

Inquiries in Social Policy

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Inquiries in Population Policies

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*The views expressed by each of the authors are strictly their own
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The Heller School for Social Policy and Management

Dear Reader,

As the Heller School for Social Policy and Management celebrates its 50th anniversary year it is wonderful to see our students in the Master of Public Policy program launch this new student directed publication, *Inquiries in Social Policy*. This continues a long tradition of Heller students being actively engaged in the generation of new knowledge that can be used in the practice of social policy and management. The need for a new generation of thinkers in social policy has never been greater. I am sure that after reading these articles, regardless if you concur or not with the viewpoints expressed, you will be left with a strong feeling of hope for our future social policy leaders. Congratulations to our students for this great undertaking.

Best regards,

A handwritten signature in cursive script that reads "Lisa M. Lynch".

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Dear Friends,

As this first edition of *Inquiries in Social Policy* “goes to press,” it is clear that the current recession is increasing the burdens on our most vulnerable populations, as well as others who are finding themselves for the first time in great need. Many across the socio-economic structure are struggling and increasingly seeking for the first time government assistance in the form of unemployment insurance, job training and counseling, food stamps, and housing assistance. At the same time, social services, nonprofits, and government agencies are being forced to scale back programming. This is clearly the time for rethinking socially just policies and programs, grounded in theory, dialogue, and research.

It is our hope that this publication will help to shed some light on five current issues in social policy in a way that highlights the multiple perspectives being cultivated at the Heller School. In the following articles, you will find two different perspectives on re-entry strategies for incarcerated populations and coverage of population concerns that include disability services for adults with autism, the effects of quality care on children, and the role of policy in the well-being of the LGBT community. The papers include M.P.P. Capstone policy analysis papers, as well as research papers exploring new topics for the first time.

The *Inquiries* committee members, select Heller faculty, and staff have all greatly contributed to the launch of this first issue. The committee would like to thank Dean Lisa Lynch, M.P.P. Program Director Michael Doonan, and the new M.P.P. Student Association for their invaluable support and feedback; Jack White, Claudia Jacobs, Alex Rubington, and Sara Haradhvala for their help with the development of our website; and Marji Erickson Warfield, Mary Brolin, and Susan Curnan for their assistance reviewing articles. We also wish to particularly thank Dr. Janet Boguslaw, who served as faculty advisor and provided tremendous guidance and assistance in the production of this publication.

We hope that you enjoy the inaugural issue!

Skye Allmang
M.P.P. '09

Unmanaged Care: The Role of Massachusetts Behavioral Health Partnership in Prisoner Reentry

A. Catherine Hulberg

“Unmanaged Care” explores the responsibility of a Medicaid behavioral health carve-out in prisoner re-entry planning and care. Utilizing the Massachusetts Behavioral Health Partnership (MBHP) as an example, the following policy brief describes the practical, clinical and economic rationales for an expanded and explicit role. Through an exploration of context, a framework is presented upon which three policy options are offered. The concluding recommendation calls for the implementation of all three options, to allow MBHP’s resources to match the variety of clinical needs of returning prisoners.

The Revolving Door Between the Streets and the Cellblock

According to the Executive Office of Public Safety and Security (EOPSS), approximately 20,000 inmates return to communities in Massachusetts each year ill-prepared to overcome the medical, behavioral health and social barriers that face them (2009). Within three years, at least 63 percent are re-incarcerated (EOPSS, 2009). The high rate of recidivism is connected to the lack of investment in coordinated reentry planning, treatment services and rehabilitative programs (EOPSS, 2009; CSG, 2002). The revolving door between the “street and the cell block” adversely impacts public safety and public health; and the rising costs of incarceration consume scarce state resources. With no single agency or entity responsible for reentry planning, efforts to ensure continuity of care are inadequate (Roberts et al., 2002). The demographics of the incarcerated population; their high rates of mental health, substance abuse and/or medical conditions; and their status as offenders, marginalize them from care when they transition home (Roberts et al., 2002; MPHA, 2003; Williams, 2005; Hammett et al., 2002). Taken in concert, these issues speak to the need of managing the care of returning prisoners.

The prison population in Massachusetts tripled between 1980 and 2002, a trend that is not Massachusetts' alone, but part of a national rush to incarcerate, putting 1 in 100 people in the United States behind bars (Brooks et al., 2005; Pew, 2008). Correctional institutions currently serve as de facto public health facilities, in part as a result of the deterioration and deinstitutionalization of public health systems, as well as the criminalization of mental illness, substance abuse and homelessness. The largest mental health institutions in the United States are urban jails, and twice as many seriously mentally ill people receive services in jails and prisons than in public psychiatric hospitals (Wilper et al., 2009; Weisman, 2005). Mental health and substance abuse problems are ubiquitous within correctional facilities across the nation, including Massachusetts (Magaletta and Verdeyen, 2005).

Massachusetts has a dual system of corrections, with a state-run Department of Correction (DOC) and thirteen county-run Houses of Corrections (HOC). The Massachusetts DOC houses 11,100 individuals annually: prisoners serving more than two-and-a-half years, female inmates unable to be housed in county facilities, and people civilly committed for detoxification and substance abuse treatment (Marshall, 2008). County HOCs house an estimated 16,500 inmates annually, accounting for 92 percent of Massachusetts' incarcerated population (MSC, 2004; MA DOC, 2009). On average, HOC inmates serve 8.5 months, with no inmate serving more than 36 months (MA DOC, 2009). The overwhelming majority of the 16,500 county inmates return to communities in Massachusetts each year (although annual release numbers are not currently tracked for county facilities) and, in 2007, the DOC released 3,140 inmates "to the streets" (MA DOC, 2008; CJPG, 2005). Within the DOC population, 90 percent of inmates have substance abuse issues and 25 percent have an open mental health case (Marshall, 2008). The rates of substance abuse and mental illness amongst the county inmate population are unknown, but assumed to be similar to those of the DOC population (CJPG, 2005).

Healthcare for Offenders

The Massachusetts Behavioral Health Partnership (MBHP), as the behavioral health carve-out for the typical MassHealth coverage returning prisoners receive, plays a major role in providing services and care for a population disproportionately affected by mental

illness and substance abuse issues. Although MBHP manages high-risk populations, the specific and special needs of ex-offenders place an additional burden on MBHP within an environment of competing mandates and dwindling resources. The task is not MBHP's alone, but requires buy-in from state legislators, the Department of Correction (DOC), county Houses of Corrections (HOC), Medicaid officials, health care practitioners, advocates and the returning prisoners themselves. With carefully crafted and implemented policies focused on the variety of behavioral health needs of the ex-offender population, MBHP can reduce costs, improve outcomes and maintain its reputation for quality care, all while filling a service gap for returning prisoners, their families and their communities.

Currently, Massachusetts policymakers do not know how many inmates across Massachusetts receive any kind of behavioral health treatment during their incarcerations. Nationally, only one-quarter to one-third of inmates with recognized mental health conditions receive treatment while in prison. Among inmates with severe psychiatric illnesses, only half receive services while incarcerated (Beck and Maruschak, 2001; Morgan et al., 2007). Massachusetts also lacks data on how many inmates have a mental and/or substance use disorder but remain undiagnosed while incarcerated. The question is not esoteric, but fundamental in terms of MBHP's ability to plan, both financially and organizationally, for the behavioral health needs of the ex-offender population.

Screening and Assessment

Under Federal guidelines, inmates recognized by correctional staff as needing psychological or psychiatric treatment, either based upon a classifications screen or during their incarceration, receive planning and coordination for such services upon discharge from the facility. As reported by the Department of Justice, an independently administered test of a national sample of inmates found that 63 percent had acute mental illness symptoms that were missed by routine screening performed by corrections staff (DOJ, 2007). Classification screens are intended to identify inmates at acute psychiatric risk and/or inmates in need of medical withdrawal from alcohol and/or narcotics. Screens also rely heavily upon past use of behavioral health services; for the incarcerated population, this is an ill-fitting diagnostic tool (Williams, 2005; Fellner, 2007). Corrections staff are poorly trained to recognize mental disorders in

the milieu, and often misinterpret clinically significant behaviors as being attempts at manipulation (Kupers, 1999). The rule in corrections is that you don't diagnosis what you don't have the resources to treat (Kupers, 1999).

If a significant number of inmates in Massachusetts have undiagnosed mental illness, then those individuals return home without the care they may desperately need. Without a link to community-based services, ex-offenders may misuse emergency room care to treat psychological issues and their resultant problematic behavior, or they may further decompensate, requiring higher levels of care than may have been needed had the right supports been in place. Overall, it can be argued that rates of mental illness and substance use disorders within the Massachusetts' incarcerated population are drastically underestimated. That said, even those who are identified and are most at risk go without comprehensive reentry planning and care coordination. For example, despite the overwhelming behavioral health issues of the DOC population, 2,562 inmates were released to the community in 2006 with only one mental health coordinator responsible for planning their reentry care (Marshall, 2008). HOCs are limited in their ability to provide such planning for the majority of returning prisoners, with Hampden County being the sole exception.

The Transition Home: Reentry Research and Practice

The main forces behind the push towards informed and coordinated reentry planning are the goal of reducing recidivism and issues related to public health. Reducing recidivism is the gold standard for any offender intervention, whether inside correctional facilities or outside in communities. Not only is incarceration costly, averaging approximately \$40,000 per inmate per year, but there are social and emotional costs for individuals, families and communities (CJPG, 2005; Rose and Clear, 2001; Williams 2006). The cycle in and out of prison, especially from and to disadvantaged neighborhoods, decreases public safety, increases violence and places unfair demands on overburdened systems of care within such communities (Williams, 2005; Williams, 2006; Rose and Clear, 2001, Sullivan, 20089; Brooks et al., 2005). However, focusing on reduced recidivism as the sole rationale for outpatient

behavioral health services in reentry care is dangerous given the weak causal links found in the research (Lovell et al., 2002; Magaletta et al., 2007, Sullivan et al., 2007).

Issues of public health arise from the fact that inmates are disproportionately infected with communicable diseases and affected by chronic diseases (Williams, 2005). Research shows that returning prisoners are linked to increased rates of HIV/AIDS, especially among African-American women, and increased rates of other infectious diseases like Hepatitis C (Williams, 2005; Miller 2007; Adimor et al., 2006; Hammett et al., 2002). The relationship between inmate behavioral health and public health is primarily experiential, although studies show public health benefits associated with intensive substance abuse treatment (Chandler et al., 2004; Melnick and Taxman, 2007). Across the board, the research is clear on the need for coordinated physical, mental and behavioral health reentry planning and care, in conjunction with support services around issues of housing and employment (Lynch and Sabol, 2001; Bazelon, 2002; Travis, 2000; Travis et. al., 2001).

Research on recidivism and Medicaid coverage for seriously mentally ill detainees (people held but not incarcerated) showed benefits for both the criminal justice and mental health systems, the report warned against generalizing the findings to the inmate population (CSG, 2007). However, as stated by the Massachusetts Public Health Association “without health care coverage, access to community programs, and assistance and support with reintegration, the criminal justice population’s illnesses will worsen, posing an increased health and safety threat to the communities to which they return (2003, p. 5).” The timing of health insurance coverage for returning prisoners is critical. Although county HOC inmates - who have on average of a fifth grade reading level – submit a MassHealth application once released, this disconnect and delay is counterintuitive to good health practice and to Massachusetts' commitment to outreach and access (CJPG, 2005). Timing is also important in terms of reducing recidivism. The first year after release is a critical period during which former prisoners are susceptible to reoffending (Brooks et al., 2005). For returning prisoners with mental illness and/or substance use disorders, insurance coverage at the time of release is vital to obtaining psychological/psychiatric services in the community. Without access to services, ex-offenders with mental illness and/or substance use disorders are left with limited options,

and are more at risk for recidivism than ex-offenders who do not have mental disorders (Bazelton, 2002; CSG, 2005; Travis, 2000).

Eligible but Uncovered

Currently the Division of Health Care Finance and Policy (DHCFP) mandates that a correctional facility may not be used as an address when applying for MassHealth and that benefits be cut after an inmate serves thirty days. Through a pilot program between the DHCFP and the DOC, a waiver allows the majority of eligible DOC inmates to have MassHealth Essential coverage (and a card in hand) at the time of release. The DOC and the DHCFP made great strides in improving access to MassHealth coverage for all DOC inmates and was nominated by the Council of State Governments for an Innovations Award because of their combined efforts (Marshall, 2008). The waiver, however, does not cover the majority of returning prisoners – those in county HOCs, and cannot ensure coverage even for DOC eligible inmates. For example, in 2006 the DOC submitted 2,656 MassHealth applications, 1,273 inmates were covered at the time of their release, and 1,383 inmates were placed on a waiting list for coverage (MBHP, 2006). Even if the DHCFP waiver were extended to include county HOCs, there is an enrollment cap for MassHealth Essential coverage. In 2006, CMS approved an increase from 44,000 to 60,000 enrollees; however 10,800 eligible applicants were placed on a waitlist that same year (MBHP, 2006).

MassHealth Essential covers adults without dependent children who meet income eligibility guidelines and automatically enrolls those covered into MassHealth's Primary Care Clinic (PCC) plan, with MBHP as the behavioral health carve-out. Unlike MassHealth Standard, in which enrollees can choose among a few managed care plans with differing behavioral health coverage schemes, enrollees in MassHealth Essential cannot change their plan. Therefore, many ex-offenders have no choice regarding their insurance plan, and MBHP is solely charged with managing their mental health needs. The challenge is then twofold: including county HOCs in the waiver and closing the enrollment gap for MassHealth Essential. Insurance coverage for this population is fundamental, but is not within itself enough to bring about the positive outcomes associated with comprehensive reentry planning and care.

A Rational Role for MBHP

Little is known nationally about the role of a Medicaid behavioral health carve-out in reentry planning and care, despite the research around the importance of coverage and access to substance abuse and/or mental health services (Morrissey, 2004; Lynch and Sabol, 2001; Lovell, 2008; CSG, 2005). MBHP can continue to demonstrate its progressive approach to caring for vulnerable populations by becoming the leader in this arena. Given the “skill set” of MBHP in providing clinically appropriate care to high-risk populations, a specialized focus on returning prisoners is a natural extension of what MBHP already knows how to do, and for which it is well regarded. In fact, MBHP is already serving returning prisoners, both intentionally and by default. With regard to the former, in 2005 MBHP completed a performance incentive project for health care service providers involving returning prisoners. MBHP set up a system linking MassHealth eligible prisoners with Community Support Persons (CSPs) and outpatient services. The health care service provider agencies operating CSP programs and local reentry centers are now independently running the program after MBHP established the connection through the incentive project. Given that the incentive project was not, and is not, a part of MBHP’s contract requirements with MassHealth, the project signals MBHP’s awareness of the service needs of returning prisoners, as well as the potential benefits of such service (Stelk, 2009). To that end, expanding MBHP’s role in reentry planning and care is practically viable, given that it has already invested financial resources in such initiatives.

MBHP also provided enhanced service provision to returning prisoners by default through a medical care management program. Known as EssentialCare, the program was available to members enrolled in MassHealth Essential and was created in response to the high utilization rates and undertreated conditions endemic in many Essential plan members. The program is no longer part of MBHP’s case management services, but consisted of twelve dedicated field-based licensed case managers that served 500 members by providing integrated care coordination and outreach (MBHP, 2006). The characteristics of the referred members included: frequent utilization of services, misuse of emergency room services, a history of noncompliance with treatment, high rates of poverty, a

chronic disease burden and predicted high medical costs (MBHP, 2006).

Although ex-offender status was not a part of the data collected for the EssentialCare program - making it difficult to know the number of involved members with a history of incarceration - many returning prisoners share these characteristics (Watson, 2000). It is conceivable that MBHP was already providing intensive care coordination to returning prisoners through the EssentialCare program without its explicit knowledge. The performance incentive project and the EssentialCare program, combined with the unknown ex-offender beneficiaries of MBHP's other care management programs, suggests that MBHP should take a decisive role for in reentry planning and care. In other words, MBHP is aware of the specialized need for care management for ex-offenders and can build off of existing practices and programs.

If the repeated legislative effort to require that all eligible returning prisoners have MassHealth at the time of discharge passes (an issue addressed later within this brief), MBHP will see a dramatic increase in its members. It is a fundamental benefit for any managed care organization to be able to plan for how many members will enroll, when, and with what kind of utilization rates and needs. MBHP will also face an influx of members who experience higher rates of medical, mental health and substance abuse issues than the general population, as well as significant barriers in regard to housing, public assistance and employment. MBHP will benefit from proactively planning for the enrollment of returning prisoners by putting in place utilization management strategies and effective care management programs to offset the risk and burden associated with this population. Moreover, given its commitment to quality care and best practices, several clinical rationales exist for MBHP to proactively coordinate and attentively manage the behavioral health needs of ex-offenders.

Decrease in Corrections Supervision

First, increasing numbers of prisoners are being "released to the streets" without the benefits of probation/parole, an issue highlighted by the Governor's Commission on Criminal Justice Intervention (EOPSS, 2009). The proportion of prisoners released from DOC facilities under supervision decreased from 80 percent in 1980 to 33 percent in 2002 (Brooks et al., 2005). The function of

probation/parole departments in requiring, referring and/or tracking behavioral health treatment for ex-offenders is lost when prisoners are released without supervision. The concern for MBHP is that this function provided some form of a safety net for high-risk ex-offenders by creating de facto case management. The conceivable negative consequences of the loss of this benefit include: delays in accessing treatment, lower retention rates in treatment and declines in mental health status and functioning. For MBHP to mitigate these consequences, it needs to fill the case management gap created by the waning role of parole/probation departments across the state.

Challenges of Reentry Environment

Second, the majority of prisoners return to disenfranchised, disadvantaged and under-resourced communities. A 2005 research report by the Urban Institute on prisoner reentry in Massachusetts found that the highest number of released prisoners return to Suffolk County, and are heavily concentrated in neighborhoods in Boston with the highest rates of poverty and unemployment in the state (Brooks et al., 2005). Worcester County is home to the second largest number of returning prisoners, with Worcester and Suffolk counties accounting for more than one third of Massachusetts' ex-offender population (Brooks et al., 2005; CJPG, 2005). The issue for MBHP is that health care service providers, organizations and agencies within these communities are ill-equipped to meet the exceptional needs of ex-offenders given the overwhelming demand and need for services within these communities as a whole. The ability to proactively plan for the treatment needs of returning prisoners not only improves their clinical outcomes, but may also result in collateral benefits for the communities in which they live.

