alaska, Department of Corrections Programs and Services 2018, https://doc.alaska.gov/doc/programs-services.pdf.
“TLC [DOC program] did a lot for me. It was important to me because it was a spiritual-based program designed to help me work on forgiveness of all my past hurts and disappointments. It helped me by allowing me to have a safe place to get rid of the past guilt and pain to begin the healing stages. It was a great program!”

-- 2021 Advisory Group member

Current DOC Policies Relating to Women, Pregnancy & Motherhood

Prison policies and procedure are generally written with male inmates in mind and later modified to meet the needs of women. This means that the needs of women prisoners, particularly those who are pregnant or have children, do not receive the same consideration as their male counterparts. The result is less-targeted services.

Alaska has limited policies that relate specifically to women prisoners. In 2014, the commissioner of DOC signed a one-page policy, Requirements Relating to Female Prisoners (See Appendix J(a)), but it is unclear if any DOC policies or procedures specific to women existed prior to that. The policies highlighted in that document are abbreviated below:

- Women shall be housed separately from men but must be provided access to facilities and programs comparable to those provided to male prisoners
- Shall be provided programs about pregnancy, childcare, and domestic violence
- Shall receive counseling regarding family and pregnancy upon request
- Shall receive proper prenatal and postnatal health care
- Children may not be housed at the facility under any circumstances
When a prisoner has children aged 3 or under, the superintendent has the discretion to allow the child to visit for up to eight hours a day.49

Policy Development

Recommendations for Implementation50

» Develop a workgroup to review and possibly revise, the following DOC policies and procedures, among others. [Responsible entity: Project Steering Committee; Timeframe: Within 6 months of receipt of project funding]:
  o Prisoner Rights: Requirements Relating to Female Prisoners, Index 808.06 (See Appendix J(a))
  o Medical and Health Care Services: Access to Health Care Services, Index 807.02 (See Appendix J(b))

» Using data, best practice research, and examples from other states, consider creating additional policies and procedures, or further define existing ones, especially as they relate to issues outlined in this Guide. [Responsible entity: Project Steering Committee; Timeframe: Within 6 months of receipt project funding]

Intensive Case Management Model

The U.S. Department of Justice, National Institute of Corrections recommends a Women Offender Case Management Model (WOCMM), which has proven results for women.51 Connecticut employed this model and found that participants had significantly lower rates of new

49 Visitation policies for children ages 4 and up follow DOC’s standard visitor policies.
50 See sections on Healthcare, Breastfeeding, and Nurse-Family Partnership for additional recommendations of policies and procedures to be considered for creation and/or revision.

arrests (31.6%) compared to members of a control group (42.5%), and new arrests were reduced by 25.6% compared to the control group.\textsuperscript{52}

The WOCMM has nine guiding practices for implementation, which the Steering Committee drew on, as well SAMHSA’s After Incarceration: A Guide to Helping Women Reenter the Community, when compiling its recommendations for development and implementation of a case management model.\textsuperscript{53} These guiding principles are:

1. Gender Responsive
2. Individualized Service
3. Engagement Strategies
4. Team Approach
5. Collaborative
6. Comprehensive
7. Continuity of Care
8. Committed to Program Integrity
9. Committed to Process and Outcome Evaluation

Research shows that the gender responsive or gender specific response recommended by the WOCMM is necessary to increase a woman’s chance of success. Such programs intentionally allow research and knowledge on female socialization, female psychological development, female strengths, female risk factors for systems involvement, female pathways through systems, female responses to traditional interventions, and females’ unique program/service needs to affect and guide ALL aspects of the program’s design, processes, and services.\textsuperscript{54}

A gender responsive approach has five core practice areas:

- A relational approach
- A strengths-based approach
- A trauma informed approach
- A culturally competent approach
- A holistic approach

DOC has social workers on staff to meet with women, but reports indicate they are often overwhelmed and cannot provide the recommended level of case management services or help locate necessary resources, despite their best intentions. The experience of one Advisory Group member illustrates the issue:

“I found out I was pregnant during the Hiland intake process when I got a pregnancy test. It wasn’t until I put in a cop-out\(^5\) that I was met by the social worker at DOC,” she explained. “The social worker was really nice, but she was the only one who handled all cases involving OCS, pregnant women, as well as child visitation. Needless to say, her caseload was massive.”

Available case management services in Alaska are limited, and those that do exist often face barriers to meeting with

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\(^5\) Advisory Group members explained that a “cop-out” is a prison term that means putting in a request for an appointment with staff or making a request for something. Anything a prisoner needs isn’t considered without first submitting a cop-out.
women in prison. Partners for Progress and the Alaska Native Justice Center (ANJC) are the only two agencies in the region that offer pre- and post-release case management services to reentrants; Set Free Alaska and the Alaska Youth and Family Network (AYFN) offer reentry services, but they are post-release only.

ANJC believes that case managers with lived experience have the most success with their clients, and therefore often hire individuals with criminal records. However, DOC policies limiting entry into its facilities for individuals with criminal records has made it difficult for ANJC case managers to meet with clients in prison. Partners for Progress typically does not hire individuals with criminal records.

Best practices indicate that reentry case plan development should begin at least six months prior to a woman’s release from prison. To improve reentry outcomes, prisons, community-based organizations, and supervisory agencies must work together to meet the needs of the reentry population both during the period of incarceration and after their release from prison. It is therefore imperative that any case management process includes strong collaboration between community-based and institution-based providers to ensure continuity of care.

“The most critical time for these women is immediately upon reentry, especially when working to get your kid back. OCS is big, scary and intimidating.”

-- Donna Fischer, former reentry case manager, Alaska Native Justice Center
Case Management Model

Recommendations for Implementation

» Work to identify an agency to assume intensive case management services for the project and work independently from the Project Steering Committee. Case management agency will develop operational procedures, including policies that outline roles and responsibilities, confidentiality, and information sharing. [Responsible entities: Project Steering Committee/Case management agency; Timeframe: Immediate, Upon receipt of project funding]

» Develop a business agreement between DOC and the health and treatment providing agencies to allow care to be provided in-facility. Alternatively, provisions could be included in an interagency MOU. (See Attachment P - Proposed Elements to Include in an Interagency MOU) [Responsible entities: Medical members of the Project Steering Committee (including Nurse-Family Partnership providers), DOC, Case management agency; Timeframe: Upon receipt of project funding]

» Develop an interagency agreement or MOU outlining how the case management and partner agencies will work together (See Attachment P - Proposed Elements to Include in an Interagency MOU) [Responsible entities: Project Steering Committee/Case management agency; Timeframe: Upon receipt of project funding]

o Define training needs and other clearance measures needed (i.e., background checks) to ensure case managers, peer support mentors, and other community-based providers can access DOC facilities.

o Outline any provisions necessary (i.e., increased screening, training, and/or supervision) to ensure case managers, peer support mentors, and other community-based providers with criminal records can access DOC facilities.

» Because of the elevated levels of trauma experienced by most program participants, the project supervisor should be a master’s level clinician, ideally with a background in trauma-focused therapies. [Responsible entity: Case management agency; Timeframe: Upon receipt of project funding]

(Continues on following page)
Case Management Model

Recommendations for Implementation

» Train agency staff and project partners to use a gender-responsive approach, meaning one that is relational, strengths-based, trauma-informed, culturally relevant, and holistic. Additionally, team members should be cross-trained to understand the unique components of each other's disciplines and should have access to quality assurance supervision, ongoing coaching, and the resources necessary to ensure adherence to the model and associated protocols.

» Assign each program participant a peer support mentor. Ideally, if budget allows, participants meet one-on-one with their peer support weekly.

» To establish community among participants, hold weekly one-hour long group events - one in the facility for institution-based participants and one in the community for community-based participants. These events can be hosted (on a rotating basis if necessary) by the peer support, case manager, or project manager. Content may vary week to week and can include a support group, talking circle, educational topics, etc.

» Program participants should be included in the development of their case management plan, including the goals and outcomes.

» Whenever possible, start pre-release services a minimum of six months before the participant’s expected release date.

» Convene a workgroup to develop a plan and corresponding flow chart for women who have not been diverted to therapeutic court but are incarcerated in pretrial status awaiting sentencing. Consider inviting court personnel, prosecutors, and the public defender agency to sit on workgroup, as they are more closely involved in the program and can recommend women for diversion. [Responsible entity: Project Steering Committee/case management agency; Timeframe: Within 3 months of receipt project funding]

(Continues on following page)
Case Management Model

Recommendations for Implementation

» Develop an institution-based treatment and support team (for program participants with sentences longer than six months) or a pre-release transition team (for program participants with sentences shorter than six months). See How it Will Work section for a list of plans to be developed by each team. [Responsible entities: Case management agency/Project Steering Committee; Timeframe: Upon receipt of project funding, Ongoing]

  o The institution-based treatment and support team includes the case manager, program participant, relevant corrections and community-based physical, mental, social, and spiritual health professionals, Nurse-Family Partnership mentor, peer support mentor, and child[ren]’s caretaker, if relevant.

  o The pre-release transition team includes the case manager, program participant, relevant corrections and community-based physical, mental, social, and spiritual health professionals, Nurse-Family Partnership mentor, peer support mentor, child[ren]’s caretaker, institution-based probation officer, community-based probation officer (when relevant), and any additional caretakers/providers involved in the participant’s reentry plan.

  o Ensure that all team members have the required clearance and training to ensure access to the facility for team meetings.

  o Consider modeling the meeting format after the Mat-Su FIT Court meetings (therapeutic court program) which are held a minimum of once a month.
General Screening and Assessment

In 2019, nearly 80% women housed at Hiland were released within six months of admission. This makes conducting screenings and assessments immediately upon admission essential to identifying each woman’s unique needs and connecting her with appropriate services.

However, when it comes to assessments, more is not always better. Assessments often require women to discuss emotionally charged topics which can be further traumatizing. As the number of assessments administered add up and women must repeatedly share their trauma, their willingness and ability to fully participate and trust in the systems may decline. One interviewee estimated that she completed 20 assessments over the course of a few years during her incarceration, addiction, and recovery process, which she found frustrating, invasive, and often a waste of everybody’s time.

“It was so frustrating because assessments are time-consuming and very personal. Every time someone would send me to a new person, I would have to say everything again and fill out a million forms. I would get one done and then there wouldn’t be a bed open so I would have to get another one done and then another one.”

-- 2020 interviewee

Numerous agencies will work on this project to provide comprehensive services and interventions to the target population; care should be taken to ensure that the number of screenings and assessments administered is minimal and that women already assessed are streamlined into partner services/programs, to mitigate the risk of further traumatization and avoid wasting the time of program participants and providers. In addition, improving the way information is shared between partner agencies will likely increase participants trust in the systems. To facilitate this process, the Project Steering Committee worked to develop a

56 State of Alaska, 2019 Offender Profile.
spreadsheet listing types of assessments and related information. (See Appendix B - Community Partner Screening and Assessment Tools)
General Screening and Assessment

Recommendations for Implementation

» Work to minimize the number of screening and assessments women are given throughout their participation and treatment while ensuring agencies obtain the information needed to provide services. [Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding]

» Develop a workgroup to consider how to streamline services and reduce repetitive screenings and assessments. [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

» Workgroup might discuss:
  o Which screening and assessment tools are needed to satisfy each agency’s needs, therefore allowing for successful assessment and interagency collaboration.
  o Any necessary policy or procedural provisions that would need to be made to allow screening and assessment tools to be shared (e.g., Screenings and assessments must be conducted by a master’s level clinician/social worker to allow an agency to accept one done by an outside agency).
  o Consider contracting with a third-party assessor, agreed upon by all agencies, to create a centralized intake process that will conduct screenings and assessments. Alternatively, develop an inter-agency process that would allow assessment administered by one agency to be used as the foundation for another to build upon. [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]
  o Ensure that all staff administering screenings/assessments have the necessary training and credentials to be accepted by the other agencies.
  o Hold interagency training(s) on how to conduct assessments to ensure consistency in administration across agencies (this will have the added benefit of improving inter-agency trust and confidence). [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]
  o Document screening and assessment tool sharing policies and provisions, including who will be responsible for administering, in the interagency MOU.
Court Diversion – Therapeutic Court

Most incarcerated mothers nationwide are convicted of non-violent crimes, and two-thirds have at least one child under the age of 18. In Alaska, roughly 70% of women are incarcerated for non-violent crimes.\(^{57}\)

Rather than incarcerating women convicted of non-violent crimes, they could instead be diverted from prison and housed in a supportive, therapeutic-based program that lets them receive appropriate services and support and remain with their children. Family-based treatment programs designed to meet the unique needs of incarcerated mothers provides the best chance to break the substance abuse/incarceration cycle and offers the greatest opportunity to make positive contributions to society when released from prison.\(^{58}\)

“Therapeutic court was one of the best programs I decided to do. That support is crucial to recovery.”

-- Advisory Group member

The Project Steering Committee felt that as many program participants as possible should be diverted from correctional facilities altogether. Alaska already has a strong therapeutic court program that serves the project’s target population and provides the following services (participation periods are rough estimates):

- Driving Under the Influence (DUI) Court: 18 months
- Mental Health Court: 12-15 months
- Substance Abuse Court: 12-15 months
- Families Infants and Toddlers (FIT) Court in the Matanuska Susitna Valley: 18 months

\(^{57}\) Alaska Department of Corrections, 2019 Offender Profile.
\(^{58}\) The Rebecca Project for Human Rights, Mothers Behind Bars, 11-12, 29.
Current data shows that the courts are underutilized and the number of women awaiting sentencing high, so increasing the number of women diverted would not overburden the system while simultaneously getting women access to services sooner. In August 2021, Janice Weiss, DOC’s Reentry Case Manager, reported that nearly two-thirds (63%) of women currently housed at Hiland had pre-trial status (awaiting sentencing), while statistics provided by Michelle Bartley, statewide coordinator for the therapeutic courts program, showed that in June 2021 the therapeutic courts were only operating at two-thirds (63%) of their overall capacity.

"Given the number of people eligible [for court diversion], we should be overflowing!"

-- Michelle Bartley, Statewide Therapeutic Court Coordinator, Core Team member

Because Alaska’s therapeutic court program already serves the target population, a new initiative isn’t necessary. Instead, these statistics, combined with anecdotal evidence from Advisory Group members who said they were unaware of the program’s existence, show that improvements in the referral process are necessary. Therapeutic court staff are best positioned to determine which program is best suited for a potential participant. DOC and therapeutic court staff met in a work group to establish a referral process.

**Court Diversion – Therapeutic Court**

**Recommendations for Implementation**

» Develop a one-page initial referral form that meets the needs of all agencies.
  [Responsible entities: Case management agency, DOC & Therapeutic Court; Timeframe: Upon receipt of project funding]

» Conduct joint interagency staff training(s) to ensure staff understands how the referral process works and to ensure that the referral process is successful.
  [Responsible entities: Case management agency, DOC & Therapeutic Court; Timeframe: Within 3 months of project funding, Ongoing]
Prison Nurseries

Studies show that mothers who participate in prison nursery programs have lower recidivism rates compared to women who do not participate.\(^5\)\(^9\) Prison nurseries also allow the mother and child to maintain or create a bond and reduces OCS involvement.\(^6\)\(^0\)

A 2010 National Women’s Law Center (NWLC) report of state policies and practices related to incarcerated mothers found that 13 states offered prison nursery programs for incarcerated women with children ages birth to 2, while two programs allowed children over age 2 to remain with their mothers.\(^6\)\(^1\)

Despite the benefits of prison nursery programs, research indicates that diversion programs are the best option for incarcerated mothers and their young children.\(^6\)\(^2\) Therefore, the NWLC’s position is that prison nurseries should be a secondary alternative to court diversion programs that let mother and child stay together.

The Project Steering Committee consensus was that while prison nursery programs should be re-considered in the future, current DOC policy prohibiting children from being housed at its institutions means Alaska is a long way from having the capacity to implement such a program.

Prison Nurseries

Recommendations for Implementation

» Revisit the feasibility of prison nurseries after the court diversion element is implemented and stabilized.

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\(^6\) The Rebecca Project, Mothers Behind Bars, 30.

\(^6\) The Rebecca Project, Mothers Behind Bars, 30.

\(^6\) The Rebecca Project, Mothers Behind Bars, 12-13, 30-31.
Peer Support Component

A peer support person, or peer specialist, is generally a formal mentee-mentor relationship where the peer specialist has personal experience with the mentee’s issues and can therefore provide meaningful support and knowledge. Peer support gives program participants a recent model of success they can look to for increased motivation and hope that they can succeed. Peer support is becoming more widely recognized as playing an integral role in improving a woman’s chance of recovery from substance abuse and having a successful reentry into the community.63

The peer support role should be distinct from the case manager role. The case manager may also have lived experience but, their primary role is to provide case management services and work toward specific goals with participants. The primary role of the peer support person, on the other hand, is to empathize with the woman and encourage forward movement from a place of experience.

“One [agency] tried to give me a mentor who came in and talked all fancy and was dressed like you [slacks and a button-down top]! It was a waste of time. We look at them and think, ‘You have never had to sell your body for drugs or laid in vomit you detoxed or had your kids taken away.’ It goes in one ear and out the other. We need to have a mentor who knows what it’s like and has come out the other side.”

-- 2020 interviewee

A secondary benefit to the peer support component is the benefit it provides the peer support person herself, especially if she was a recent program graduate. Acting as a role model gives the peer a sense of pride in her accomplishments and serves as additional encouragement to “stay the course,” because she knows someone else is looking to her for inspiration and motivation.

Non-staff individuals serving as peer support should be compensated for their time in an amount that recognizes the value they bring to the reentry process. Stephanie Autumn, senior consultant for the American Institute of Research and a technical advisor for this project, explains that “too often, [peer supports] are compensated with a very low wage that can feel disrespectful – especially when research tells us how vital they are to the process. The lived experience has provided peer guides an expertise that is unique that others do not have, and they should be compensated accordingly.”

Peer Support Component

Recommendations for Implementation

» Begin to identify women who can serve as peer support for women enrolled in the project. [Responsible entities: Case management agency/Project Steering Committee; Timeframe: Within 3 months of receipt project funding, Ongoing]

» Potential sources of peer support members include:
  o Advisory Group members from the planning grant
  o Referrals from the Project Steering Committee
  o Project graduates

» Consider allowing mothers sentenced to three years or more to act as mentors to participants with shorter sentences while in the facility.

» Work with DOC to navigate institutional policies and procedures that would allow peer support persons direct, in-person access to the facilities, with video conferencing a secondary option. [Responsible entity: Case management agency; Timeframe: Within 3 months of receipt of project funding, Ongoing]
Peer Support Component (cont.)

Recommendations for Implementation

» Establish a compensation guide for non-staff individuals serving as peer support. Compensation can be in the form of gift cards. If the primary funding stream doesn’t permit gift card purchases, consider pursuing an additional funding stream that does. [Responsible entity: Case management agency; Timeframe: Upon identification of funding source]

» The following is the proposed peer support compensation:
  - Hour long advisory group meeting: $35
  - One-on-one, virtual hour-long session: $40
  - One-on-one, in-person hour-long session: $6
  - Leading a group session up to 90 minutes: $150

Health Services

Research indicates that many people admitted to correctional facilities have a variety of health issues that have gone untreated, often due to repeated incarcerations. Because of this, correctional facilities can present “a unique opportunity” to provide individuals with “at least some medical care that they haven't gotten otherwise.” However, women comprise a smaller percentage of the overall prison population, which means that medical care and rehabilitative

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65 Committee on Causes and Consequences of High Rates of Incarceration, et. al., “Health and Incarceration.”
programs designed specifically to treat them are often scarce.\textsuperscript{66} Alaska DOC’s policies pertaining to women track what is seen nationally, and the policies that do exist could be revised to eliminate the potential for misinterpretation and ensure consistency in their application.

DOC policies require that every woman admitted to a facility be given a health examination, which includes a pregnancy test, within 14 days of admission and, if pregnant while incarcerated must receive proper pre- and post-natal care.\textsuperscript{67} However, it does not clearly define what constitutes proper care, which can lead to inconsistent treatment. For example, one Advisory Group member who was pregnant while incarcerated said she was often hungry and lightheaded because she wasn’t provided sufficient snacks to account for a woman’s increased caloric needs during pregnancy.

National attention has increasingly been paid to the issue of shackling or restraining pregnant women in prison. While DOC does not have a specific policy limiting the use of restraints on pregnant women, Janice Weiss, DOC’s reentry program manager, said that shackling is not practiced by the Alaska DOC. However, the lack of a written policy either allowing or disallowing the practice opens the door to misunderstandings or misinterpretations of DOC’s position and can result in potentially arbitrary decisions regarding the use of shackling or restraints during labor.

Research indicates that the delivery of health care services to women in prison should be adapted to allow for continuity of the provider/patient relationship. This need for continuity of care is especially important given the high rates of turnover in Alaska’s prison system: nearly 80% of women admitted to the facilities are incarcerated for less than six months, so, if pregnant, are likely to deliver following their release from prison. And Advisory Group members shared that they often neglected scheduling visits with healthcare providers following their release from prison because finding a new one was low on their priority list.


Because of this, the American College of Obstetricians and Gynecologists recommends that obstetrician-gynecologists and other women’s health care partitioners “work inside prisons, jails, and detention centers to provide medical care to incarcerated individuals, and consultation and training to other clinicians in these settings.” Allowing women to see the same provider both in and outside of prison will increase the chance that they continue to receive care after they are released. The Alaska Native Medical Center has expressed interest in contracting with DOC to provide healthcare services to women in DOC facilities. For the purpose of the planning project, Providence Alaska Medical Center, Alaska Regional Medical Center, and other providers were not contacted.

Health Services

Recommendations for Implementation

- To ensure continuity of services, develop a workgroup to establish policies that will allow community-based providers to provide healthcare services to program participants while incarcerated; this is particularly important for pregnant women likely to deliver after their release. [Responsible entities: Project Steering Committee healthcare members (including Nurse-Family Partnership staff), DOC, case management agency; Timeframe: Upon receipt of project funding]

- Develop and provide training and other opportunities for correctional officers and institutional and community-based healthcare providers to increase their knowledge of issues surrounding the healthcare needs of pregnant and post-partum women. [Responsible entity: Case management agency; Timeframe: Within 3 months of receipt of project funding].

(Continued on following page.)

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Health Services (cont.)

Recommendations for Implementation

» Develop a workgroup/task force to collaborate with the DOC to review and modify policies and procedures related to the healthcare needs of pregnant and postpartum women. Include specific policy recommendations for breastfeeding (See Breastfeeding and Breast Pumping section) and the use of restraints on pregnant, laboring, or post-partum women. [Responsible entities: Project Steering Committee healthcare members (including Nurse-Family Partnership staff), DOC; Timeframe: Within 6 months of receipt of project funding or upon project stabilization]

» Recommended workgroup tasks:
  o Reference and discuss the National Commission on Correctional Health Care’s statements on Breastfeeding in Correctional Settings (Appendix N) and Women’s Health Care in Correctional Settings (Appendix O).
  o Advocate for the creation of a specific policy that would prohibit shackling pregnant women. Use language like that recently adopted by the State of New Mexico and endorsed by the American Medical Association (Appendix K).
  o Once policy and procedure recommendations are developed, work with appropriate entities to ensure policies and procedures are adopted.
Substance Use and Mental Health Therapies

Incarcerated individuals are 10 times more likely to meet the criteria for drug dependence or abuse versus the general population, while individuals with a serious mental illness are three times more likely to be incarcerated as they are to be hospitalized.\textsuperscript{69}

Providing appropriate substance abuse and mental health services to women while they are incarcerated is an important part of reducing recidivism rates and decreasing the chance that women relapse when they are released from prison. Although substance abuse treatment varies depending on each individuals’ needs, the most successful programs provide a combination of therapies and other services. Evidence based treatments can include behavioral therapy, such as cognitive-behavioral therapy or contingency management, medications, or a combination of the two.

Although the FDA has not approved any medication to treat opioid addiction during pregnancy, research has shown that methadone combined with prenatal care and a comprehensive drug treatment program can improve many of the negative outcomes related to heroin abuse.\textsuperscript{70}

“\textit{In our experience, the biggest time for relapse is when you get your kids back or when they are taken away from you.}”

- Paul Cornils, Alaska Youth and Family Network & Core Team member

Studies have shown that combining prison and community-based treatment for inmates with substance use issues reduces the risk for recidivism and relapse to drug use, which in turn reduces costs to society. A 2009 study in Baltimore, MD, found that opioid-addicted inmates who began methadone treatment and counseling while in prison and continued after release

\textsuperscript{69} London, et. al., Implementing case management for individuals involved with the justice system.

had reduced drug use and criminal activity compared to those who only received counseling in prison or those who started methadone treatment (with no therapy) after their release.\textsuperscript{71}

Research has also shown that individuals who enter treatment as a condition of their sentence have outcomes as good as those who voluntarily enter treatment. Women who have not received mental health and/or substance use treatment while incarcerated experience high rates of relapse upon release, especially when there is a lack of community-based services available to meet their needs.\textsuperscript{72} Failure to provide appropriate services both inside and outside correctional facilities does nothing to end the individual and generational trauma and ensures that the drug-prison cycle continues, as it did for one Advisory Group member who found herself in the same position as her mother and grandmother, despite promising herself she wouldn’t follow in their footsteps:

“My grandmother was an addict, and my mom is an addict in long term recovery,” she shared. “Despite telling myself over and over as I grew up that I would never follow in their footsteps and that I would never leave my future child for anything…I did.”