Health Effects of Incarceration

The third rationale encompasses research related to the beneficial and harmful health effects of incarceration itself. A report on correctional health by the Massachusetts Public Health Association (MPHA) found that the majority of inmates across the state do not receive regular medical or mental health care prior to incarceration. Studies found that the health status of many inmates improved as a result of the medical care received while incarcerated, gains that are lost when inmates are released without coordinated reentry planning (Wilper et al., 2009). For example, a

study using self-reported data by the Hampden County Jail found that general health and emotional functioning improved from the time of intake to shortly after release (Lincoln and Conklin, 2002). However, it is important to note that Hampden County employs a public health model of correctional care that is exceptional and is not replicated in any other state or county facility.¹ If incarceration is a period of intervention that improves physical and mental health status for many inmates, then it is in-line with best practices to ensure continued services in the community to support and strengthen such gains.

Research also shows that incarceration negatively impacts the physical and behavioral health of inmates (Wilper et al., 2009; Massoglia, 2008). A study exploring the association between incarceration and health found that a single episode in prison had a much larger relationship with poor health than current drug use (Schnittker and John, 2006). Dr. Kupers, author of *Prison Madness: The Mental Health Crisis Behind Bars* (1999), writes of the decline in mental health functioning for inmates as a result of the harshness and brutality of correctional facilities themselves. Moreover, Dr. Kupers (1999) notes that the inability and/or unwillingness of correctional staff to recognize signs of emotional distress and decline in inmates (those who may or may not have had a previously diagnosable disorder), leads to inmates being released with untreated acute mental illness. For a population already disproportionately affected, the heightened prevalence and severity of behavioral health issues caused by incarceration is justification for intensified and coordinated care upon release.

The transition process from prison, a very controlled and regulated environment, to the community has implications for mental health functioning. "Gate fever," a syndrome defined by anxiety and irritability, is widely recognized by those working with returning prisoners. The limited research on this syndrome found that it is not ultimately debilitating, but when coupled with the documented ineffective and destructive coping mechanisms of released offenders, can adversely impact mental health status and functioning (Travis et al., 2001; Zamble and Porporino, 1997). By providing assistance at the moment of release, an opportunity is created to build a bridge to the kinds of health and social services that can support healthy and effective coping mechanisms while reducing symptoms of anxiety.

The moment of release is also a critical time to ensure that inmates with substance abuse issues, who may have experienced a significant period of abstinence during their incarceration, receive the support and services needed to sustain recovery. In the absence of treatment, rates of relapse following release from prison are strikingly high. It is estimated that two-thirds of untreated heroin abusers resume their patterns of use and criminal behavior within three months of release (Wexler et al., 1998). The clinical and social consequences of substance abuse are well documented, and with 90 percent of Massachusetts' returning prisoners reporting a substance abuse issue, the need for coordinated care at the time of release is essential (Marshall, 2008; MA DOC, 2009).

Although the specific clinical benefits of coordinated services for returning prisoners in Massachusetts is yet to be studied, an evaluation of the EssentialCare program provided some evidence. As previously discussed, the EssentialCare program provides enhanced care management to MBHP members with characteristics and demographics similar to those of ex-offenders. The Center for Health Policy Research at the University of Massachusetts Medical School evaluated the program in 2005 and found improved outcomes across all domains. Regarding clinical outcomes, EssentialCare members were more compliant with treatment, had improved scores on a standardized measure of mental health functioning and fewer acute and emergency care services. A hybrid care management model like EssentialCare could result in similar positive outcomes for returning prisoners.

Racial Disparities and Quality of Care

The final clinical rationale is MBHP's commitment to quality care as it relates to racial and ethnic health disparities. While only 14 percent of Massachusetts' general population is identified as being "non-white," 57 percent of inmates in DOC facilities, 92 percent of whom are male, are identified similarly (Marshall, 2008). The reality of Disproportionate Minority Confinement (DMC) means that "correctional facilities, as social institutions, will continue to be important in shaping the life-course and health trajectories of Black and Latino men, as well as their families and communities" (London and Myers, 2006, p. 165). By providing enhanced behavioral health services through planning and care coordination to returning prisoners across the state, Massachusetts can work to rectify the racial/ethnic health disparities endured by

prisoners in the past, and counteract the same disparities they face when they return home.

Effective Use of Resources

For any behavioral health carve-out, clinical goals related to prevention, intervention and coordination are also associated with the managing of costs and the efficient use of resources. The same holds for MBHP, as many improvements in clinical outcomes result in financial savings. The risk-pool of MBPH behavioral health members is already highly skewed. Eligible returning prisoners who are able to access and retain coverage are already included amongst MBHP's members, although efforts to expand coverage at the time of release may increase the financial risk of MBHP under its current contract with the Massachusetts' Medicaid program. The difficulty in detailing the economic implications and rationales lies in what is unknown about the utilization patterns of ex-offenders in Massachusetts. Concrete conclusions cannot be drawn; however, inferences are possible through the application of research conducted on similar populations.

The only available information regarding health services utilization by ex-offenders in Massachusetts is a survey of inmates at the Hampden County Correctional Center (HCCC). The survey found that 80 percent of chronically ill inmates did not receive regular health care prior to incarceration and many used local hospital emergency rooms as their primary care practitioner (MBHA, 2003). The Massachusetts Public Health Association (MBHA) cited this survey during testimony before the Massachusetts' Senate in support of insurance coverage at the time of release. According to the MPHA, insurance coverage, access to primary care and care coordination after release, will result in "cost savings of fewer emergency room visits requiring expensive medical intervention from advanced and untreated illness" (MBHA, 2003, p. 3). The inappropriate use of expensive health services pre and post incarceration can be legitimately generalized to a significant share of Massachusetts' returning prisoner population.

A study of male drug-abusing inmates in Kentucky was conducted to investigate the impact on the U.S. health care system and health care costs associated with the increasing numbers of prisoners returning to communities (Leukefeld et al., 2006). Within a year after release, many of the ex-offenders frequently

utilized emergency rooms and hospitals. The strongest predictor of use of these high-cost health services was health status, which includes substance use disorders and mental disorders (Leukefeld et al., 2006). Based upon these findings, the researchers recommend that with “targeted community reentry services, which include learning how to control personal health problems, it is possible that costly health services could be reduced” (Leukefeld et al., 2006, p. 83).

The financial implication is that returning prisoners commonly access and misuse costly services that are not clinically indicated. By ensuring that ex-offenders receive the appropriate level of care at the time of release, MBHP can decrease costs by diverting returning prisoners from utilizing unnecessary emergency care services. The evaluation of the EssentialCare program supports this statement, while also offering evidence related to decreased psychiatric hospitalizations and rates of office visits (MBHP, 2006). Again, the EssentialCare program did not specifically target ex-offenders, but served characteristics. As seen in Table 1, EssentialCare demonstrates statistically significant reductions in inpatient hospitalizations, emergency room visits, and office visits when comparing pre- and post-data.

The changes in utilization resulted in a 19 percent reduction in per member-per month (PMPM) claims, a savings of \$150 per member per month (MBHP, 2006). Comparable efforts to manage the health needs of ex-offenders could offset projected costs associated with enhanced service delivery. To fully understand the financial risks and financial benefits associated with reentry planning and care coordination by any managed behavioral health care company, additional research is needed. However, the information available suggests that proactive planning through appropriate service referrals, and care coordination, can result in savings.

Counter Arguments

The rationales presented are not conclusive. For example, practical rationales also exist for MBHP to continue to rely upon current mechanisms that identify members with acute behavioral health needs. Case workers and reentry coordinators within correctional facilities are charged with making the necessary referrals for inmates with severe mental disorders, significant

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Table 1

Utilization Outcomes of EssentialCare Programs

Service	Pre-enrollment visits/year	Post-enrollment visits/year
Inpatient Hospitalization	12.9	5.6
Emergency Room Visits	2.6	1.3
Office Visits	1.7	0.5

Note: From Massachusetts Behavioral Health Partnership (2006).

substance abuse problems and/or chronic medical conditions to support the inmate upon release. Health care service providers can then refer the individual to MBHP's care management programs without any specialized system recognizing the ex-offender status of the member. Those returning prisoners with the most acute needs can be served by the system as it already exists, especially if the member is a "frequent flier" as MBHP uses software to identify and target such members.

Behavioral health care, especially substance abuse treatment, is not the purview of MBHP alone; nor are referrals and connections to social service providers. The Department of Public Health (DPH) and the Department of Mental Health (DMH) can provide case management and treatment services to returning prisoners. Regional reentry centers (RRCs) and designated non-profit organizations are designed to respond to the complex needs of ex-offenders and may be more capable of working with this population and understanding the systems that most affect this population. Returning prisoners who want behavioral health treatment can seek treatment on their own, ensuring that those receiving treatment are the ones who value the service and will benefit from the service.

The EssentialCare evaluation used to argue for improved clinical and financial outcomes should not be overstated in its generalizability to the returning prisoner population – who are indeed not one entity, but a mix of people with differing risks, needs and strengths. The evaluation design was limited in regard to its inability to control for non-program related changes resulting in

observed outcomes being inaccurately attributed to the program (Posavac and Carey, 2006). The reported cost savings in terms of service utilization do not take into account the costs of the program; therefore the savings may not be savings at all. The reduction in service utilization is assumed to be beneficial; however the evaluation was unable to determine whether or not these reductions were clinically appropriate. Finally, the interaction between care managers and members was not discussed. The style and clinical approach of the care managers, and their therapeutic relationships with members, may be the driving force behind the reported clinical outcomes, resulting in overstatement of the impact of the design and components of the program.

The arguments against a proactive, informed and decisive role for MBHP in prisoner reentry are cogent and need to be considered. However, the rationales supporting such a role are overwhelming. If MBHP is to consistently apply its mission across the membership it serves, a mission that speaks to meeting needs as defined by members; effectively and efficiently managing state resources; facilitating linkages, consensus building and collaboration among state agencies, consumers and other public policy makers; consumer involvement in service delivery and design; strengthening links between psychological and medical services; and attending to behavioral health in terms of all health behaviors and increasing health care innovations and best practices, then prisoner reentry planning and care coordination needs to be fully integrated into the policies and practices of MBHP.

Clinical Care Management

Reentry planning and care needs to be: a team effort, with true consumer involvement; a managed transition from services “inside the walls” to the community; a connection to clinically and culturally appropriate services; coordinated and monitored (Miller, 2005; Travis, 2000). In other words, clinical care managers are essential (Watson, 2000). MBHP either operates itself, or funds through health care service provider agencies, several models of clinical care management. Given MBHP’s commitment to best practices, and its status as a for-profit company, these models signal MBHP’s confidence in clinical case management as a means of improving outcomes for members and as a source of cost savings.

Moreover, the Massachusetts Medicaid Policy Institute reported that care management was a way to manage MassHealth's spending trends under Massachusetts' reform (MMPI, 2007). The proposed policy options for MBHP's role in prisoner reentry and care are based upon its models of clinical care management, which is supported both by research on effective reentry services and by research regarding the effectiveness of clinical care management.

No matter its name - clinical care management, case management, Assertive Community Treatment, etc – the proactive functions of this kind of service for adults with serious behavioral health issues are supported theoretically and empirically (Mueser et al., 1998; Rapp and Goscha, 2004; Bedell et al., 2000). Clinical care management is found to significantly improve consumers' functional status and quality of life, while also reducing the cost of care and the amount of time spent in jail (Gorey et al., 1998; Ziguras and Stuart, 2000). The need for clinical care management is also supported by research, which found that few ex-offenders received clinically meaningful levels of outpatient care after their release, and decreased recidivism and improved mental health status require enhanced services like those offered by "case managers" and services accessed for ex-offenders by "case managers" (Lovell et al., 2002).

Technicalities of Proposed Policy Options

The Assessment Unit at MBHP reviews referrals by health care practitioners for care coordination services and determines the level of care needed for the member based on clinical, social and medical indicators. The care coordination programs are CSPs and Intensive Case Managers (ICMs) - and formerly, EssentialCare - and comprise the three policy options offered in this article. For each alternative MBHP needs to work with the Reentry Services Division at the DOC and its counterparts in the county HOCs. The responsible personnel at the correctional facilities identify MassHealth eligible inmates in need of care coordination well before discharge. Until MassHealth is guaranteed for all returning prisoners, county HOCs will need to submit a MassHealth application for the inmate, which will be denied, but can be activated upon release.² Referrals to the Assessment Unit (which are available on-line) are made by the reentry/discharge

coordinator(s) on behalf of the identified inmate, who should, in keeping with good practice, be aware of the referral.

MBHP will need to develop a specialized system for processing referrals from correctional facilities due to issues around timeliness of insurance coverage. For returning prisoners, MBHP could identify one of its care management programs to serve all referred inmates or choose amongst them. The following details some of the augmentations to the CSP, ICM and EssentialCare programs that may be necessary to serve the particular needs of returning prisoners.

Policy Options

1. Enhance Use of Community Service Providers

MBHP has already identified CSPs as a beneficial service for returning prisoners through its aforementioned performance incentive initiative. However, MBHP is not actively involved in the initiative and could reinsert itself in a meaningful way. First, MBHP can reinstate the incentives for CSPs to work with ex-offenders. Second, contracts with higher rates can be offered to provider agencies running CSP programs that invest in clinical trainings focused on ex-offenders, and who dedicate CSP “slots” for referred returning prisoners. Third, MBHP can hold conferences for CSPs working with returning prisoners to highlight best practices and support information sharing across the medical and psychological spectrum, particularly with respect to behavioral factors impacting health outcomes. Fourth, authorizations for CSPs serving ex-offenders can begin shortly before the inmate is discharged to improve planning and continuity of care.³

2. Creation of Specialized Intensive Care Managers

ICMs are Master’s level employees of MBHP and work out of MBHP’s regional areas. The purpose of the ICM program is to coordinate care for referred members, typically those with high utilization rates of intensive and costly services. ICMs develop and monitor treatment plans, can authorize all levels of care covered by MassHealth, and can act as gatekeepers to higher levels of care to prevent the misuse of inpatient hospitalizations. The outreach component of ICMs is limited, although they do communicate directly with the member and the member’s treatment team, while

also hosting or attending treatment conferences. A MBHP member can have an ICM in conjunction with other care management services, which is often the case.

ICMs in each regional office can be identified as exclusively serving ex-offenders and be provided with the appropriate clinical training on an on-going basis. Before an inmate is discharged, the ICM can be assigned, allowing them to team with reentry/discharge coordinator(s) and treating professionals at the facility to ensure that the appropriate service referrals are in place before the inmate is released. Specialized ICMs can develop a robust knowledge of the community services available to returning prisoners, as well as tactics to manage the specific health services barriers ex-offenders face (Iguchi et al., 2005). Finally, specialized ICMs can serve as a source of assistance to providers unfamiliar with treating returning prisoners.

3. Reinstate the EssentialCare Program

The EssentialCare program can be reinstated and explicitly serve returning prisoners. Care managers can work with the inmate prior to discharge and collaborate with correctional staff so the inmate is released with the necessary services in place. The timing of behavioral health and medical appointments is critical, as delays often lead to decompensation and re-incarceration (NIC, 2007). MBHP can also replicate the EssentialCare model and create a separate program that solely serves ex-offenders, allowing the program to operate in the same manner as EssentialCare but with a dedicated focus.

Implementation Concerns

All of the proposed options involve three essential components that can impact the feasibility and viability of the programs as described. First, the availability of clinical training on treatment and other issues related to ex-offenders is almost non-existent. However, there are provider groups and organizations across the state that specialize in serving this population. The University of Massachusetts Medical School maintains the contract with the DOC to provide medical and behavioral health services and the University's Commonwealth Medicine is a leading research and advocacy institute for best practices in correctional care. MBHP, in

conjunction with the DOC and the University of Massachusetts, can promote and sponsor trainings initiatives, conferences and forums to enhance and inform the delivery of services to returning prisoners.

Second, the policy options offered herein insist upon the clinical care coordinator working with reentry/discharge planning coordinator(s) prior to a referred inmate's discharge. Correctional facilities may not be open to outside health practitioners, and correctional staff may have little time to dedicate to collaboration. Clinical care coordinators may be intimidated by the facility itself and may have a different perspective than correctional staff. For example, the main focus in correctional facilities is public safety, which can be in direct opposition to a clinical care coordinator's focus on treatment. MBHP will need to provide outreach to correctional facilities so that the responsible personnel are aware of the referral process to the Assessment Unit and know what to expect in working with clinical care coordinators. Correctional facilities will need to introduce clinical care coordinators to the culture and practices of the facility. Through an on-going process of relationship building, such obstacles can be overcome.

Third, prisoners will need to understand the services available to them through MBHP, and actively engage in the care provided. Prisoners may be reluctant given their past history with behavioral health providers and treatment, a belief that they need to manage their own problems, or out of fear of stigma, before and after release (Morgan et al., 2007). The challenge for MBHP and correctional facilities alike is educating soon-to-be-discharged prisoners about the benefits of reentry planning and care.

The barriers to implementation make the task for MBHP complicated, but not impossible. An opportunity exists for MBHP and the State to begin an overt effort to understand the behavioral health, medical and social needs of returning prisoners, their impact on the Massachusetts health care system and the effectiveness of clinical care management programs for this population. However, MBHP operates in a context with multiple barriers to such an initiative. MBHP cannot act alone and key stakeholders may be unwilling or unable to provide the requisite support. The complicating and complementary political, health literacy, economic, organizational and social factors must be analyzed before any policy solutions are designed - not only to

ensure for the feasibility of the solutions, but also in recognition that decisions are not made in a vacuum.

Barriers and Advantages of Context

As the effects, impacts and consequences of Massachusetts Health Reform continue to unfold, MBHP operates in a context that is constant only in its changing. Beyond the aftershocks of the individual mandate - tremors felt by MBHP and its network providers - other state initiatives require a shift in resources and service delivery across the behavioral health field. The transforming field is the landscape upon which MBHP must meet its contractual obligations and performance incentives, while the recession creates financial shortfalls across sectors. Undertaking any new initiative within this climate is challenging, if not impossible. Even if the case is made for a strong and present role for MBHP in prisoner reentry and care, proposed policy solutions are feasible only if the barriers of context are taken into consideration.