-- Advisory Group Member

Watching as the cycle repeats itself with the next generation is equally as traumatizing. One Advisory Group member described the experience of finding out that her adult daughter had been admitted to Hiland while she herself was incarcerated there:

“When I saw my daughter there, I tried to stay strong, but there were so many tears,” she shared. “I didn’t even recognize my daughter. She was right in front of me, and I literally didn’t recognize her [drugs had caused her to lose weight and altered her appearance]. It was everything I could do to keep from breaking down. I went back to my cell and was devastated. All that guilt and shame, but at least now, I knew she was safe.”


\textsuperscript{72} Cowan, Incarcerated women: Poverty, trauma and unmet need.
Substance Use and Mental Health Therapies

Recommendations for Implementation

» Convene a workgroup to ensure agencies maximize resources to benefit the health, safety, and well-being of program participants and the community. Identify which community-based agencies will support the project’s treatment process by providing services. [Responsible entities: Medical, mental health and substance use Project Steering Committee members, DOC; Timeframe: Upon receipt of project funding]

» Formalize agreements in an interagency MOU. (See Attachment P - Proposed Elements to Include in an Interagency MOU.)

Trauma-Informed Institutions and Trauma-Focused Therapy

While therapy is an important part of treating substance misuse and mental health disorders, it is just as important to address the root causes of trauma, which can be an – if not the – underlying cause for a woman’s substance misuse or mental health issues. An Urban Institute study found that the majority of incarcerated women experienced trauma before entering the criminal justice system. Of those women, 90-95% experienced a traumatic injury, while 50% were victimized by a close partner and/or raped.\(^{73}\) Department of Justice data shows that more than 84% of Native women will be victims of violence in their lifetime.\(^{74}\)

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Incarceration is a life-altering experience that, for women, is often the culmination of years of physical and emotional trauma. In other words, **trauma begets more trauma**. For incarcerated women who are also mothers, imprisonment brings the additional trauma of being separated from their children and, in some cases, not knowing who is caring for them or even where they are living. One Advisory Group member said that she was not able to see or talk to her three young children for the seven months she was incarcerated. Another member, who entered Hiland when her daughter was 12 months old, felt fortunate to have monthly visits and speak with her daughter three times a week, compared to her peers who often had no contact with their children. But she said the separation was still hard, and the fact that her daughter was too young to understand why she wasn’t around was “an added hurt.”

**The trauma mothers experience during incarceration can exacerbate any trauma they experienced prior to incarceration.**

Incarceration is traumatic enough on its own; in Alaska, that trauma can sometimes be made worse based on where a woman is incarcerated. Because Alaska only has one jail for women, they are often held at men’s jails across the state while awaiting sentencing. One Advisory Group member who spent seven months at a Juneau Correctional facility awaiting sentencing said, “I am still in therapy years later from some of the trauma I experienced being jailed at a men’s jail.”

Educating staff who work with individuals in the target population about trauma, its effect on the brain, and how it may impact behavior, is therefore crucial to ensure that their needs are adequately met and to reduce the risk of further traumatization. The most important training areas include general information about trauma and self-care needs for staff.75

Addressing the root causes of trauma requires more than just traditional talk therapy. Trauma-based and trauma-targeted therapies, can help reduce the effects of trauma, help women better

75 Benedict, Using-Trauma Informed Practices.
understand triggers that could lead to relapse and can help heal the brain in ways that talk therapy cannot. It is therefore imperative that correctional facilities create and implement trauma-sensitive settings and services, increase staff awareness of the trauma most female inmates experienced prior to incarceration, and train them on the effect this trauma had, and may continue to have, on their lives.\textsuperscript{76}

There are numerous evidence-based types of trauma-targeted therapies that may be useful to the target population. Several of these are listed below:

1) **Eye Movement Desensitization and Reprocessing (EMDR):** EMDR is a psychotherapy treatment designed to alleviate the distress of traumatic memories. It involves accessing traumatic memories while simultaneously having the patient focus on external stimuli to help with healing.\textsuperscript{77}

2) **Cognitive Processing Therapy (CPT):** Cognitive processing therapy is a cognitive-behavioral treatment shown to help reduce symptoms of PTSD related to traumatic events, including child abuse and rape.\textsuperscript{78}

3) **Prolonged Exposure Therapy (PE):** PE is a form of cognitive behavioral therapy that helps patients heal from past traumatic events by teaching them to gradually approach memories, feelings, and situations related to those events.\textsuperscript{79}

4) **Age Regression Therapy:** Age regression therapy uses hypnosis to guide patients mentally back to the age where the trauma or traumas occurred to change their perception of the events.\textsuperscript{80}

5) **Clinical Emotional Freedom Technique (EFT):** EFT combines the stimulation, via tapping, of eight pre-established acupuncture points with elements drawn from cognitive and exposure therapies. (For this reason, EFT is often simply referred to as


“tapping.”) A typical sequence in the treatment of PTSD might have the patient vividly recall details of a traumatizing event (exposure) while pairing the memory with emotionally neutral statements (cognitive reframing).\textsuperscript{81}

The Project Steering Committee was unable to locate any of the trauma-based therapies listed above in the Anchorage area that are available for low-income individuals (i.e., do not appear to accept Medicaid).

Trauma Informed Institutions and Trauma-Focused Therapy

Recommendations for Implementation

» Establish a workgroup to identity and/or develop a trauma-sensitive screening tool, accepted by all necessary partner agencies, to administer to women upon entry to prison. [Responsible entities: Mental health and substance abuse Project Steering Committee members & DOC; Timeframe: Upon receipt of project funding]

» Establish a workgroup focused on increasing participant access to trauma-focused therapies, which should be considered separate from or in addition to traditional mental health or talk therapy. [Responsible entities: Mental health and substance abuse Project Steering Committee members & DOC; Timeframe: Within 3 months of receipt project funding]

Recommended workgroup tasks:

- Identify appropriate, targeted trauma-focused therapies in Anchorage and the Mat-Su.
- Develop a plan for the program to partner with entities that provide the identified trauma-focused therapies.

\textit{(Continued on following page.)}

Trauma Informed Institutions and Trauma-Focused Therapy (cont.)

Recommendations for Implementation

» Conduct a review of the number of women in pre-trial status who are housed at men’s facilities around the state, paying special attention to how much interaction they have with prisoners at each the facility (do they eat with male prisoners, share a gym, potentially pass men in the halls who may have previously victimized or threatened them etc.). Begin a conversation about reducing the trauma experienced by women at the male institutions and whether an alternative is available.

» Establish a workgroup to focus on further developing DOC and other project partners into trauma-informed institutions. [Responsible entities: Mental health and substance abuse Project Steering Committee members & DOC; Timeframe: Within 3 months of receipt of project funding]

Recommended workgroup tasks:

- Identify an appropriate agency or individual to train those who will work with program participants on trauma-informed care. The training should focus on trauma’s effect on behavior and work to reduce acknowledged or unacknowledged stigmas toward the target population that can act as a barrier to successful reentry.

Educate healthcare and treatment staff, correctional officers and other partners who work with individuals in the target population about trauma, its effect on the brain, and how it may impact behavior. The most important training areas include general information about trauma and self-care needs for staff.
Mother/Child Connectedness

The first few days of life are believed to be optimal for mother/child bonding, which is why standard practice in most U.S. hospitals is for mothers to spend as much time as possible with her infant immediately after birth.\(^8^2\)

For women who give birth while incarcerated, most are allowed only a few days of contact with their baby.

In Alaska, a woman who gives birth while incarcerated is separated from her newborn within 48 hours.

DOC policy allows women to see their baby for one hour per day, provided the child’s caregiver brings them to the facility.\(^8^3\)

This lack of time not only interferes with the mother/child bond but can negatively affect the infant’s development and lead to emotional and behavioral issues.\(^8^4\) **Separation** between mother and child **due to incarceration** has been linked to poorer peer relationships compared to children whose mothers have not been incarcerated, diminished cognitive ability, and emotional or psychological problems, including anxiety, withdrawal, depression, eating disorders, and anger, aggression, and hostility toward siblings and caregivers.\(^8^5\)

Maintaining contact between female inmates and their children is therefore extremely important to **improve the health outcomes of both mother and child**; it reduces both the mother’s

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\(^8^5\) Parke, et. al., Effects of Parental Incarceration.
recidivism risk and the chance that her child will enter the criminal justice system later in life. According to the National Institute of Justice, children of incarcerated parents are six times more likely to be incarcerated themselves and that number is even higher when it is the child’s mother that is incarcerated over that father.

While there is no data in Alaska to indicate how many incarcerated youths had one or more parents incarcerated during their childhood. The Alaska Division of Juvenile Justice (DJJ) administers a 14-question trauma screening tool to all youth under court-ordered probation supervision or who reside in a detention or secure treatment facility. Youth are asked whether a household member or someone they cared about has gone to prison; in FY20, 51.5% of youth asked this question answered yes.

Ideally, family contact would occur daily and, if not, twice, weekly, and include developmentally appropriate activities and instruction to help the mother understand the importance of such support to a child’s development. Advisory Group members shared that while they appreciated the classes Hiland offered, they needed more than basic parenting lessons.

"I know how to parent my child. It would have been helpful for someone to talk to me about how to explain what was happening to my three-year-old in language she would understand so that I could feel more connected to her."

-- Advisory Group member

Project Steering Committee members state that DOC currently employs someone to conduct supervised visitation between mothers and their children, but the time they have available to spend with each family is limited. There is hesitance to allow an outside, third-party agency to supervise visitation, because of a concern of children being used as mules to bring drugs or

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87 Martin, Hidden Consequences: The Impact of Incarceration on Dependent Children.
other paraphernalia into the facility. The person who conducts the supervision must also have the appropriate level of clearance.

Mother/Child Connectedness

Recommendations for Implementation

» Develop a class to teach mothers how to create and maintain a connection to their children while in prison. [Responsible entities: Project Steering Committee, case management agency, Advisory Group members; Timeframe: Upon receipt of project funding]

» Implement activities that can help mothers remain connected to their children while incarcerated. [Responsible entities: Project Steering Committee/case management agency & DOC; Timeframe: Upon receipt of project funding]

» Suggested activities, based on interviews with Advisory Group members, may include:
  o Weekly 30-minute Zoom call (when visitation is unavailable).
  o Craft projects to do over Zoom (craft materials will be sent to the child’s caregiver before the call to allow mom and child to do it together over Zoom).
  o Help program participants send packages to their children. To facilitate, the case management agency should include a line item titled, discretionary case management budget, which can be used to help women send these packages.

» Work with Department of Juvenile Justice to collect data on the number of incarcerated teens who had a parent, particularly mothers, incarcerated during the teen’s lifetime.
Breastfeeding and Breast Pumping

The American College of Obstetrics and Gynecologists (ACOG) clinical guidance, adopted in October 2018, states that “whenever possible and not precluded by security concerns, correctional facilities that house pregnant and postpartum women should devise systems to enable postpartum women to express breast milk for their babies and to breastfeed them directly.” Participation in a lactation program may decrease the likelihood of reoffending once released and/or provide motivation for mothers with substance use issues to maintain their sobriety.

To the extent possible, correctional facilities should develop a system so that mothers who choose to breastfeed can pump breast milk and store it at the facility until a designated person can pick it up for delivery to the child. This should occur at least throughout the child’s first year of life, or when the mother decides to stop pumping, whichever occurs first. Even if a mother decides not to breastfeed, she should be provided access to a breast pump so that she can gradually decrease her supply to minimize the pain of engorged breasts and decrease the chance of developing mastitis, an inflammation of the breast tissue that can result in infection.

Access to providers who can educate women on the health benefits to mom and baby of breastfeeding and who can help facilitate that would also be extremely beneficial. One Advisory Group member, who was pregnant throughout most of her incarceration, said the lack of access to breastfeeding resources while in prison was the reason she ended up not breastfeeding. She believes that women’s prisons need to allow lactation specialists and other pregnancy experts:

“One of the biggest issues was not knowing how to breastfeed and therefore, unfortunately, my daughter wasn’t,” she shared. “I wasn’t able to attend any kind of [breastfeeding] classes, nor did [the prison] have any books regarding being pregnant or giving birth.”

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Some federal and state correctional facilities have implemented policies that allow incarcerated women to pump milk for delivery to their child or to keep their supply up so they can continue breastfeeding upon release and/or allow women to breastfeed during visits with their child. The Federal Bureau of Prisons gives incarcerated mothers the option to pump breast milk, with a prison-provided pump, so that she can nurse during visits and/or maintain her milk supply until released.\(^9\) The policy does not require that the prison store the milk, although the Warden can request an exception from the Health Services Division.\(^9\)

In 2021, Minnesota became the first state to prohibit incarcerated mothers from being separated from their infants when it enacted the Healthy Start Act.\(^9\) The Act allows the DOC commissioner to divert pregnant and postpartum women into alternative facilities, such as a halfway house, and stay with their baby for up to a year.\(^9\)

In 2019, in response to a request by the American Civil Liberties Union, the Illinois Department of Corrections modified its policies to let incarcerated mothers at the Logan Correctional Center breastfeed their infants; the department is working to change the policy for facilities across the state.\(^9\) In New York, the Department of Corrections may permit a woman who gives birth in prison or enters prison with a child under the age of one to bring the child into the facility with her in order to nurse.\(^9\) And in one Philadelphia County jail, women who gave birth immediately prior to or shortly after incarceration can pump their milk in a lactation room under the direction

of a doula and a nurse or use express pumps in their cells. If the women choose to store the milk, case managers from local non-profits deliver the expressed milk to the woman’s child.\textsuperscript{97}

Failure to give incarcerated women the right to breastfeed or pump milk \textbf{may also potentially be a civil right violation}. In 2017, a New Mexico District Court ruled in \textit{Hidalgo v. New Mexico Department of Corrections}, 1st J.D. Ct. of Santa Fe County (NM), Case No. D-101-CV-2017-01658, that the state’s Department of Corrections violated a female inmate’s civil rights under the New Mexico Constitution when it failed to allow her to pump and store breastmilk to deliver to her infant.\textsuperscript{98} In response to the court’s decision, the New Mexico Association of Counties agreed to create a lactation policy for county correctional facilities. Although that decision is not binding on Alaska courts, it is something to keep in mind as breastfeeding policies for female inmates are developed.


Breastfeeding and Breast Pumping

Recommendations for Implementation

» Develop a policy that will allow a certified lactation consultant to meet with pregnant or post-partum mothers who intend to breastfeed before delivery or release (if woman will deliver in the community or delivered in the community shortly before admission into prison). [Responsible entities: Medical Project Steering Committee members (including Nurse-Family Partnership staff), DOC; Timeframe: Upon receipt of project funding]

» Work to provide breast pumps to the DOC facility so that post-partum mothers, regardless of their participation in the project, can pump. The pumps should be made available to mothers who are currently breastfeeding (via pumping and storing their milk for later delivery or, breastfeeding during visits, if permitted), mothers who wish to maintain their breastmilk supply so they can resume breastfeeding upon release, or mothers who choose not to breastfeed but need to pump to gradually reduce their supply. [Responsible entities: Medical Project Steering Committee members (including Nurse-Family Partnership staff), DOC; Timeframe: Upon receipt of project funding]

» Develop a workgroup to collaborate with DOC to review and revise breastfeeding and breast pumping policies and procedures. [Responsible entities: Medical Project Steering Committee members (including Nurse-Family Partnership staff), DOC; Timeframe: Within 3 months of receipt project funding]

» Recommended workgroup tasks:
  o Review The National Commission on Correctional Health Care’s statement on Breastfeeding in Correctional Settings (See Appendix N) among other publications.
  o Develop a policy that will allow mothers to pump and store breastmilk for later transport to their children by a family member, caregiver, or case manager, or to pump to relieve pressure and pain. The policies should also include providing a dedicated space for women to pump and eventually, the ability to store breastmilk in the medical department freezer until transport can be arranged.
  o Research into other state’s breastfeeding practices for incarcerated women, including whether they permit breastfeeding during mother-child visitation and how that is accomplished.
Nurse-Family Partnership

Nurse-Family Partnership is a national model that provides specially trained nurses, including lactation specialists and doulas, to visit first time moms on a regular basis; these visits begin early in the pregnancy and continue through the child’s second birthday. During these visits mothers receive proper prenatal care and support necessary for a healthy pregnancy. The program combines research from both prenatal health and early childhood development with individualized mental health and trauma expertise. Research has proven that Nurse-Family Partnership helps keep children healthy and safe and improves the lives of moms and babies.

A National Institute of Justice analysis found that the Nurse-Family Partnership program works to reduce crime, with participating families showing significant decreased rates of child abuse/neglect and domestic violence compared to control families.

Anchorage has two Nurse-Family Partnership programs, one at the Alaska Native Medical Center and another at Providence Alaska Medical Center. Both partnerships have expressed interest in working to provide care to women housed at Hiland and/or reentering the community. While a partnership has not yet been established between the agencies, DOC currently provides a pamphlet to incarcerated women with information about the Nurse-Family Partnerships.


Planning for Pregnant and Postpartum Reentrants: Final Project Report
Nurse-Family Partnerships

Recommendations for Implementation

» All eligible program participants should have access to a nurse mentor from one of the two Nurse-Family Partnerships: Nutaqsiivik at Southcentral Foundation or the Providence Nurse-Family Partnership program.
  o If the initial project can only fund Alaska Native participants, DOC should work to establish a formal agreement (business agreement or MOU) with the Providence Nurse-Family Partnership program so that non-Native pregnant women incarcerated at Hiland can also access services.

» Include the Nurse-Family Partnership (NFP) program[s] on any interagency business agreement or MOU with the other involved agencies to ensure its ability to provide services to program participants. Provisions on the MOU should include, what services will be provided by the NFP program[s], how access to Hiland will be granted, and training and level of screening required for entry (See Appendix P, Proposed Elements to Include in an Interagency MOU). [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

Incorporate Traditional Healing

Alaska Native women comprise 44% of female offenders in the Alaska Correctional System.¹⁰² Many of the services provided to Alaska’s female offenders fail to address the unique challenges Alaska Native women face and neglect the tribal traditions and knowledge passed down by elders. ANMC has a department focused solely on traditional healing.

Traditional healing often has an elder who operates as a counselor in talking circles, where they are hearing and responding in story. Case management agencies also have participants gather for group activities, such as making tea and salve, discussions about traditional foods, and mixing with modern day foods. Traditional healing also involves sauna or sweat houses to heat

¹⁰² State of Alaska, 2019 Offender Profile.
and clean from the inside out. For Alaska Native or American Indian women, participating in traditional practices may be an essential component to reentry success.

## Traditional Healing

**Recommendations for Implementation**

- Consider partnering with Southcentral Foundation’s traditional healing department to provide traditional healing services to program participants. [*Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding*]
- Consider a review and possibly modification of existing supports and services to incorporate more traditional healing practices.
- Consider consulting with traditional healers to incorporate various traditional healing practices such as talking circles and summer fish camp retreats into programs when possible.

## Establishing Community Among Participants

The Advisory Group spoke extensively about feeling isolated during incarceration and especially during the period following release into the community. One member described the experience of having a toddler while in jail as “really, really hard” and said, “there was nothing for me when I got out.” Another shared that that while she took advantage of every program available to her in prison, once released she began using again “because I didn’t have good people to rely on for support.”

Without a supportive community of other women with similar experiences, group members reported they are more prone to return to the people and behaviors that landed them in prison once released. It was their desire to keep other women from experiencing those same feelings
of isolation and therefore temptations to return to prior bad habits that motivated them to join the project.

Establishing Community Among Participants

Recommendations for Implementation

» Upon a program participant’s release from Hiland, arrange a gathering with the other community-based participants to celebrate her release and welcome her into the community. [Responsible entity: Case management agency; Timeframe: Upon receipt of project funding, ongoing]

» Hold relevant classes/talking circles, etc. that are only for project participants both in the facility and the community. [Responsible entity: Case management agency; Timeframe: Upon receipt of project funding, ongoing]
Housing

It is not surprising to learn that housing insecurity is associated with an increased risk of recidivism. Nationally 25 to 50% of the homeless population has at some point been incarcerated, and homelessness is 11 times greater among inmates compared to the general population. Interventions that increase housing access for reentrants are shown to reduce recidivism, especially for those who are relatively low risk and not likely to reoffend.103

Project Steering Committee members report that current DOC practice calls for Institutional Probation Officers (IPOs) to help inmates submit paperwork to Partners for Progress, which has a six-month housing program, 30 days prior to release. This program covers security deposits and the first two months’ rent. The second two months, Partners for Progress offers partial assistance based on the participant’s job status. Participants are expected to cover their final two months’ rent for a transitional housing program. Following its six-month program, Partners for Progress will pay the first month’s rent for permanent housing.

While Partners for Progress provides a much-needed service, there are limitations for reentrants with children. For example, children are not allowed on the premises because Partners for Progress also serves sex offenders. This is frustrating to women seeking services, who put forth a great deal of time and effort only to be turned away through no fault of their own.

“It is a great big process to try and take the bus with a toddler, and when I did that with my baby and went to try and get services from Partners for Progress, they told me I couldn’t come in because I had my baby with me and there may be sex offenders inside,” one Advisory Group member shared. “I felt so frustrated because it took me so much to get there, I was trying so hard to get help and was being turned away. What was I supposed to do?”

Unfortunately, even with a voucher from Partners for Progress, Anchorage has no dedicated housing program that supports female reentrants and their children. The Project Steering

Committee was aware of three programs in Anchorage and the MatSu Valley that accept women and their children; however, none of these are designated specifically for reentrants.

“There is no housing. Nothing. I know so many women who had nowhere to go. The only option is to call old friends, which are your drug dealers or pimps... It doesn’t take long to end up back in.”

- 2020 interviewee

Even if reentrants can pay for housing, whether through a voucher or independent means, many private landlords are unwilling to rent to individuals with criminal records. Cook Inlet Housing Authority is working to address this through several programs. One, Path to Independence, is intended to reduce the risk of homelessness and engages private landlords as partners and investors. Participants receive up to six months of financial assistance to help with rent and utility payments, one year of case management, and connection to employment opportunities. They are each are assigned a landlord liaison, which provides a single point of contact and connects landlords, case managers, and participants. The program appeals to landlords because the risk pool guarantees landlords will receive 100% of the security deposit and a percentage of any damages that may exceed that deposit.
Housing

Recommendations for Implementation

» Assemble a workgroup to discuss the process and partnership(s) needed to secure housing for participants with the currently limited available options. Add any provisions necessary to facilitate successful program partnership into the interagency MOU. (See Attachment P - Proposed Elements to Include in an Interagency MOU)

[Responsible entities: Case management agency/Project Steering Committee; Timeframe: Upon receipt of project funding]

» Develop a workgroup and/or task force to address extreme housing shortages for the target population and their children once project stabilizes.

» Consider modeling any new housing program after Cook Inlet Housing Authority’s Path to Independence program, which includes a landlord liaison that serves as a navigator between the landlord, program participant, and case manager.

Transportation

Alaska Native Justice Center and Partners for Progress, the main local reentry case management providers provide program participants with bus vouchers. Some churches, such as Faith Christian, also provide transportation assistance for reentrants.

However, given the target population, it would be wise to look for additional options. The Advisory Group discussed at length the difficulties they had upon release trying to navigate the bus system with their kids. Anchorage’s bus system can be inconsistent, there are limited routes so numerous transfers can be necessary to get across town and during winter uncovered bus stops can be slippery and unsafe, especially when carrying small children. Besides the bus system, the only other transportation option are cabs, which is cost-prohibitive.
Project Steering Committee members shared reports of predators such as drug dealers and pimps occasionally waiting near correctional facilities ready to prey on vulnerable women upon release. Therefore, there was discussion about the importance of the case manager or peer support person picking the participant up from the facility and helping her settle into new housing. Janice Weiss, reentry case manager for DOC agrees:

“It would be very beneficial for women who are being released from prison and do not have transportation already lined up to have a safe, secure ride available so that they do not head down the wrong road immediately.”

**Transportation**

*Recommendations for Implementation*

- Assemble workgroup to explore possible transportation options and potential partnership with church or other non-profit to establish program that would donate or lend cars to program participants at release. [Responsible entities: Case management agency/Project Steering Committee; Timeframe: Upon receipt of project funding]

- Include a budget line item specifically for transportation. The ideal solution would be to partner with a non-profit already providing transportation and establish a cost-share program. An alternative option would be to provide case managers and peer support members mileage reimbursement to meet with program participants and/or assist with essential errands and services.

- Establish a rideshare system between the case management agency and program participants (if a formal transportation procedure listed above cannot be established). [Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding]
Job Training/Placement

Job training and job placement is essential to ensuring a successful reentry. Of the nine semi-structured interviews conducted with program participants, all considered themselves single mothers at or around the time they were incarcerated and received little child support. This makes finding gainful employment even more important, as they had no other means of financial support. Goal 3, Objectives 3 and 4 deal with program participant work readiness and obtaining employment.

“Having support with employment after incarceration would have been so helpful to me,” an Advisory Group member shared. “I’ve heard time and time again from other women I know how disheartening it is trying to find a good job after prison, and most women I know have a very difficult time finding employers that will hire felons. I’m unsure why but I have noticed professions that are more ‘male dominant,’ like construction, welding, plumbing, etc., seem to be more open to hiring felons versus the jobs women tend to search for. It was so difficult for me that there were times I wanted to just give up completely because of my record and work history gap. I believe having some sort of employment placement and work ready portion of this woman’s program would be super beneficial for its participants.”

Job Training/Placement
Recommendations for Implementation

- Assemble a workgroup to determine elements to include in a work training/work placement plan, how it will fit into the current plan (e.g., types of relevant service[s], pre- and/or post-release), and which community groups (e.g., Partners for Progress, the Job Center) to partner with for service delivery. [Responsible entities: Case management agency/Project Steering Committee; Timeframe: Upon receipt of project funding]
Childcare/Procurement of Essential Items

Childcare is essential to allowing reentering mothers to return to the workforce. Finding quality, affordable childcare, whether in-home daycare, preschool, a childcare facility, or before/after school program was difficult even before the COVID-19 pandemic; it is even harder now.\(^{104}\) CITC has a childcare program available for Alaska Native women and the non-profit group, thread, has information on childcare resources and can point women in the direction of agencies that provide financial assistance.

Mothers recently released from prison often have little funds, making it difficult to purchase essential items for their children, such as car seats, beds, diapers, or formula. Advisory Group members shared that it would have been helpful if they could connect with an agency, church, or even a group of moms for help purchasing these essentials or swapping items with moms who had some to spare.

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Childcare and Procurement of Essential Items

Recommendations for Implementation

» Before release, case managers should help program participants complete an application for childcare assistance and/or connect with thread, a local non-profit that can help with placement. [Responsible entity: Case management agency; Timeframe: Upon receipt of project funding]

» If possible, partner with local churches to obtain donations of essential items mothers will need for reentry (i.e., crib or bed for child, car seat, diapers, bed for mom, etc.) and/or consider developing a community of moms (possibly program graduates) to facilitate sharing items no longer needed with other participant moms in need. [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

» Maintain a line item for discretionary purchases of essential items when donations are unavailable. [Responsible entity: Case management agency; Timeframe: Upon identification of funding source]
HOW THE PROJECT WILL WORK

For purposes of the planning process, the Project Steering Committee developed a program for women who met the target population criteria and were sentenced, with a diversion element added for pre-trial women. However, DOC statistics in August, 2021, showed that nearly two-thirds (63%) of women housed at Hiland were in pre-trial status or otherwise without a sentence. Therefore, during the implementation phase of this project, the Steering Committee and/or case management agency should develop a specific plan for pre-trial, non-diverted women.

Institution-Based Initial Intake/Screening and Assessment

1. DOC will conduct an initial intake, ideally within 48 hours, to determine if potential participants meet the program criteria.

2. DOC will refer eligible women to the case management agency for additional screening to assess the woman’s willingness and desire to participate and her readiness for change.

3. If a woman is in pretrial, the following steps will be taken to connect her to the court diversion program. (This step can be skipped if woman is entering to serve a sentence).

   a. DOC staff will have her complete a one-page Therapeutic Court referral form.

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105 The percentage of unsentenced women in all DOC facilities is likely significantly higher than what is indicated by this single point in time statistic. Pre-trial women are held in the men’s facility in their home community and are not transferred to Hiland until they have been sentenced, therefore, those women are not reflected in this statistic.
Therapeutic Court will review the referral and determine which of the four therapeutic court programs, if any, would be the best fit. They will then send the full application for that program to DOC staff.

d. DOC staff will help the participant complete the application.

Institution-Based Additional Forms and Training Needed for Initial Intake

- Therapeutic Court and DOC should develop a one-page referral form, for Therapeutic Court diversion services.
- DOC and the case management agency should develop a one-page referral form (or select one from existing documents) for case management services.
- DOC, Therapeutic Court, and case management agency staff should be trained on the information sharing protocol(s) that are developed during the project’s implementation phase.
- DOC staff should be trained on how to help pre-trial participants complete the one-page referrals and the full application for the Therapeutic Court program.
- The case management agency should first choose an assessment tool to determine a participant’s readiness for change and then train staff on how to use the assessment tool.

Institution-Based Case Management Program

Institution-Based Admission to the Program

1. Once referred by DOC, the case management agency (case manager or supervisor) will meet with the participant to conduct a screening to determine their readiness for
change. Acceptance will be determined by the case management agency; DOC may advise this decision.

2. If admitted to the project, the case manager meets with the participant to develop a case plan. They will also work with the DOC social worker as needed.

3. If not admitted to the project, the case manager will meet with the woman to explain the decision and make referrals to other relevant DOC-programs.

Point of admission to six months prior to release

1. During the first month after program admittance, the case manager and program participant will meet weekly to:
   
   a. Develop a plan for mother/child connection while incarcerated (for children under age three).

   b. Develop a plan for placement (if pregnant and expected to deliver while serving sentence).

   c. Facilitate connection with Nurse-Family Partnership mentor.

   d. Assist social worker/DOC staff in finding community (where applicable) and institution-based treatments.

   e. Start initial plan for release. This will include creating an initial plan for housing, reunification with child(ren) and connection to community-based services.

(Note: The vast majority (85%) of women spend less than 12 months at Hiland. For participants sentenced to more than a year, and on a case-by-case basis, the case management agency may choose to meet with participants bi-weekly or as needed during this stage (more than six months out from release). If their sentence is less than six months, they will move to #4 below in Six Months Prior to Release.)

2. If a participant’s sentence is more than six months, the case management agency will work with the participant [and DOC social worker/staff when relevant] to develop the
institution-based support/treatment team which will include the following, where relevant:

a. The participant, case manager & peer support
b. The Nurse-Family Partnership provider (Providence Nurse-Family Partnership or Nuutassivik (Southcentral Foundation))
c. Institutional provider(s) (Substance abuse treatment, mental health treatment, trauma-based therapies, physical health care, etc.)
d. Institution-based social worker
e. Community based provider(s) (Substance abuse treatment, mental health treatment, trauma-based therapies, physical health care such as OBGYN/family doctor/pediatrician)
f. OCS case worker and/or caretaker of children (if relevant)
g. Spiritual Guide (Pastor, Rabbi, Deacon, Priest, spiritual leader, traditional healer, other)
h. AA/NA sponsor
i. Elder

3. Once the support/treatment team is developed, the case management agency will hold an institution-based support/treatment team meeting to discuss the case and treatment plan. This meeting will occur quarterly following the initial meeting until the participant has six months remaining of her sentence when she will move to #4 below in Six Months Prior to Release.
Six Months Prior to Release

1. Intensive reentry case management begins. Case manager begins to meet with participants weekly or twice weekly if needed to further develop the reentry plan and begin implementation.

2. Case manager begins the process of developing the reentry transition team. If a participant had an institution-based support/treatment team, then the necessity of the team members will be reevaluated. For example, institution-based providers should transition out and community-based providers should transition in. The transition team should include all relevant members listed in #2 above and:
   a. Institutional probation officer and community-based probation officer (if relevant)
   b. Other relevant supports
   c. Family Advocate from the Alaska Youth and Family Network (if relevant)

3. Monthly reentry transition team meetings will be coordinated by the case management agency.

4. Case manager continues to meet weekly with participant to assist with progress and to:
   a. Help apply for Medicaid/other health coverage, public assistance, childcare support
   b. Develop a community-based mental health/substance use treatment plan
   c. Develop a transportation/job/housing plan
   d. Assist with the procurement of essential items (crib, diapers, car seat, etc.)
   e. Create a relapse prevention plan
   f. Develop a domestic violence safety plan.
Community-Based Case Management Program

Day of Release & First Weeks

1. The case manager or peer support picks up the participant when released and spends a half day with them to help them settle into their accommodations, get groceries, etc.

2. When possible, and especially when supportive (safe and sober) friends and family are unavailable, the other program participants and case manager should plan a community welcome reception for the reentrant. If the participant has children, they should be invited along with their caretaker.

3. The day after release, the participant will meet with her case manager to review the case plan. Reentrants meet daily with their case manager for the first week following release; meetings then move to three times a week during weeks 2 and 3 and twice a week for weeks 4 through 6.

4. Reentrant meets with peer support once a week in a one-to-one or group setting.

5. Case managers work with participants and continue to revise the case plan as needed.

Month 1-3 post-release—Stabilization

1. The participant meets with their case manager weekly as needed to work on their reentry case plan.

2. Focus is placed on continued stabilization and job training/placement begins. In addition, if the participant has children, the reunification plan is reviewed and prioritized.

3. Case management agency will schedule and facilitate monthly transition team meetings where the reentry plan will be reviewed, progress assessed, and new goals set. Again, in this phase, the transition team will be re-evaluated, and additional team members added.
when necessary. The following individuals, along with those already mentioned above, should be considered for inclusion:

- Landlord Liaison (if relevant)
- Boss/Supervisor (if part of a supervised program)
- Community-based probation officer (if relevant)
- Addiction provider(s) (Substance abuse treatment, mental health treatment, trauma-based therapies, physical health care such as OBGYN/family doctor/pediatrician)
- Therapeutic Court Case Manager (if relevant)

4. Reentrant continues to meet with peer support once a week in a one-to-one or group setting.

Month 3-6 post-release—Growth

1. The Participant continues to meet with their case manager weekly as needed to work on the reentry case plan. At the transition team’s discretion, case manager meetings can be twice a week during this phase.
2. Focus is placed on continued treatment, job placement, reunification with children and reviewing permanent housing options.
3. Case management agency will schedule and facilitate monthly transition team meetings where the reentry plan will be reviewed, progress assessed, and new goals set. Team members should be reassessed for need and additional members should be included if relevant.
4. Reentrant continues to meet with peer support once a week in a one-to-one group setting.

Month 6-12 post-release—Transition

1. The participant begins to meet with her case manager bi-weekly to work on transitioning out of the program. At the transition team’s discretion, meetings with the case manager can occur monthly.
2. Focus is placed on continued treatment, job stabilization, reunification with children and moving into permanent housing options in market-rate housing. If possible, case manager should facilitate a connection with a landlord liaison.

3. Case management agency will schedule and facilitate quarterly transition team meetings in this phase. At the final meeting, lunch should be ordered, and success celebrated. Team members should be reassessed for need and additional members should be included if relevant from all previous lists.

4. Reentrants may decide to continue to meet bi-weekly with their peer support person, reduce to occasional meetings, or discontinue meetings altogether.

(Note: If the participant delivers a baby in this phase, the treatment plan, focus and priorities will need to be reevaluated.)

EVALUATION PLAN

Overview

This evaluation plan was developed primarily by Dr. Ruby Fried, PhD and Dr. Lauren Lessard, PhD, from the Center for Circumpolar Health at the University of Alaska-Anchorage using the Centers for Disease Control and Prevention’s (CDC) framework for program evaluation in public health. It details each of the six steps to be followed in evaluation practice, including the progress made during the planning period. The six steps are: 1) engage stakeholders, 2) describe the program, 3) focus evaluation design, 4) gather credible evidence, 5) justify conclusions, and 6) ensure use and share lessons (Fig. 5). In addition, the evaluation plan is guided by the four standards of utility, feasibility, propriety, and accuracy.

As the project may change from how it is described in this Guide, changes to the evaluation plan should be made accordingly. Therefore, the plan as described is an evaluation approach that can be adapted to coincide with any changes made to the project. The evaluation process should include both cross-sectional and longitudinal measures, utilize qualitative and quantitative measures, and pull from existing data wherever possible to decrease burden on project participants and team members and increase sustainability and effectiveness. Baseline
data exists for some key indicators, while others will require the program to collect baseline and longitudinal data. Details of baseline data, indicators, and data sources are outlined in Appendix F and are organized by the project goals and objectives. In addition, data sharing between stakeholders will greatly enhance the effectiveness and comprehensiveness of this project and evaluation plan.

Figure 5: CDC Framework for Program Evaluation in Public Health

Evaluation Steps

1. Stakeholder Engagement

The project presented in this Guide was developed by three groups that together comprised The Project Steering Committee: the Core Team, the Advisory Group, and Workgroups. Gulling
Consulting engaged with Steering Committee members, multiple agencies within the court, criminal justice, and reentry support systems, the Institute for Circumpolar Health Studies, and others to create this evaluation plan. (See “Project Steering Committee” section for further details.) Together, these stakeholders created and approved the goals and objectives and the project design, activities and outcomes through multiple Zoom sessions, individual phone calls, emails, and in-person meetings. We strongly recommend that these stakeholders continue to be meaningfully engaged in the development of this project and the evaluation plan in any future efforts.

2. Program Description

The logic model below (Fig. 6) identifies the proposed program evaluation’s inputs (resources needed to implement activities), activities (what the program does), outputs (tangible products, capacities, and deliverables that result from activities), outcomes (changes that occur because of the activities and outputs), and impacts (distal/long-term outcomes). It is important to note that there will be additional contextual factors that are out of the program’s control, such as existing family relationships and institutional policies, that may help or hinder achievement of the outcomes.

Due to the personalized nature of each participant’s case plan (See “How It Will Work” and “Goals and Objectives” sections), a comprehensive evaluation plan that includes explicit details is beyond the scope of this Guide. However, this logic model provides a broad overview of program investments, action, and potential outcomes and impacts and includes activities that will occur across the duration of the project.
3. Evaluation Design

**Purpose:** The overall purpose of this evaluation is to identify whether the proposed program is effective in reducing recidivism among women with co-occurring disorders who were incarcerated at Hiland Mountain Correctional Center. In addition, measures of key indicators outlined for each project goal and objective should be included in the evaluation, which are included in the “Proposed Goals and Objectives” section of this report and Appendix E. The “How It Will Work” section identifies certain indicators of success, including participation in case manager meetings, obtaining housing stability, and mother-child relationships. Based on prior research and the combined expertise of the Project Steering Committee, achieving success in multiple goals and objectives is believed to reduce the possibility of recidivism among program participants.
**Scope:** Evaluation should measure program effectiveness in terms of whether the resources provided to participants are appropriate and meet their identified needs and whether the program reduces participants’ probability of recidivism. As mentioned above, a detailed evaluation plan is outside the scope of this planning grant. However, baseline and other measurement data are indicated for each goal, objective, and indicator in Appendix F.

**Design:** Due to the small number of women who meet the program participant criteria and the urgency and severity of circumstances many participants will likely experience, we believe a non-experimental evaluation design is the most appropriate. The creation of a “control group” that meets the criteria for, but is not invited to, participate was not explicitly discussed during Project Steering Committee meetings. However, it was decided that anyone who fits the participant criteria and is interested in participating should be allowed to do so. Therefore, experimental or quasi-experimental approaches are not advised. Instead, longitudinal tracking and analysis of individual and group progress should be the primary mode of evaluation. This includes long-term follow-up with participants to track recidivism rates and how they compare to the overall population.

**Methods:** Both qualitative and quantitative methodologies should be considered for evaluation. Subjective experiences of the program, as well as objective measures of engagement, are necessary to evaluate program effectiveness. For example, tracking program participation through documentation of participant attendance at case manager meetings, informational classes, health care/treatment provider visits, and job and/or housing assistance activities should be conducted to identify whether higher attendance is associated with decreased risk in recidivism and an increase in positive outcomes within different life domains (e.g., stability in housing, job, family relationships (reunification, visitation rights, quality of relationships with child(ren), pre- and postnatal social support), mental health, sobriety, low criminal exposure, and avoiding recidivism). Other quantitative data may be useful, including brief surveys designed to gauge participants’ satisfaction with the program and their opinion on the effectiveness of offered programs. These brief surveys could be conducted during a case manager meeting to ensure participation and provide immediate feedback. However, anonymous surveys conducted on paper or electronically may be more effective in avoiding biased reporting.
To complement these quantitative data, we recommend that qualitative methods be utilized before, during, and after program participation to gain insight into participants’ experience with the program. Interviews could include questions regarding program activities participants found to be helpful or unhelpful to their recovery, connection with their child(ren), and avoiding recidivating. Focus groups with three to five program participants may be advisable to elicit attitudes, feelings, beliefs, experiences, and reactions, while interviews may help discern success or failure in meeting certain indicators, objectives, or goals and learn whether it was a function of program activities or design or external factors outside of the program’s control. Longitudinal qualitative data will also allow for real-time changes to be made to the program to account for previously unidentified needs and/or barriers to success that program participants may identify before, during, or after participation.

The following questions, which are adapted from the Centers for Disease Control and Prevention’s Framework for Program Evaluation, can be used to guide the development of a program evaluation:

- How well does the case plan suit the program participants’ needs?
- Does the project focus on addressing key issues of interest to important stakeholders?
- Was [specific] activity implemented as planned?
- Did [specific] outcomes occur and at an acceptable level?
- Were the changes in [specific] outcomes due to activities as opposed to something else?
- What factors prevented the activities in the focus from being implemented as planned? Were [specific inputs and moderating factors] responsible?
- What factors prevented (more) progress on the outcomes in the focus? Were [specific moderating factors] responsible?
- What was the cost-benefit or cost-effectiveness of certain activities and the outcomes that were achieved?
- How sustainable are the program’s activities and resources, and therefore how sustainable and replicable are the achieved outcomes?

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• How will stakeholders employ the results of the evaluation, such as making modifications as needed, monitor progress toward program goals, and making decisions about continuing funding for the program?

4. Gathering Credible Evidence

Data gathered and compiled for evaluation purposes should be relevant to the project goals, be accurate and reliable, and collected systematically using appropriate methods. To decrease the evaluation burden to program participants, case managers, and other agency staff, existing data should be used and shared to its fullest extent, and new data should be collected during established meeting times in the least intrusive manner possible. While minimal burden should be a primary goal of evaluation, we also recognize that activities such as semi-structured interviews and focus groups can be illuminating and helpful to program success; therefore, though they may pose additional time commitments, they are a useful tool when used appropriately and with a clear rationale.

Available data on the target population, at both the national and local levels, is limited (See “Alaskan Data Limitations” section). Data used to evaluate this project will therefore need to be gathered from a variety of sources, including those listed in Attachment B: Community Partner Screening and Assessment Tools. These data sources include a variety of qualitative and quantitative baseline measures for participants, such as clinical diagnoses (DSM-V Clinical interview), risk sensitivity (LSI-R), family functioning (NC Family Assessment tool), ACES, and TBI screening. Additional data future programs will need to collect directly include data on job readiness and obtaining employment, housing status, attendance at case management meetings, access medical and therapeutic service, and self-reported measures of personal wellness, child- and family-related success, sobriety, and adherence to treatment plans.

Changes to the project goals and objectives should only be made after careful consideration of the program evaluation and data collection.

5. Justifying Conclusions

Conclusions from the program evaluation should be based on sound analysis and synthesis of high-quality data. Interpretation of data should be done in collaboration with program
participants and/or an advisory group whose members have lived experience similar to the target population. In addition, principles of equity should be at the forefront of the data interpretation and should focus on strengths and opportunities wherever possible. Alternative interpretations or analyses should be adequately considered, and data and information that supports the identified conclusion clearly stated. Any conclusions drawn must also consider the appropriate social and historical context of Alaskan women who are currently incarcerated.

6. Ensuring Use and Sharing Lessons

All stakeholders who participated in this project, including program participants, should have access to the final program evaluation, and lessons learned should be widely available and accessible; this may require disseminating the findings via multiple formats, including technical reports, trainings/presentations, recorded oral presentations, and infographics that make the information understandable to a lay audience. Data collected through this project should also be shared with appropriate agencies and parties for additional analysis on ways to reduce recidivism among the target population.
Program Evaluation

Recommendations for Implementation

» Engage stakeholders, including women with lived experience similar to those in the target population, and representatives from reentry programs, the court system, and the criminal justice system to assist, further refine, and conduct program evaluation.  
[Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

» Work with DOC and other partner agencies to identify data already being collected to avoid duplication. This will decrease the potential burden to program participants and partner agencies by reducing redundancies in the collected information.

» Establish data-sharing agreements between partner agencies so that relevant data can be tracked and utilized without each agency having to collect the same information.  
[Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding]

» Ensure that program evaluations are longitudinal, where appropriate, and allow for real-time changes to the program in response to the needs of program participants. Use both quantitative and qualitative evaluation methods.

» Share and disseminate conclusions based on program evaluations to program participants, stakeholders, and non-experts to maximize the project’s real-world impact and evaluation.  
[Responsible entity: Project Steering Committee; Timeframe: Discern & document in signed interagency agreement]

Recommended Budget

Personnel

Given the complexity of these cases and the fact that the case manager will also be providing services to program participants’ children, the Project Steering Committee recommends that a full case load for one case manager be twelve women.
The Project Steering Committee also recommends that a master’s level clinician or social worker oversee the project. This position will manage the case managers and peer support members, oversee referrals, facilitate the relationship between DOC and agency partners, and facilitate team meetings. The individual hired should therefore have a proven ability to work with multiple disciplines and across multiple sectors. In addition, given the acute, non-acute, and historical trauma the majority of program participants experience, a master’s level clinician or social worker will have the education, skills, and experience to address these challenges.

Additional case managers would increase the project’s annual costs by $91,000 ($65,000 base salary & 40% fringe benefits). Administration costs or a full-time equivalent was calculated at 10% of the overall project budget.

**Operating Costs**

While the project manager will be responsible for maintaining the relationships and formalizing agreements between DOC and agency partners, having a contracted facilitator assume these responsibilities may be beneficial, particularly during the project’s infancy so that the project manager can focus their attention and efforts elsewhere. The budget includes a $60,000 line item for facilitation, consultation, and evaluation should a decision be made to contract with an outside facilitator for these services.

The training and travel budget covers occasional and as needed training and conference costs for members of the Project Steering Committee, staff from the case management agency and staff from partner agencies. Alternately, the budget can be used to bring outside trainers to Anchorage as needed.

The transportation budget should be used to fund transportation for essential errands, appointments, and occasional visits with family and friends for program participants. Items such as cribs, car seats, clothing, formula, and other essential items program participants will need upon release for themselves and their children should be purchased using the case manager discretionary budget when donated items are unavailable.

The peer support incentive budget should be used to purchase gift cards or other incentives for peer support mentors. Ideally, peer supports would be recent program graduates, making their
mentorship of other women something of a continuation in the program and gives them an additional incentive to continue working to ensure their reentry is successful. Alternately, the budget could be used to fund a permanent peer support position. The peer support incentive budget was calculated using the suggested incentive amounts (See Peer Support section) and the following proposed schedule:

- 52 one-hour long group sessions/events, with the weekly sessions alternating between community-based participants and facility-based participants.
- Program participants and their assigned peer support should meet every other week (can be weekly if budget allows) for a one-to-one meeting. The budget accounts for 40 virtual and 40 in-person meetings.

The budget accounts for compensation for eight Advisory Group members to attend six Project Steering Committee meetings.

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OTHER IMPLEMENTATION CONSIDERATIONS

Gather Statewide Input Before Expansion

During the project planning phase Gulling Consulting worked with a Municipality of Anchorage-based steering committee of institutional stakeholders (two members were in Juneau) and individuals with lived experience. These meetings provided valuable insight into the project’s target population, their unique needs, and their perspectives on how best to meet those needs.

However, because Hiland is a state facility, conversations about how to best serve women who plan to return to communities outside of the Anchorage and Mat-Su area upon release must continue, with input from stakeholders across the state. Upon implementation, the Project Steering Committee should take care to ensure that the program is modified to serve the needs of participants moving outside Anchorage.

Conduct Needs Assessment for Criminal Justice Involved Agencies

Over the course of this project, the Project Steering Committee acknowledged that there is often a disconnect between the state and social service agencies that work with reentrants. According to one state employee, “Folks don’t even remember who all the support services/agencies are they are working with, so it’s hard for us to have a baseline when we want to refer.”