Political Environment

Strong partnerships are needed to overcome silos in the state system and the competing interests among key stakeholders. Political will, in the area of prisoner reentry, is fundamental to opening the door to strong partnerships. The Second Chance Act, federal legislation that passed with overwhelming bipartisan support and was signed into law by President Bush in April 2008, authorized \$165 million for states, local governments and community partners to improve coordination of reentry services (Reentry Roundtable, 2009). The American Recovery and Investment Act of 2009 allocated \$133 million for prisoner reentry initiatives and programs (Reentry Council, 2009). Taken in concert, these federal acts signal a concern from both sides of the aisle regarding issues of prisoner reentry, and a willingness to take action.

Political will in Massachusetts' state government is evident in key commissions, executive office initiatives and legislative attempts. The Governor's Commission on Criminal Justice Innovation and the Governor's Commission on Corrections Reform produced "reports highlighting the need to reform strategies for

transitioning offenders back into the community, starting with the moment they are incarcerated” (EOPSS, 2009). In response to the recommendations in each report, the EOPSS and the DOC created Regional Reentry Centers (RRCs). Key Massachusetts legislators, including Senator Richard Moore, the Chairman of the Committee on Health Care Financing, continue to propose bills regarding prisoner reentry. Most recently Senator Moore proposed a bill that would allow all eligible returning prisoners to obtain MassHealth coverage upon discharge from a correctional facility, a bill that has been before the legislature for the past six years. In the 2007-2008 legislative session the bill died in the Senate Ethics and Rules committee; however it is unclear why the bill continues not to pass (MA Leg, 2009). A possible reason is that, no matter the increased political palpability of issues regarding reentry, prisoners are not a priority and remain marginalized in the political system.

Massachusetts Healthcare Reform

Another possible reason the proposed bill has yet to pass is that, if signed into law, the bill would impact the enrollment cap on MassHealth Essential. To comply with the law, the DHCFP would need to request an amendment to the 1115 demonstration waiver between Massachusetts and the Center for Medicare and Medicaid Services (CMS). The state cannot guarantee CMS’ approval, making the enrollment cap a significant barrier to an initiative by MBHP to provide cohesive behavioral health services. MBHP cannot coordinate care for ex-offenders on a waiting list, and no current mechanism exists between the DHCFP and the DOC to identify which of the 52 percent of eligible returning prisoners on the waitlist are most in need of coverage at the time of release (Marshall, 2008). The only option for MBHP is to advocate for the expansion of the enrollment cap, which the state may be unwilling to request given the unpredicted costs of health insurance reform.

The individual mandate was projected to decrease the need for the Uncompensated Care Pool (UCP) and result in substantial savings. Although spending on the UCP decreased over the past two years, the anticipated savings have yet to come to fruition (DHCFP, 2009). According to the Massachusetts Medicaid Policy Institute (MMPI), reductions in UCP spending are critical to the renewal of health insurance reform (2007). It is possible that a proportion of individuals accessing services paid by the UCP are ex-offenders (Leukefeld et al., 2006). By including obligations and

incentives regarding prisoner reentry in its contract with MBHP, the state could shift a share of the costs of treating ex-offenders under the UCP, and through other state funded systems, to Medicaid, which is subject to a 50 percent match in funding by the federal government.

Competing Priorities

Even if a prisoner reentry initiative by MBHP results in costs savings for the state and MBHP, both are under financial pressure related to the Children's Behavioral Health Initiative (CBHI). In 2005, a class action lawsuit (*Rosie D. v. Romney*) was brought against the state for failure to comply with the Early Periodic Screening Diagnosis and Treatment (EPSDT) provision of the Medicaid Act (CPR, 2006). The court-ordered remediation plan, known as the CBHI, mandates that the DHCFP and DMH provide enhanced community based services and care for MassHealth children; the majority of whom are MBHP members. As the state begins the process of dramatically altering its behavioral health service delivery model, the financial burden of CBHI is unknown – but it is projected to have drastic effects on state agencies and MBHP alike (Kenny, 2007). Financial and organizational resources must be directed to the CBHI given that they are court ordered, meaning that other initiatives by the DHCFP, DMH and MBHP may need to take a backseat.

Practitioner Concerns

The CBHI also impacts health care practitioners, raising concerns about practitioner capacity in general, as well as concerns regarding the additional administrative burdens placed on network providers as a result of the CBHI (Kenny, 2007). However, there are benefits to the changes under the CBHI that include: augmentation of clinical outreach services, like the CSP program, potential decreased workloads for MBHP's ICMs, and an overall focus on care coordination for Medicaid members. The issue of practitioner capacity is endemic across the state, and intensified for the returning prisoner population. First, few practitioners specialize in working with ex-offenders, in part due to the lack of training in graduate and doctoral clinical programs (Magaletta and Verdeyen, 2005). Second, a case study by the National Institute of Corrections and the Criminal Justice/Mental Health Consensus Project found that many providers and community mental health

clinics (CMHCs) are reluctant to serve ex-offenders (CSG, 2007). The reasons cited included provider and CMHCs “worry about safety, liability and reliability of some segments of the ex-offender population” (CSG, 2007, p. 11).

Overcoming the challenges of the lack of practitioner skill and comfort in treating returning prisoners, the lack of providers in general (which results in lengthy waitlists across the network), and the reluctance (and sometimes resistance) of providers to serve ex-offenders will be difficult. However, MBHP’s performance incentive program referenced earlier in this brief was an attempt to encourage CSP to work with this population. Additional actions by MBHP in this area will be discussed in conjunction with the proposed policy options. The issues are not solely MBHP’s to solve, but require that academic clinical programs incorporate training in behavioral health treatment and the needs of ex-offenders, and that on-going training in this area is available to clinicians and practitioners in the field.

Beyond the clinical and capacity concerns of the practitioner network, practitioner agencies are experiencing drastic cuts in their budgets due to the recession and diminished (or dismantled) funding from the state. Practitioner agencies across the state are cutting programs and staff making it difficult for them to serve their current clientele, let alone taking on the challenge of treating a disproportionately ill population. The Governor’s budget cuts to agencies under the Executive Office of Health and Human Services (EOHHS) impacts services for returning prisoners and shifts a share of the costs onto MBHP.

Funding Within State Agencies

The loss of funding for staff and programs at EOHHS agencies like the DMH, Department of Public Health (DPH) and Department of Mental Retardation (DMR) means that those returning prisoners who would have been eligible for services through these agencies in the past may be denied services due to increasing restrictions on eligibility. These returning prisoners will go without the benefits of the case management, outreach and residential services of the agencies. Ex-offenders who manage to pass the eligibility determination phase will find that their caseworker is overwhelmed, and that there is limited funding for community-based outreach services and almost no funding for residential

and/or inpatient treatment facilities. MBHP and safety net health care service providers are left to care for returning prisoners in relative isolation or must fill in the gaps left by the diminished resources of EOHHS agencies. Advocacy groups and consumers across the spectrum are reeling, pushing back against the state to save their specific programs and support their specific populations. Ex-offenders are always low on the list in an environment of zero-sum thinking. However, such thinking is counterproductive to improving the health and well-being of all residents across the state, and this time of crisis should be a time of consensus building for those dedicated to serving the needs of vulnerable populations.

Stakeholder Relationships

An initiative involving prisoner reentry ultimately involves reaching consensus across multiple stakeholders with differing ideologies, resources, mandates, agendas and politics. MBHP already formed connections with DMH, DPH, DOC, RRCs and non-profit agencies in regard to reentry services and care. The largest disconnect is between MBHP and county HOCs. For MBHP to take on an initiative regarding prisoner reentry, they must build relationships with county HOCs, since the majority of returning prisoners in the state are released from county HOCs. However, the relationship is more complex than that of MBHP and DOC, in which MBHP coordinates with one entity – the reentry services division. Thirteen county HOCs involve thirteen different discharge-planning units, with varying levels of resources. The multitude of players, and the lack of uniformity, makes coordination difficult, but not impossible.

MBHP highlights its role in serving as “the coordinating entity for numerous state departments and agencies,” and through these relationships “buil(t) programs that offer easy access, a minimum of bureaucratic barriers, and the highest standards of care” (MBHP, 2009; para. 3). MBHP can expand this role to include county HOCs. Each county may be willing, but unable. Lack of personnel, overwhelming caseloads, other priorities and organizational impediments may interfere with a county HOC engaging in a coordinated effort with MBHP. Examples of overcoming these barriers exist in multiple counties. Dr. Thomas Conklin, the creator of the award winning public health model at the HCCC, and Sheriff Ashe of Hampden County, are two strong advocates for county correctional reform (Montalto, 2006). Sheriff Cabral of Suffolk

County currently supports an initiative linking discharged inmates to a specialized program of integrated care at a CHC in Boston (Sullivan, 2008; SCSD, 2008). Initiatives and structures for coordinated reentry care are in place in many county HOCs, allowing MBHP to enter into the conversations and systems already in effect.

MBHP Role and Constraints. Certain systemic barriers are outside MBHP's control, although its resounding voice will amplify attention to such barriers. MBHP can't improve the diagnosis and recognition of behavioral health issues of inmates during their incarceration. MBHP can't authorize MassHealth coverage for every eligible prisoner at the time of release or his or her placement on a waitlist for Essential coverage. MBHP can't change the financial forecast or the competing demands on all behavioral health systems. What MBHP can do is build off its existing care coordination programs, with the expressed purposes of supporting the transition home for Massachusetts' prisoners, and providing the appropriate treatment opportunities to help keep them there.

Recommendations and Conclusion

Returning prisoners are a population with a range of medical and behavioral health issues. The Assessment Unit at MBHP is capable of determining the level of care required for members, and can continue to do so within an informed system dedicated to processing and evaluating referrals from correctional facilities. The investment of financial, organizational and staffing resources will pay for itself over time. Given the sheer numbers of returning prisoners, MBHP can begin by implementing the program with the DOC, with whom it already has a working relationship, and running pilot programs in Hampden County, Suffolk County and Worcester County. Hampden County is committed to improving correctional and reentry services, can easily adopt the initiative, and is capable of supporting MBHP in data collection and evaluation of a pilot program. Worcester and Suffolk counties have the highest number of returning prisoners and are most in need of enhanced partnerships and reentry programs.

In response to MBHP's proactive and enhanced role in prisoner reentry, DHCFP should incorporate the functions of this role into MBHP's contract with MassHealth, while also seeking CMS

approval for increasing the enrollment cap for Essential coverage. Continued advocacy is needed to support legislative attempts to cover all MassHealth eligible inmates at the time of release and until this is realized, DHC FP can extend the waiver with the DOC to cover county HOCs. Vested stakeholders need to come together to translate the importance of prisoner reentry to the public. Massachusetts needs evaluation of MBHP's reentry programs and research on returning prisoners. The Center for Health Policy and Research at the University of Massachusetts Medical School conducted the evaluation of the EssentialCare program and MBHP can build off of this working relationship, while also tapping into the multitude of health policy institutes and researchers across the state.

The recommendations of this brief take the best of what is currently practiced, and addresses the issues of access, inclusion, equity and connection for returning prisoners. MBHP has a great responsibility for ensuring that the incarcerated population is indeed counted and cared for, and a great opportunity to effect change. With the precedent set by Massachusetts in having the first and largest Medicaid behavioral health carve-out contract, MBHP can set its own precedent in proactively managing the behavioral health needs of returning prisoners (Sabin and Daniels, 1999).

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Notes

1. A public health model of correctional care takes a comprehensive approach to the health care needs of inmates and the community and includes a spectrum

of high-quality health and behavioral health services. The core values of the model include: wellness, treatment of disease, prevention of illness, collaboration and access to care during and after incarceration (Conklin, 2004).

2. County HOCs can follow the model of the HCCC, which has an on-going understanding with MassHealth. During the discharge planning process, MassHealth applications are submitted and then denied. Once the inmate is discharged, the inmate has a standing appointment at a community health clinic that resubmits the application for approval. Once approved, coverage is retroactive to the date of original submission, thereby covering services immediately upon release.
3. MassHealth allows for services to be billed back to the date of the original application, even if the activation of coverage is delayed.

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Finding a Path to Financial Security and Self-Sufficiency: An Asset-Based Analysis of Re-Entry Programming

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Former offenders face a variety of barriers to successful re-integration into society, particularly in the areas of labor market prospects, debt obligations, and public policy. This paper conducts a comparative analysis of several in-prison and community-based re-entry programs to determine their potential for improving financial outcomes for this population. The analysis uses an asset-based framework, identifying promising program features that help participants build financial, human, and social capital. These features include preparation for and intervention in the labor market, helping participants build a foundation of financial assets, and approaches that integrate services and leverage multiple assets simultaneously. The paper concludes that given the many mutually reinforcing barriers former offenders face to financial well-being, programs would do well to expand financial asset-building features and expand their often narrow focus to encompass multiple asset-building approaches. They must also make an improved case for their cost-effectiveness in order to ensure their survival and provide for future implementation on a larger scale.

Rates of incarceration in the United States have quadrupled in the past three decades (Travis and Petersilia 2001; Visher and Travis 2003). According to the Pew Center on the States (2009), one out of every thirty-one Americans is either currently in prison, jail or on probation/parole. As a result of these developments, more people than ever before are facing the challenges of re-entering society. One especially difficult challenge is establishing and maintaining financial well-being after release. The first portion of this paper will demonstrate that this difficulty is largely due to multiple barriers in the areas of labor market prospects, debt obligations, and public policy.

Programming focused on building financial, human, and social assets offers a potential pathway toward diminishing these barriers. After briefly discussing the merits of asset building for creating financial security, stability, and opportunity, the second section of

this paper will evaluate the potential of several different types of federal, state, and local re-entry programs (both in-prison and post-release) to lead to financial well-being. Many of these initiatives are government sponsored and funded, but some are also run by or in collaboration with private/non-profit organizations. The analysis is divided into three mini-case studies, which examine three broad approaches to this work: in-prison work programs, employment training and vocational guidance programs, and expanded, holistic re-entry program models.

Barriers to Ex-Offender Financial Well-Being

Labor Market Disadvantage and Discrimination

Former offenders face several challenges that make labor market success difficult. Their educational attainment tends to be low; recent data shows that only 57 percent of all state prison inmates hold a high school diploma or its equivalent (Bureau of Justice Statistics 2007). Incarceration has also become concentrated among populations that are already economically marginalized, particularly black males, who now face a one in three chance of incarceration in their lifetime (Western 2002, 526; Bureau of Justice Statistics 2007).

Indeed, in a matched-pairs field experiment in Milwaukee, Devah Pager (2003) found that criminal history and race *both* had significant, independent effects on job offers. There was also evidence to suggest that the negative effect of a criminal record was more pronounced for blacks; employers were more likely to offer positions to white ex-offenders than black *non-offenders*. The difference in interview call-back rates for offenders and non-offenders was also 40 percent higher for blacks (though not statistically significant). More research is needed, but the significant main findings do suggest an idea of compounding disadvantages.

As part of their national *Returning Home* prisoner re-entry study, the Urban Institute conducted an extensive series of pre- and post-release interviews with inmates in Baltimore, Chicago, and Cleveland (Visher, Kachnowski, LaVigne, and Travis 2004; LaVigne, Visher, and Castro 2004; Visher and Courtney 2006). These interviews provided clear evidence of respondents'

widespread difficulties securing gainful employment after release.¹ In their urban focus areas of Baltimore, Chicago, and Cleveland, most respondents reported during initial in-prison interviews that they needed help finding a job after prison. Indeed, their employment success was limited after release – in Chicago and Cleveland, less than half of respondents had worked for at least one week, and fewer were working at the time of their interview (up to eight months after their release). In all three cities, those with steady employment were more likely to be working full-time and generally satisfied with their work environment, although largely *dissatisfied* with their pay; average wages were \$9 per hour in Chicago, and median monthly income was \$640 in Cleveland. Baltimore respondents had better labor market outcomes, though the researchers note the causes are unclear.

Finally, using data from the 1979 National Longitudinal Survey of Youth, Western (2002) also found significant evidence that incarceration leads to reduced lifetime wage mobility. In the sample, incarceration tended to decrease aggregate wages after release by about 10 percent, but the rate of lifetime wage growth fell much more sharply, by approximately 30 percent. He summarizes prior research that suggests wage growth is primarily a result of a trajectory leading to stable, “career” jobs, and other research showing that incarceration leads to diminished human capital, reduced opportunity for job seniority, and (especially) increased stigmatization that impedes the hiring process, particularly for higher-paying, trusted occupations. Western theorizes that these effects are the mechanism that prevents former offenders from entering a “career trajectory,” and are therefore a primary reason for their observed lack of earnings mobility. Taken together with the above evidence of discrimination, low wages, and limited employment security, a clear picture emerges of both short and long-term labor market disadvantage.

Debt Obligations

A less-studied but crucially important determinant of re-entry success is the weight of debt obligations that many ex-offenders bear. The majority of *Returning Home* respondents both expected and encountered significant difficulty supporting themselves financially after release, and debt was a dominant source of this difficulty (Visher et al. 2004; LaVigne, Visher, and Castro 2004; Visher and Courtney 2006). Indeed, most inmates leave prison

with no personal savings (Petersilia 2001). Prisons will sometimes provide a small amount of “gate money” (usually about \$50), and perhaps a set of clothes and a bus ticket, but little else (Visher and Travis 2003).

Unpaid child support payments are an especially problematic source of debt. In Massachusetts and Colorado, for example, inmates who are parents enter prison with an average of over \$10,000 in child support arrears. In both states, this balance tends to grow substantially; support owed continues to accrue during imprisonment, plus penalties and interest, as many courts do not view imprisonment as a justification for reducing these financial obligations. Since even inmates who do work earn far below minimum wage, there is little hope for them to meet these obligations while imprisoned. Limited post-release employment prospects continue to make repayment difficult, as support orders may represent up to 60-80 percent of income for those who are working (Pearson 2004; Pearson and Griswold 2005; Holzer, Offner, and Sorensen 2005).

Public Policy Barriers

Finally, ex-offenders also face a range of policy barriers in the areas of employment, public benefits, and higher education. For example, the 1996 welfare reforms allow states to permanently ban all drug offenders from receiving TANF assistance or food stamps, and most states have done so (Mukamal 2000). In 1998, an amendment to the Higher Education Act also denied Federal Student Aid to this group (Mauer 2003). Individual states also bar ex-offenders from many occupations, especially in the areas of youth services, education, health care, and law enforcement (Mukamal 2000). Together, such policies have the dual effect of restricting opportunities for both basic subsistence and upward mobility. They tend to be enacted in a piecemeal fashion, contained in legislation focused on other goals, such as reducing drug abuse (Mauer 2003, 16-17; Page 2004). However, they have a far-reaching effect on the labor market capacity of former offenders, and by extension, their economic well-being. Because these measures have become so widespread, some researchers have even likened them to a “blunt instrument” of social control (Visher and Travis 2003, 106).