There, upon implementation, the Project Steering Committee should consider conducting a needs assessment of non-governmental agencies who serve reentrants and individuals at risk of incarceration. The central question for the assessment would be to determine what service providers need, but are not currently getting, from the DOC and/or court system that would help their program and participants be successful.
Appendices

A. Full Recommendations for Implementation
B. Community Partner Screening and Assessment Tools
C. Additional Relevant Data from 2003-2019 DOC Offender Profile Reports
D. Project Steering Committee Contact List: Core Team, Advisory Group and Other Key Advisors
E. Complete Project Goals, Objectives, and Key Indicators
F. Evaluation Plan: Objectives, Key Indicators and Data Sources for Each Project Goal
G. Report on Semi-Structured Interviews Conducted by Gulling Consulting
H. The Four Core Elements of the Women Offender Case Management Model
I. Guiding Practices of the Women Offender Case Management Model
J. State of Alaska DOC Policies and Procedures:
   a. Prisoner Rights, Requirements Relating to Female Prisoners
   b. Medical and Health Care Services, Access to Health Care Services
K. American Medical Association Policy Statement: Shackling of Pregnant Women in Labor
L. Women’s Transitional Housing Options in Anchorage and the Mat-Su
M. Flow Charts
   a. Initial Intake/Screening and Assessment
   b. Institution-Based Case Management Program
   c. Flow Chart: Community-Based Case Management Program
N. National Commission on Correctional Health Care Position Statement: Breastfeeding in Correctional Settings
P. Proposed Elements to Include in an Interagency Memorandum of Understanding (MOU)
Appendix A

Full Recommendations for Implementation

This appendix was omitted from the printed version. You will happily find it in its place on the digital version.
Appendix A:
Planning for Pregnant & Postpartum Reentrants

Summary Recommendations for Implementation

Data Collection

» Establish a baseline for evaluation (See Appendix E - Complete Project Goals, Objectives and Key Indicators). [Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding]

» Reestablish a workgroup that includes, at minimum, the project evaluation team, OCS, and DOC to determine which additional data points agencies should collect moving forward. If relevant, a data collection and information sharing agreement should be developed between entities that work with the target population. [Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding]

Potential ideas for improved data collection:

  o Focused data-sharing project between DOC, Division of Public Health (DPH), the Department of Health and Human Services (DHSS), and vital records. Determine the number of women admitted to DOC within a particular timeframe. These names are then cross-checked with Medicaid records or live birth data to determine how many women admitted had children under age 3 and/or became pregnant within 12 months of release.

  o Obtain funding to hire contractors to conduct intake screenings to improve consistency. (Note: This is also a recommendation for Screening & Assessments)

» Focus a discussion on prosecution and conviction data, including number of prosecution referrals to Therapeutic Court, to determine why therapeutic court is operating at two-thirds capacity when two-thirds of incarcerated women at Hiland have pre-sentence status. [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

» Develop a workgroup to further analyze the data presented in the Planning Report and Implementation Guide and/or host community conversations to examine the following questions and discuss which potential policies, practices, interagency cooperation, or resources should be developed or reviewed to improve the landscape for the target population. [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]
o Why are women being incarcerated at a much higher rate than men?

o Why are so many more women than men awaiting sentencing (pre-trial vs. post-trial)?

o Why is Therapeutic Court operating at only two-thirds capacity when more than two-thirds of incarcerated women have not been sentenced?

o Why are Alaska Native women of childbearing age possibly the most disproportionately incarcerated population in the state?

Goals and Objectives

» Review DOC policies and procedures and other laws related to the target population and advocate for any changes. [Responsible entities: Case management agency/Project Steering Committee; Timeframe: Upon identification of funding source]

  o Convene a workgroup to review relevant policies, procedures, and laws that relate to target population and discuss any changes that need to be made.

  o Review and possibly revise the goals and objectives before submitting a grant application to add goal related to Project Steering Committee conducting policy reviews and advocating additions, revisions, and/or deletions.

» Any revisions should focus on maintaining simple objectives to ensure the project doesn’t stall during periods of staff turnover.

Policy Development

» Develop a workgroup to review and possibly revise, the following DOC policies and procedures, among others. [Responsible entity: Project Steering Committee; Timeframe: Within 6 months of receipt of project funding]:

  o Prisoner Rights: Requirements Relating to Female Prisoners, Index 808.06 (See Appendix J(a))

  o Medical and Health Care Services: Access to Health Care Services, Index 807.02 (See Appendix J(b))

» Using data, best practice research, and examples from other states, consider creating additional policies and procedures, or further define existing ones, especially as they relate to issues outlined in this Guide. [Responsible entity: Project Steering Committee; Timeframe: Within 6 months of receipt project funding]

See sections on Healthcare, Breastfeeding, and Nurse-Family Partnership for additional recommendations of policies and procedures to be considered for creation and/or revision.
Case Management Model

» Work to identify an agency to assume intensive case management services for the project and work independently from the Project Steering Committee. Case management agency will develop operational procedures, including policies that outline roles and responsibilities, confidentiality, and information sharing. [Responsible entities: Project Steering Committee/Case management agency; Timeframe: Immediate, Upon receipt of project funding]

» Develop a business agreement between DOC and the health and treatment providing agencies to allow care to be provided in-facility. Alternatively, provisions could be included in an interagency MOU. (See Attachment P - Proposed Elements to Include in an Interagency MOU) [Responsible entities: Medical members of the Project Steering Committee (including Nurse-Family Partnership providers), DOC, Case management agency; Timeframe: Upon receipt project funding]

» Develop an interagency agreement or MOU outlining how the case management and partner agencies will work together (See Attachment P - Proposed Elements to Include in an Interagency MOU) [Responsible entities: Project Steering Committee/Case management agency; Timeframe: Upon receipt of project funding]

  o Define training needs and other clearance measures needed (i.e., background checks) to ensure case managers, peer support mentors, and other community-based providers can access DOC facilities.

  o Outline any provisions necessary (i.e., increased screening, training, and/or supervision) to ensure case managers, peer support mentors, and other community-based providers with criminal records can access DOC facilities.

» Given the complexity of these cases and the fact that the case manager will also be providing services to program participants’ children, the Project Steering Committee recommends that a full caseload be no more than twelve women.

» Because of the elevated levels of trauma experienced by most program participants, the project supervisor should be a master’s level clinician, ideally with a background in trauma-focused therapies. [Responsible entity: Case management agency; Timeframe: Upon receipt of project funding]

» Train agency staff and project partners to use a gender-responsive approach, meaning one that is relational, strengths-based, trauma-informed, culturally relevant, and holistic. Additionally, team members should be cross-trained to understand the unique components of each other’s disciplines and should have access to quality assurance supervision, ongoing
coaching, and the resources necessary to ensure adherence to the model and associated protocols.

» Assign each program participant a peer support mentor. Ideally, if budget allows, participants meet one-on-one with their peer support weekly.

» To establish community among participants, hold weekly one-hour long group events – one in the facility for institution-based participants and one in the community for community-based participants. These events can be hosted (on a rotating basis if necessary) by the peer support, case manager, or project manager. Content may vary week to week and can include a support group, talking circle, educational topics, etc.

» Program participants should be included in the development of their case management plan, including the goals and outcomes.

» Whenever possible, start pre-release services a minimum of six months before the participant’s expected release date.

» Develop an institution-based treatment and support team (for program participants with sentences longer than six months) or a pre-release transition team (for program participants with sentences shorter than six months). See How it Will Work section for a list of plans to be developed by each team. [Responsible entities: Case management agency/Project Steering Committee; Timeframe: Upon receipt of project funding, Ongoing]

  o The institution-based treatment and support team includes the case manager, program participant, relevant corrections and community-based physical, mental, social, and spiritual health professionals, Nurse-Family Partnership mentor, peer support mentor, and child[ren]’s caretaker, if relevant.

  o The pre-release transition team includes the case manager, program participant, relevant corrections and community-based physical, mental, social, and spiritual health professionals, Nurse-Family Partnership mentor, peer support mentor, child[ren]’s caretaker, institution-based probation officer, community-based probation officer (when relevant), and any additional caretakers/providers involved in the participant’s reentry plan.

  o Ensure that all team members have the required clearance and training to ensure access to the facility for team meetings.

  o Consider modeling the meeting format after the Mat-Su FIT Court meetings (therapeutic court program) which are held a minimum of once a month.

» Convene a workgroup to develop a plan and corresponding flow chart for women who have not been diverted to therapeutic court but are incarcerated in pretrial status awaiting sentencing. Consider inviting court personnel, prosecutors, and the public defender agency to sit on workgroup, as they are more closely involved in the program and can recommend
women for diversion. [Responsible entity: Project Steering Committee/case management agency; Timeframe: Within 3 months of receipt project funding]

General Screening and Assessment

» Work to minimize the number of screening and assessments women are given throughout their participation and treatment while ensuring agencies obtain the information needed to provide services. [Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding]

» Develop a workgroup to consider how to streamline services and reduce repetitive screenings and assessments. [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

Workgroup might discuss:

- Which screening and assessment tools are needed to satisfy each agency’s needs, therefore allowing for successful assessment and interagency collaboration.

- Any necessary policy or procedural provisions that would need to be made to allow screening and assessment tools to be shared (e.g., Screenings and assessments must be conducted by a master’s level clinician/social worker to allow an agency to accept one done by an outside agency).

» Consider contracting with a third-party assessor, agreed upon by all agencies, to create a centralized intake process that will conduct screenings and assessments. Alternatively, develop an inter-agency process that would allow assessment administered by one agency to be used as the foundation for another to build upon. [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

» Ensure that all staff administering screenings/assessments have the necessary training and credentials to be accepted by the other agencies.

» Hold interagency training(s) on how to conduct assessments to ensure consistency in administration across agencies (this will have the added benefit of improving inter-agency trust and confidence). [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

» Document screening and assessment tool sharing policies and provisions, including who will be responsible for administering, in the interagency MOU (See Attachment P - Proposed Elements to Include in an Interagency MOU). [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

Court Diversion – Therapeutic Court
» Develop a one-page initial referral form that meets the needs of all agencies. [Responsible entities: Case management agency, DOC & Therapeutic Court; Timeframe: Upon receipt of project funding]

» Conduct joint interagency staff training(s) to ensure staff understands how the referral process works and to ensure that the referral process is successful. [Responsible entities: Case management agency, DOC & Therapeutic Court; Timeframe: Within 3 months of project funding, Ongoing]

Prison Nurseries
» Revisit the feasibility of prison nurseries after the court diversion element is implemented and stabilized.

Peer Support Component
» Begin to identify women who can serve as peer support for women enrolled in the project. [Responsible entities: Case management agency/Project Steering Committee; Timeframe: Within 3 months of receipt project funding, Ongoing]

Potential sources of peer support members include:
  - Advisory Group members from the planning grant
  - Referrals from the Project Steering Committee
  - Project graduates

» Consider allowing mothers sentenced to three years or more to act as mentors to participants with shorter sentences while in the facility.

» Work with DOC to navigate institutional policies and procedures that would allow peer support persons direct, in-person access to the facilities, with video conferencing a secondary option. [Responsible entity: Case management agency; Timeframe: Within 3 months of receipt project funding, Ongoing]

» Establish a compensation guide for non-staff individuals serving as peer support. Compensation can be in the form of gift cards. If the primary funding stream doesn’t permit gift card purchases, consider pursuing an additional funding stream that does. [Responsible entity: Case management agency; Timeframe: Upon identification of funding source]

The following is the proposed peer support compensation:
  - Hour long advisory group meeting: $35
  - One-on-one, virtual hour-long session: $40
  - One-on-one, in-person hour-long session: $60
Health Services

To ensure continuity of services, develop a workgroup to establish policies that will allow community-based providers to provide healthcare services to program participants while incarcerated; this is particularly important for pregnant women likely to deliver after their release. [Responsible entities: Project Steering Committee healthcare members (including Nurse-Family Partnership staff), DOC, case management agency; Timeframe: Upon receipt of project funding]

Develop and provide training and other opportunities for correctional officers and institutional and community-based healthcare providers to increase their knowledge of issues surrounding the healthcare needs of pregnant and post-partum women. [Responsible entity: Case management agency; Timeframe: Within 3 months of receipt of project funding]

Develop a workgroup/task force to collaborate with the DOC to review and modify policies and procedures related to the healthcare needs of pregnant and postpartum women. Include specific policy recommendations for breastfeeding (See Breastfeeding and Breast Pumping section) and the use of restraints on pregnant, laboring, or post-partum women. [Responsible entities: Project Steering Committee healthcare members (including Nurse-Family Partnership staff), DOC; Timeframe: Within 6 months of receipt of project funding or upon project stabilization]

Recommended workgroup tasks:

- Reference and discuss the National Commission on Correctional Health Care’s statements on Breastfeeding in Correctional Settings (Appendix N) and Women’s Health Care in Correctional Settings and (Appendix O).
- Advocate for the creation of a specific policy that would prohibit shackling pregnant women. Use language like that recently adopted by the State of New Mexico and endorsed by the American Medical Association. (See Appendix K)
- Once policy and procedure recommendations are developed, work with appropriate entities to ensure policies and procedures are adopted.

Substance Use and Mental Health Therapies

Convene a workgroup to ensure agencies maximize resources to benefit the health, safety, and well-being of program participants and the community. Identify which community-based agencies will support the project’s treatment process by providing services. [Responsible entities: Medical, mental health and substance use treatment Project Steering Committee members, DOC; Timeframe: Upon receipt of project funding]
Formalize agreements in an interagency MOU. (See Attachment P - Proposed Elements to Include in an Interagency MOU)

**Trauma-Informed Institutions and Trauma-Focused Therapy**

» Establish a workgroup to identity and/or develop a trauma-sensitive screening tool, accepted by all necessary partner agencies, to administer to women upon entry to prison. [Responsible entities: Mental health and substance abuse Project Steering Committee members & DOC; Timeframe: Upon receipt of project funding]

» Establish a workgroup focused on increasing participant access to trauma-focused therapies, which should be considered separate from or in addition to traditional mental health or talk therapy. [Responsible entities: Mental health and substance abuse Project Steering Committee members & DOC; Timeframe: Within 3 months of receipt project funding]

Recommended workgroup tasks:

- Identify appropriate, targeted trauma-focused therapies in Anchorage and the Mat-Su.
- Develop a plan for the program to partner with entities that provide the identified trauma-focused therapies.

» Conduct a review of the number of women in pre-trial status who are housed at men’s facilities around the state, paying special attention to how much interaction they have with prisoners at each the facility (do they eat with male prisoners, share a gym, potentially pass men in the halls who may have previously victimized or threatened them etc.). Begin a conversation about reducing the trauma experienced by women at the male institutions and whether an alternative is available.

» Establish a workgroup to focus on further developing DOC and other project partners into trauma-informed institutions. [Responsible entities: Mental health and substance abuse Project Steering Committee members & DOC; Timeframe: Within 3 months of receipt of project funding]

Recommended workgroup tasks:

- Identify an appropriate agency or individual to train those who will work with program participants on trauma-informed care. The training should focus on trauma’s effect on behavior and work to reduce acknowledged or unacknowledged stigmas toward the target population that can act as a barrier to successful reentry.
- Educate healthcare and treatment staff, correctional officers and other partners who work with individuals in the target population about trauma, its effect on the brain, and how it may impact behavior. The most important training areas include general information about trauma and self-care needs for staff.
Mother/Child Connectedness

» Develop a class to teach mothers how to create and maintain a connection to their children while in prison. [Responsible entities: Project Steering Committee, case management agency, Advisory Group members; Timeframe: Upon receipt of project funding]

» Implement activities that can help mothers remain connected to their children while incarcerated. [Responsible entities: Project Steering Committee/case management agency & DOC; Timeframe: Upon receipt of project funding]

Suggested activities, based on interviews with Advisory Group members, may include:

- Weekly 30-minute Zoom call (when visitation is unavailable).
- Craft projects to do over Zoom (craft materials will be sent to the child’s caregiver before the call to allow mom and child to do it together over Zoom).
- Help program participants send packages to their children. To facilitate, the case management agency should include a line item titled, discretionary case management budget, which can be used to help women send these packages.

» Work with Department of Juvenile Justice to collect data on the number of incarcerated teens who had a parent, particularly mothers, incarcerated during the teen’s lifetime.

Breastfeeding and Breast Pumping

» Develop a policy that will allow a certified lactation consultant to meet with pregnant or postpartum mothers who intend to breastfeed before delivery or release (if woman will deliver in the community or delivered in the community shortly before admission into prison). [Responsible entities: Medical Project Steering Committee members (including Nurse-Family Partnership staff), DOC; Timeframe: Upon receipt of project funding]

» Work to provide breast pumps to the DOC facility so that post-partum mothers, regardless of their participation in the project, can pump. The pumps should be made available to mothers who are currently breastfeeding (via pumping and storing their milk for later delivery or, breastfeeding during visits, if permitted), mothers who wish to maintain their breastmilk supply so they can resume breastfeeding upon release, or mothers who choose not to breastfeed but need to pump to gradually reduce their supply. [Responsible entities: Medical Project Steering Committee members (including Nurse-Family Partnership staff), DOC; Timeframe: Upon receipt of project funding]

» Develop a workgroup to collaborate with DOC to review and revise breastfeeding and breast pumping policies and procedures. [Responsible entities: Medical Project Steering Committee members (including Nurse-Family Partnership staff), DOC; Timeframe: Within 3 months of receipt project funding]
Recommended workgroup tasks:

- Review The National Commission on Correctional Health Care’s statement on Breastfeeding in Correctional Settings (See Appendix N) among other publications.

- Develop a policy that will allow mothers to pump and store breastmilk for later transport to their children by a family member, caregiver, or case manager, or to pump to relieve pressure and pain. The policies should also include providing a dedicated space for women to pump and eventually, the ability to store breastmilk in the medical department freezer until transport can be arranged.

- Research into other state’s breastfeeding practices for incarcerated women, including whether they permit breastfeeding during mother-child visitation and how that is accomplished.

**Nurse-Family Partnerships**

- All eligible program participants should have access to a nurse mentor from one of the two Nurse-Family Partnerships: Nutaqsiivik at Southcentral Foundation or the Providence Nurse-Family Partnership program.

- If the initial project can only fund Alaska Native participants, DOC should work to establish a formal agreement (business agreement or MOU) with the Providence Nurse-Family Partnership program so that non-Native pregnant women incarcerated at Hiland can also access services. 

- Include the Nurse-Family Partnership (NFP) program[s] on any interagency business agreement or MOU with the other involved agencies to ensure its ability to provide services to program participants. Provisions on the MOU should include, what services will be provided by the NFP program[s], how access to Hiland will be granted, and training and level of screening required for entry (See Appendix P, Proposed Elements to Include in an Interagency MOU). [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

**Traditional Healing**

- Consider partnering with Southcentral Foundation’s traditional healing department to provide traditional healing services to program participants. [Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding]

- Consider a review and possibly modification of existing supports and services to incorporate more traditional healing practices.

- Consider consulting with traditional healers to incorporate various traditional healing practices such as talking circles and summer fish camp retreats into programs when possible.
Establishing Community Among Participants

» Upon program participant’s release from Hiland, arrange a gathering with the other community-based participants to celebrate her release and welcome her into the community. [Responsible entity: Case management agency; Timeframe: Ongoing]

» Hold relevant classes/talking circles, etc. that are only for project participants both in the facility and the community. [Responsible entity: Case management agency; Timeframe: Ongoing]

Housing

» Assemble a workgroup to discuss the process and partnership(s) needed to secure housing for participants with the currently limited available options. Add any provisions necessary to facilitate successful program partnership into the interagency MOU (See Attachment P - Proposed Elements to Include in an Interagency MOU). [Responsible entities: Case management agency/Project Steering Committee; Timeframe: Upon receipt of project funding]

» Develop a workgroup and/or task force to address extreme housing shortages for the target population and their children once project stabilizes.

» Consider modeling any new housing program after Cook Inlet Housing Authority’s Path to Independence program, which includes a landlord liaison that serves as a navigator between the landlord, program participant, and case manager.

Transportation

» Assemble workgroup to explore possible transportation options and potential partnership with church or other non-profit to establish program that would donate or lend cars to program participants at release. [Responsible entities: Case management agency/Project Steering Committee; Timeframe: Upon receipt of project funding]

» Include a budget line item specifically for transportation. The ideal solution would be to partner with a non-profit already providing transportation and establish a cost-share program. An alternative option would be to provide case managers and peer support members mileage reimbursement to meet with program participants and/or assist with essential errands and services.

» Establish a rideshare system between the case management agency and program participants (if a formal transportation procedure listed above cannot be established). [Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding]

Job Training / Placement

» Assemble a workgroup to determine elements to include in a work training/work placement plan, how it will fit into the current plan (e.g., types of relevant service[s], pre- and/or post-release), and which community groups (e.g., Partners for Progress, the Job Center) to partner with for service delivery. [Responsible entities: Case management agency/Project Steering Committee; Timeframe: Upon receipt of project funding]
Childcare and Procurement of Essential Items

» Before release, case managers should help program participants complete an application for childcare assistance and/or connect with thread, a local non-profit that can help with placement. [Responsible entity: Case management agency; Timeframe: Upon receipt of project funding]

» If possible, partner with local churches to obtain donations of essential items mothers will need for reentry (i.e., crib or bed for child, car seat, diapers, bed for mom, etc.) and/or consider developing a community of moms (possibly program graduates) to facilitate sharing items no longer needed with other participant moms in need. [Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding]

» Maintain a line item for discretionary purchases of essential items when donations are unavailable. [Responsible entity: Case management agency; Timeframe: Upon identification of funding source]

Budget

» Pay competitive staff salaries. Budget a minimum of $91,000 ($65,000 base salary & 40% fringe benefits) annually for each case manager and $128,000 ($92,000 base salary & 40% fringe benefits) for the project manager (master’s level clinician or social worker).

» Budget some travel funds (suggested, $30,000) for Project Steering Committee members [in addition to project staff] to attend national training or conferences. This will help increase the expertise of project staff and Steering Committee members but also help deepen interagency relationships, which are crucial to project success. Alternately, the budget can be used to bring outside trainers to Anchorage to provide training to the Project Steering Committee.

» Include significant budget (suggested: $50,000) for transportation of reentrants. The transportation budget should be used to fund transport to and from the airport, for shopping, and occasional visits with family and friends.

» If grant allows, budget significant funds (suggested: $45,000) that project staff can use, at their discretion, to purchase essential items for reentrants if donated items are unavailable.

» Maintain a large line item (suggested: $57,480) for gift card incentives for non-staff peer supports and compensation to Advisory Group members who serve on the Project Steering Committee. Alternatively, the budget could be used for staff peer supports.
### Administration & Personnel

<table>
<thead>
<tr>
<th>Position</th>
<th>Salary</th>
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</thead>
<tbody>
<tr>
<td>Case Manager 1</td>
<td>$65,000</td>
</tr>
<tr>
<td>Case Manager 2</td>
<td>$65,000</td>
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<tr>
<td>Project Manager</td>
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<td><strong>Total Personnel Services</strong></td>
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<td>Fringe Benefits (40%)</td>
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<tr>
<td>Admin (FTE)</td>
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<tr>
<td><strong>Administration and Personnel Subtotal</strong></td>
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### Operating

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<thead>
<tr>
<th>Department</th>
<th>Cost</th>
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</thead>
<tbody>
<tr>
<td>Office, Technology &amp; Supplies</td>
<td>$24,000</td>
</tr>
<tr>
<td>Consultation, Facilitation &amp; Evaluation</td>
<td>$60,000</td>
</tr>
<tr>
<td>Steering Committee Conferences, Training and Travel</td>
<td>$30,000</td>
</tr>
<tr>
<td>Project Steering Committee Meeting Expense (other than facilitation)</td>
<td>$2,500</td>
</tr>
<tr>
<td>Peer Support Incentives</td>
<td>$57,480</td>
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<tr>
<td>Participant Transportation</td>
<td>$54,000</td>
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<tr>
<td>Case Manager Discretionary Budget</td>
<td>$45,000</td>
</tr>
<tr>
<td><strong>Operating Subtotal</strong></td>
<td><strong>$249,100</strong></td>
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</tbody>
</table>

**Annual TOTAL** $619,780

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### Program Evaluation

» Engage stakeholders, including women with lived experience similar to those in the target population, and representatives from reentry programs, the court system, and the criminal justice system to assist, further refine, and conduct program evaluation. [*Responsible entity: Project Steering Committee; Timeframe: Within 3 months of receipt of project funding*]

» Work with DOC and other partner agencies to identify data already being collected to avoid duplication. This will decrease the potential burden to program participants and partner agencies by reducing redundancies in the collected information.

» Establish data-sharing agreements between partner agencies so that relevant data can be tracked and utilized without each agency having to collect the same information. [*Responsible entity: Project Steering Committee; Timeframe: Upon receipt of project funding*]

» Ensure that program evaluations are longitudinal, where appropriate, and allow for real-time changes to the program in response to the needs of program participants. Use both quantitative and qualitative evaluation methods.

» Share and disseminate conclusions based on program evaluations to program participants, stakeholders, and non-experts to maximize the project’s real-world impact and evaluation. [*Responsible entity: Project Steering Committee; Timeframe: Discern & document in signed interagency agreement*]
Appendix B

Community Partner Screening and Assessment Tools

This appendix was omitted from the printed version. You will happily find it in its place on the digital version.
## Assessment and Screening Tools

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>TOOL</th>
<th>WHEN CONDUCTED</th>
<th>WHO HAS ACCESS TO TOOL</th>
<th>WHO ADMINISTERS TOOL</th>
<th>WHO SCORES TOOL</th>
<th>PURPOSE</th>
<th>HOW IS TOOL RECORDED AND STORED</th>
<th>WHO DOES QUALITY ASSURANCE ON TOOL</th>
<th>OTHER</th>
<th>TARGET POPULATION (Felons, Pre-trial etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOC/PRISON-In</td>
<td>SAMHSA GAINS Brief Jail Screen</td>
<td>w/ 24 hours of prison entry</td>
<td>MH, Nursing Staff</td>
<td>RNs</td>
<td>RNs</td>
<td>to identify possible needs for MH, SA treatment</td>
<td>Part of EHR</td>
<td>Anyone requesting offender medical records</td>
<td>evaluates 10 different criminogenic issues</td>
<td>Offenders entering system.</td>
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<tr>
<td>DOC/PRISON-In</td>
<td>LSI-R</td>
<td>inmates in &gt; 90 days, second LSR</td>
<td>Probation staff</td>
<td>POs</td>
<td>POs</td>
<td>identify criminogenic needs</td>
<td>Electronically in ACOMS</td>
<td>Consultant</td>
<td>MH Courts, Re-entry Coalitions</td>
<td>inmates sentenced and pretrial.</td>
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<tr>
<td>DOC/PRISON-In</td>
<td>LSI-R (risk sensitivity model)</td>
<td>upon release</td>
<td>Probation staff</td>
<td>POs</td>
<td>POs</td>
<td>part of offender management plan (reentry needs)</td>
<td>Electronically in ACOMS</td>
<td>Consultant</td>
<td>MH Courts, Re-entry Coalitions</td>
<td>OFFENDERS ON FEBNY PROBATION</td>
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<td>DOC/PRISON-In</td>
<td>ASAM Cottage SUD Screening Tool</td>
<td>Varies throughout incarceration</td>
<td>SUD Staff</td>
<td>SUD Staff</td>
<td>SUD Staff</td>
<td>SA screening</td>
<td>Electronic</td>
<td>SUD Supervisors</td>
<td>Tx Agencies, PO's</td>
<td>low triage and as needed.</td>
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<tr>
<td>DOC/PRISON-In</td>
<td>Continuum Assessment Tool</td>
<td>Varies throughout incarceration</td>
<td>SUD Staff</td>
<td>SUD Staff</td>
<td>SUD Staff</td>
<td>SA screening</td>
<td>Electronic</td>
<td>SUD Supervisors</td>
<td>Tx Agencies, PO's</td>
<td>All offenders.</td>
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<tr>
<td>DOC/PRISON-In</td>
<td>DSM-V Clinical Interview</td>
<td>Varies throughout incarceration</td>
<td>Masters Level Clinician</td>
<td>Master Level Clinicians</td>
<td>Clinical Assessment</td>
<td>assessment and screening tool for pg women</td>
<td>Part of EHR</td>
<td>MHC Supervisors</td>
<td>Anyone requesting offender medical records</td>
<td>All offenders.</td>
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<tr>
<td>DOC/PRISON-In</td>
<td>AK Screening Tool</td>
<td>Done with SUD Assessment</td>
<td>SUD Staff</td>
<td>SUD Staff</td>
<td>SUD Staff</td>
<td>SA screening</td>
<td>Electronic</td>
<td>SUD Supervisors</td>
<td>Tx Agencies, PO's</td>
<td>All offenders.</td>
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<tr>
<td>DOC/ENTRY-In</td>
<td>Sign Up to Stay Out (Second Chance Act)</td>
<td>Institution PO, Reentry PO</td>
<td>Institution PO, Reentry PO</td>
<td>Institution PO, Reentry PO</td>
<td>Institution PO, Reentry PO</td>
<td>help with reentry services</td>
<td>TX Provider, Therapeutic Court Team Members and Therapeutic Court Administrative Office</td>
<td>None</td>
<td>Misconduct and Felony Offenders where the nexus of the crime is alcohol or drug related.</td>
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<td>WELLNESS COURTS</td>
<td>DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure-Adult</td>
<td>Once referred to treatment provider</td>
<td>Therapeutic Court Team Members</td>
<td>TX Providers</td>
<td>TX Providers</td>
<td>SUD/MH Assessments completed to determine participant eligibility</td>
<td>Recorded by TX Provider</td>
<td>TX Provider, Therapeutic Court Team Members and Therapeutic Court Administrative Office</td>
<td>None</td>
<td>Miscarriages, And Mental Health clients</td>
</tr>
</tbody>
</table>

### SASSI-4 Adult Form

- **ANJC**: Motivational Interviewing
  - w/ 24 hours of entry to program
  - Case Managers: Everyone
  - Case Managers: Case Managers
  - Case Managers: Case Managers
  - Determine motivation to change and participate in program
  - N/A
  - Program Manager: BJA
  - Reentrants

- **ANJC**: LSI-R
  - at entry and exit interview for program
  - Certified Staff: Staff
  - Certified Staff: Certified Staff
  - Certified Staff: Certified Staff
  - Determine score and appropriate referrals
  - Scanned into digital files
  - Program Manager: BJA
  - Reentrants

- **ANJC**: AK Screening Tool
  - at entry and exit interview for program
  - Case Managers: Case Managers
  - Case Managers: Case Managers
  - Case Managers: Case Managers
  - Determine score and appropriate referrals
  - Scanned into digital files
  - Program Manager: BJA
  - Reentrants

- **CITC**: Client Status Review
  - Conducted at intake, intervals at 90-135 days and at discharge
  - All Clinical Staff: All Clinical Staff
  - All Clinical Staff: All Clinical Staff
  - All Clinical Staff: All Clinical Staff
  - To help guide treatment plan
  - PFD locked form and uploaded to chart
  - Supervisors, managers and QA team
  - n/a
  - Can't be reused, every organization has to use their own
  - SA and Mental Health clients

- **CITC**: C-SSRS Screener with Protocol
  - Conducted at intake for each level of care
  - All Clinical Staff: All Clinical Staff
  - All Clinical Staff: All Clinical Staff
  - All Clinical Staff: All Clinical Staff
  - Person who administers tool: To Assess suicide risk
  - PFD locked form and uploaded to chart
  - Supervisors, managers and QA team
  - n/a
  - Evaluates suicidal tendencies
  - All clients
### Assessment and Screening Tools

<table>
<thead>
<tr>
<th>Tool</th>
<th>Purpose</th>
<th>Scored by</th>
<th>Administered by</th>
<th>Provided to</th>
<th>Summary/Reported to</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK Screening Tool</td>
<td>Intake only, done once every episode of care</td>
<td>All staff that provide direct service to families</td>
<td>Program supervisor</td>
<td>OCS, Courts, Others as necessary. Never without parent’s consent</td>
<td>Excellent pre/post tool for measuring progress of a family/evidence-based parents</td>
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<tr>
<td>NC Family Assessment Tool</td>
<td>Within 30 days of intake/discharge</td>
<td>All staff that provide direct service to families</td>
<td>Program supervisor</td>
<td>OCS, Courts, Others as necessary. Never without parent’s consent</td>
<td>Good way for our providers and parents to better understand their history in context that promotes healing</td>
</tr>
<tr>
<td>ACES</td>
<td>At intake</td>
<td>All staff that provide direct service to families</td>
<td>Program supervisor</td>
<td>OCS, Courts, Others as necessary. Never without parent’s consent</td>
<td>Allows collaboration with other agencies</td>
</tr>
<tr>
<td>OH TBI Screening Tool</td>
<td>At intake</td>
<td>All staff that provide direct service to families</td>
<td>Program supervisor</td>
<td>OCS, Courts, Others as necessary. Never without parent’s consent</td>
<td>Allows collaboration with other agencies/a other agencies allows for better communication with DBH for funding reports</td>
</tr>
<tr>
<td>CSR</td>
<td>At intake/30 days after intake</td>
<td>All staff that provide direct service to families</td>
<td>Program supervisor</td>
<td>OCS, Courts, Others as necessary. Never without parent’s consent</td>
<td>Allows collaboration with other agencies/allows for better communication with DBH for funding reports</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>Throughout Service Delivery</td>
<td>All staff that provide direct service to families</td>
<td>Program supervisor</td>
<td>OCS, Courts, Others as necessary. Never without parent’s consent</td>
<td>Allows collaboration with other agencies/other agencies allows for better communication with DBH for funding reports</td>
</tr>
<tr>
<td>Shared Service Model</td>
<td>Throughout Service Delivery</td>
<td>All staff that provide direct service to families</td>
<td>Program supervisor</td>
<td>OCS, Courts, Others as necessary. Never without parent’s consent</td>
<td>Allows collaboration with other agencies/other agencies allows for better communication with DBH for funding reports</td>
</tr>
<tr>
<td>Protective Family Survey</td>
<td>Pre and Post Service</td>
<td>All staff that provide direct service to families</td>
<td>Program supervisor</td>
<td>OCS, Courts, Others as necessary. Never without parent’s consent</td>
<td>Allows collaboration with other agencies/other agencies allows for better communication with DBH for funding reports</td>
</tr>
</tbody>
</table>

**Behavioral Health Clients**

- Adults and Youth
Appendix C

Additional Relevant Data from 2003-2019 DOC Offender Profile Reports
Additional Relevant Data from 2003-2019 DOC Offender Profile Reports

Table 1: Total Female and Male Admissions by Year in all Facilities and Percent of Female Offenders From Total (single point in time counts)

<table>
<thead>
<tr>
<th></th>
<th>2003 (Dec 31)</th>
<th>2005 (Dec 31)</th>
<th>2007 (Dec 31)</th>
<th>2010 (Dec 31)</th>
<th>2015 (June 30)</th>
<th>2019 (July 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Admissions</td>
<td>6,678</td>
<td>7,209</td>
<td>8,340</td>
<td>9,166</td>
<td>9,347</td>
<td>10,186</td>
</tr>
<tr>
<td>Male Admissions</td>
<td>23,727</td>
<td>23,989</td>
<td>25,259</td>
<td>26,942</td>
<td>25,665</td>
<td>24,557</td>
</tr>
<tr>
<td>TOTAL Offender Admissions</td>
<td>30,405</td>
<td>31,198</td>
<td>33,599</td>
<td>36,108</td>
<td>35,012</td>
<td>34,743</td>
</tr>
<tr>
<td>Female % of Total Admissions</td>
<td>22%</td>
<td>23%</td>
<td>25%</td>
<td>25%</td>
<td>27%</td>
<td>29%</td>
</tr>
</tbody>
</table>

Table 2: Counts and Percentages of Female Offenders in Institutions by Age and Year (single point in time counts)

<table>
<thead>
<tr>
<th></th>
<th>2003 (Dec 31)</th>
<th>2005 (Dec 31)</th>
<th>2007 (Dec 31)</th>
<th>2010 (Dec 31)</th>
<th>2015 (June 30)</th>
<th>2019 (July 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>6 (2%)</td>
<td>12 (3%)</td>
<td>15 (3%)</td>
<td>16 (3%)</td>
<td>7 (1%)</td>
<td>9 (2%)</td>
</tr>
<tr>
<td>20-29</td>
<td>89 (30%)</td>
<td>110 (29%)</td>
<td>139 (30%)</td>
<td>173 (35%)</td>
<td>212 (34%)</td>
<td>130 (30%)</td>
</tr>
<tr>
<td>30-39</td>
<td>103 (35%)</td>
<td>109 (28%)</td>
<td>141 (30%)</td>
<td>146 (29%)</td>
<td>225 (36)</td>
<td>181 (42%)</td>
</tr>
<tr>
<td>40-49</td>
<td>78 (27%)</td>
<td>123 (32%)</td>
<td>128 (27%)</td>
<td>121 (24%)</td>
<td>109 (18%)</td>
<td>69 (16%)</td>
</tr>
<tr>
<td>50-59</td>
<td>11 (4%)</td>
<td>25 (7%)</td>
<td>39 (8%)</td>
<td>39 (8%)</td>
<td>55 (9%)</td>
<td>36 (8%)</td>
</tr>
<tr>
<td>over 60</td>
<td>6 (2%)</td>
<td>4 (1%)</td>
<td>6 (1%)</td>
<td>6 (1%)</td>
<td>9 (2%)</td>
<td>6 (1%)</td>
</tr>
<tr>
<td>Total #</td>
<td>293 (100%)</td>
<td>383 (100%)</td>
<td>468 (100%)</td>
<td>501 (100%)</td>
<td>617 (100%)</td>
<td>431 (100%)</td>
</tr>
</tbody>
</table>

Table 3: Counts and Percentages of Female Offenders in Institutions by Race/Ethnicity and Year (single point in time counts)

<table>
<thead>
<tr>
<th></th>
<th>2003 (Dec 31)</th>
<th>2005 (Dec 31)</th>
<th>2007 (Dec 31)</th>
<th>2010 (Dec 31)</th>
<th>2015 (June 30)</th>
<th>2019 (July 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>141 (48%)</td>
<td>205 (54%)</td>
<td>246 (53%)</td>
<td>269 (54%)</td>
<td>304 (49%)</td>
<td>188 (44%)</td>
</tr>
<tr>
<td>Alaska Native/ American Indian</td>
<td>117 (40%)</td>
<td>132 (34%)</td>
<td>159 (34%)</td>
<td>172 (34%)</td>
<td>238 (39%)</td>
<td>188 (44%)</td>
</tr>
<tr>
<td>Black</td>
<td>18 (6%)</td>
<td>27 (7%)</td>
<td>42 (9%)</td>
<td>32 (6%)</td>
<td>38 (6%)</td>
<td>21 (5%)</td>
</tr>
<tr>
<td>Asian/ Pacific Island</td>
<td>8 (3%)</td>
<td>8 (2%)</td>
<td>7 (1%)</td>
<td>13 (3%)</td>
<td>18 (3%)</td>
<td>19 (4%)</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>7 (2%)</td>
<td>9 (2%)</td>
<td>11 (2%)</td>
<td>14 (3%)</td>
<td>14 (2%)</td>
<td>13 (3%)</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>2 (1%)</td>
<td>2 (&lt;1%)</td>
<td>3 (1%)</td>
<td>1 (&lt;1%)</td>
<td>5 (1%)</td>
<td>2 (&lt;1%)</td>
</tr>
<tr>
<td>Total #</td>
<td>293 (100%)</td>
<td>383 (100%)</td>
<td>468 (100%)</td>
<td>501 (100%)</td>
<td>617 (100%)</td>
<td>431 (100%)</td>
</tr>
</tbody>
</table>
Table 4: Counts and Percentages of Offenders in Institutions by Length of Time From Admission: July 1, 2019 (point in time count)

<table>
<thead>
<tr>
<th>Months In</th>
<th>Females</th>
<th>Percent of All Females</th>
<th>Males</th>
<th>Percent of All Males</th>
<th>Total</th>
<th>Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 MONTHS OR LESS</td>
<td>342</td>
<td>79.35%</td>
<td>1,922</td>
<td>47.26%</td>
<td>2,264</td>
<td>50.33%</td>
</tr>
<tr>
<td>7 MONTHS - 12 MONTHS</td>
<td>35</td>
<td>8.12%</td>
<td>532</td>
<td>13.08%</td>
<td>567</td>
<td>12.61%</td>
</tr>
<tr>
<td>13 MONTHS - 24 MONTHS</td>
<td>15</td>
<td>3.48%</td>
<td>474</td>
<td>11.65%</td>
<td>489</td>
<td>10.87%</td>
</tr>
<tr>
<td>25 MONTHS - 36 MONTHS</td>
<td>9</td>
<td>2.09%</td>
<td>212</td>
<td>5.21%</td>
<td>221</td>
<td>4.91%</td>
</tr>
<tr>
<td>37 MONTHS OR MORE</td>
<td>30</td>
<td>6.96%</td>
<td>927</td>
<td>22.79%</td>
<td>957</td>
<td>21.28%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>431</td>
<td>100.00%</td>
<td>4,067</td>
<td>100.00%</td>
<td>4,498</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
Appendix D

Project Steering Committee Contact List:
Core Team, Advisory Group and Other Key Advisors
<table>
<thead>
<tr>
<th>First</th>
<th>Last</th>
<th>Email</th>
<th>Agency</th>
<th>Title</th>
<th>Project Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josh</td>
<td>Adams</td>
<td><a href="mailto:Joshuaadams@pfpalaska.org">Joshuaadams@pfpalaska.org</a></td>
<td>Partners for Progress</td>
<td>Deputy Director</td>
<td>Advisor</td>
</tr>
<tr>
<td>Donna</td>
<td>Fischer</td>
<td><a href="mailto:drfischer2@gmail.com">drfischer2@gmail.com</a></td>
<td></td>
<td>Former Reentry Case Manager</td>
<td>Advisor</td>
</tr>
<tr>
<td>Ayisha</td>
<td>Horton</td>
<td><a href="mailto:ayishahorton@gmail.com">ayishahorton@gmail.com</a></td>
<td>Mothers on the Inside</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teri</td>
<td>Tibbett</td>
<td><a href="mailto:teri.tibbett@alaska.gov">teri.tibbett@alaska.gov</a></td>
<td>Alaska Mental Health Board</td>
<td>Advocacy Coordinator</td>
<td>Advisor</td>
</tr>
<tr>
<td>Sammie</td>
<td>Werkheiser</td>
<td><a href="mailto:mothersontheinside@gmail.com">mothersontheinside@gmail.com</a></td>
<td>Mothers on the Inside</td>
<td></td>
<td>Advisor</td>
</tr>
<tr>
<td>Raveyn</td>
<td>Ailey</td>
<td><a href="mailto:harperlyric1221@gmail.com">harperlyric1221@gmail.com</a></td>
<td></td>
<td></td>
<td>Advisory Group</td>
</tr>
<tr>
<td>Kori</td>
<td>Blake</td>
<td><a href="mailto:kblake@live.com">kblake@live.com</a></td>
<td></td>
<td></td>
<td>Advisory Group</td>
</tr>
<tr>
<td>Sue</td>
<td>Clum</td>
<td><a href="mailto:sueclum1@gmail.com">sueclum1@gmail.com</a></td>
<td></td>
<td></td>
<td>Advisory Group</td>
</tr>
<tr>
<td>Jennifer</td>
<td>Hartsock</td>
<td><a href="mailto:alasjen37@outlook.com">alasjen37@outlook.com</a></td>
<td></td>
<td></td>
<td>Advisory Group</td>
</tr>
<tr>
<td>Nickelle</td>
<td>Reagle</td>
<td><a href="mailto:nickellereagle@gmail.com">nickellereagle@gmail.com</a></td>
<td></td>
<td></td>
<td>Advisory Group</td>
</tr>
<tr>
<td>Benny</td>
<td>Briggs</td>
<td><a href="mailto:bbriggs@anjc.net">bbriggs@anjc.net</a></td>
<td>Alaska Native Justice Center</td>
<td>Adult Reentry Case Manager</td>
<td>Core Team</td>
</tr>
<tr>
<td>Dana</td>
<td>Burgan</td>
<td><a href="mailto:dburgan@citci.org">dburgan@citci.org</a></td>
<td>CITC</td>
<td>Quality Assurance Manager</td>
<td>Core Team</td>
</tr>
<tr>
<td>Christina</td>
<td>Love</td>
<td><a href="mailto:clove@andvsa.org">clove@andvsa.org</a></td>
<td>Alaska Network of Domestic Violence and Substance Abuse</td>
<td>Substance Use Disorder &amp; Trauma Specialist</td>
<td>Core Team</td>
</tr>
<tr>
<td>Patrick</td>
<td>Lawlor</td>
<td><a href="mailto:PLawlor@cookinlethousing.org">PLawlor@cookinlethousing.org</a></td>
<td>Cook Inlet Housing Authority</td>
<td>Cook Inlet Housing Authority</td>
<td>Core Team/Housing Work Group</td>
</tr>
<tr>
<td>Justin</td>
<td>Hatton</td>
<td><a href="mailto:jmhatton@anjc.net">jmhatton@anjc.net</a></td>
<td>Alaska Native Justice Center</td>
<td>Reentry &amp; Recovery Dept Manager</td>
<td>Core Team/Management</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>Email/Website</td>
<td>Organization</td>
<td>Position</td>
<td>Team/Groups</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------</td>
<td>----------------------------------------------</td>
<td>------------------------------------</td>
<td>-----------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Michelle Bartley</td>
<td><a href="mailto:mbartley@akcourts.us">mbartley@akcourts.us</a></td>
<td>State of Alaska - Therapeutic Courts</td>
<td>Therapeutic Courts Program Coordinator</td>
<td>Core Team/Work Groups</td>
<td></td>
</tr>
<tr>
<td>Mary Chouinard</td>
<td><a href="mailto:MChouinard@cookinlethousing.org">MChouinard@cookinlethousing.org</a></td>
<td>Cook Inlet Housing Authority</td>
<td>Director of Asset Management</td>
<td>Core Team/Work Groups</td>
<td></td>
</tr>
<tr>
<td>Paul Cornils</td>
<td><a href="mailto:paul.cornils@ayfn.org">paul.cornils@ayfn.org</a></td>
<td>Alaska Youth and Family Network</td>
<td>Executive Director</td>
<td>Core Team/Work Groups</td>
<td></td>
</tr>
<tr>
<td>Jonathan Pistotnik</td>
<td><a href="mailto:jpistotnik@nwalaska.org">jpistotnik@nwalaska.org</a></td>
<td>Anchorage Reentry Coalition</td>
<td>Project Coordinator</td>
<td>Core Team/Work Groups</td>
<td></td>
</tr>
<tr>
<td>Adam Rutherford</td>
<td><a href="mailto:Adam.rutherford@alaska.gov">Adam.rutherford@alaska.gov</a></td>
<td>State of Alaska - Department of Corrections</td>
<td>Chief Mental Health Officer</td>
<td>Core Team/Work Groups</td>
<td></td>
</tr>
<tr>
<td>Nekeysha Taylor</td>
<td><a href="mailto:nekeysha.taylor@alaska.gov">nekeysha.taylor@alaska.gov</a></td>
<td>State of Alaska - Department of Corrections</td>
<td>Medical Social Worker</td>
<td>Core Team/Work Groups</td>
<td></td>
</tr>
<tr>
<td>Janice Weiss</td>
<td><a href="mailto:janice.weiss@alaska.gov">janice.weiss@alaska.gov</a></td>
<td>State of Alaska - Department of Corrections</td>
<td>Reentry Project Manager</td>
<td>Core Team/Work Groups</td>
<td></td>
</tr>
<tr>
<td>Travis Erickson</td>
<td><a href="mailto:travis.erickson@alaska.gov">travis.erickson@alaska.gov</a></td>
<td>State of Alaska - Office of Children’s Services</td>
<td>Division Operations Director</td>
<td>Data Collection Work Group</td>
<td></td>
</tr>
<tr>
<td>Jared Parrish</td>
<td><a href="mailto:jared.parrish@alaska.gov">jared.parrish@alaska.gov</a></td>
<td>State of Alaska - Department of Health and Social Services</td>
<td>Senior Epidemiologist</td>
<td>Data Collection Work Group</td>
<td></td>
</tr>
<tr>
<td>Gulling Chelsea</td>
<td><a href="mailto:chelsea@gullingconsulting.com">chelsea@gullingconsulting.com</a></td>
<td>Gulling Consulting</td>
<td>Principal Owner</td>
<td>Planning Process Facilitator</td>
<td></td>
</tr>
<tr>
<td>Angela Michaud</td>
<td><a href="mailto:a.michaud@citci.org">a.michaud@citci.org</a></td>
<td>Cook Inlet Tribal Council</td>
<td>Senior Director of Program Operations for Recovery Services</td>
<td>Project Manager</td>
<td></td>
</tr>
<tr>
<td>Stephanie Autumn</td>
<td><a href="mailto:sautumn@air.org">sautumn@air.org</a></td>
<td>American Institutes for Technology</td>
<td>Senior Technical Assistance Consultant</td>
<td>Technical Assistance</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E

Complete Project Goals, Objectives and Key Indicators

This appendix was omitted from the printed version. You will happily find it in its place on the digital version.
Mission

To generate lasting change in the region’s reentry and recovery systems of care to improve outcomes related to key life domains among pregnant and postpartum women with co-occurring disorders (CODs) who are involved with the Alaska criminal justice system.