Ex-offenders also face a major policy barrier in the hiring

process itself. Criminal record information is now more widely and easily available from both state repositories and private providers, and record expungement is available in only 17 states, and sometimes only under limited circumstances. The records themselves are also likely to contain one or more errors. Despite these flaws, they have become an increasingly important part of the hiring process (Pager 2006; Mukamal 2000; Harrison and Schehr 2004). Indeed, a widely cited study by Harry Holzer (1996) of 3,200 employers in four major metropolitan areas found that only about one-third of employers were willing to hire someone with a criminal record.

Asset Development and Former Offenders: Untapped Potential

The emerging research area of asset building holds largely untapped promise to create deeper, more comprehensive well-being for this vulnerable population. The concept of assets is related to income, yet also distinct. Michael Sherraden (1991) defines assets as “the stock of wealth in a household or unit.” By contrast, income is a “flow of goods, money, or services” (96-97). Income can be used to build assets, and assets may yield income.

In the most immediate sense, assets can enhance financial security and stability by providing a cushion that helps households maintain their standard of living when income is interrupted. Haveman and Wolff (2005) develop this idea into the concept of an “asset poverty line,” which they define as the level of asset holdings needed for a family to remain above the Federal poverty line for three months in the event of a loss of wage income. Over the longer term, assets can also lead to “transformative” opportunities, such as higher education that opens up a new career path, or access to home ownership and the resulting accumulation of equity (Sherraden 1991; García 2008, 2). In such cases, assets are “leveraged” to create additional assets in an increasing cycle of accumulation and transformation, breaking individuals out of “path dependency” and altering their life chances (Sherraden 1991).

Federal, state, and local policymakers have been showing increasing interest in asset-based policy for low-income individuals and families, including the creation of Individual Development Accounts (IDAs) for the poor (an idea originally advanced by

Sherraden). Government subsidizes these accounts by matching deposits for certain approved purposes, typically for education, self-employment, home ownership, and retirement. A growing base of empirical literature is providing evidence for the beneficial effects of these types of policies on savings, educational attainment, and economic mobility, among other indicators (Schreiner et al. 2005; Zhan and Sherraden 2003; Zhan 2006). However, although researchers, practitioners, and policymakers are becoming increasingly aware of the many disadvantages that ex-offenders face in the labor market, few programs serving this population take an explicitly asset-based approach. In light of the above discussion, such an approach provides the opportunity to establish a more long-lasting foundation of economic security and future opportunity.

Indeed, as a group ex-offenders are likely to be facing asset poverty. While little quantitative evidence of their asset holdings is available, their overwhelmingly poor labor market outcomes, coupled with widespread debt obligations, suggest little hope of accumulating any sort of cushion against income or other kinds of shocks such as poor health or disability. As Edin (2001) reminds us, the poor often count on their labor – the ability to leverage their human capital – as their chief productive asset. In an environment of extensive criminal record checks, hiring restrictions, and low human capital accumulation, the rate of return on this asset is likely to be low.

An Asset-Based Re-Entry Program Analysis

Overall, very little theoretical or practical work has been done relating the idea of asset building to ex-offenders. To make an initial contribution in this area, this paper will now present a series of mini-case studies that evaluate the potential of several different types of federal, state, and local re-entry programs (both in-prison and post-release) to lead to financial well-being. The programs presented below encompass three broad approaches to this work: in-prison work programs, employment training and vocational guidance programs, and expanded, holistic re-entry program models. The case studies evaluate the potential of each program type to enhance financial well-being through both the reduction of labor market disadvantage and the promotion of financial, human,

and social asset building. Specifically, they answer the following questions:

1. Does this program promote ex-offender financial well-being by reducing institutional barriers and/or labor market disadvantages? If so, how?
2. Does this program enhance this well-being through an asset-building approach, or at least some of its component elements? Again, if so, how?

The first question points to a more traditional approach, closely tied to the financial and institutional barriers many ex-offenders face. The second question focuses on an approach that is less prevalent, and rarely receives explicit mention with regard to re-entry programming. However, by developing an understanding of asset-building features in existing programs, the promise behind this approach can be more widely shared, and additional such features can be built into future interventions.

Case Study 1: Enhanced In-Prison Work Programs

In-prison work programs have long been a means for inmates to earn money while incarcerated. They represent a very basic form of financial asset building. However, the wages paid in many of these programs are far below minimum wage, making asset accumulation difficult. The Prison Industry Enhancement Certification Program (PIECP) modifies this “Traditional Industry” approach. Through this federally-funded program, state and local inmates are released to work for private employers and earn market wages instead of the \$1.25 per hour average wage paid by “Traditional Industry” jobs (Moses and Smith 2007). Wages are automatically set aside to cover incarceration, court and restitution costs, pay child support, and provide for re-entry needs through mandatory savings accounts (McLean and Thompson 2007). Program participation has greatly increased since its inception in 1979, but still represents only a small fraction of all state and local inmates (Moses and Smith 2007).

Evaluators compared the post-release employment outcomes of a matched pairs sample of PIECP participants with inmates participating in Traditional Industries (TI), as well as “Other than Work” activities such as education or treatment/counseling. PIECP participants obtained employment sooner after release, and

maintained it longer, than those in the other two groups, although TI participants also had much higher one-year continuous employment rates than those in the OTW group. PIECP participants also earned the highest overall wages, though over half (55 percent) still did not earn the equivalent of a full-time, minimum wage salary in the first year after release (Moses and Smith 2007).

PIECP indeed seems to offer an advantage in entering the labor market. The emphasis on building real job skills and work experience may qualify participants for higher-skilled job opportunities, with better pay and more stability. The evaluation results seem to support this trend. However, it is unclear to what degree the increased skills and experience will offset the routine, often categorical nature of hiring discrimination, as well as the initial economic disadvantage posed by other institutional barriers (such as the ban on cash assistance for felony drug offenders).

Still, the potential benefits of increased post-release income and job security are clear, both for immediate consumption and possible asset building. If inmates are allowed to keep more than the \$1.25 per hour (maximum) paid by TI programs, their financial well-being is enhanced. In addition, the fact that states direct a portion of earnings toward debt obligations such as child support helps combat a major barrier to re-entry success.

The mandatory savings accounts also have clear asset-building benefits, as they are intended for immediate post-release needs such as obtaining housing. The state of Vermont actually takes this approach one step further within its Correctional Industry programs. For offenders who choose to participate in the savings program, the Department of Corrections provides a one-to-one match for their contributions. The program has become very popular, and now has a 70 percent participation rate. The Department views it as a key means for teaching delayed gratification and money management, as well as an explicit mechanism to build the financial assets needed for post-release success (Beal 2007).

Overall, corrections-based savings programs such as those in PIECP and the Vermont initiative have strong asset-building potential, particularly when coupled with opportunities for debt reduction and matched savings. Still, their potential to generate financial security through the labor market may be more limited. The fact that over half of PIECP participants earned less than a

minimum wage-level salary suggests that increased work experience alone may be insufficient to surmount the profound post-release economic barriers faced by participants.

Case Study 2: Employment Training and Vocational Guidance Programs

Given the multiple labor market disadvantages of ex-offenders, employment-focused training and placement assistance programs are very important. It is critical that they provide skills which are “in demand” in order to ensure job security and livable wages. For example, one of the employment-based re-entry programs reviewed by Harrison and Schehr (2004), Project CRAFT, focuses on training for the building trades. As many offenders also face multiple barriers to work, the program provides case management, access to substance abuse treatment, and life skills training to help them succeed.

Another common approach is transitional work – typically low-skilled, temporary jobs intended to serve as a training ground for future permanent employment. Such programs offer training in basic work skills such as punctuality, communication, and following directions, creating a mutually beneficial situation for entry-level employers seeking these skills. A particular reason for the adoption of these programs is a growing body of research showing that the immediate post-release period is a particularly effective countervailing factor against recidivism. Indeed, one such program, run by the New York City-based Center for Employment Opportunities (CEO), showed a statistically significant effect on recidivism in a random-assignment study – but only for those employed within three months. Participants earned an average of \$9.25 per hour in the private market after leaving the program (Tarlow and Nelson 2007).

This employment training/vocational guidance approach has achieved significant visibility on the national level. Under the Prisoner Re-Entry Initiative (PRI), the Department of Health and Human Services provides \$19.8 million in grants per year to local faith-based and community organizations to provide employment assistance and related support services to ex-offenders. Since its inception in 2004, 63 percent of PRI participants have become employed, with an average hourly wage of \$9.41 and 66 percent of those employed staying in jobs for nine months or longer

(Department of Health and Human Services 2008).

However, the high average wages noted in the above programs do not match typical post-release employment experiences cited elsewhere in this paper, such as those of the *Returning Home* participants. One plausible explanation is that PRI and CEO participants were self-selected. Comparative demographic and crime history data is not available.

These employment training/vocational guidance programs mentioned above are also strongly focused on recidivism, and less concern is directly expressed about the economic well-being of participants (although this is true of many ex-offender initiatives). Their exclusive focus on the income paradigm is also troubling; nothing is mentioned about savings, for example (although there is a secondary focus on human capital). Given the role of assets in promoting self-sufficiency and financial stability (not to mention their transformative potential), adding such a component would be a key means of improving these programs. For example, a matched savings program similar to the one implemented in Vermont would be a logical addition to these work-based initiatives. If cost were an issue, a simple automatic savings program would still encourage gradual asset accumulation.

Case Study 3: Holistic Re-Entry Programming

In addition to this specific, focused programming, policymakers and corrections officials are showing an increasing interest in a more holistic approach. To some extent, these programs focus both on labor market interventions and explicit asset building. For example, the Ohio Department of Rehabilitation and Correction (ODRC) now requires nearly all prison inmates to engage in a six-month, comprehensive Release Preparation Program. This program has a strong employment readiness component, but gives equal weight to other topics such as recovery issues (substance abuse and mental health), accessing faith-based/community resources, and more. In addition, inmates work with case managers to obtain identification, secure housing, find employment, and connect with post-release treatment. Their progress both in the program and after release is closely monitored, and those determined to be “Re-Entry Intensive” (via an initial risk assessment) receive extra case management, post-release supervision, and support from multi-service, community re-entry

teams. ODRC also emphasizes working closely with families both during incarceration and after release (LaVigne and Thomson 2003).

A more recently implemented jail-based project in Oneida County, New York has an in-jail phase that is similar to the ODRC program. The program is one of several initiatives nationwide funded through the Life Skills for Prisoners program at the U.S. Department of Education. What makes the program unique is its array of post-release services. Former inmates work with a Transitional Services Coordinator to continue their skill development, connect with treatment and support services, and get help with practical issues such as finding an apartment, opening a bank account, and more. They also receive community-based pre-employment support, peer mentoring, and additional practical assistance, such as resume preparation, interview training, transportation, and materials such as clothing and tools. In addition, the Oneida County Workforce Investment Board employs a Job Developer who builds partnerships with area employers and encourages them to hire ex-offenders (Francis, Pauline, and Darman, forthcoming).

Long recognized as an innovator in ex-offender re-entry, the Safer Foundation has adopted a unique, more intensive version of the comprehensive approach. Safer operates two Adult Transition Centers (ATCs) for the Illinois Department of Corrections. In these work-release facilities, offenders spend the last months of their sentence working in private employment, attending GED classes, and preparing for a smooth transition to the community. Safer has developed working relationships with several local employers such as the local sanitation department, who see the program as a source of motivated, quality workers. They also mandate that inmates put aside 20 percent of their earnings in a savings account, which many later use to secure a car or an apartment. Some inmate earnings are also used to help defray the cost of the program (McGarvey 2003).

Programs dealing with more specific re-entry challenges may also take a holistic approach. For example, as noted earlier there is a growing recognition that child support is a financial burden that can have an especially large effect on re-entry success. Colorado, Illinois, Massachusetts, and Texas have all implemented programs to address both this issue and related re-entry challenges. The programs generally combine two approaches: 1) training to increase

parenting skills, employment success, and understanding of the child support system, and; 2) assistance with child support order modification and arrears forgiveness requests. The programs also help to facilitate family visiting and re-integration. Their larger goal is to prevent the accumulation of large amounts of arrears, with the recognition that in such a situation, both parent and child are worse off. Comparison of pre- and post-test evaluation data in Colorado and Texas showed varying degrees of increase both in employment and in the proportion making child support payments, as well as the amount of these payments. However, large proportions of participants in these states and Illinois still had earnings well below minimum wage, infrequent work, or no earnings at all. Child support was thus still a large (but reduced) burden – Colorado parents paid an average of 39 percent of child support owed, as opposed to a pre-program rate of 17.5 percent (Pearson and Griswold 2005; Pearson 2004).

Because it addresses ex-offenders' multiple barriers to employment in a systematic, coordinated way, the comprehensive approach taken by all of these programs could be expected to lead to significant improvements in their labor market outcomes. The combination of increased practical education and connections with community resources should help overcome common re-entry obstacles such as accessing housing and mental health treatment. The community-based support and practical assistance have been successful in the past; during an earlier funding cycle of the Second Chance program, Oneida County exceeded many of its targets for both number of clients served and employment outcomes (Francis et al., forthcoming). The Oneida County Job Developer position also makes a region-wide contribution to decreasing institutional employment barriers, though many of these entrenched practices are likely to remain to some degree. In the case of the Safer ATC program, the direct advocacy and hiring connection with employers effectively bypasses hiring discrimination in a more systematic way than through Job Development alone. In both cases, participants' potentially increased earnings could indirectly lead to greater opportunities for savings, home ownership, and other forms of asset building.

The combination of a comprehensive labor market approach with specific asset-building features is also a hallmark of these programs. The mandatory savings accounts used in the Safer Foundation ATCs are the most concrete example. However, the

program is relatively small and precariously funded; only about 3 percent of Illinois inmates are able to participate, and it also narrowly survived a round of budget cuts early this decade (McGarvey 2003). The asset building implications of child support assistance programs are clear; offenders are provided significant economic relief, while family members and victims are more likely to receive just, much needed compensation and support. These programs also acknowledge the role of family as a key asset.

The fact that the Oneida County program helps offenders open bank accounts is another promising practice. This step of integration into the mainstream financial system provides the foundation for future asset building, including interest-bearing savings accounts and access to automobile loans.

Beyond the realm of financial assets, the “soft skills” that these programs teach (such as anger management, dealing with employers, etc.) are also a form of human capital development with clear implications in the labor market. In addition, the emphasis of the ODRC and Oneida County programs on family social capital is important; the *Returning Home* studies unanimously cite this intangible asset as a vital part of securing positive financial, housing, and employment outcomes (Visher et al. 2004; LaVigne, Visher, and Castro 2004; Visher and Courtney 2006).

Though they do promote offender well-being in many areas, the Life Skills and Second Chance programs still also have a primary evaluative focus on recidivism and employment, respectively (Francis et al., forthcoming). While these outcomes are important, broader success could be measured in terms of well-paying employment and increased assets, which would lead to long-term stability and transformational life opportunities. In the case of the child support-focused programs, their employment readiness components seem to be limited in helping such a disadvantaged population increase their success in their labor market (the more specifically employment-focused initiatives face similar limitations). Pearson and Griswold (2005) note that limited employment outcomes may also be due to funding cuts in several programs, which have reduced the comprehensiveness and duration of some services.

Discussion: Promising Features and Room for Improvement

As mentioned earlier, asset-based re-entry policy holds great promise for addressing the unique barriers that ex-offenders face to financial well-being. The programs reviewed above aim to enhance participants' financial well-being through the pathways of reducing labor market disadvantage, building a foundation of financial assets, and/or integration of services and leveraging multiple asset types. Each approach has key advantages, which can be best realized in combination. Many programs could be improved by incorporating additional elements or approaches. Specifically, some would benefit from adding technical features such as automatic savings mechanisms, while others would benefit from a more wide-ranging change of focus away from an income-based paradigm. All must make a continued, strong case for their effectiveness in order to maintain funding and provide for possible future implementation on a larger scale.

Many of the programs reviewed focus primarily on reducing labor market barriers, leveraging labor and human capital and creating greater opportunity to build financial assets. Many also have direct skill-building components, while some such as the Oneida County Life Skills Training Project also include “soft skills” development, and PIECP and transitional employment focus on gaining skills through work experience. Programs, such as Project CRAFT, that promote in-demand skills (in this case, construction) are particularly useful in a competitive labor market. The “holistic” model programs hold additional promise for improving labor market outcomes through their emphasis on reducing barriers to work (widely defined, from substance abuse disabilities to transportation problems) and stimulating increased employer demand through job development services.

Programs which help ex-offenders build financial assets are crucial in order to help them escape the mutually reinforcing cycle of labor market, debt, and policy setbacks. The built-in savings aspects of PIECP, the Vermont savings program, and the Safer Foundation ATC are examples of this approach. In addition, the efforts of Oneida County Life Skills staff to open savings accounts for participants are also promising in providing access to the mainstream financial system. Such opportunities could create additional institutional asset-building opportunities in the future,

such as the possibility of securing an automobile loan. The state-level programs addressing child support obligations also make a clear contribution in this area by addressing the largest source of ex-offender debt, which dramatically impacts the ability to accumulate and leverage the “cushioning” effects of financial assets.

Finally, under the “Holistic” programs, the close integration of services and leveraging of multiple asset types is particularly promising. The “Holistic” programs recognize the compounding disadvantages that ex-offenders face, and take measures at multiple points in time in order to address them, including post-release planning while in prison, securing identification, connecting with housing and treatment providers, pre-employment supports, and the job development services mentioned above. Both types of programs recognize the importance not only of financial asset building, but also of human capital (through their strong educational components) and social capital (through channels such as job development, mentoring, and closely working with offenders' families). However, it is important to note that none of the programs reviewed incorporates all three main approaches referenced above, or even the latter two (more explicitly asset-based) elements. By combining these elements, programs' asset building and leveraging features can be significantly enhanced.

For example, more employment and training-based programs could incorporate savings plans – preferably automatic, and with matched contributions. The popularity of the Vermont program suggests that inmates would take advantage of the opportunity. All three reviewed programs with savings-related elements have some mechanism for automatically allocating the use of funds, and such mechanisms should be incorporated into other programs as well. Policymakers should ensure that funds – including matching funds – are used for purposes specifically connected to successful re-entry and self-sufficiency, such as securing housing or purchasing a vehicle. In general, these types of programs should be brought to scale in more prisons and jails nationally, though funding will likely be a problem, as it has been for the Safer ATC program (McGarvey 2003).

The employment and training components of the programs surveyed also tend to be too narrowly targeted. The majority of these interventions focus on human capital development. While a critical factor, it remains unclear to what degree increased

competencies and work readiness alone will offset institutional barriers, such as the widespread employment discrimination discussed previously. The persistently low earnings of state child support program participants are one indicator of this issue. The design of the more “holistic” programs explicitly recognizes that the well-being of offenders requires simultaneous attention not only to their many barriers to work and financial security, but also to multiple methods of building and leveraging their financial, human, and social capital.

Finally, these programs face serious challenges in the areas of evaluation and ongoing funding. Little quality data on effectiveness is available. Barriers to evaluating these programs can include difficulty in randomizing experiments and obtaining needed data, or a “tension” between program implementation and evaluation goals (Linton 2005). More rigorous – perhaps quasi-experimental – evaluations are needed to better understand the independent impacts of these programs. In particular, better data on long-term economic outcomes would help researchers and policymakers better understand which are the most promising asset-building features to incorporate into future interventions

This data is essential in order to maintain ongoing funding for these programs, laying the groundwork to expand their scale in the future. Several of them have faced varying degrees of budget cuts in recent years (Pearson and Griswold 2005). Though not the focus of this paper, it is important to note that the most convincing financial justification for their existence may be on the grounds of crime prevention. In 2001, the average cost nationwide to house a state prison inmate for one year was \$22,650 (Bureau of Justice Statistics 2010). In comparison, the average annual cost per inmate in 2002 at the Safer Foundation “Crossroads” ATC was \$21,529, a cost which includes a range of academic, vocational, treatment, and other services (Illinois Department of Correction, 2002). Despite the similar cost, the three-year recidivism rate in 2003 for clients who participated in Safer programs and achieved employment was only 24 percent, compared to a statewide average of 51.8 percent.

Conclusion

Asset-based re-entry programming is a promising strategy to improve the financial well-being of ex-offenders. Increasing

earning potential through such means as human capital and job development is the most basic step toward helping participants better leverage their most basic asset, their labor. However, given the labor market disadvantages, debt obligations, and policy barriers ex-offenders face, asset building interventions are essential for establishing financial security. Building a financial asset foundation through savings and debt reduction programs is an important step, protecting participants against income shocks and allowing them to make transformational life choices, such as the purchase of a vehicle or a deposit on an apartment or home. Re-entry programs that intervene in multiple ways and build multiple assets (financial, human, social) offer the most complete approach, recognizing that both disadvantages (such as labor market barriers) and advantages (i.e. asset building) are multiple and interactive. Given the many mutually reinforcing barriers former offenders face to financial well-being, many of the programs reviewed would do well to expand financial asset-building features and/or expand their often narrow focus to encompass multiple asset-building approaches.

Indeed, none of the programs surveyed take all of the asset-building approaches outlined in this paper. However, if the most promising of these can be combined, refined, and brought to a larger scale, the implications for the aggregate financial well-being of ex-offenders could be significant. Taxpayers may also reap substantial cost savings through reducing the costs of crime to victims, the justice system, and in terms of tax revenue foregone (Management & Training Corporation 2003). Asset-based policy is still a relatively new area, and has yet to be explicitly applied to work with ex-offenders. Therefore, the field is ripe for program development and evaluation to better understand and support this most marginalized of populations.

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Notes

1. Though groundbreaking, this research has certain limitations; respondents were largely male, and in Chicago they were self-selected through participation in re-entry programs.
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Where Are We Now?

The State of Disability Services for Adults with Autism in Massachusetts

Caroline Budney Zimmerman

Over the past six years, the number of students diagnosed with autism in Massachusetts has doubled. Many of these individuals will be looking for some level of supportive services once they leave the educational system. Massachusetts currently lacks the resources and infrastructure needed to meet the demands of this growing population. To address these issues, Massachusetts needs to take a two-pronged approach to prepare for the increasing adult population with Autism Spectrum Disorder (ASD). By combining short- and long-term approaches, the Commonwealth can transition to a more effective service model while ensuring that those currently in the system are supported. This includes: (1) moving to electronic record-keeping, (2) allowing an individual's case files to follow them to each referral and (3) developing a research commission to gather and analyze data around the needs of adults with autism. Through research and analysis, Massachusetts can re-frame the way they approach disability services for adults with ASD and become a leader for other states as they experience similar challenges in managing their population of aging individuals with ASD.

Over the past six years, the number of primary and secondary students diagnosed with autism¹ in Massachusetts has doubled, according to data from the Massachusetts Department of Elementary and Secondary Education. Individuals identified as having Autistic Disorder are characterized as demonstrating a combination of the following characteristics: impairment in social interactions, challenges in verbal and nonverbal communication, repetitive and patterned behaviors, and having delays in these areas before the age of 3 (CDC, 2009; APA, 2009). Many of these individuals will be looking for some level of supportive services once they leave the educational system.

Context

Autism Prevalence in Massachusetts

The prevalence of adults with autistic disorder in Massachusetts is difficult to determine with accuracy because adults with disabilities interact with a number of agencies, most commonly the Department of Developmental Services (DDS) and the Massachusetts Rehabilitation Commission (MRC) (Kritz, 2009). There is no single department charged with serving and tracking all adults with this condition, so each agency is responsible for its own data. DDS currently does not categorize the type of disability or diagnosed condition among its adult clients, so it is not known how many of their clients have autism. MRC currently tracks autism in its vocational rehabilitation (VR) program due to reporting requirements from its federal funding agency. MRC may provide services to adults with autism through its other programs, such as community living or home care assistance, but there is no data available at this time to show demographic detail on who they serve. So, even though their VR program is adding to the knowledge around how adults are being served, the agency as a whole still has room for improvement.

Adult prevalence can be estimated by looking at data that are available on children, which is gathered due to regulations surrounding the Individuals with Disabilities Education Act (IDEA) legislation. There are two parts to the act, IDEA Part B and Part C; each addresses a different set of distinct needs which children of all ages face. IDEA Part B targets children and youth ages 3-21, and gives students access to special education and other support services for students in K-12 and preschool programs. One provision of the IDEA legislation, Title 1, part B, section 618 describes the reporting procedures that each state is responsible for. It includes the number of students with disabilities and includes those who are at risk for developmental delay and those who use early intervention services (U.S. Department of Education, 2009b).

Massachusetts has kept individual data on the number of children with a diagnosis of autism since 2001. In a 2005 report, the Massachusetts Department of Public Health determined that the Department of Education had the best data on autism in Massachusetts (Massachusetts Department of Public Health, 2005).

Table 1

IDEA Part B: Children with Autism in Massachusetts

	Ages 3-21	Ages 18-21
2002-2003	4,080	205
2003-2004	5,087	263
2004-2005	5,706	304
2005-2006	6,494	321
2006-2007	7,545	390
2007-2008	8,699	460

Note. From Data Accountability Center, IDEA, 2009.

Table 1 shows that in 2002-2003 there were 4,080 students aged 3-21 with autism, and in 2007-2008 this increased 2.1 times to 8,699 students with autism enrolled in special education in Massachusetts public schools.

By looking at the oldest cohort, it is possible to estimate the number of individuals who may be in need of adult services in the next few years. In 2007-2008, there were 460 students with autism in Massachusetts ages 18-21. This is 2.2 times the number in 2002-2003. These figures represent students who participate in special education programs in the Massachusetts public schools, but it does not necessarily include all individuals with autism in the state. For example, students who are out of school would not be included in this count; however, it is a good starting point. Most of these students will be in need of some form of adult services once they turn 22.

In terms of program utilization, MRC has data on the number of individuals with autism as a primary or secondary disability in their Vocational Rehabilitation program. As seen in Table 2, MRC currently serves 655 individuals with autism in its Vocational Rehabilitation program. While this is a small percentage of its

Table 2

MRC Consumers with Autism as a Primary or Secondary Disability

	Primary disability	Secondary disability	Total	% of MRC consumers
Current active consumers	552	103	655	2.19
Served FY 2008	386	85	471	1.89
Served FY 2007	296	56	352	1.34
Served FY 2006	268	43	311	1.27
Served FY 2005	224	40	264	1.07
Served FY 2004	172	27	199	1.02

Note. Served is defined as the period from eligibility to case closure. From MRC, 2009.

entire client base, the numbers of individuals with autism has risen since 2004. Although MRC does not have data on consumers in community living programs, data from the vocational rehabilitation program clearly demonstrate that there is an increasing need for vocational programs for individuals with autism.

It is important to note that there has been much debate nationally over whether there is an increase in the number of people with autism or whether it is being diagnosed more often (Frombonne, 2003; Blaxill, 2004). For the purposes of this article, this issue will not be discussed in depth. Regardless of the reasons for the increased number of adults with autism, as a provider of adult services, Massachusetts must focus on the increase in the number of autism cases, and prepare to serve a larger cohort than in the past. Currently, Massachusetts doesn't know how this cohort is faring in the adult service system and there is great concern that the state is unprepared for the influx, over the coming decade, of adults with autism who will seek services.

Current Service Models in Massachusetts

In Massachusetts, there are a number of different service models used to support adults with autism. Most services fall into three general categories: day services, residential services, and home-based services.

For day services there are two typical models of service: Day Habilitation Services and Vocational Services. Day Habilitation Services focus on the habilitative or clinical needs of the individual. Habilitation, as defined by DDS, means “the process by which an individual is assisted to acquire and maintain those life skills necessary to cope more effectively with personal and environmental demands or to improve physical, mental, and social competencies” (DDS, 2009a). Services focus on such skill and habilitation needs can include: Occupational Therapy, Physical Therapy, Speech and Language Therapy, or Behavioral Treatment. These programs are funded by the Division of Medical Assistance (DMA).

Vocational Services encompass a broad range of opportunities, but focus on paid employment. These types of programs can range from a sheltered workshop, where the individual works in a group on piecework, to supported employment in the community with or without a job coach. However, only some adults with autism are able to work in the community. Recent national estimates suggest that 35% of high functioning adults with autism work, while only 10% of adults with moderate to severe autism are able to work in a supported employment environment (Ganz, 2007).

In terms of residential services, there are two options that families and individuals in Massachusetts can take advantage of, based on availability: campus-based or community-based programs. Community-based programs seek to integrate the individuals into the local community. Organizations such as the May Institute provide this kind of opportunity for adults with autism. In community living programs, there is a specific focus around community integration and socialization, since these living arrangements are located throughout many towns and cities. Campus-based programs, such as the New England Village, provide residential services on-site (New England Village, 2009). The campus models offer a variety of supportive and recreational services on site, but also provide opportunities for community involvement. They are often in rural areas and a good option for individuals who have a heightened sensitivity to noises common to

metropolitan areas. Currently, community-based residential programs are more commonly used than campus-based programs.

Lastly, there are home-based service models which allow for treatment and assistance to take place in the individual's own home. In this service model, support service workers provide all services on site. The advantage to this kind of service model is that it allows for individuals with autism to learn therapeutic techniques in their everyday environment, which can help in the development of routines or in learning new behaviors.

While these are the most commonly used services, individualization and flexibility according to the needs of an individual with autism are critical. Research surrounding the effectiveness and appropriateness of each service would be useful in helping Massachusetts plan for an increase in need. Lastly, although it is not formally tracked, there are many individuals who end up on waiting lists especially for residential services due to a lack of capacity. In 2006, over 64,000 people with developmental disabilities were reported to be on waiting lists nationally for placements into residential services; research studies have estimated that the figure could be as high as 84,500 (Braddock et al., 2008). This is likely to become a more significant problem as individuals with disabilities in the baby boom generation age and more adults need out-of-home services. The availability of research evidence on appropriate adult services will help the state provide services for the current disabled population, as well as plan for future needs.

Related Legislation: Chapter 688

Massachusetts enacted Chapter 688 in 1983 to create a transition into the adult services system for students with disabilities (Horace Mann, 2009). It is also known as the "Turning 22 Law" because in Massachusetts, individuals with disabilities exit the educational system when they graduate or when they turn 22 years of age. Administered by the Executive Office of Health and Human Services (EOHHS), this law connects individuals leaving the educational system with adult services through a two-year planning process and the development of a transition plan. This law is not an entitlement; it does not guarantee services but it does help to plan for the future needs of the individual (DDS, 2009b). Students are eligible if they are receiving special education services,

need continuing services, and are only able to work 20 hours per week or less in non-supported employment (Commonwealth of Massachusetts, EOHHS, 2009). Depending on their needs, cases are referred to the Department of Developmental Services (DDS), the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind or the Massachusetts Commission for the Deaf and Hard of Hearing.

Current Challenges in Service Provision

There are a few gaps in knowledge that Massachusetts needs to address before attempting to change the way they provide services to individuals with disabilities. First, Massachusetts does not know the size of its current adult autism population, let alone how they are being served or by which programs. Secondly, due to the fragmentation of disability services and lack of data, Massachusetts is unable to compare across programs or agencies and determine the effectiveness of current programming or placements for adults. Lastly, there is little state or national data to indicate what best practices in adult services look like for adults with autism.

(Lack of) Information Sharing

Upon leaving the educational system between ages 18 and 22, the Department of Developmental Services (DDS) and the Massachusetts Rehabilitation Commission (MRC) refer individuals with disabilities to adult services and programs. Massachusetts does not currently have a unified tracking mechanism for adults with disabilities; each agency is responsible for tracking its own clients and referring them to the appropriate services. Currently DDS does not keep track of diagnoses other than the primary one, so when an individual is placed through their agency, additional disabilities or conditions are not taken into account. This is problematic because individuals with autism commonly experience multiple conditions including seizures, impulsive behavior, mood instability, anxiety and depression (Charles et al 2008). If these conditions are not taken into account when planning placements, adults with autism may end up in a program that does not effectively suit their needs.

Additionally, since autism is on a spectrum, it requires scaled treatment as the diagnosis can affect people with differing severity.

For example, three typical scenarios on the autism spectrum include: (1) an adult requiring 24/7 supervision, (2) an adult going to a day habilitation program who is heavily supervised and requires transportation, and (3) an adult who works in the community with support from a job coach and is living at home. Each of these individuals will need vastly different levels of support, and therefore individualized referrals are needed to meet the specific needs of each client. DDS's current approach may be due to the high volume of individuals that they manage and the large case loads that their employees carry.

By sharing information across programs, some of this challenge could be alleviated. Under the Individuals with Disabilities Education Act (IDEA) legislation, school districts must keep track of the number of students enrolled in special education with autism. So, the Massachusetts Department of Education has a lengthy history on the progress of each child in special education, including developmental disability status, severity of need and types of interventions that have been tried while they have been in school. If this information could follow the child into the adult system, agencies like DDS would be able to better place these individuals.

(Lack of) Available Research

The dearth of evidence available surrounding best practices for serving and caring for individuals with autism creates many challenges for service providers and states. It limits the ability to plan future services, make decisions on the expansion of services, focus on the use of effective services, and estimate the efficiency or lack thereof of different service delivery models.

The possible causes of autism are still unknown, so much of the research focuses on finding the cause and the effects of autism on young, developing children. For example, the National Institutes of Health (NIH) supports two major research networks for autism: the Collaborative Programs of Excellence in Autism (CPEA) and Studies to Advance Autism Research and Treatment (STAART). CPEA's research focuses on determining the possible causes of autism by looking at a variety of factors including genes, immunology, and the environment. They also look at the ways that autism is diagnosed and treated (NIH, 2009). The STAART Network focuses on

“causes, diagnosis, early detection, prevention, and treatment of autism” (NIH STAART, 2009).

It is critical, however, to fund research at different stages of life, including adulthood, to better understand how the disability progresses or changes over time. Individuals with autism can live well into their 40’s and beyond, although their mortality rate is higher than in the general population (Mouridsen et al., 2008). So, expanding research to include all stages of life could help inform needs for learning and skill development for those who are past school-age and in the adult system.

Inherent in the question of aging is the fact that some of these individuals may outlive their parents or outgrow the age at which their parents can effectively care for them. Therefore, adult care and programming is a significant and growing issue for many families with autism. By supporting research that looks at treatment and programming geared towards adults, we can better serve current and future generations of adults with disabilities.

Leaders of Change

Consumers and families are the main supporters and advocates of improvements to disability services. The Arc of the United States (formerly known as the Association for Retarded Citizens), Autism Speaks, and the National Autism Association (NAA) are just some of the special interest groups that would voice support for improving service delivery in Massachusetts. Especially given Massachusetts’ progressive approach to healthcare, national advocacy groups would support efforts to improve disability services in the hopes that Massachusetts would be used as a model for other states.

In the Massachusetts legislature, there are a number of strong supporters interested in investing in disability services. Representative Barbara L’Italien (D-Andover), Representative Tom Sannicandro (D-Ashland), and Senator Karen Spilka (D-Ashland) are among the key supporters for statewide efforts to improve disability services in Massachusetts. In 2009-2010, Rep. Sannicandro is sponsoring 6 disability-specific bills, Rep. L’Italien is sponsoring 10 disability-specific bills, and Sen. Spilka is sponsoring 2 disability-specific bills (Commonwealth of

Massachusetts House, 2009; Commonwealth of Massachusetts Senate, 2009).

While it is difficult to get a broad base of support for new spending in this economic climate, the short term expenditures associated with the following policy alternatives could create long-term cost-savings. New policy options need to be considered to develop a long-term strategy to avoid the inefficient use of state resources.

Scopes for Improved Services

Massachusetts is not prepared to meet the needs of an increase in the number of individuals with autism. The Executive Office of Health and Human Services (EOHHS) needs to plan for the increasing cohort of adults with autism over the next 10 years and dramatically improve the current knowledge and information systems used in disability services. There are two options that should be considered, each with a specific time horizon.