Goal 1: Implement [Project Name] to improve outcomes and well-being among pregnant and postpartum women with CODs who are involved with the Alaska criminal justice system and increase knowledge of, and reduce stigma surrounding, CODs among program participants and partner agencies.

Definition: “Involved with the Alaska criminal justice system” means someone who currently is, or in the twelve months prior to their acceptance into the program has been, incarcerated, on probation or parole, or enrolled in a therapeutic court program.

Rationale: Many entities are involved in serving this population. The perspective of these various entities are key to achieving effective change. Therefore, to impart real or lasting changes, the ability of these groups to work together is vital to helping the target population achieve long-term success. In addition, if any policy or legislative change is needed, the group will be equipped to handle it.

Goal 1, Objective 1

Within two (2) months of receipt of project funding, establish a Steering Committee composed of key project partners, institutional stakeholders, and
non-traditional allies to meet monthly during the project’s first year and quarterly thereafter.

**Key indicators:** Committee formation; documentation of meetings (agendas, meeting minutes, etc.).

**Rationale:** Reentry support service agencies must collaborate in order to provide effective and efficient services. More frequent meetings will be required during the first year of rollout, as there will likely be numerous issues to navigate and address.

### Goal 1, Objective 2

Within 18 months of receipt of project funding, the Steering Committee will complete an assessment of community assets and policy and procedural barriers to successful program completion, including data collection methods and capacity among project stakeholders, that can be used to guide project implementation and advocate for potential policy changes.

**Key indicators:** Documentation of community assets, policy and procedural barriers and changes that result from needs assessment, and Steering Committee actions/recommendations; documentation of agencies adapting data collection strategies based on Steering Committee and project evaluator recommendations; MOU or business agreements outlining data collection methods and/or sharing between partner agencies

**Rationale:** Given that the Steering Committee has a targeted composition of reentry services, people with lived experience from the target population, and DOC/probation staff, the depth and breadth of this committee's lens on the target population is extensive. Therefore, they have an opportunity to identify systemic strengths, gaps, and barriers for the target population. Improved data collection will provide better information regarding the entire reentry population at the local and national levels. A steering committee and an evaluator’s expertise will identify missing data.
Goal 1, Objective 3

Within 36 months of receipt of program funding, the Steering Committee will develop a sustainability plan that includes key considerations for continuation and/or development and implementation of the project elsewhere in the state.

Key indicators: Documentation of sustainability plan.

Rationale: This project may be considered a pilot project at the local, state, and national levels. The Steering Committee will determine the project’s course and identify any necessary modifications for future funding applications, such as a need for additional case management agencies, funding structure, etc. They are also responsible for ensuring that the project can sustain funding cycles and staff turnover.

Goal 1, Objective 4

Within 36 months of receipt of project funding, 75% of partner agency staff in direct contact with the target population will have attended at least one (1) joint training session on the intersection of CODs and the criminal justice system.

Key indicators: Documentation of training(s) attended; pre- and post-training survey regarding stigma.

Rationale: Stigma among reentry service providers decreases their ability to effectively and efficiently provide support services. To meet the primary goal of creating lasting change, stigma must be decreased in both the general public and the support services agencies themselves. This goal operates from a belief that providing joint training with curriculum advised by the Steering Committee will reduce stigma. Ideally, the training will be a collaboration between institutional stakeholders and non-traditional allies.
Goal 2: Implement integrated COD care and comprehensive case management services targeted to the recovery and reentry needs of pregnant and/or postpartum women who are involved with the Alaska criminal justice system. Addressing root causes of substance abuse disorder, depression, anxiety, and other mental health conditions, such as history of trauma, will be prioritized.

*Rationale:* The target population must have access to recovery services based on addressing root causes so as not to provide only temporary solutions. Providing case management to women with CODs to help them navigate the system is key to reducing recidivism, increasing their quality of life, etc.

**Goal 2, Objective 1**

Within six (6) months of receipt of project funding, create and implement a universal screening and referral process for all women housed at Hiland Mountain Correctional Center (HMCC) for more than three (3) days or on probation/parole to identify and assess for medical and/or pre- or post-natal care needs and/or history of trauma.

*Key indicators:* Number of women referred to the program from HMCC.

*Rationale:* Collaboration between reentry support service agencies and DOC is needed to improve the target population’s access to services, help them achieve improvements to life domains, and meet the project’s other goals and objectives.

**Goal 2, Objective 2**

Within 36 months of receipt of project funding, provide 56 program participants with comprehensive case management services that include
coordinated client-centered, integrated mental health services, substance use disorder services, general healthcare, and/or pre- or post-natal care to meet their specific re-entry needs.

**Key indicators:** Identify and house documentation in an electronic health record; case management needs documented on a treatment plan; documentation of services provided; conclusion of chart with discharge summary (when relevant) to validate completion.

**Rationale:** A full caseload for two case managers is 15-20 clients; therefore, this number was selected based on the assumption that two full-time case managers would be assigned to the project. In addition, this objective was written with the assumption that the case manager will be funded through this project and will coordinate with existing mental, physical, emotional, and/or spiritual services. The number is subject to change depending on the project’s ultimate funding source.

**Goal 2, Objective 3**
Within 36 months of receipt of project funding, 85% of program participants will have attended at least one (1) class on the intersection of CODs and the criminal justice system.

**Key indicators:** Documentation of class(es) attended.

**Rationale:** It is important that participants understand some of the influencers that possibly led to their incarceration, such as racist/sexist culture, lack of support services systems, ACEs, resiliency factors, etc. The idea is that if we can reduce the existence of shame associated with the participant’s behavior, they will have an increased ability to heal and/or make sustained life changes. Understanding CODs and how addiction/mental health/past trauma/resiliency factors has impacted their ability to make good choices is also important to create lasting change.

**Goal 2, Objective 4**
Within 36 months of receipt of project funding, 75% of program participants identified as having a history of trauma will have been referred to a trauma-centered treatment program and/or class(es). Identification will be based on ACEs and resilience factor test scores.

**Key indicators:** Documentation of ACEs and resilience factors tests administered; documentation of referrals to treatment and/or classes.

**Rationale:** ACEs and resilience factors have a tremendous impact on an individual's future chance of violence victimization/perpetration, health, and opportunities. Helping program participants recognize and acknowledge past trauma and understand how it has impacted their decision-making can help them heal, which in turn can decrease their recidivism/revictimization rates and increase their long-term health and opportunities.

**Goal 2, Objective 5**

Within 36 months of receipt of project funding, 75% of program participants identified as having medical and/or pre- or post-natal care needs will have been referred to medical providers and/or services, including relevant class(es).

**Key indicators:** Documentation of assessments made; documentation of referrals to providers, services, and/or classes.

**Rationale:** Taking care of medical and pre- and post-natal needs is important to the overall physical, mental, and emotional health of program participants and/or their children. Helping program participants access appropriate and relevant medical and pre/post natal care, whether actual medical care and/or classes (i.e., parenting, breastfeeding, nutrition, child development, etc.), can help reduce the risk of relapse, which in turn can decrease recidivism/victimization rates, and increase long-term health and opportunities of program participants and their children.
Goal 3: Improve life domains among pregnant and postpartum women with CODs who are involved with the Alaska criminal justice system and reentering the community.

Rationale: Choosing to measure success by a program participant's improvements to their life and/or the lives of their children is a better indicator of resiliency and lasting success, as opposed to measuring success only by whether a participant obtains and maintains her sobriety.

Goal 3, Objective 1

Within 36 months of receipt of project funding, identify need and increase participant engagement in services that support various life domains including housing, employment, and family reunification. Additional services may also include mental health and substance misuse treatment services, education, financial responsibility, services for children/family, and/or other relevant services that provide a pathway to recovery and improve the chance for project success. Case managers will create an individualized plan to use as a baseline to identify specific goals and to measure program participant success.

Key indicators: Documentation of priority outcome-related measures collected for the individualized plan (i.e., number of participants that obtain housing, employment, are reunified with children, etc.) using a tool that measures life domains.

Rationale: Completion of recovery treatment services is generally thought to be linked to improved quality of life for the participant and her children. Using an individualized case plan as a baseline to measure success allows participants to grow based on their own curve and takes into account individual factors that may not allow them to achieve a “national” standard of success.
Goal 3, Objective 2

Within 36 months of receipt of project funding, 75% of program participants released into the community will be working toward obtaining, or will have obtained, stable housing.

Key indicators: Documentation of program participants’ entry into, or attempts to enter into, permanent residence (i.e., signed lease/rental agreement, confirmation from landlord, self-report).

Rationale: Housing is a measure of quality of life and a basic need, making it a good measurement of project success. For purposes of this objective, “permanent housing” is defined as community-based housing without a designated length of stay. Data from the Partner Reentry Center on the number of women housed will be used as a baseline to measure success of this objective.

Goal 3, Objective 3

Within six (6) months of acceptance into the program, 100% of program participants will be assessed for work readiness and will have an individualized job training/placement plan developed.

Key indicators: Documentation of program participants’ work readiness assessments, job training/placement plans.

Rationale: Employment is necessary for long-term success and independence. The project will work to provide participants with access to job training and placement to meet this goal.

Goal 3, Objective 4

Within 36 months of receipt of project funding, 75% of work-ready program participants released into the community will have obtained either full- or part-time employment. Non-work ready participants will be working on job development and/or equivalent needs-based services.
Key indicators: Documentation of program participants’ employment status including length of employment and possibly an employer-completed form to demonstrate performance.

Rationale: Employment is necessary for long-term success and independence. The project will work to provide participants with access to job training and placement to meet this goal.

Goal 3, Objective 5

Within three (3) months of release from HMCC, 75% of program participants with OCS involvement will have been connected with a parent advocacy organization and have a family connectedness case plan developed to facilitate move toward eligibility for reunification.

Key indicators: Documentation of completion of case management plan; eligibility for reunification of children (full or shared physical custody, dependent upon other parent’s involvement); documentation of referrals to parent advocacy organization and family connectedness case plans.

Rationale: Because this project is geared toward women working to regain custody, this objective operates from the belief that being a mother to young children is generally a motivator for making positive life changes. However, some women may not want to regain full custody (i.e., mother only wants shared/partial with other parent, their child is settled in a good home/location and mother doesn’t want to disrupt, etc.); framing the objective in terms of eligibility for reunification rather than full reunification takes those differing goals into consideration. We are coming from a generational understanding of recidivism. In other words, supporting mother/child reunification and connectedness will facilitate a mother’s drive to make positive changes in her life, thus reducing her recidivism risk. In addition, studies tell us that this connectedness will reduce the risk of her child(ren) being incarcerated later in life.
Goal 4: Improve public safety in Alaska by reducing the criminal exposure of program participants and reducing the risk of criminal exposure to their children.

*Rationale:* Potential project funders may appreciate improved general public safety being one of the goals. This cannot be measured with recidivism alone.

**Goal 4, Objective 1**

Within three (3) years of receipt of project funding, recidivism among program participants with felony conviction(s) will be reduced by 5% more than the recidivism rate of the Alaska DOCs overall female population.

**Key indicators:** Tracking program participants at 6, 12-, and 18-months post-discharge to determine felony re-offense.

*Rationale:* Using the Alaska recidivism definition: *AS 44.19.647 Recidivism Definition:* A felony offender who is re-incarcerated within three years of release for any offense conviction including parole or probation violation. Reducing recidivism will increase quality of life for the participant and increase public safety by reducing criminal activity.

**Goal 4, Objective 2**

Within three (3) years of receipt of project funding, [choose aspect of criminal exposure: days in jail, number of arrests, criminal charges (Courtview), type/severity of charge] will be reduced by 5% more than the [insert aspect of criminal exposure chosen] rate of the Alaska DOCs overall female population.

**Key indicators:** Tracking program participants at 6, 12-, and 18-months post-discharge to determine [days in jail, number of arrests, criminal charges (Courtview), type/severity of charge].
Rationale: As parole violation/s can be a minor infraction, recidivism cannot be the sole indicator of goal attainment. The objective should also illustrate a decrease in criminal activity.

Goal 4, Objective 3

Within 36 months of receipt of project funding, [six (6) (?)] pre-trial participants will be diverted from jail to a therapeutic court probation program.

Key indicators: Tracking pre-trial program participants to determine diversion to therapeutic court probation program.

Rationale: Diverting participants with low level offenses to therapeutic court will potentially keep them from interacting with and modeling the behavior of other high-level offenders in the facility. With access to intensive case management and other support services, the target population will have an improved chance of retaining custody of their children and a reduced risk of reincarceration. By providing a supportive structure for reentry, participants will have a reduced chance of recidivism.
Appendix F

Evaluation Plan: Objectives, Key Indicators and Data Sources for Each Project Goal

This appendix was omitted from the printed version. You will happily find it in its place on the digital version.
<table>
<thead>
<tr>
<th>GOAL 1: Implementation of Project</th>
<th>OBJECTIVES</th>
<th>KEY INDICATORS</th>
<th>Data source(s)</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Establish steering committee and meet regularly (within 2 months)</td>
<td>a. Committee formation</td>
<td>Project, project partners</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Meeting documentation</td>
<td>Project</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>2: Complete assessment of assets and barriers to program completion (within 18 months)</td>
<td>a. Community asset documentation</td>
<td>Project, steering committee</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Policy and procedural changes resulting from assessment</td>
<td>Project, steering committee</td>
<td>Original policies and procedures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Adaptation of data collection strategies based on Steering Committee and evaluator recommendations</td>
<td>Project, steering committee</td>
<td>Original data collection strategies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Agreements for data collection and/or sharing between partner agencies</td>
<td>Project, steering committee</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>3: Develop sustainability plan (within 36 months)</td>
<td>a. Sustainability plan</td>
<td>Project, steering committee</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>4: 75% of partner agency staff attend one or more joint training session(s) (within 36 months)</td>
<td>a. Documentation of training(s) attended</td>
<td>Project, partner agency staff</td>
<td># of staff who have attended trainings prior to project</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Pre-training survey regarding stigma</td>
<td>Project, partner agency staff</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Post-training survey regarding stigma</td>
<td>Project, partner agency staff</td>
<td>Pre-training survey</td>
<td></td>
</tr>
</tbody>
</table>
Table 2: Goal 2, objectives, key indicators, and data sources

<table>
<thead>
<tr>
<th>GOAL 2: Implementation of Integrated COD care and case management services</th>
<th>OBJECTIVES</th>
<th>KEY INDICATORS</th>
<th>Data source</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Create and implement a universal screening and referral process (within 6 months)</td>
<td>a. Number of women referred to program from HMCC</td>
<td>Project, HMCC</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>2: Provide participants (56) with case mgmt services (within 36 months)</td>
<td>a. Electronic health record documentation</td>
<td>Project, HMCC?</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Case management needs documented</td>
<td>Project, treatment plan</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Documentation of services provided</td>
<td>Project, project partners, DOC?</td>
<td>Services provided prior program participation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Discharge summary to validate completion of program</td>
<td>Project, project partners, chart</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>3: 75-100% of participants attend one or more class on CODs and the criminal justice system (within 36 months)</td>
<td>a. Documentation of classes attended</td>
<td>Project</td>
<td># of participants who have attended trainings prior to project</td>
<td></td>
</tr>
<tr>
<td>4: 75% of participants with trauma history will be referred to a treatment program and/or classes (within 36 months)</td>
<td>a. Documentation of ACEs and resilience factors tests administered</td>
<td>Project, partner agency staff</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Documentation of referrals to treatment and/or classes</td>
<td>Project, partner agency staff</td>
<td># of participants who have attended treatment programs prior to project</td>
<td></td>
</tr>
<tr>
<td>5: 75% of participants with medical/pre- or post-natal care needs will be referred to medical services (within 36 months)</td>
<td>a. Documentation of need assessments</td>
<td>Project</td>
<td>Care prior to program participation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Documentation of referrals to providers, services, and/or classes</td>
<td>Project</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>GOAL 3: Improve life domains among target population</td>
<td>OBJECTIVES</td>
<td>KEY INDICATORS</td>
<td>Data source</td>
<td>Baseline</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>------------</td>
<td>----------------</td>
<td>-------------</td>
<td>----------</td>
</tr>
<tr>
<td>1: Increase participant engagement in multiple life domains (within 36 months)</td>
<td>a. Documentation of priority outcome-related measures collected for the individualized plan using a tool that measures life domains</td>
<td>Project, participants?</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>2: 75% of participants released engaged in obtaining/obtained stable housing (within 36 months)</td>
<td>a. Documentation of participants’ entry into, or attempts to enter into, permanent residence</td>
<td>Project, participants?</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>3: 100% of participants assessed for work readiness and have employment plan (within 6 months of acceptance to the program)</td>
<td>a. Documentation of program participants’ work readiness assessments and/or job training/placement plans</td>
<td>Project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4: 75% of work-ready participants released will have full- or part-time employment (within 36 months)</td>
<td>a. Documentation of participants’ employment status, including length of employment and possibly an employer-completed form to demonstrate performance.</td>
<td>Project, participant</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>5: 75% of participants with OCS involvement will have a family connectedness plan (within 3 months of release from HMCC)</td>
<td>a. Documentation of case management plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Eligibility for reunification of children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Documentation of referrals to parent advocacy organization and family connectedness case plans</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3: Goal 3, objectives, key indicators, and data sources
<table>
<thead>
<tr>
<th>GOAL 4: Improve public safety in Alaska</th>
<th>OBJECTIVES</th>
<th>KEY INDICATORS</th>
<th>Data source</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Reduce recidivism among participants by 5% more than the AK DOC’s total female population (within 36 months)</td>
<td>a. Number of participants who have not recidivated 6 months post-discharge</td>
<td>Project, AK DOC</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Number of participants who have not recidivated 12 months post-discharge</td>
<td>Project, AK DOC</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Number of participants who have not recidivated 18 months post-discharge</td>
<td>Project, AK DOC</td>
<td>Overall recidivism rate</td>
<td></td>
</tr>
<tr>
<td>2: Criminal exposure of participants will be reduced by 5% more than the AK DOC’s total female population [including days in jail, # arrests, criminal charges, type/severity of charge] (within 36 months)</td>
<td>a. Number of participants who have not engaged in aspects of criminal exposure at 6 months post-discharge</td>
<td>Project, AK DOC, Courtview</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Number of participants who have not engaged in aspects of criminal exposure at 12 months post-discharge</td>
<td>Project, AK DOC, Courtview</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Number of participants who have not engaged in aspects of criminal exposure at 18 months post-discharge</td>
<td>Project, AK DOC, Courtview</td>
<td>Overall rates of aspects of criminal exposure</td>
<td></td>
</tr>
<tr>
<td>3: Divert pre-trial participants (at least 6) from jail to a therapeutic court probation program (within 6 months of acceptance to the program)</td>
<td>a. Identify and divert participants with low-level offenses to therapeutic court</td>
<td>Project, AK DOC, Therapeutic court</td>
<td>n/a</td>
<td></td>
</tr>
</tbody>
</table>
Appendix G

Report on Semi-Structured Interviews Conducted by Gulling Consulting

This appendix was omitted from the printed version. You will happily find it in its place on the digital version.
Seven women were interviewed who have cooccurring disorders and were pregnant while in prison and/or had child/ren ages 0-3 in their custody at the time of incarceration and/or became pregnant within twelve months of release. The mental health issues include bipolar disorder, depression, anxiety and PTSD. The substances abused include alcohol, methamphetamine, marijuana, heroin and prescription pills.

**Parenting and pregnancy during incarceration and reentry**

Five of the women surveyed had children before they entered Hiland – one had a 6-month old, one had a 2-year-old, one had three children (ages not provided), one had three children (ages not provided) and one had 12-year-old.

Two of the women were pregnant while incarcerated. Four of the women became pregnant after they reentered the community, two of which were on parole.

Of the two women who were pregnant while incarcerated, one felt that Hiland did a good job providing prenatal care. She also felt the caseworker assigned to work with pregnant inmates did a good job despite her caseload being so large. While the supports provided in prison were helpful, she felt more services related specifically to pregnancy were greatly needed. The woman felt the proposed project should include a focus on maintaining a family bond with members who are not incarcerated.

One of the women who became pregnant following reentry was living at the halfway house at the time. She reported that her probation officer (PO) helped her find housing through Alaska Housing and the STEP program. Another woman who gave birth shortly after her release from Hiland said her PO discussed reentry resources with her, but that transportation was one of the biggest challenges she faced. Many of the available transportation options don’t allow children, which makes it difficult to get to appointments.

Of the four women who had children before they entered Hiland, one reported that the father had custody during her incarceration and she maintained contact through letters and telephone calls. Upon her release from Hiland, she “followed the program” and was eventually able to regain joint custody of her children and later obtained full custody when the children’s father died.
The woman who entered Hiland with a 2-year-old reported that her mother cared for her child during the 1 ½ years she was incarcerated but did not specifically mention how she kept in touch with her during that time.

The women reported that Hiland administers pregnancy tests to every woman upon entrance unless she is obviously pregnant. One of the two women pregnant while incarcerated learned of the pregnancy following the required test.

**Mental health supports**

Almost all of the women reported that the information provided in the classes was informative. The most helpful aspect however, was the opportunity to talk with others who had similar experiences and challenges.

Women reported getting medication but found that the staff was so overwhelmed that there was often a “long line”.

**Other available supports**

One woman lived in the HOPE Wing and found that the structure helped her “stay on track and get ready to change.”

The women reported that their PO’s were extremely helpful and supportive. Two women reported that their POs helped them secure housing through the Alaska Housing reentry program. Another worked with Partners for Progress and was able to get transitional housing and transportation assistance in the form of bus passes and helped her locate a job. One also went through the FACE program and now has a job with the State of Alaska.

One woman reported that while the PO and the GAL assigned to her case following reentry were very supportive, there were few treatment programs available, specifically ones that treat individuals with CODs.

One woman reported having few community supports available following her release, since it happened during COVID. She said she was fortunate that her family was supportive.
What else is needed

Survey respondents were asked what programs or services, in a perfect world, they would create/develop to support new moms and/or parents entering prison and upon reentry:

- Identification of reentry services (i.e., mental health treatment, substance abuse treatment, education opportunities, food banks, parenting services, etc.) would occur prior to release.
- Prison staff would create individualized reentry plan for inmates that identified resources specific to their needs (i.e., treatment programs that allow children.)
- Educational opportunities, such as vocational and technical schools, need to be discussed. Many of the women in prison don’t have even a GED, so lack the education and/or experience to identify and locate resources or even know how to advocate for themselves.
- Offer more parenting and family reunification classes and make enrollment easier. The respondents indicated that “there are already many women in jail who are pregnant,” but getting into the classes is difficult. For example, a class will have already started when a woman arrives, or can only complete part of a class, or has to complete prerequisite classes. This makes it “hard for parents that get into prison halfway through classes.”
- Increased education on mental health issues for staff and inmates. Staff often consider women suffering from CODs as “just detoxing, when the drugs are just compounding the mental health issue.”
- Prison staff would continually approach women they suspect of having mental health issues and help them reach out for help. This should specifically be done for repeat offenders, since many are incarcerated due to mental health issues.
- Program for pregnant women in prison to meet and receive parenting information (i.e., breastfeeding instruction) and learn how to care for children.
- Staff should focus on teaching women to care for their mental, physical, and social/emotional health.
- More attention given to the safety of pregnant women in jail (i.e., pregnant woman should not be sleeping on the top bunk).
Appendix H

The Four Core Elements of the Women Offender Case Management Model
CHAPTER 3: THE PROCESS

Guide to Contents:
A. Overview
B. What Does the Process Look Like?
C. The Four Core Elements:
   a. Engage and Assess
   b. Enhance Motivation
   c. Implement the Case Plan
   d. Review Progress
D. Delivering WOCMM

A OVERVIEW

In this section we begin to explore the case management process and how it is delivered across all phases of supervising women offenders sentenced to probation or in transition from prison to the community. We also look more closely at the core elements of WOCMM. Essentially we see 4 distinct but overlapping stages that are consistently revisited as goals are achieved and/or modified to accommodate the needs of women. Practitioner expectations and participant outcomes are summarized for each of the core elements in Table 3.1 below. A more detailed description of each element is provided in section C.