Short –Term Options (1-4 years): Information Gathering, Dissemination and Sharing

One major issue that can be addressed over the next 1-4 years is improved information dissemination and data management regarding individuals with disabilities. For example, information regarding diagnoses, prior therapies that have been tried, prior work placements, secondary conditions, and behavioral conditions would all be useful for an agency to have to make a successful placement. Logistically, agencies have their own data collection methods based on their eligibility criteria and the data they feel is critical to have. Targeted information gathering is necessary for agencies; intake would require an incredible amount of time if each agency tried to get a complete personal history. However, having a complete and accurate personal history available could ensure that appropriate services are provided for individuals with disabilities in Massachusetts. Therefore, there are a few ways that information management could be improved and made more useful to the state and inform both providers and clients in their decision making. First, there could be improvement in terms of information sharing across agencies. Secondly, there could be improvement in the way that data are collected and managed for each individual case, as

evidenced by efforts begun by the Massachusetts Rehabilitation Commission (MRC).

Information sharing across agencies. Disability services are fragmented, with multiple agencies and programs providing supports to individuals with autism. Currently, when an individual is deemed eligible for adult services and leaves the educational system, a new case file is opened at the transition or referral agency. Each agency has its own standard operating procedures when it comes to intake of new clients. For example, DDS does not track dual or multiple diagnoses; they focus on intellectual quotient to ensure that the client is eligible for services. When an individual is placed through DDS, other disabilities or conditions are not taken into account. As stated earlier, this is problematic because individuals with autism commonly experience seizures, impulsive behavior, mood instability, anxiety and depression in addition to cognitive impairments (Charles et al., 2008). If these conditions are not taken into account when planning their placement, they may end up in programs that do not effectively suit their needs.

One solution to this is having case files follow each individual from the Department of Education to DDS or the individual's specific referral agency. Given that the IDEA legislation already mandates certain reporting procedures that states are required to follow, specifically around keeping track of students with disabilities, it is a duplication of effort for the transition agency to open an entirely new case for an individual who already has a history with the Department of Education (U.S. Department of Education, 2009c). That would help alleviate any information falling through the cracks, and give the referring agency much more background to work with to make a successful and efficient placement.

Some challenges in moving forward with this option might relate to privacy issues around the sharing of personal information. One way to alleviate concerns around the release of information is to include other family members in planning and releasing information. For example, there could be an option for individuals to sign release forms to allow their information to travel with them across agencies. Additionally, if even only a basic treatment history or primary diagnostic information could be shared between agencies, it would vastly improve the ability of DDS and MRC to make effective referrals.

Data management. Another way that information dissemination and utilization can be improved is through changes in the way that agencies manage their consumer data. Currently, the Massachusetts Rehabilitation Commission's Vocational Rehabilitation program collects information on primary and secondary disabilities for all consumers. At the point of application, the counselor collects this information and enters it into MRC's case management database. This reporting procedure is mandated by their federal funder, the Rehabilitation Services Association (RSA), which influences the way that they collect and manage their client information. Other agencies, such as DDS, are not funded by RSA, and thus do not have to conform to the same reporting regulations or eligibility requirements. However, if data systems can facilitate information sharing across agencies, then the DOE, MRC and DDS could coordinate the information they have on an individual to create a more complete picture of each individual without having to change their eligibility requirements or other agency-specific functions.

There are three main steps that can be taken to improve data management. First, the move to electronic recordkeeping is critical for improved operations. Most agencies are moving this way, but there are still some areas in which paper documents are being used. Another approach is to utilize an agency-wide cross-database comparison tool. This is a type of software tool that is able to look at multiple databases, such as Oracle and SQL Server, and compare fields in each database against each other. Instead of trying to implement a single database across multiple agencies, this tool allows the database administrator to compare fields, such as service areas, and compare utilization rates or financing across an entire agency or even between agencies. If an agency cannot take a snapshot of itself and understand how its money is being spent, where people are being placed and if any service duplication is occurring, then their standard operating procedures are not efficient. Lastly, DDS should consider ensuring that its database is compatible with other agencies serving the adult disabled population. This recommendation seeks to consolidate and make uniform information on individuals being served by the Commonwealth.

Before establishing an effective system of data management, several challenges need to be addressed. First, there is variation across programs within the same agencies for how data are

managed. For example, two programs within the MRC, the Home Care program and the Vocational Rehabilitation program, use different disability categories. They are, however, working on a key to enable cross-program comparisons. So even within agencies, it is acknowledged that it will be a challenge to coordinate; however the benefits of transparency and referral coordination could potentially save money in the long run by eliminating the duplication of services.

Secondly, DDS will have concerns that uniform reporting for all of their disability services will create extra paperwork for them, considering they already don't have enough time or resources to serve the current need. However, if coordinated reporting is developed to align with the federal reporting requirements DSS already has, this would not create extra work. DDS can select a database that has the capability to select out fields for various types of reporting, so in the long-run it can make things easier. Also, instituting uniform tracking across the agency can make all of DDS's disability services more efficient, not just programs for individuals with autism.

DDS should take note of MRC's management of their Vocational Rehabilitation program, as well as their attempt at agency-wide coordination. DDS should consider how MRC's model can be adapted for its case management and referral needs. If DDS can improve its ability to coordinate with MRC, then its improved data management could increase information sharing and facilitate comparisons across agencies, providing consistent disability service tracking.

Long-Term Option (one to 10 years): Need for Research

As evidenced in this paper, there is a significant lack of information around services for adults with autism. Considering the youth prevalence of autism in Massachusetts, there will be more adults with autism with service needs over the next ten years. Effective policy decisions require accurate information on which to base future recommendations.

Research commission. Massachusetts should consider forming a commission to gather data surrounding the status and future needs of adults with autism as well as formulate policy and service recommendations for the Commonwealth. This commission could report to EOHHS and involve a number of local stakeholders

including state agencies, service providers, and universities. The work of a research commission would enhance the current knowledge base and assist in developing policy recommendations for improving the delivery of disability services for adults with autism and other developmental disabilities.

Policymakers and practitioners need accurate state-level data for a clear understanding of the current state of autism services in Massachusetts. The following areas are understudied and need more attention to formulate effective and efficient future policies:

- *Number of adults* with autism who are *served* in Massachusetts
- Number of adults with autism currently on *waiting lists* for services
- Service *utilization* by adults with autism
- *Intensity of services* used
- Longitudinal *cost estimates*, both to the individual and to the state

By compiling these data, Massachusetts will better understand the current state of its disability services. It could also enable EOHHS to begin looking at specific areas in which overlap and inefficiencies may occur.

Information is also needed to facilitate effective program design and future policy planning. By gathering the following data, this commission could better inform policymakers and practitioners in terms of priority setting and policy development:

- Evidence around *best practices* for serving adults with autism
- Research on *implementation, effectiveness and efficiency* of various behavioral therapies
- Research on *training and retaining* front line workers and primary caregivers.

First, this research commission could assist in disseminating findings around best practices for serving adults with autism, especially around behavior therapies. Most of the current research is around children, and it is entirely possible that adults will have different needs and reactions to therapy. There also needs to be research on various kinds of behavioral therapies. Only applied behavior analysis (ABA) has been tested over time, and only with

children. Lastly, there needs to be research around training front line workers and primary caregivers as well as more analysis on how to retain them in their positions for longer periods of time. Included in this is determining the distinct needs of adults with autism, and how to make training cost-effective for agencies and organizations. This might include looking at ways to include training in Medicaid reimbursement formulas. In the future, Massachusetts will be able to look at the costs to individuals, communities, and tax-payers, and weigh alternative service options with confidence.

While this research agenda covers a broad range of focus areas, it speaks to the lack of understanding that remains around autism especially for adults. This research commission could also build on work that is currently being done. For example, the Waisman Center at the University of Wisconsin-Madison along with a researcher at Boston University are doing a research project called Adolescents and Adults with Autism (Seltzer et al, 2009), looking at how autism affects adolescents, adults, and their families over a 12 year period. They currently are investigating 405 families and are funded by the NIH (Waisman Center, 2009). Over the course of this study, other Massachusetts institutions, including Brandeis University, have been involved as well.

IT investment. Massachusetts needs to consider investing in research around using IT solutions to streamline service delivery and daily operations. While there are a number of software packages that exist, there are two in particular that have a national presence. The first example is the AWARE case management system which integrates case management and fiscal information for vocational rehabilitation programs as well as programs for the blind. It is currently used by organizations in 17 states, including Maryland, California, Michigan and Florida (Alliance Enterprises, 2009). MRC has considered a program like this for their vocational rehabilitation program, but has been limited by the capital that is needed to purchase and switch over to this program. Another example is a software solution called Therap Services. Therap Services offers, “an integrated suite of cost effective applications for the developmental disability community” (Therap Services, 2008). This software suite is currently used by providers in 28 states, including California, Florida, Massachusetts, and New York. Therap Services is a web-based application, so one benefit is that there are

no costs to the agency in terms of software purchasing, installation or upgrades.

It is important to look at evaluations of these software programs and investigate whether they can be used for a variety of disabilities and program types. With the retirement of the baby boom generation, IT systems are a good way to ensure that knowledge gets passed along to new case workers. While these systems may not be a complete solution for all agencies and services, IT solutions can be used to facilitate information sharing. There is much research that can be done around a new IT infrastructure that could facilitate coordination across a number of agencies.

Improving communication between agencies and even intra-agency can facilitate more effective service delivery and improved coordination. In the long run, an improved and streamlined IT system facilitates information sharing and improves the accuracy of referrals for all individuals with disabilities in Massachusetts. The impact of moving forward with this option would be felt far beyond the autism community.

The cost of investing in an IT infrastructure shift is significant; especially upfront. So while this is an ideal solution to service coordination and information management, it may be difficult to fund. However, one opportunity for financing some of these IT options is through the American Recovery and Reinvestment Act of 2009. There is a significant amount of funding going towards green jobs, and perhaps the move away from paper documents to an all-online system could fit within the purview of one of the many greening projects (Pelosi, 2009).

Recommendations

Massachusetts needs to take a two-pronged approach to prepare for the increasing adult population with ASD. As can be seen in Table 3, both short- and long-term strategies need to be utilized to improve service delivery and streamline daily operations.

Phase 1: Short-Term Investment: Improved Data Management

EOHHS should consider taking action on two short-term recommendations. First, all agencies in EOHHS handling disability

Table 3

Policy Recommendations

Phase 1: Short-Term Investments

1. Agencies move to electronic record keeping
2. Individuals have personal files follow them to each referral agency

Phase 2: Long-Term Investments

1. Develop research commission to gather and disseminate information
-

services should move to electronic record keeping. This includes DDS, MRC and any other agency that manages and makes referrals for individuals with disabilities. IT systems can streamline data collection and ensure that knowledge gets passed along to case workers. While there are some up-front costs in moving to electronic databases and case management systems, the long-run benefits of improved communication within agencies, transparency of information across case workers and potential for improved referrals outweigh the short-term costs.

Second, individuals eligible for adult services need to have their own treatment files follow them to each agency to which they are referred for services. It is understandable that agencies have certain operating procedures that can make it difficult to spend a lot of time with each client getting his or her personal history. By allowing the individual's case file to stay with him or her, it saves time for both the agency and individual, and opens up the opportunity to make referrals that target the strengths of the individual; since that information would now be available. It also gives the opportunity for the agency to make placement choices that build on the individual's past experiences. This can make the transition into adult services more appropriate and seamless because the individual may end up in a situation similar to one they have experienced in the past.

These short-term recommendations will have immediate impact on disability services and would require the least disruption to the current system.

Phase 2: Long-Term Investment: Research Commission

EOHHS should formulate and support a research commission focusing on research and policy solutions for adult disability services, with a specific focus on autism. This research commission could initiate statewide data gathering, become a clearinghouse for current research and partner with state or federal organizations in furthering areas in which there are gaps in the literature.

Through research and analysis, Massachusetts and the EOHHS have the opportunity to re-frame the way that they approach disability services for adults with ASD. With more information surrounding best practices, effective interventions and the specific needs of adults with autism, Massachusetts can effectively manage the incoming cohort of adults with autism and ensure appropriate referrals and placement. This recommendation could also set up Massachusetts to be a leader for other states to model as they experience similar challenges in managing their population of aging individuals with ASD.

Conclusion

As evidenced through this analysis, EOHHS is not prepared for an increase in the autism population. Massachusetts lacks accurate information on the numbers of adults with autism that are currently being served. Due to the fragmentation of the system and lack of data, EOHHS is unable to compare across programs or agencies and determine the effectiveness of current programming or placements for adults. Because of the lack of research available, Massachusetts is not able to develop its disability services around best practices in adult services.

To effectively plan for an increasing cohort of adults with autism into the Massachusetts adult disability system over the next 10 years, the EOHHS needs to ensure that agencies improve their information dissemination by moving to electronic databases across the board, and allowing individual case files to follow the individual to all referral agencies so that personal needs don't fall through the cracks. Long-term investments such as an autism research

commission will enable EOHHS and Massachusetts to serve its adult population with autism more effectively and efficiently.

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Notes

1. Note on use of language in this article. There is scattered consistency in the use of “autism” and “autism spectrum disorder (ASD)” in the literature. According to the DSM-IV, ASDs include autistic disorder, Asperger’s Disorder, pervasive developmental disorder-not otherwise specified (PDD-NOS), Rhett’s Disorder and Childhood Disintegrative Disorder. Also, across agencies there may be variation in the categorization of ASDs, since there are no biological markers, only behavioral. So for the purposes of this article, ‘autism’ will be used synonymously with ‘ASDs’; however it is understood that high functioning individuals will be less likely to need state supported services as adults.
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Helping Vulnerable Families: Providing High-Quality Infant-Toddler Care for Mississippi's Young Children

Anna Gazos

High-quality infant and toddler care promotes all aspects of early childhood growth and development, including social, emotional, cognitive, and physical development. However, the United States struggles to provide an adequate amount of high-quality care at a reasonable price for vulnerable families that need it the most. When it comes to child well-being, Mississippi ranks lowest in the country because it is home to the highest percentage of single parent headed families, children in poverty, and low-birthweight babies, ultimately containing the highest vulnerable family population. Additionally, Mississippi reimburses infant and toddler care providers at a lower rate than federally recommended, making it difficult for providers to invest in quality service and perhaps accounting for the lack of high-quality early child care centers in the state. This article outlines four solutions for making infant and toddler center-based care more affordable and accessible: a) create partnerships between existing Early Head Start programs and community-based infant and toddler centers, b) ensure high-quality care in the home, c) mandate provider participation in the Mississippi Child Care Quality Step System, and d) provide tax incentives for families to use high-quality care and for providers to offer high-quality service. Ultimately, Mississippi must invest in an ordered sequence of action that first increases the availability of high-quality infant and toddler center-based care, then provides incentives for high-quality infant and toddler usage, and finally evaluates its impacts on the needs of vulnerable infants, toddlers, and their families.

High-quality infant and toddler care nurtures rapid brain development for children birth to age three (National Research Council, 2000). The creation of the National Association for the Education of Young Children (NAEYC) in 1929 began the movement towards high-quality early education. NAEYC accreditation ensures a variety of evidenced-based practices proven to facilitate social, emotional, cognitive, and physical development. These practices reinforce behaviors in later life, including higher

school achievement, controlled aggression, and greater cooperative interactions (National Scientific Council, 2004; Cohen & Ewen, 2008).

Recent research shifts the attention from high-quality benefits to low-quality damage. Of the 119,174 early child care centers in the United States, only 9.4% are accredited, meaning many more children use child care without approved standards (NACCRRA, 2009b). Scientists and researchers confirm the harmful effects of low-quality care on children's growth and development, such as low trust towards adults and poor brain and emotional development (NCCP, 1999).

Vulnerable families are at or below 200% of the poverty line (\$21,200 for a family of four), and most likely headed by a single parent dependent on non-parental child care to fulfill labor force commitments. In 2007, the percentage of infants and toddlers living in poverty rose to 5.4 million, or 43% of 0-3 year olds in the US (Douglas-Hall & Chau, 2008). Parents, especially in vulnerable families, depend on outside work to support their children financially. This dependency accounts for the 49% of low-income parents with infants working full-time and year-round (p. 2). The demand to work often results in a reliance on non-parental infant and toddler care. The high cost of high-quality child care, however, causes more low-income parents to enroll their young children in low-quality care (Capizzano & Adams, 2003).

The cost of infant and toddler care runs between \$4,560 and \$15,895 per child a year, depending on the state. Within each state, the cost of high-quality infant and toddler care lies in the upper range of state averages. For single parents, this expense consumes anywhere from 28% to 60% of their annual income, often leaving parents no choice but to find the best economical choice (NACCRRA, 2009b). Currently, child care subsidies allay some of the expense for parents. However, 40% of young children are in low-quality care mainly due to the limited number of high-quality options in low-income neighborhoods and the fact that some centers do not accept child care subsidies (Schumacher & Hoffmann, 2008; Cohen & Ewen, 2008).

Consequently, disparities between infants and toddlers using high-quality and low-quality care, or in another sense, between those who can access and afford it and those who cannot, grow. Young children in poverty face enormous barriers to success, such

as unstable housing, higher rates of maternal depression, poorer nutrition, and sporadic health care (Maternal & Children Health Bureau, 2007). These barriers give low-income infants and toddlers a delayed start in development, increasing the need for high-quality care. In fact, research shows that children in low-income families experience the effects of low-quality care more severely than their peers (Cohen & Ewen, 2008; Schumacher & Hoffmann, 2008).

Supporting children's growth and development requires states to provide high-quality infant and toddler care and incentives for its usage. States can build upon an established infrastructure of proven high-quality infant and toddler care, such as Early Head Start and a Quality Rating and Improvement System. However, providing more slots for high-quality care needs to be coupled with incentives to encourage low-income families to use the service, such as consumer tax credits for high-quality infant and toddler care usage. Promoting healthy growth and development for young children depends on a state's commitment to such initiatives and creative use of resources.

Understanding High-Quality Infant and Toddler Care

What High-Quality Infant and Toddler Care Means

Current research and policy standards. Four decades of research on neuroscience and developmental behavior conclude that early brain development depends on an infant's genetic make-up, early experiences, and the environment. Although genetics set the stage for brain circuits, experiences and the environment determine the direction those circuits take. Infants develop best when in a loving and caring relationship with an adult – one that is responsive, interactive, and stimulating. Additionally, positive stress events, such as encountering new people while in the presence of a stable and supportive adult, help the brain develop positive coping and self-control skills. According to research led by the Center on the Developing Child at Harvard University, high-quality infant and toddler care promotes healthy brain development, which links to “emotional well-being, social competence, and emerging cognitive abilities,” in infancy and lasting well into adulthood (National Research Council, 2007).

The neuroscience and early education policy and research fields acknowledge that high-quality care provides the best avenue for positive child development. The effects of poverty greatly alter the development of the brain if not buffered by high-quality standards of operation and nurturing relationships found in high-quality centers. Studies from Early Head Start and other high-quality early education and care programs show that society gains between \$2 and \$17 for every \$1 invested in high-quality early education – primarily from lower crime, fewer teen pregnancies, and higher education levels and individual earnings (RAND, 2008 & Schweinhart, 2004). The money lost from the damaging effects of low-quality infant and toddler care is also of significance for vulnerable young children, as this creates a cycle of poverty.

NAEYC accreditation. Since 1985, the NAEYC’s voluntary accreditation system has represented the high-quality standard for both infant and toddler and preschool education. NAEYC accreditation meets many of the criteria professionals in the field deem necessary for high-quality infant and toddler care (see Table 1). The Association weaves accreditation criteria into program implementation through specific best practices. These include a low child-to-teacher ratio, small group size, highly skilled and educated teachers that are responsive and sensitive to both the child and parents, evidence-based curriculum in the classroom, and the use of frequent child assessments (National Scientific Council, 2007; Cohen & Ewen, 2008).

NAEYC’s standards prove developmentally effective in the way they address factors needed for ensuring school readiness and positive development. Its early learning standards – expectations for the learning and development of young children – meet the four essential criteria for a developmentally effective system. These factors include early learning standards that (a) emphasize significant, developmentally appropriate content and outcomes, (b) build on a valid source of multiple stakeholders’ expertise, (c) support all development in ethical and appropriate ways, and (d) require a foundation of support for early childhood professionals, programs, and families (NAEYC, 2002). NAEYC accreditation continually creates a stronger, more committed community of teachers, administrators, and families committed to high-quality early education. In support of NAEYC accreditation, the *Wall Street Journal* said “the primary gauge of quality has been

Table 1

NAEYC Early Childhood Program Standards and Accreditation Criteria

1. Supportive relationships among all children and adults.
 2. Curriculum that promotes social, emotional, physical, language and cognitive development.
 3. Developmentally, culturally and linguistically appropriate and effective teaching.
 4. Ongoing, systematic, formal and informal assessment approaches of child progress.
 5. Promotes nutrition and health of children and protects children and staff from injury and illness.
 6. Teaching staff with educational qualifications, knowledge, and professional commitment necessary to promote children's learning and to support families' diverse needs and interests.
 7. Collaborative relationships with each child's family.
 8. Establishes relationships with and use the resources of the community to support program goals.
 9. Safe and healthful indoor/outdoor spaces that are well maintained.
 10. Strong leadership and management that effectively implements policies, procedures, and systems.
-

Note: Adapted from NAEYC (2005), *NAEYC Early Childhood Program Standards and Accreditation Criteria: the Mark of Quality in Early Childhood Education*.

accreditation by the NAEYC...whose seal of approval is regarded as the gold standard by parents, educators and facilities" (Wall Street Journal, March 24, 2006).

NAEYC accreditation epitomizes a practical benchmark for infant and toddler centers and, therefore, represents the high-quality standard for this article. Legal operation does not require accreditation; however, early education leaders and early childhood experts recommend NAEYC accreditation criteria for high-quality care. Unfortunately, the cost of quality has discouraged many states, Mississippi included, from investing in high-quality standards. However, high-quality care enhances children's growth

and development, which builds a strong foundation for learning, adapting, and contributing to society in later life.

Federal funding. Ongoing events in the House and Senate reveal that government officials understand the necessity of high-quality infant and toddler care. In February 2009, President Obama signed the American Recovery and Reinvestment Act (ARRA) that agreed to fund an additional \$2 billion for the Child Care and Development Block Grant (CCDBG) over a two-year period. The Act reserves \$93.6 million of CCDBG funds for quality improvements in infant and toddler care. For CCDBG, Mississippi will gain \$30,983,386. Another funding stream competitively provides Head Start \$2.1 billion, split between Head Start and Early Head Start. This news comes at a pivotal point for the early education arena. States currently deny financial assistance to hundreds of children due to budget deficits caused by the current economic recession. The bill signifies a commitment to infant and toddler care and a promise towards accessible and affordable high-quality care for all families.

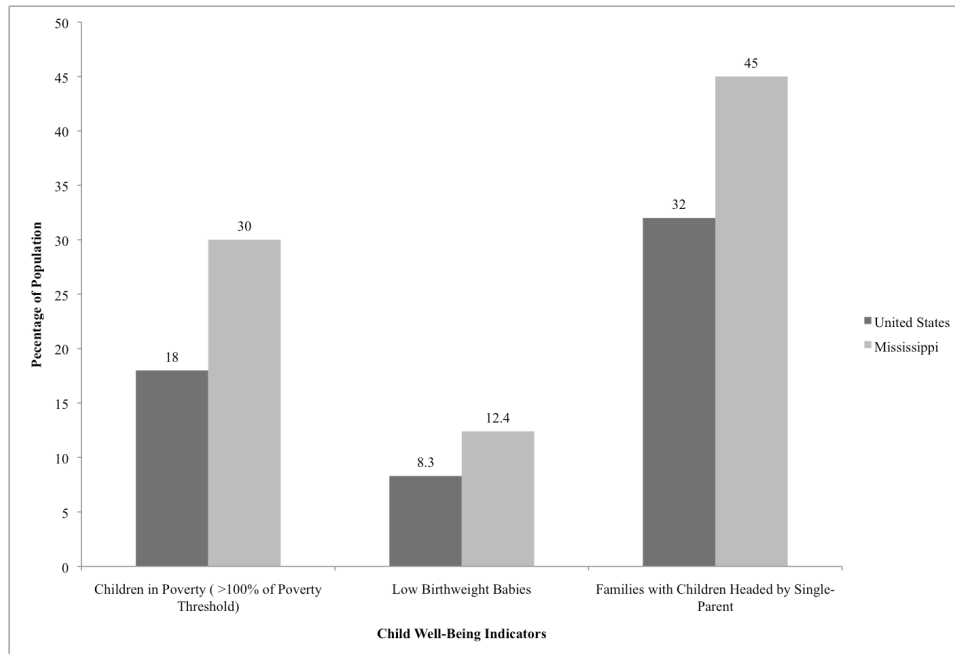
Secretary of Education Arne Duncan proclaimed on NPR Radio that stimulus package money will “not just increase seats and access [for early education], but make sure those [seats] are quality seats, not glorified babysitting” (Stephenson, 2009). Duncan also noted the many factors influencing future change in early education, such as bipartisan support from Congress, strong leadership from President Obama, a comprehensive agenda supported by proven strategies for success, and unprecedented resources from the ARRA.

Affording and Accessing High-Quality Care in Mississippi

Providing high-quality infant and toddler care is a nationwide concern. Mississippi, however, represents the state in most need of action for several reasons. First, as seen in Figure 1, Mississippi has the highest percentages in low-birthweight babies, children in poverty, and single parent families (Casey Foundation, 2008). These children need high-quality care the most. Low birthweight results in a higher risk of developmental delays and learning disabilities, and requires highly skilled teachers to identify problems and the use of child assessments to confirm such concerns.

High-quality care reduces the effects of poverty, such as poor nutrition. Further, as the poorest state in the nation, the current

Figure 1

Comparison of 2006 Child Well-Being Indicators

economic recession has hit Mississippi particularly hard. In the last few years, Mississippi placed job creation and job opportunities as top priorities on the state's agenda. The influx of more parents in the labor force, however, must be coupled with increased accessible child care (Sivak & Dixon, 2008). Single parents needing to work multiple jobs or extra shifts to make ends meet need out-of-home child care the most.

The cost of infant and toddler care in Mississippi burdens both families and providers. The average cost per child for infant and toddler care is \$124 per week. The state reimburses centers \$84 per week for each child. This translates into a 68% return of the market rate (Sivak & Dixon, 2008), 7% lower than the Federal recommendation (NCCIC, 2008-09). Federal reimbursement makes quality improvement costs more manageable for providers. Unfortunately, an already tight budget and a low reimbursement rate persuade many providers in Mississippi to avoid quality improvements.

Vulnerable families cannot manage the cost of infant and toddler center care without state assistance. Mississippi has one of the lowest full-time infant and toddler care costs in the country at \$4,560 annually. For a single parent household, however, child care costs comprise 28% of the family's income (NACCRRA, 2009b). With one-third of parents in low-wage jobs, the cost of infant and toddler care keeps vulnerable parents looking for the most economical solution. High-quality infant and toddler care comes at a cost, and when most parents are given the choice, they choose low-quality care as the only option that works within their budgets.

Mississippi's child care system struggles with far more than costs. Throughout the state, only 13 of the 1,174 early education centers are NAEYC-accredited (NACCRRA, 2009b). The high cost of accreditation presumably causes high-quality centers to locate in wealthy areas, leaving one to suspect that the 13 accredited centers are inaccessible for vulnerable families in Mississippi. The move towards high-quality infant and toddler care must include increasing accessibility of high-quality facilities in vulnerable neighborhoods.

This article focuses on center-based infant and toddler programs over family-based programs as a vehicle for high-quality care in Mississippi for numerous reasons. In Mississippi, family-based child care lacks state regulations, meaning there are no standards or benchmarks required for operation (NITCCI, 2007). Startlingly, family-based providers in Mississippi face no limits for the amount of children served in each home. Moving from non-existent state regulations to high-quality standards would require many more resources and much more effort than working with center-based programs that follow state regulations. Furthermore, vulnerable families are much more likely to place their child in center-based rather than family-based programs, as seen through reported child care placement of CCDBG recipients in Mississippi (CLASP, 2008). The data demonstrate that improved practices in center-based infant and toddler programs would target vulnerable families.

Current Policies Promoting High-Quality Infant and Toddler Care

Early Head Start. In 1995, the Federal government addressed the need for high-quality care for vulnerable young children by

establishing Early Head Start (EHS). Funded through Head Start by the Administration for Children and Families (ACF), EHS focuses on healthy infant, toddler and family development (a list of their nine principles is found in Table 2). EHS targets vulnerable families by setting enrollment eligibility determinant on income and serving enrolled children at no cost to parents.

EHS represents a two-generational program – center-based care, home-based care or a combination of both forms of care offered for children and their parents. Services include prenatal health care and support, child health care and screenings, support systems for parents, and high-quality child care services. EHS center-based programs offer infant and toddler care that enhances children's growth and development, provide parental education and health services, and facilitate two yearly home visits for each family. Mississippi currently has 38 EHS programs scattered throughout the state.

Evaluation of Early Head Start. Between 1996 and 2001, Mathematica Policy Research Inc., Columbia University's Center for Children and Families, and the EHS Research Consortium (17 EHS programs, 15 university-based research teams, and ACF) evaluated 3-year old graduates from EHS in 17 programs throughout the country. The 3,000 children involved in the study also included a non-EHS comparison group of children with similar demographics. Between 2001 and 2004, the team evaluated the same children in a pre-kindergarten follow-up study. Evaluators measured children's cognitive, language, and social-emotional outcomes through direct observations and parental reports. Parents were also assessed through interviews and self-reports. At age 3, center-based participants scored higher on cognitive and social-emotional measures and had larger vocabularies, lower levels of aggression, and higher levels of sustained attention compared to children in non-EHS centers. Parents involved in all forms of EHS had greater warmth towards their child, provided more stimulating environments at home, read to their child daily, and used physical punishment less frequently (DHHS, 2002). By 2010, the team plans to evaluate the same children in their sixth year of formal schooling.

The pre-kindergarten evaluation demonstrated that high-quality care could generate positive outcomes for vulnerable infants, toddlers and their families. Even though only 4 of the 17 sites

Table 2

Early Head Start's Nine Guiding Principles

1. **High Quality:** implement policies and practices that embrace child and family development and community building.
 2. **Prevention and Promotion:** promote healthy child development and family functioning, prevention, and detection of developmental concerns.
 3. **Positive Relationships with Continuity:** support child attachment by minimizing the number of different caregivers and support long-term caregiver relationships.
 4. **Parent Involvement:** support the role of fathers, recognize that parents are the child's primary advocate, and involve parents in policy and decision-making activities.
 5. **Inclusion:** welcome and include children with disabilities.
 6. **Culture:** support home culture and language of each family.
 7. **Comprehensive, Flexibility, Responsiveness & Intensity:** maintain the flexibility to respond with varying levels of intensity based on families' needs and resources.
 8. **Transitions:** facilitate a smooth transition from EHS to Head Start or other high-quality programs and support services.
 9. **Collaboration:** build strong alliances with local community agencies and service providers.
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Note. Adapted from ACF (2009), What is Early Head Start? Retrieved February 26, 2009 from <http://www.ehsnrc.org>.

evaluated were center-based, it provides a framework for determining the success of high-quality infant and toddler center care. Positive results remained consistent across all children using EHS center care. However, a wider sample of EHS center-based programs would strengthen the evaluation.

Child Care and Dependent Block Grant. In addition to EHS funding for high-quality infant and toddler centers in states, the Child Care and Dependent Block Grant (CCDBG) Act gives money to vulnerable families with children under the age of 13 for child care cost assistance. In 2008, this Act funded \$5 billion to states,

and the 2009 ARRA promised an additional \$2 billion. One-fourth of CCDBG funds must always be used for quality initiatives, while the remaining amount helps families. CCDBG participants may or may not be recipients of Temporary Assistance for Needy Families (TANF); however, TANF agencies may transfer up to 30% of its dollars to CCDBG funds. For Mississippi, the 2009 ARRA plans to distribute \$30,983,386 to CCDBG, with \$1,483,365 specifically devoted to infant and toddler care (CLASP, 2009).

Within Mississippi's CCDBG program, children ages 0–3 comprised 43% of all recipients in 2007. The majority of parents reported supervision during employment as the main reason for participating in CCDBG (CLASP, 2008). Center-based programs remain the most commonly used facility for CCDBG recipients, in both Mississippi and the US as a whole. However, the uncertainty of available funds from one year to the next and the inaccessibility of this fund for many vulnerable families remains a major concern with CCDBG. Due to tight state budgets, the state dropped the number of children served each month from 39,100 children in 2006 to 30,600 children in 2007, meaning many vulnerable families who relied on CCDBG funds for infant and toddler care must now pay more of the bill. Although the funds support many children, without a funding increase or development of a more secure form of government assistance, the high price of high-quality infant and toddler care discourages vulnerable families from its usage.

Other policies. Smaller policies also contribute to increases in high-quality child care. In 2004, the Mississippi Department of Education applied for federal funding through Child Care Access Means Parents in Schools (CCAMPIS) – a program that supports campus-based child care for parents enrolled in higher education programs. The University of Southern Mississippi, Mississippi State University, and the Coahoma and Mississippi Gulf Coast Community Colleges encourage on-campus child care that meets Head Start standards and obtains NAEYC accreditation (Sivak & Dixon, 2008). The program provides not only flexible early child care, but *high-quality flexible early child care*. Although services are not limited to infant and toddler care, it exemplifies motivation towards high-quality care from early education activists in Mississippi.

New research from the Center on the Developing Child, influential findings published in *From Neurons to Neighborhoods: The Science of Early Childhood Development*, and continuing work from early education organizations such as the NAEYC all support stronger policies for the early education field. Federal policies and grants, such as EHS, CCDBG, and CCAMPIS help families access and afford child care. States such as Mississippi, however, need stronger and more creative policies that support high-quality care. The following section outlines four policy alternatives for ensuring that high-quality infant and toddler center-based care is affordable and accessible to vulnerable families.

Ensuring High-Quality Infant and Toddler Center-Based Care in Mississippi

Key agencies in Mississippi, including the state's Department of Education, Department of Human Services, and Child Care Resource and Referral Agencies understand the importance of high-quality infant and toddler care. Without support from everyone in the community, however, committing to high-quality infant and toddler care remains a problem. A public education effort that describes the multiple benefits of high-quality care, with the message that benefits accrue overtime, will increase the probability of achieving any sort of long-term policy change. Additionally, positive outcomes gained in infant and toddler centers may decline if not followed by a strong preschool education (serving children 3-5). Helping vulnerable families cannot be limited to infancy and toddler-hood. Rather, early education lies on a continuum of care, starting at birth and continuing until age 5.

With this in mind, the following proposed solutions provide Mississippi with alternatives to increase high-quality infant and toddler centers throughout the state and create incentives for consumers and providers:

1. Create partnerships between Early Head Start and community-based infant and toddler centers.
2. Ensure a high-quality environment in the home.
3. Mandate participation in the Mississippi Child Care Quality Step System.

4. Provide tax incentives for families to use high-quality care and for providers to offer high-quality services.

These alternatives represent a framework for increasing the supply and usage of high-quality infant and toddler centers among vulnerable families.

Create partnerships between existing EHS and community-based infant and toddler centers

Early Head Start (EHS) – an infant and toddler program targeted at low-income families – offers services through center-based programs, family-based programs, or a combination of the two practices. States generally set eligibility criteria following the federal poverty guidelines. As discussed earlier, the ongoing EHS evaluation study confirms small, yet significant, benefits for young children enrolled (DHHS, 2002).

Many modifications incorporated into the 2007 Head Start make EHS initiatives more viable for states. Changes include allocating half of Head Start expansion funds to EHS, distributing 20% of Head Start training dollars to EHS, and allowing conversion of Head Start programs into EHS dependent on community needs (Zero to Three, 2008). Additionally, the 2009 ARRA competitively provided states a share of \$1.1 billion for EHS. The government rewards states that comply with Head Start Program Performance Standards in existing EHS programs. These developments in EHS funding make expansion of the program an achievable goal.

Research shows that states have expanded upon EHS in four categories: lengthening the day/year of existing EHS services, expanding the capacity of EHS programs so a larger number of vulnerable families can use their services, providing resources and assistance to non-EHS providers to reach EHS standards, and supporting partnerships between EHS and non-EHS center-based providers for improving child care quality throughout the community (Schumacher & DiLauro, 2008). These initiatives serve as a launching pad for the Mississippi Department of Health and Human Services' expansion of its 38 EHS programs.

Missouri's EHS/Child Care Partnership Project is one example of an innovative EHS initiative that enhanced the quality of infant and toddler care throughout the community. In 1999, the state used a combination of money set aside from gaming revenues (\$4.2

million) and CCDBG funds (\$500,000) to create partnerships among EHS and community infant and toddler centers. The partnership helped expand services to full-day, full-year care and to attain Federal Head Start Program Performance Standards (Schumacher & DiLauro, 2008). EHS agencies recruited infant and toddler community-based centers that served children eligible for EHS, used state funds to help the centers reach EHS standards, and offered technical assistance, professional development, and additional health and family support services (Raikes & Love, 2002). The partnership symbolizes an agreement between EHS and community-based centers: EHS provides resources to the community-based infant and toddler center, and the center agrees to provide high-quality care to EHS eligible children (Schilder et al., 2005).