Table 3.1: THE FOUR CORE ELEMENTS

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>CASE MANAGEMENT TEAM RESPONSIBILITIES</th>
<th>ANTICIPATED OUTCOMES</th>
</tr>
</thead>
</table>
| #1: Engage and Assess | • Create a safe environment  
| | • Focus on building rapport and establishing a respectful relationship  
| | • Pre-Assessment Preparation  
| | • Orientation  
| | • Assessment  
| | • Case Analysis | • Increased awareness of the personal, situational and contextual factors that contribute to criminal justice involvement and that impact on life satisfaction.  
| | Intervention Tools: Gender-responsive assessment battery, Case Analysis Worksheet, Looking | • Increased awareness of strengths that can be mobilized to mediate the impact of risk. |
### ELEMENT
<table>
<thead>
<tr>
<th>CASE MANAGEMENT TEAM RESPONSIBILITIES</th>
<th>ANTICIPATED OUTCOMES</th>
</tr>
</thead>
</table>

#### #2: Enhance Motivation
- Use a gender-responsive approach to enhance motivation
- Provide feedback by summarizing the assessment results
- Explore the priority targets
- Woman is asked to identify personal goals
- Review incentives and disincentives

*Intervention Tools: Feedback Worksheet, Decisional Balance Worksheet…*

- Priority targets are identified and defined
- Woman expresses the commitment to focus on one or more of the priority targets

#### #3: Implement the Case Plan
- Work collaboratively to develop the case plan.
- Develop SMART goals action steps.
- Identify personal and social resources that will augment the case plan.
- Provide opportunity to explore service and treatment options across four dimensions: Personal, Vocational, Life Needs, and Family Community.
- Promote healthy informal relationships that will support change efforts.

*Intervention Tools: Eco-Map; Menu of Gender-Responsive Services; Generic Case Plan*

- Action steps are formalized.
- Woman can identify personal and social supports necessary to achieve personal goals.

#### #4: Review Progress
- Review and update progress.
- Reinforce successes.
- Introduce problem-solving strategies when obstacles arise.
- Begin to develop maintenance strategies.

- Women are able to self-reinforce when successful and to problem-solve when faced with challenges.
strategies.

*Intervention Tools: Updated Case Plan, Guidelines for progress review, problem-solving worksheet; maintenance worksheets.*

- Women have developed maintenance strategies to ensure a proactive response to high-risk situations.

### B WHAT DOES THE PROCESS LOOK LIKE?

As indicated above the case management process consists of four distinct but overlapping core elements that are consistently reviewed as new priority targets are incorporated into the case plan. A schematic of the case management process is presented in Figure 3.1.

Ideally goals are achieved by moving through the core elements in a sequential fashion. However, it is anticipated that as women transition through the system or face alternate life circumstances – priority targets will change and/or shift necessitating movement forward or backward.

*Figure 3.1: The Case Management Process*
Core elements can be introduced at all phases of the case management process. Information is carried forward from one phase to another via the case plan.
Appendix I

Guiding Practices of the
Women Offender Case Management Model
### Table 1: Guiding Practices to Implement WOCMM

<table>
<thead>
<tr>
<th>Guiding Practice</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gender-Responsive</td>
<td>Professionals will be trained to use a gender-responsive approach when interacting with the woman. This means that staff will use an approach that is: relational, strengths-based, trauma-informed, and culturally competent.</td>
</tr>
<tr>
<td>2. Individualized Service</td>
<td>Consistent with evidence-based practice, the risk and need principles are applied to determine the intensity of services required as well as the need areas that will be targeted. This means that SPIn-W, a standardized gender informed assessment, will be administered with each woman. To ensure that the needs of women are addressed, the assessment will include traditional correctional measures as well as those that are gender-responsive.</td>
</tr>
<tr>
<td>3. Use Engagement Strategies</td>
<td>Staff work intentionally and strategically to engage the woman in the change process while respecting the woman’s right to choose what and when to address needs and challenges.</td>
</tr>
<tr>
<td>4. Team Approach</td>
<td>The “team” approach to case management is essential to the delivery of this model. Team members consist of the “woman” and other natural supports (e.g., family members) who work in conjunction with available representatives from a variety of disciplines that might include correctional, health professionals, Clergy, and other supports. Formation of the case management team is a critical first step in the implementation. Once team members are identified they should develop a mission statement and operating procedures including a policy outlining role and responsibilities, limits to confidentiality and information sharing, etc.</td>
</tr>
<tr>
<td>5. Collaborative</td>
<td>Collaboration refers to mutuality of purpose and intent among team members. This means that the woman, as part of the team has a voice with respect to the targets and ultimate outcomes of the case management process.</td>
</tr>
<tr>
<td>6. Continuous Service</td>
<td>The central importance of relationships in the lives of women argues strongly for continuity in services. This means that whenever appropriate the case manager and members of the team are encouraged to offer direct services, including assessment, treatment and mentoring. When services cannot be provided directly by a team member another professional within the team should be present to introduce the woman to the external resource.</td>
</tr>
</tbody>
</table>
7. Comprehensive

The model recognizes that women often present with complex needs and face multiple challenges. Therefore, a critical element of WOCMM is to ensure that services are designed to help women build personal resources as well as social capital. Services may include, information, advice, treatment, assessment, brokerage and referral across an array of need areas including, vocational, family/social, personal, and life needs.

The need to provide comprehensive services requires partnerships with service providers across institutional and community settings. Many women transitioning from prison or who are supervised in the community reside in neighborhoods that elevate risk to their personal safety as well as expose them to situations that may contribute to future criminal justice involvement. Often communities lack basic resources or women no longer qualify for services. To address these challenges, WOCMM should work to organize stakeholders and to build partnerships with service providers who wish to work more effectively with women.

The WOCMM team works to build relationships with the women and agencies in the community to provide holistic services including:

- Individual supportive therapy
- Medical services
- Child-Care
- Housing
- Family Reintegration/Parenting/Domestic Violence
- Substance abuse services
- Work-related services
- Social, interpersonal relationship, and leisure skills training
- Vocational supports
- Other support services

8. Program Integrity

The safe and effective delivery of services to women requires attention to program integrity and quality assurance. Team members are cross-trained and provided with formal training, access to quality assurance supervision, ongoing coaching, and the resources necessary to ensure adherence to the model.

9. Program Evaluation

Evaluation is critical to the implementation of this model. This means that a number of measurement and case management tools are used to monitor the woman’s progress throughout her involvement in the case management process. In addition to process information, WOCMM was designed to contribute to the outcome literature and to increase knowledge about promising practices.

---

2 Social capital refers to connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them. In that sense social capital is closely related to what some have called “civic virtue.” The difference is that “social capital” calls attention to the fact that civic virtue is most powerful when embedded in a sense network of reciprocal social relations.
Appendix J

State of Alaska DOC Policies and Procedures:
(a) Prisoner Rights, Requirements Relating to Female Prisoners
(b) Medical and Health Care Services, Access to Health Care Services

Part (b) of this appendix was omitted from the printed version. You will happily find it in its place on the digital version.
I. Authority
In accordance with 22 AAC 05.155, the Department will maintain a manual composed of policies and procedures established by the Commissioner to interpret and implement relevant sections of the Alaska Statutes and 22 AAC.

II. References
Alaska Statutes
AS 33.30.011

III. Purpose
To provide consistent standards for housing female prisoners

IV. Application
All Staff

V. Definitions
None

VI. Policy
It is the policy of the department that all female prisoners will be housed separately and must be provided access to facility programs and facilities comparable to those provided to male prisoners and consistent with the mission of the institution. Female prisoners shall be provided programs about pregnancy, child care, and domestic violence. Counseling shall be made available to female prisoners who are pregnant.

VII. Procedures
A. Female prisoners shall be housed separately from male prisoners.
B. Female prisoners shall be provided with counseling regarding family and pregnancy upon request.
C. Pregnant Prisoners
   1. Medical Care
      The Department shall provide the medical facilities and health care necessary for a pregnant prisoner and her child. The prisoner shall receive proper prenatal and postnatal health care.
   2. After the Birth
      No female prisoner may keep her child in the facility under any circumstances. The prisoner must place the infant with family members or in foster care.
D. Prisoners with Children
   The Department will consider a female prisoner’s proximity to her children during her designation.
   1. When there is a child age 3 and under:
      A prisoner whose child is age 3 or under may, at the Superintendent’s discretion, visit with her child for up to eight hours per day. The Superintendent shall consider the length of the prisoner’s sentence, suitability of the visiting environment, program participation and conduct of the prisoner. Visitation must comply with the following:
         a. When brought to, and returned from, the facility, the child must be accompanied by an adult family member, foster parent, or guardian legally authorized to have that child in his or her care;
         b. The child and accompanying paraphernalia are subject to appropriate security screening;
         c. The child’s guardian is not required to be present during visitation.
   2. Children age 4 and older shall visit according to Policy & Procedure 810.02 [Visitation].
VIII. **Implementation**
This policy and procedure is effective when it is signed by the Commissioner. Each Manager shall incorporate the directions outlined in this document into local policy and procedure.

1/29/2014 ___________________________________________ SIGNATURE ON FILE
Date
Joseph D. Schmidt, Commissioner
Department of Corrections

Revised 7/7/1995
Revised 6/3/1991
Original 1/20/1986
I. Authority

In accordance with 22 AAC 05.155, the Department will maintain a manual composed of policies and procedures established by the Commissioner to interpret and implement relevant sections of the Alaska Statutes and 22 AAC.

II. References

Alaska Statutes
AS 33.30.011
AS 33.30.028

Alaska Administrative Code
7 AAC 27.005
22 AAC 05.005
22 AAC 05.120
22 AAC 05.121
22 AAC 05.122
22 AAC 05.485

Court Decisions
Rust v. State, 582 P.2d 134, modified on other grounds, 584 P.2d 38 (1978)

4-4258, 4261, 4344, 4347, 4348, 4350, 4351, 4353

Standards for Adult Local Detention Facilities; 3rd Edition 1991
3-ALDF-4E-01, 4E-06, 4E-10, 4E-30, 4E-33, 4E-35, 4E-39

III. Purpose

To establish uniform procedures within the Department for prisoner access to health care services.

IV. Application

All staff and prisoners.

V. Definitions

VI. Policy

A. The Department shall ensure that sentenced and unsentenced prisoners have access to medical, dental, and mental health care services comparable in quality to those available to the general public. The Department also shall ensure that special health care services are available to prisoners, contingent upon available resources. Prisoners in punitive and administrative segregation must receive the same access to health care as that provided to the general prison population.

B. Health care staff, other than a physician, dentist, psychiatrist, psychologist, optometrist, osteopath, podiatrist, physician assistant, or advanced nurse
practitioner, shall perform health care treatment per written orders of licensed practitioners or per nursing protocols as approved by the Health Care Administrator and Medical Director of Inmate Health.

C. The Department shall use the most cost effective health care treatment to meet the prisoner’s needs for essential and special health care services. The Department shall ensure that essential health care services are available from other sources if the services are not available within the institutions.

D. The same quality of care will be provided to sentenced and unsentenced prisoners. As indicated in the Prisoner Health Plan (attachment A), a number of factors are related to the level of health care delivered. Among these is the “estimated date of release.” This is important in a number of specific situations where the Department makes a decision not to provide a specific service. The reason may be due to an inability to follow through to completion on a particular intervention or treatment or the non-urgent nature of the request. Regardless of the prisoner’s status, all essential and medically necessary care will be approved and delivered in a timely manner. In certain instances an unsentenced prisoner may be allowed access to community-based, selective medical services not provided by the Department, at the prisoner’s own expense.

VII. Procedures

A. General

1. Information Regarding Health Care Services
   A prisoner’s orientation upon admission to an institution must include instructions for obtaining medical, dental, or mental health care services. See Policy 811.08, Prisoner Orientation. The Prisoner Handbook and Prisoner Health Plan (see Attachment A) also describe access to health care and the Department may post information in prisoner living areas. See Policy 809.01, Prisoner Handbook.

2. Non-Emergency Health Care
   Prisoners should attend sick call (see Policy 807.11, Sick Call) or complete a Request for Medical Care, Form 807.02A, for non-emergency health care.

3. Emergency Health Care
   Prisoners who need emergency health care, or any other person perceiving such a need, shall immediately notify institution staff. Staff shall call on-site medical staff and initiate first-aid. When on-site medical staff is not available, staff will notify the Shift Supervisor who will contact the on-call health care practitioner. In the case of extreme emergency (i.e., threat to life or limb) that cannot wait for medical consultation, the shift supervisor shall contact emergency medical services to arrange for appropriate transport for the prisoner. See Policy 1208.15, Transportation of Prisoners.

   a. Health care staff must prepare and submit to the Inmate Health Central Office a Prisoner Hospital Admission Form 807.05D when a prisoner is transported for emergency health care.

   b. The Superintendent or designee shall notify the appropriate military authority or the Federal Marshal’s office of emergency actions taken for federal prisoners in the Department’s custody.
4. Treatment Plans
A physician, dentist, or other health care practitioner shall develop a written treatment plan for each prisoner who needs special health care. The plan must include a statement of short and long term goals, specific courses of therapy, referrals to supportive and rehabilitative services when needed, and recommended travel arrangements, if the prisoner may need to be transferred in the future.

5. Elective Health Care
The Department need not provide prisoners with elective health care. Elective health care is those procedures that are not necessary for the maintenance of basic medical, mental, and oral health.

B. Essential Health Care Services
1. Essential Health Care
A prisoner has the right to receive essential health care services. Essential health care services include dental, psychological, psychiatric, or medical services when a health care provider, with reasonable medical certainty and exercising ordinary skill and care at the time of observation, concludes that:
   a. The prisoner’s symptoms indicate a serious disease or injury;
   b. Treatment could cure or substantially alleviate the disease or injury; and
   c. The potential for harm if treatment is delayed or denied could be substantial; or
   d. Services are needed to alleviate significant pain and suffering, including: procedures necessary to aid in increasing the level of functioning throughout the prisoner's sentence, such as prosthetic devices; and health care needed to enable a prisoner to participate in or benefit from rehabilitative services. See Policy 807.15, Health Care Prosthetics.

2. Unusual or Costly Procedures
The Commissioner must approve any unusual or costly health care or dental procedures that go beyond essential health or dental care. The Commissioner has the discretion, after consulting with health care authorities, to disapprove health care or dental procedures for ailments that do not seriously threaten the prisoner's health or well being while in prison.

3. Mental Illness
A prisoner who suffers from a mental illness shall receive appropriate mental health treatment. See Policy 807.13, Mental Health Administration and Services.

C. Special Health Care Services
Special health care services include services for the prisoner’s well being beyond those services received in everyday general practice. These services include:

1. Health Education
Each institution's health care unit shall have health education material available for prisoners upon request. The material must be the same or
similar to the material that volunteers and governmental agencies provide to the general public for free or at minimal cost. The Medical Director or designee must approve any material that the Department's health care staff produces for prisoners.

2. Hearing Services
   The Department shall provide hearing aids and other hearing prosthesis for prisoners under Policy 807.15, Health Care Prosthetics.

3. Diagnostics
   The Department shall provide health care screening, testing, diagnoses, and tests to prisoners for their special health care needs. See Policy 807.13, Mental Health Administration and Services; Policy 807.14, Health Examinations; and Policy 807.16, Involuntary Administration of Psychotropic Medication.

4. Maternity Care
   a. The health care practitioner shall ensure that pregnant prisoners receive pre-natal, natal, and post-natal care. See also Policy 808.06, Requirements Relating to Female Prisoners. Health Care Staff shall provide special counseling to these prisoners.
   b. The Department shall not provide medical services for any newborn child or children of prisoners.

5. Sterilization
   The Department will not provide medical services to sterilize a prisoner. This does not preclude the delivery of essential medical care that may result in sterilization.

6. Contagious Diseases
   a. Staff shall immediately report all suspected cases of contagious diseases to the on-site medical staff. The on-site medical staff shall report all cases and seek guidance for the assessment of contagious diseases reportable under 7 AAC 27.005 to the Section of Epidemiology, Division of Public Health, Department of Health and Social Services. The on-site medical staff shall work with the local public health authorities to treat and control the infected persons. The health care practitioner shall promptly inform the superintendent of contagious diseases that could affect other prisoners or staff.

      (1) The Department shall follow guidelines published by the Centers for Disease Control of the U.S. Public Health Service for the institutional control of disease unless to do so would compromise the security appropriate for the affected prisoners.

      (2) A health care practitioner may prescribe mandatory blood or tissue screening for prisoners to detect Hepatitis-B, syphilis, tuberculosis, or other contagious diseases.

   b. The Department may isolate, transfer, or reclassify infected prisoners when necessary to prevent transmission of a contagious disease. See Policies 804.01, Administrative Segregation; and 750.01, Administrative Transfers.
(1) Infected prisoners must receive periodic tests, health screenings, and physical examinations until health care staff determine that the prisoner’s condition is arrested, cured, or non-communicable.

7. Communicable Diseases
A treating health care provider may authorize a prisoner to be placed in administrative segregation if the provider diagnoses or suspects the prisoner of having a communicable disease of public health concern and if the prisoner refuses treatment. An infected prisoner may be treated over his or her objection when public health concerns require immediate intervention to prevent spread of a communicable disease.

8. Detoxification
Health care practitioners shall supervise detoxification and withdrawal programs. The Department will not treat prisoners with Methadone for purposes of opiate withdrawal. However, all pregnant prisoners on Methadone or requiring Methadone for opiate withdrawal shall be treated under the direction of an on-site health care practitioner. In cases of prisoners receiving treatment with Methadone for pain control, a case-by-case review will be undertaken to ascertain the appropriateness of continued treatment.

D. Consultant or Specialist Services
The Department may use consultants and specialists as needed to provide health care services to prisoners as outpatients or through hospitalization. The health care practitioner, in coordination with the Superintendent, shall initiate referrals for special services and routine consultation services. The Medical Director must approve all non-emergency referrals.

1. Prisoner Health Care Referral Authorization
Health care staff and the Superintendent shall complete a Prisoner Health Care Referral Authorization, Form 807.02B, for each outside referral.

E. Prisoners in Punitive and Administrative Segregation
1. A health care staff member shall visit segregation units at least daily during routine rounds or while dispensing medication.
2. Health care staff shall evaluate and treat segregated prisoners in their cells or units unless sound medical judgment requires transfer of the prisoner to the clinic, an infirmary, or hospital. In that case, the Department must transfer the prisoner in a timely manner.
3. Health care staff shall record all segregation visits in the Segregation Log and all health care actions in the appropriate medical record. See Policy 1208.11, Permanent Record Logs. Health care staff shall report any problems with health care that they observe during their visits.
4. Security staff must immediately report emergency medical situations to the health care staff.

F. Prisoner Assistance
Prisoners may not participate in examining or treating patients. The health care practitioner and the Superintendent must approve any duties that a prisoner performs in the health care unit.

G. Health Care Expenses
The Department shall, when practical and if the prisoner is eligible, seek reimbursement of a prisoner's health care expenses from a third party (e.g., Veteran's Administration, Alaska Native Health Services Hospital, union health plan coverage, Medicare or Medicaid, major health care insurance coverage, or public assistance benefits). See Policy 807.07, Prisoner Responsibility for Health Care.

H. Outside Medical, Dental, or Vision Care
When approved by both the prisoner and DOC Medical Staff, a prisoner on furlough may obtain outside medical care at their own expense. Both forms 807.02C and 807.02E must be completed prior to any appointments being scheduled by the prisoner.

I. Health Care Services Complaints
The Department shall handle all prisoner complaints regarding health care services in accordance with Policy 808.03, Prisoner Grievances.

VIII. Implementation
This policy and procedure is effective 14 days following the date signed by the Commissioner. Each Manager shall incorporate the directions outlined in this document into local policy and procedure. All local policies and procedures must conform to these directions; any deviation must be approved in writing by the Division Director.

12/30/09  
Date

Joseph D. Schmidt, Commissioner  
Department of Corrections

Applicable Forms to this Policy:
Attachment A: Prisoner Health Plan
807.02A
807.02B
807.02C
807.02D
807.02E
Appendix K

American Medical Association Policy Statement:
Shackling of Pregnant Women in Labor
Shackling of Pregnant Women in Labor H-420.957

<table>
<thead>
<tr>
<th>Topic: Pregnancy and Childbirth</th>
<th>Policy Subtopic: NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting Type: Annual</td>
<td>Year Last Modified: 2020</td>
</tr>
<tr>
<td>Action: Reaffirmed</td>
<td>Type: Health Policies</td>
</tr>
<tr>
<td>Council &amp; Committees: Board of Trustees</td>
<td>undefined</td>
</tr>
</tbody>
</table>

1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
   - An immediate and serious threat of harm to herself, staff or others; or
   - A substantial flight risk and cannot be reasonably contained by other means.
If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.

**Policy Timeline**

Res. 203, A-10

Reaffirmed: BOT Rep. 04, A-20
Appendix L

Women's Transitional Housing Options in Anchorage and the Mat-Su
# Women's Transitional Housing Options in Anchorage and the Mat-Su

<table>
<thead>
<tr>
<th>Transitional House</th>
<th>Type of supportive Housing (Ex. Live in staff, 24 hour staff, Weekly check in etc.)</th>
<th>Who Runs Facility?</th>
<th>Location</th>
<th>Transportation Available as part of Housing?</th>
<th>Children Allowed to Live?</th>
<th>Length of Stay Available</th>
<th>Length of Wait List for Entry</th>
<th>Partners Voucher Available?</th>
<th>Housing Available to Gender(s)</th>
<th>Number/Type of Units</th>
<th>Contact</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Harbor</td>
<td>24/7 Staff</td>
<td>Rural Cap</td>
<td>Knik</td>
<td>No</td>
<td>No</td>
<td>6-9 months</td>
<td>No, not at this time</td>
<td>Yes</td>
<td>All</td>
<td>Efficiency</td>
<td>Stacey</td>
<td>Freedom time is from 7 AM - 6:30 PM, with exception of those working late shifts. They distribute medication as needed.</td>
</tr>
<tr>
<td>Daniel House</td>
<td>24/7 Staff</td>
<td>Privately Owned</td>
<td>Fairview</td>
<td>No</td>
<td>No</td>
<td>6 month</td>
<td>Yes</td>
<td>No</td>
<td>All</td>
<td>12 Units</td>
<td>John Perez 907-240-7100</td>
<td><a href="mailto:lindaaleak@gmail.com">lindaaleak@gmail.com</a></td>
</tr>
<tr>
<td>Oak House</td>
<td>Live-in Staff</td>
<td>Privately Owned</td>
<td>Mountain View</td>
<td>Yes</td>
<td>No</td>
<td>As long as you need it</td>
<td>No right now</td>
<td>Yes</td>
<td>All</td>
<td>One 4-plex and One 6-bed house</td>
<td>Crystal Jacquet 907-205-2117 or 907-891-0512</td>
<td>Freedom time is from 7 AM - 6:30 PM, with exception of those working late shifts. They distribute medication as needed.</td>
</tr>
<tr>
<td>New Life Development</td>
<td>24/7 Staff</td>
<td>New Life Development Inc.</td>
<td>Russian Jack</td>
<td>No, depends on case by case situation</td>
<td>No</td>
<td>Minimum is 6-months.  Does not make people leave after 6-months</td>
<td>Not right now</td>
<td>Yes</td>
<td>All</td>
<td>30 female beds</td>
<td>TroyLuckner 907-646-2200</td>
<td>Non-profit</td>
</tr>
<tr>
<td>House of Transformation</td>
<td>24/7 Staff</td>
<td>Privately Owned</td>
<td>Abbott Loop</td>
<td>Yes</td>
<td>Yes</td>
<td>Extensions</td>
<td>Yes</td>
<td>Yes</td>
<td>All</td>
<td>32 beds</td>
<td>Sharese, ext 102, Program Director 907-663-6845</td>
<td>An active house?</td>
</tr>
<tr>
<td>Emmanuel Transitional House</td>
<td>24/7 Staff</td>
<td>Catholic Social Services</td>
<td>Spenard</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Women</td>
<td>32 beds</td>
<td>Melodee, ext 957-6733</td>
<td>Path-based, Hope House is the Female-only ACM residence.</td>
</tr>
<tr>
<td>Clare House</td>
<td>24/7 Staff</td>
<td>Blood and Fire Ministries</td>
<td>Wasilla</td>
<td>Yes</td>
<td>No</td>
<td>1-18 months</td>
<td>No right now</td>
<td>Yes</td>
<td>Women</td>
<td>2 apartments upstairs. 2 girls max to one apartment.</td>
<td>Sherry, Executive Director 907-745-6678</td>
<td>Individual needs to be 30-days sober, this program is more of a job placement program, also helps develop life skills and work skills.</td>
</tr>
<tr>
<td>Knik House</td>
<td>Qualifications</td>
<td>Blood and Fire Ministries</td>
<td>Wasilla</td>
<td>Yes</td>
<td>Yes</td>
<td>3 girls max to one apartment.</td>
<td>Yes</td>
<td>Yes</td>
<td>Women</td>
<td>2 apartments upstairs. 2 girls max to one apartment.</td>
<td>Sherry, Executive Director 907-745-6678</td>
<td>Individual needs to be 30- days sober, this program is more of a job placement program, also helps develop life skills and work skills.</td>
</tr>
<tr>
<td>Sarah's House</td>
<td>M-F 8 AM - 4 PM</td>
<td>Blood and Fire Ministries</td>
<td>Wasilla</td>
<td>Yes</td>
<td>No</td>
<td>4 apartments upstairs. 2 girls max to one apartment.</td>
<td>Yes</td>
<td>Yes</td>
<td>Women</td>
<td>2 apartments upstairs. 2 girls max to one apartment.</td>
<td>Sherry, Executive Director 907-745-6678</td>
<td>Individual needs to be 30- days sober, this program is more of a job placement program, also helps develop life skills and work skills.</td>
</tr>
<tr>
<td><strong>Generally 2 people per bedroom</strong></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Appendix M

Flow Charts:

(a) Initial Intake/Screening and Assessment

(b) Flow Chart: Institution-Based Case Management Program

(c) Flow Chart: Community-Based Case Management Program
Initial Screening, Assessment, and Admission

Forms Needed for Initial Screening:

- One-page referral form for case management services
- One-page referral form for Therapeutic Court

DOC determines if candidate meets program criteria and assists with form submission

If pre-sentence, possible court diversion

Initial one-page referral form for services sent to case management agency

Case manager conducts screening with candidate for readiness

If not admitted to program

If admitted

Case manager meets with candidate, explains denial and refers to other relevant programs

Candidate begins program

Candidate begins court diversion program, receiving case management services from program as needed

Candidate is referred for institution-based case management services

TC reviews form, determines appropriate court program & sends full application to DOC

DOC assists candidate with full application and submission to TC

If admitted to TC

If not admitted to TC

Initial one-page referral form sent to Therapeutic Court (TC)
Appendix N

National Commission on Correctional Health Care Position Statement:
Breastfeeding in Correctional Settings
POSITION STATEMENT

Breastfeeding in Correctional Settings

Introduction

Breastfeeding has well-established physical and psychological benefits for newborns and mothers, and enhances long-term bonding. A woman’s breast milk supply relies heavily on being able to continue to produce milk, either through direct feeding or expressing milk. Although the logistical constraints of correctional settings pose challenges for breastfeeding, there are many ways to make breastfeeding possible. The National Commission on Correctional Health Care supports and recommends making accommodations for nursing women in custody, including at short-stay facilities, that will enable them to maintain their breast milk supply.

Acceptance of the medical and social importance of breastfeeding has become more widespread, and the Fair Labor Standards Act (29 U.S. Code 207) now requires employers in community workplaces to provide reasonable break time and clean, private space (excluding a bathroom) for an employee to express breast milk for her nursing child for 1 year after the child's birth each time the employee needs to express milk. These laws also apply to employees working in correctional facilities. This accepted community and legal standard for employees highlights the importance of making accommodations for postpartum inmates who wish to breastfeed.

This position statement addresses the unique issues surrounding breastfeeding for postpartum inmates in correctional settings.

Background

The majority of incarcerated women are of reproductive age. Some women enter jails, prisons, and juvenile facilities already pregnant and then give birth while in custody, and others have recently given birth and are breastfeeding their infants. While postpartum women represent a small proportion of the incarcerated population, they and their newborns have unique needs that the correctional facility should address. One of those needs is accommodating breastfeeding for postpartum women who want to provide their infants with breast milk.

Breastfeeding and breast milk have many short-term and long-term benefits for both the infant and the mother. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend exclusive breastfeeding for the first 6 months of life, except in women with medical or physical conditions that prohibit breastfeeding, then introduction of other foods along with breast milk until at least 12 months (American Academy of Pediatrics, 2012). The Agency for Healthcare Research and Quality conducted a comprehensive analysis of scientific literature that concluded that, compared to infants fed commercial formula, breastfed infants have fewer incidents of respiratory tract infections, ear infections, GI tract infections, necrotizing enterocolitis, sudden infant death syndrome, infant mortality, allergic disease, celiac disease, obesity, diabetes, childhood leukemia, and lymphoma (Breastfeeding and Maternal and Infant Health Outcomes, 2007).

For the mothers, improved health outcomes include less postpartum blood loss, less postpartum depression, and greater postpartum weight loss (American College of Obstetricians and Gynecologists [ACOG], 2013). Breastfeeding is also protective against later development of breast and ovarian cancer, cardiovascular disease, diabetes, and other conditions (ACOG, 2013). Psychological benefits include improved bonding between mother and child, which is particularly important when the mother is incarcerated (ACOG, 2013).
Whether or not they are breastfeeding, postpartum women may experience several breast-related medical issues that correctional health staff must be prepared to address. For instance, pain from breast engorgement, blocked milk ducts, and mastitis may require frequent breast milk expression as part of medical care.

There are very few contraindications to breastfeeding. Many women in custody have substance use disorders. Breastfeeding is safe and encouraged for women who are taking methadone or buprenorphine as there are benefits to their infants. However, breastfeeding is discouraged among women who are actively using illicit substances. Breastfeeding is also safe for women with hepatitis C, but is not recommended for HIV-positive women (American Academy of Pediatrics, 2013). Most common medications are safe with breastfeeding, although women should consult with their providers. While smoking is not a contraindication to breastfeeding, it can reduce a mother’s milk supply. In addition, exposure to tobacco smoke is harmful to children.

Proper nutrition is essential for breastfeeding mothers. They should receive a well-balanced diet with additional calories, calcium, vitamin D supplementation, prenatal vitamins, no more than three cups of caffeinated beverage per day, and increased fluid intake.

**Facilitating Breastfeeding in Custody**

Correctional facilities can enable postpartum women to provide breast milk for their infants in numerous ways, all of which require collaboration among medical and custody staff, and, in some cases, social services. One way is to allow women to have contact visits with their newborns as often as possible and with appropriate privacy so that they can directly breastfeed them. Skin-to-skin contact is an important factor in breast milk supply and also is psychologically important to maintain bonding and commitment to breastfeeding. Some prisons and jails have special nursery programs where newborns reside with their mothers, enabling full breastfeeding. Some facilities create systems so women can pump and store breast milk that can later be delivered to the infant. If it is not possible to store the breast milk, at a minimum, lactating women should be allowed to pump breast milk so that they can maintain their milk supply for when they are reunited with their infants. This is especially important in short-stay facilities.

To enable pumping and storage of breast milk, facilities need to acquire the appropriate equipment, allow women to pump frequently in a private and clean space, devise protocols for appropriate handling and storage of milk, and coordinate transfer of breast milk to infant caregivers. If a woman is released and has milk in storage, it should be provided to her upon release. Because breast milk supply is highly sensitive to the frequency of expressing breast milk, women should be able to pump or nurse at least every 4 hours.

**Position Statement**

Wherever possible and not precluded by security concerns, correctional facilities that house pregnant and postpartum women should devise systems to enable postpartum women to express breast milk for their babies and to breastfeed them directly.

The following practices are ways to support this objective:

1. Screen women on entry to determine if they are postpartum and breastfeeding.
2. Counsel pregnant women on the benefits and nutritional needs of breastfeeding and inform them of the systems and supports in place at the facility.
3. Provide breastfeeding women with a special diet with appropriate caloric, fluid, calcium, and vitamin D intake. Prenatal vitamins offer a convenient way to provide essential nutrients that are often missing from correctional diets.
4. Allow immediately postpartum women to breastfeed their babies and have lactation support services from the hospital.

5. Support visiting arrangements that allow direct contact between infants and mothers.

6. Provide accommodations to express breast milk, since regular breastfeeding on infant demand is rarely feasible for women in custody. Accommodations may include providing a manual or electric breast pump and storage bags, a private place to pump on a frequent basis, a freezer, and a system for proper storage of the breast milk and, when possible, transfer to the infant.

7. Establish nursery programs or alternative programs for postpartum women that will allow the infants to stay with their mothers, making breastfeeding much easier.

8. Develop an arrangement for lactation specialist services to provide support to women who need it.

Adopted by the National Commission on Correctional Health Care Board of Directors November 5, 2017; revised April 2018

References


Appendix O

National Commission on Correctional Health Care Position Statement:
Women’s Healthcare in Correctional Settings
POSITION STATEMENT

Women’s Health Care in Correctional Settings

Introduction
In 2017, women represented 15% of adults in jails and 7% of adults in prisons in the United States (Bronson & Carson, 2019; Zeng, 2019). While the number of incarcerated males has steadily declined, the number of incarcerated females continues to rise. Women have gender-specific health needs that correctional facilities must address. Rates of substance use disorder, prior trauma and abuse, mental illness, and sexually transmitted infections (STIs) are high among incarcerated women, and higher than those of incarcerated men, and these factors intersect with various adverse social determinants of health that characterize their preincarceration lives (Sufrin et al., 2015). Moreover, the majority of incarcerated women are younger than 45 (Bronson & Carson, 2019) and therefore have specific reproductive health needs. Research on the provision of gynecologic and other women’s health care services for incarcerated females is limited, but what does exist has identified neglect of their gender-specific health care needs (Sufrin et al., 2015). This position statement addresses some of the unique health care needs of women in correctional settings.

Background

Gynecological
Research has documented that incarcerated women tend to have higher rates of gynecological conditions, such as irregular menstrual bleeding and vaginal discharge, than nonincarcerated women, and may have had limited access to gynecologic care prior to incarceration. For instance, the chronic stress that characterizes the lives of many incarcerated women, including factors such as unstable housing, poverty, exposure to trauma and violence, addiction, and mental illness, may influence menstrual bleeding. In one study, up to 40% of incarcerated women had abnormal menstrual bleeding (Allsworth et al., 2007). Although the majority of incarcerated women are young and therefore menstruating, their access to menstrual hygiene products is inconsistent and often inadequate (Kravitz, 2019).

To optimize care, a thorough gynecologic history should be collected at intake; standard elements should include menstrual history, sexual activity, prior STIs, prior diagnoses of pelvic pain or fibroids, prior breast and cervical cancer screening, and contraception history. It should also inquire about current symptoms such as vaginal discharge, bleeding, and pelvic pain, and whether the woman has had unprotected sex with a man within the last 5 days (to assess the need for emergency contraception). The U.S. Preventive Services Task Force (USPSTF; 2017) has determined that evidence is insufficient to recommend routine pelvic examinations on asymptomatic, nonpregnant women. Therefore, pelvic exams must be done only when indicated, such as when a woman has symptoms of pain, abnormal bleeding, or discharge, or when cervical cancer screening is due. If a pelvic exam is indicated, health care providers should incorporate a trauma-informed approach (see, for instance, the Reproductive Health Access Project, 2015).

Trauma, Substance Use, and Mental Illness
Incarcerated women have high rates of mental illness and substance use disorders, which are often inadequately treated in the community. In prisons, 66% of females had a history of a mental health
diagnosis compared to 35% of males (Bronson & Berzofsky, 2017). Similarly in jails, 68% of females had a history of a mental health diagnosis compared to 41% of males (Bronson & Berzofsky, 2017). In state prisons, 69% of females met criteria for drug dependence or abuse (using DSM-IV criteria; Bronson, Stroop, et al., 2017).

The prevalence of histories of sexual, physical, and emotional trauma, including intimate partner violence, among incarcerated women is also astoundingly high, as high as 90% in one study (Lynch et al., 2012). Trauma and victimization may relate to women’s involvement in the criminal justice system, and incarceration itself may retraumatize some of these individuals. Such histories can lead to lifelong mental health issues, such as depressive disorders, stress disorders, anxiety disorders, learning problems, substance use disorders (with their attendant physical health problems), and behavioral problems. Screening for traumatic histories can help identify women who need treatment and other resources, and should be done for all women entering correctional facilities. Correctional health staff should be trained in trauma-informed care and be aware of appropriate referrals for those with a positive screen. Importantly, pelvic and breast exams can be retraumatizing for people with a history of sexual trauma and should be done only when clinically indicated.

**Breast and Cervical Cancer**

Rates of cervical and breast cancer are higher among incarcerated women, likely related to under-screening both before incarceration and while in custody (Brousseau et al., 2019; Pickett et al., 2018). Most cervical cancers are preventable with appropriate screening via Pap smears and HPV testing. The American College of Obstetricians and Gynecologists (ACOG; 2018) recommends screening all females ages 21 to 29 every 3 years, and those ages 30 to 65 every 3 to 5 years. Immunocompromised women and those with history of cervical dysplasia should have more frequent screening, per national guidelines. Importantly, abnormal Pap smear results must be followed up appropriately, which often means colposcopy. Correctional facilities should not routinely perform Pap smears upon intake, unless the woman is due for one based on previous screening, nor annual Pap smears for women serving long sentences. The Centers for Disease Control and Prevention (CDC; n.d.) recommends HPV vaccination through age 26 to reduce cervical cancer risk, and this can be implemented in correctional settings.

National guidelines for screening mammograms for women of average risk should be followed in correctional settings. ACOG (2017a), USPSTF (2016), and the American Cancer Society (ACS; 2019) all have evidence-based guidelines that differ based on the age of initiation of mammograms, screening intervals, and the role of shared decision making. Correctional facilities should decide on one set of guidelines to follow. Recommendations on screening clinical breast exams also vary, with USPSTF and ACS recommending against it and ACOG recommending annual exams beginning at age 40. As with avoiding unindicated pelvic exams due to lack of benefit and potential to retraumatize women, breast exams for asymptomatic women should not be part of routine intake/exam procedures. Women with known personal or familial risk for breast cancer who are serving long sentences should also undergo screening and diagnostic imaging according to national guidelines (Society of Gynecologic Oncology, 2017).

Follow-up of abnormal pap smear or mammogram results may present challenges in short-stay facilities as women may be released before results are returned. Tracking systems and contact with community health providers may facilitate postrelease cancer prevention and diagnosis.
**Sexually Transmitted Infections (STI)**

A common reported symptom among women in custody is vaginal discharge, which may be related to higher rates of STIs, nonsexually transmitted bacterial vaginosis, or physiologic discharge that women may not be aware can be normal. To distinguish among these diagnoses, women with symptoms should undergo appropriate testing. Women entering correctional facilities have high rates of STIs: A Rhode Island study found that 33% of women tested positive for an STI at admission, including 26% with trichomoniasis (Willers et al., 2008). Rates of gonorrhea as high as 3% (Javanbakht et al., 2014) and chlamydia as high as 14% (Willers et al., 2008) have been reported. The prevalence of HIV among incarcerated women was 1.3% in 2015 (Maruschak & Bronson, 2017).

Based on this high prevalence, the CDC recommends that all females age 35 or younger receive screening for gonorrhea and chlamydia at intake to a correctional facility (Workowski & Bolan, 2015). Vaginal NAAT testing has the highest accuracy and women can collect this as a self-swab. Urine testing, while less accurate, is easier to collect and may be appropriate when vaginal swabs cannot be feasibly collected. Given the trauma that pelvic exams can cause, pelvic exams for the sole purpose of GC/CT testing should be avoided. Women in custody should also be screened for HIV and other STDs in accordance with CDC guidelines (Workowski & Bolan, 2015).

**Family Planning**

Incarcerated women generally have had limited access to contraceptive services in the community and have high rates of prior unintended pregnancy (Clarke, Herbert, et al., 2006; LaRochelle et al., 2012). A study in Rhode Island showed that only 28% of sexually active women had consistently used birth control in the 3 months prior to incarceration; 85% of these women planned to be sexually active upon release, yet only 9% reported wanting to be pregnant (Clarke, Herbert, et al., 2006). In this same setting, nearly half of the pregnant inmates had become pregnant in between incarcerations (Clarke et al., 2010). Moreover, 60% of incarcerated women who could become pregnant upon release wanted to start a method of contraception while in jail (LaRochelle et al., 2012). Despite this need for contraception among incarcerated women, in a national study of correctional health providers only 38% reported that contraceptive methods were available on-site and 55% said that women could not continue using their current method of contraception (Sufrin et al., 2009). In another study, nearly one-third of women entering jail had had unprotected sex within the last 5 days and could therefore be candidates for emergency contraception (Sufrin et al., 2010).

Research has documented the feasibility in a variety of correctional settings of offering the full range of reversible contraceptive methods, including pills, injectable contraception, intrauterine devices, and implants (Sufrin et al., 2017). However, given the potential for women to experience diminished autonomy and coercion in correctional settings, care should be taken when providing long-acting reversible contraceptive methods, which require a provider to insert and remove the device. Likewise, especially given documented recent abuses in prisons, and in accordance with ACOG guidelines, sterilization should generally not be performed on incarcerated people (ACOG, 2017b). Incarceration is also a time to help women who want to become pregnant after release. These women should receive preconception counseling that focuses on the risks of substance use, improving nutritional status such as folate supplementation, and optimizing physical and mental health (ACOG, 2012).
Aging and Chronic Disease
Many prisons may be failing to recognize and prepare for the special physical, preventive health, social, and psychological needs of older females (Reviere & Young, 2004), such as menopausal hot flashes, which can be challenging for women to manage in the correctional environment. Incarceration also has been linked to greater prevalence of hypertension, hepatitis, and cancer in women when compared to men, which indicates a need for better health care resources for older females (Binswanger et al., 2009).

Nutrition and Diet
Correctional institutions should ensure that women across all life stages receive a healthy diet consistent with federal dietary and nutrient guidelines (U.S. Department of Agriculture [USDA], 2020). Obesity is more common among incarcerated women (37%-43%) compared to incarcerated men (20%-27%; Maruschak et al., 2015). While the USPSTF has concluded that evidence is insufficient to recommend routine calcium and vitamin D supplementation to prevent fractures in community-dwelling women, they do not make recommendations for women in institutional settings; diets for women in correctional settings should have adequate calcium and vitamin D, following recommendations from the USDA and the National Academies (n.d.).

Pregnancy, Postpartum, and Parenting
Some women enter correctional settings pregnant. Sexually active women remain at risk for pregnancy until they go through menopause or have a hysterectomy. Correctional facilities should screen all women for pregnancy with a history, and offer urine testing to all females under age 50 within 48 hours of arrival. There is a dearth of data on pregnancy frequency and outcomes for people in custody, but a 2019 study reported that a total of 4% of women admitted to 22 state and all federal prisons were pregnant, and that 753 women gave birth in custody (Sufrin, 2019). Additionally, most incarcerated women are mothers and the primary caregivers to young children, ranging from 56% in federal prisons to 70% in local jails (Glaze & Maruschak, 2010). Facilities should support efforts for women to provide breast milk for their infants and to maintain contact with their children, and should recognize the psychological difficulties that separation may cause to incarcerated mothers and their families.

Correctional facilities must provide pregnancy and postpartum care in accordance with community standards of care and national guidelines. More information about pregnancy and postpartum care and nutrition in corrections, the nonuse of restraints in pregnancy, and promoting breastfeeding is available from NCCHC through the following resources:
• Pregnancy and Postpartum Care (white paper)
• Restraint of Pregnant Inmates (position statement)
• Breastfeeding in Correctional Settings (position statement)

Standards
NCCHC recognizes that incarcerated women have gender-specific health care needs that correctional facilities must address. In the Standards for Health Services (the basis of NCCHC’s accreditation program for jails, prisons, and juvenile detention and confinement facilities), standards that impact women’s health care include the following:
• Receiving Screening (E-02) requires inquiry into current and past illnesses, health conditions, and special health requirements; this would encompass current gynecological problems and pregnancy status for women and female adolescents.
• Initial Health Assessment (E-04) recommends that clinical practice guidelines be followed for pelvic examinations and Pap smears.

• Medically Supervised Withdrawal and Treatment (F-04 for adults) and Intoxication and Withdrawal (G-07 for juveniles) acknowledge the special management of pregnant patients with opioid use disorders.

• Contraception (B-06 for adults) and Contraception and Family Planning Services (G-08 for juveniles) recommend providing nondirective contraception counseling and methods, access to emergency contraception, and, along with Medication Services (D-02 for adults), continuation of current contraceptive method while incarcerated.

• Counseling and Care of the Pregnant Inmate (F-05 for adults) and Counseling and Care of the Pregnant and Postpartum Juvenile (G-09) specify that comprehensive counseling and assistance are given to pregnant individuals in keeping with their express desires in planning for their unborn children, whether they desire abortion, adoptive service, or to keep the child. It also addresses prenatal care and the nonuse of restraints during childbirth.

• Response to Sexual Abuse (F-06 for adults) recommends that emergency contraception is available.

Position Statement

NCCHC recognizes that the number of incarcerated females is large and growing annually, presenting unique issues for health services. Therefore, NCCHC recommends the following:

1. Correctional institutions must meet recognized community standards for women’s services as promoted by standards set by NCCHC.

2. Correctional health services, community clinicians, and advocacy groups can collaborate to provide leadership for the development of policies and procedures that optimize women’s gender-specific health care needs in corrections, and to do so in trauma-informed ways.

3. Correctional institutions should provide comprehensive services for women’s unique health issues:
   a. Follow age-appropriate screening guidelines established by national organizations for STD screening, breast and cervical cancer screening, and HPV vaccination.
   b. Implement intake procedures that include histories on menstrual cycle, prior pregnancies, gynecologic problems, STI risk factors, HPV vaccine history, current and prior contraception use, current breastfeeding, and history of sexual and physical abuse.
   c. Offer a pregnancy test within 48 hours of admission to all females who could be pregnant—i.e., those who are sexually active (until they go through menopause or have a hysterectomy).
   d. Screen all women at entry for sexual and physical trauma histories and refer for services as indicated; do not perform routine pelvic and breast exams on asymptomatic women as this is medically unnecessary and may be traumatizing.
e. Make trauma-informed, gender-appropriate counseling and treatment available for all women, especially those with mental health issues.

f. Make counseling and treatment available for women with alcohol and other substance use disorders.

g. Recommendations for contraception and pregnancy planning:
i. Allow women to continue contraceptive methods they are already on pre-incarceration, especially if their incarceration is short term or if the method is for noncontraceptive reasons.

ii. Offer contraception counseling and access to initiating reversible methods of contraception methods in a noncoercive manner, especially in preparation for release.

iii. Screen for eligibility for emergency contraception at intake and make such contraception available in a timely fashion.

iv. Defer sterilization until release.

h. Address the unique health care needs of older women, including symptom management and treatment of menopausal hot flashes.

i. Provide individuals with access to an appropriate, no-cost supply of menstrual hygiene products.

4. Correctional institutions should provide comprehensive sexual and reproductive health education to females that includes education about topics such as STIs, normal and abnormal vaginal discharge, and family planning.

*Adopted by the National Commission on Correctional Health Care Board of Directors: September 25, 1994
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**References**


Appendix P

Proposed Elements to be Included in a Memorandum of Understanding (MOU)
Appendix P: Proposed Elements to Be Included in an Interagency MOU

Organizations to be included in an interagency MOU:

- Alaska Court System, Therapeutic Court Program
- Department of Corrections
- Case Management Agency (Cook Inlet Tribal Council, Alaska Native Justice Center, Partners for Progress, Alaska Youth and Family Network, etc.)
- Hiland Mountain Correctional Facility
- Providence Alaska Medical Center Nurse-Family Partnership Program (if relevant)
- Southcentral Foundation Nutaqsiviik Nurse Family-Partnership Program
- Southcentral Foundation, OB-GYN’s, pediatricians, etc.
- Other relevant community-based providers, such as Cook Inlet Tribal Council Recovery Services, Southcentral Foundation, Alaska Behavioral Health
- Trauma-focused therapy provider

Content to include in an interagency MOU:


- Role and responsibility of each participating agency as they relate to the project, including what data each will collect and how and when it will be shared.

- Entity or entities responsible for conducting initial intakes and assessments, required credentials of the individual assessors, location where intakes and assessments will be stored, and who will have access to the documents.

- Referral process, including expectation of timeframes, between:
  - DOC and Therapeutic Court.
  - DOC and case management agency.
  - Case management agency, DOC, and care agencies (Nurse Family-Partnership, mental health, substance abuse treatment).
Agencies that will participate in Institution-Based Treatment and Support Team and Reentry Transition Team meetings, which are defined in the Planning Guide and Implementation Report.

Policies and procedures regarding information sharing and confidentiality.

Screening process and policies regarding entry of case managers and peer supports into DOC facilities for in-reach, including special procedures for case managers and peer supports with criminal histories.

Policies and protocols regarding entry of community-based providers (physical, mental, emotional, substance use, trauma-focused, and traditional healers) into DOC facilities and any necessary screening and/or training they must undergo to obtain clearance.

Policies and protocols for when community members (e.g., child’s caregivers) who are part of the Institution-Based Treatment and Support Team or the Reentry Transition Team are permitted into the facility and any necessary screening and/or training they must undergo to obtain clearance.

Situations when program participants are permitted to exit the facility for treatment, care, and/or to prepare for release, and which agency will be involved in transport and safe return. (Review DOC policies and procedures, Index #818.04 & #807.02 and Form # 807.02E)

Process for conflict resolution between member agencies.

The training requirements representatives from each agency must undergo (e.g., trauma-informed care, criminal justice process, assessment forms, project protocols and/or necessary training to obtain clearance for entry into DOC facilities).

Interagency Release of Information, if one is developed, should be attached to MOU.