In the absence of an evaluation study of EHS partnerships, the evaluation of Ohio's Head Start (HS) partnerships serves as an indicator of expected outcomes. The Center for Child and Families (CC&F) conducted a longitudinal, comparative study of Ohio's partnerships between 2001 and 2005. The group analyzed 78 preschool centers in partnership with HS and 63 centers without Head Start programs. The research found that partnering centers received \$3,600 for every eligible HS child served. The funds primarily increased teacher compensation packages, supplies and materials, and helped achieve HS Program Performance Standards (high-quality practices). Additionally, centers received teacher training, HS supplies, materials, and technical support. Partnerships increased curriculum usage in the classroom, child assessments, and additional services, including screenings and referrals for families. The evaluation identified best practices, including strong partnerships from the outset, consistent goals set for the community-based center, and good communication between all players (Schilder et al., 2005).

For Mississippi, funds to strengthen partnerships between their EHS centers and the hundreds of infant and toddler centers could increase high-quality services for vulnerable families. Families already using community-based centers will experience a transformation towards higher quality. Families in the process of finding an infant and toddler center will encounter greater options of high-quality care within their neighborhoods. Spreading the HS Program Performance Standards will increase high-quality infant

and toddler care throughout the community and offer vulnerable families more choice.

Ensure High-Quality Care in the Home

NAEYC accreditation targets center-based child care. Yet, the concept of high-quality infant and toddler care can be replicated in a family's home. A few states have implemented an at-home infant child care program (AHIC) that provides cash directly to vulnerable parents with children under the age of two, allowing them to care for their child personally at home (Waldfogel, 2006). In 2004 and 2005, a federal stipulation funded five AHIC demonstration projects included in the reauthorization of TANF. Of the five demonstrations, Minnesota, Montana, and New Mexico continue to implement such programs for parents.

A combination of Minnesota's and Montana's AHIC programs serves as a workable model for Mississippi (National Partnership, 2005). In the early 2000's, both states signed AHIC into law and started distributing benefits to eligible families. Benefits partially supplemented a loss in income in return for parental care in the home. The pilot Montana AHIC program used TANF Maintenance of Effort (MOE) funds – 80% of state funds spent under the former Aid to Families with Dependent Children (AFDC) program. However, Minnesota reserves 3% of the state's Basic Sliding Fee (BSF) Child Care Assistance program funds for AHIC. In 2005, the 3% totaled \$513,130, although the 32 families in the program only required \$156,000 (\$4,875 per family). Eligibility for AHIC in Minnesota follows the BSF criteria, equaling 174% of the federal poverty line (\$27,423 for a family of three). The cash benefits covered a 12-month period and reflected 90–100% of the states' child care cost at a full-time infant family-based provider. In Mississippi, that amount equals between \$3,510 and \$3,900 a year (NACCRA, 2009b).

Both programs issued regulations and requirements for eligible families. While on the program, families in Montana cannot access TANF cash assistance. Minnesota families cannot use state assistance programs, such as the Diversionary Work Program or the Minnesota Family Investment Program. Before applying for services, the parent must show evidence of labor force participation, education/training, or job search activities. Once enrolled in AHIC, parents are required to discontinue any participation in such

activities. For a cash transaction, the parent must become the full-time caregiver for his/her child (below the age of 2) in his/her household.

Montana's AHIC program also requires completion of a child development education plan specifying activities and experiences that will enhance the infant's development. This portion of the program should be emphasized, for this requirement ensures AHIC programs will reflect high-quality practices. Mississippi should ensure that an AHIC program supplies participating parents with parent education and early child development classes, literature, and other resources. An additional benefit could grant parents useful, age-appropriate equipment, such as toys and books, as a way to ensure that families better utilize their newly learned knowledge and parenting techniques.

Mississippi, like Montana, can administer an AHIC program through the state's 12 Child Care Resource and Referral Agencies (CCR&R). Mississippi's CCR&R's improve the quality of child care throughout the state by offering technical and training assistance/workshops to providers; resource centers for parents, providers, and community members filled with classroom toys, books, educational media, and curricula material for temporary use; and a database of licensed child care providers available to parents (NACCRA, 2009a). Most of Mississippi's CCR&R's are located on community college campuses through the Mississippi State University Extension Service. This network provides an excellent vehicle for AHIC because the 12 CCR&R's service all of Mississippi's 82 counties.

Although this program could be feasible with proper implementation and the right amount of funding, it has a few drawbacks. First, the cash benefit per family poorly supports a family, an issue for single parent families in particular. Although the possibility of combining AHIC benefits with paid-leave benefits increases the amount slightly, vulnerable parents in Mississippi are more likely employed in low-wage jobs (Sivak & Dixon, 2008) and many working parents may not have the privilege of paid-leave benefits. Additionally, the threat of losing employment after parental leave frightens some working parents from taking a leave-of-absence.

Second, vulnerable parents may not want to discontinue state assistance. The cash benefits from TANF and other Mississippi

assistance programs, along with a working salary, are substantially greater than the amount provided solely by AHIC. To meet other basic needs, parents might choose the option that provides the most financial resources for their family. Following Minnesota's and Montana's example, the Mississippi AHIC program would supplement parents between \$3,510 and \$3,900 a year – an amount far less than any family can possibly survive on.

Lastly, Mississippi would have to dedicate funding towards monitoring the program and its participants. The Minnesota and Montana programs do not do so; however, a fully-implemented AHIC program should incorporate a system of tracking compliance and success. For example, a case worker that regularly checks in with participating parents ensures that parents are indeed staying at-home with their child and providing them with a safe and stimulating environment.

Even in light of these drawbacks, however, the implementation of an AHIC program would make an impact on Mississippi's infant and toddler child care system. Introducing an AHIC program may persuade some Mississippian parents to raise their young children at home full-time, especially in the presence of few high-quality providers in the community. If fewer infants and toddlers accessed low-quality child care, cognitive disturbance would decrease. Additionally, parents choosing to participate in the program would lower the total need for center-based child care slots and relieve some pressure for infant and toddler providers.

Mandate participation in the Mississippi Child Care Quality Step System

In 2006, Mississippi implemented a voluntary pilot Mississippi Child Care Quality Step System (CCQSS) in 9 counties through the Office of Children and Youth in the Department of Human Services. The pilot will last until 2011 (NCSL, 2007). Mississippi's CCQSS is a Quality Rating and Improvement System (QRIS). Similar to restaurant and hotel star-ratings, a QRIS assesses, improves and communicates program quality. The system awards early education programs for achieving multiple stars that represent progressive program standards (see Table 3 for the five common elements of QRIS).

Table 3

Common Elements in a Quality Rating and Improvement System

1. Standards: multiple steps between licensing and accreditation
 2. Accountability: how well programs meet standards
 3. Program and Practitioner Outreach & Support: training, mentoring, and technical assistance are included to help programs achieve higher levels of quality
 4. Financing Incentives: tiered subsidy reimbursement awarded with each quality level achieved
 5. Parent/Consumer Education Efforts: recognizable symbols, such as stars, to indicate the levels of quality
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Note. Adapted from Mitchell, A. (2008). *Quality Rating and Improvement Systems: Powerful Policy for Improving and Unifying Early Care and Education*. Presentation at the MA Recognizing Quality 2008 lecture.

The goals of a QRIS include recognizing quality, improving customer awareness of quality, rewarding quality financially outside of subsidy systems, and establishing a consistent approach to quality across all early education programs in the state (Mitchell, 2005). When properly implemented, child care quality, professional development among early education providers, parents' understanding of quality care, and program accountability all increase (NCCIC, 2007). As of 2007, 14 states officially incorporated a statewide QRIS and 9 states implemented a pilot.

The cost of a QRIS varies dramatically among participating states. Variability depends on administrative costs, assessment tools that establish compliance of standards and quality levels, and the frequency by which states require assessments. In Mississippi, child care facilities earning 2 to 5 stars and serving families using CCDBG assistance receive quality bonuses. The Office of Children and Youth (OCY) within the Mississippi Department of Human Services (MDHS) provided \$2 million in fiscal year 2008 for the QRIS pilot initiative. The pilot expanded from 9 counties in 2006 to 60 in 2008.

Table 4
Mississippi Early Education 5-Star Rating

Mississippi Department of Health license	Director training on MS Early Learning Guidelines
Director's Self-Assessment	Director must have BA in Child Development or ECE
Director's Professional Development Plan	Implement monthly on-site professional development
All teachers have GED/high school diploma	25% of teachers earn Child Development Associate
Employee evaluations	Plan and hold one parent workshop
Teacher trainings	Create lending library for parents
Obtain staff handbook	Teachers in 3-4 yr. old classroom complete training on MS Early Learning Guidelines
Create learning centers in all classrooms	File parent sign-in sheet for voluntary projects
Review and file weekly lesson plans	Create a family resource center
5.1-7.0 on Early Childhood Environmental Rating Scale	Conduct parent surveys
Prepare monthly calendars of facility activities for parents	File developmental checklist for all children
Prepare weekly notes and monthly newsletter for parents	Directors mentor another child care Director
Install a bulletin board for parent information	File kindergarten transition plan agreements with elementary schools
Complete parent-teacher conferences twice a year	
Director must complete course "Child Care as Business"	

Note. From Grace C. & Shores E.F. (2008). *Earn Your Stars! The Step-by-Step Workbook for Child Care Directors in the MS Child Care Quality Step System.*

Early education programs participating in Mississippi's CCQSS strive for a 5-star rating (see Table 4 for details). Each level meets specific requirements in administrative policy, professional development, learning environments, parent involvement, and evaluation. Centers prepare for participation by completing a

Director's self-assessment, developing a professional development improvement plan for each employee, completing staff evaluations, and planning for the monitoring visit (Grace & Shores, 2008).

Once the pilot is completed in 2011, and an evaluation confirms positive outcomes for children and centers, Mississippi must seriously consider expanding its QRIS to all counties and shifting from voluntary participation to mandatory compliance for infant and toddler centers. For example, North Carolina and Tennessee require all early education programs to participate in their states' QRIS by attaching the rating system to the child care licensing process. Additionally, this system should incorporate NAEYC accreditation, with accreditation achieved in conjunction with the 5-star level of the QRIS.

To institutionalize a QRIS, Mississippi must establish stable financing. As seen in the pilot, the state reimburses centers at a higher rate depending on the level of quality achieved (quality bonuses), referred to as a tiered reimbursement system. Typically, this form of reimbursement is financed through the Child Care and Development Fund (CCDF), TANF, or general funds (Stone, 2004). If Mississippi does expand participation to every licensed infant and toddler center, however, the state must create a dependable funding source.

Lessons learned from the 14 states currently implementing QRIS offer examples of creative financing. Eight of the nine states established grants or merits for quality funded by CCDF quality dollars or state general funds. For example, Vermont established a special annual grant for infant and toddler programs that participate in their QRIS. Likewise, Pennsylvania created Star Support Grants for programs ranging from \$1,250 to \$12,000 per center per year dependent on the center's size and star level (must achieve at least 3 stars to qualify). This form of financing is a creative opportunity for Mississippi. However, many states reported that this money was vulnerable to state budget cuts (Stone, 2004).

Provide tax incentives for families to use high-quality infant and toddler care centers and for providers to offer high-quality service

The creation of high-quality infant and toddler care solutions must include incentives for provider development and consumer

usage. Consumers in Mississippi – in this case vulnerable families – feel burdened by the high costs associated with quality care. Consequently, the demand for high-quality services declines. Early education providers also feel the burden from quality costs, leading many to increase their prices to supplement infrastructure improvements. Using incentives would give Mississippi two complimentary ways to combat this dilemma: providing consumer tax credits for families using high-quality care, and providing business investment tax credits to offset the costs of offering high-quality service.

Consumer tax credits. The availability of high-quality infant and toddler center care in no way ensures that vulnerable families will use these services. The cost of such care remains an issue. Early education represents a market-driven system, meaning consumers choose services and pay the price set by providers. However, economists at Cornell University claim that early education is an “underdeveloped market” because of the inadequate demand from consumers for high-quality services due to its costs (Stoney & Mitchell, 2007) and competing demands to pay for other basic necessities with limited resources.

The tax system helps working parents with children pay for expenses, including programs such as the Child and Dependent Care Tax Credit (CDCTC), the Earned Income Tax Credit (EITC), and the Child Tax Credit (CTC), which can be used to lessen the financial burden of child care. The Family Tax Relief Act of 2008 improved CDCTC – a credit for individuals who pay for child care – by making it fully refundable, raising the percentage of expenses that can be claimed, increasing the expense limit of child care costs, and adjusting the credit for inflation (NWLC, 2008). The EITC helps low-income working individuals and families rise above poverty levels by offering a tax credit of \$2,917 for one child and \$4,824 for two or more children. The CTC gives taxpaying families earning \$11,300 – \$110,000 annually \$1,000 per child.

Although current tax credit programs provide extra money for families, they do not encourage use of high-quality child care. Once high-quality infant and toddler centers are available for families in Mississippi, the state might provide higher tax credits for families that use these services. Maine, Vermont and Louisiana have increased tax credits for families using high-quality child care centers that have a Quality Certificate from a Quality Rating and

Improvement System (QRIS) or NAEYC accreditation. Maine doubled the CDCTC for parents who enroll their children in Maine Quality Certificate programs. Vermont increased the CDCTC to 50% of child care costs if the center in use is NAEYC accredited. Louisiana enacted a “school readiness tax” that created a refundable, progressive tax credit for families with children under the age of 6 enrolled in a participating QRIS program (Stoney & Mitchell, 2007). Such tax credit strategies encourage families to choose high-quality care, when available, by providing financial relief.

Mississippi must bear in mind two paradoxical factors when structuring a consumer tax credit. Relying on lessons learned from the “green” energy tax credits, the tax must be large enough to create incentive to use higher priced services of higher quality. At the same time, the tax credit cannot be so large as to create fear of over-consumption, leading to an abrupt elimination of the credit. Additional tax credit considerations include advertising quality infant and toddler centers so parents can easily distinguish eligible providers, assuring public understanding of high-quality goals and tax credit options to help shift behaviors of consumers, offering applications at point of purchase, and ensuring benefits for low-income parents.

Business investment tax credits. Quality improvements in early education costs money, and providers pay the bill. It remains unwise for providers to pass the costs to the consumer because increased costs deter parents from using high-quality care. Mississippi can increase its supply of high-quality centers by creating business investment tax credits for quality improvements.

Several states endorse tax credits that partially reimburse costs spent on improving quality. The Maine Quality Child Care Improvement Tax Credit, launched in 1999, compensates \$1,000 for every \$10,000 invested in quality improvements yearly for 10 years. Oklahoma reimburses 20% of high-quality improvements deemed eligible by the state. Florida established a sales tax exemption for educational material for early education programs that achieve one of several state accreditations. Although no evaluations of business investment tax credits exist, Maine noticed an increase in early education quality improvement initiatives (Stoney & Mitchell, 2007).

Consumer and provider tax policies introduce an important aspect in promoting high-quality infant and toddler center-based care. As seen in “green” energy tax credits, tax relief has been shown to greatly alter consumer and provider behavior. When pursuing tax incentive strategies, Mississippi could utilize tax experts and ensure that financial resources are dedicated to these credits. Tax policies remain an important feature for Mississippi to consider in its formulation of new infant and toddler policies.

Recommendation for Action

High-quality early education is the only way to combat the devastating challenges and effects of vulnerability – single parent households, children in poverty, and low-birthweight babies. High-quality care reverses many of the effects associated with vulnerability, such as lower levels of cognitive stimulation in a home with a time-constrained single parent, emotional detachment by parents experiencing depression from living in poverty, and undiagnosed developmental delays resulting from low-birthweight (National Research Council, 2000 & Federal Interagency Forum, 2007). Early services for infants and toddlers promote proper social, emotional, cognitive, and physical development – a formula for a strong and active community in the future. High-quality care reinforces not only the child’s growth and development, but also helps parents through referral services and opportunities for parental involvement in the classroom. As money trickles down from the Federal government, Mississippi must invest wisely in the care provided for its youngest citizens.

The policy alternatives pursued by Mississippi officials should ensure a gain in benefits superior to the costs. Ensuring high-quality care in the home through an at-home infant care program is not likely to produce these results. The concerns associated with the program – creating a monitoring system to decrease system abuse, insufficient cash benefits to support a family, public discontent about restricting state assistance, and a questionable funding source – outweigh the minimal benefits of the program. Furthermore, the only known implementation of AHIC consists of programs serving roughly 30 participants. Mississippi has far too many vulnerable families to rely on a program serving so few.

Therefore, this alternative will not produce the results Mississippi needs at this time.

Given the benefits of the other policy alternatives, and the fact that they can be used in combination with one another, Mississippi should consider a sequenced approach to high-quality infant and toddler care for vulnerable families (see Table 5). Before Mississippi advertises any tax incentives for consumers, they must ensure that high-quality options exist. Therefore, Mississippi should start by evaluating their current infant and toddler care system and determine why so few of them are high-quality. Then that the state can determine which option(s) – creating partnerships between EHS and community-based centers, enforcing Mississippi Child Care Quality Step System as mandatory, and/or providing business investment tax credits – best suits its vulnerable families. If money allows, a combination of all three options presents itself as an additional option for the state.

Creating EHS partnerships and enforcing a QRIS represent excellent choices because of the existing infrastructure, including 38 EHS programs throughout the state and a pilot QRIS. Strong evidence supports each option, predicting great outcomes for early education enrollees influenced by either initiative. Once high-quality infant and toddler care exists for all vulnerable families, Mississippi should then take a second step to ensure usage by creating consumer tax incentives. This sequence reduces the risk of solely benefiting those families that can access and afford high-quality care, by also ensuring that vulnerable families can access high-quality care.

Evaluation is an important step for any new policy. Funds should be reserved for evaluation, both during and after implementation. Documented gains – in this case, more vulnerable children in high-quality infant and toddler care – strengthens the argument for continued funding and replication in new communities. The goal for Mississippi is high-quality care throughout the state, and evaluation serves as the source of such accountability.

Lastly, Mississippi must extend state support to preschool education (services for children 3–5 years old). Investing time and money into infant and toddler care will only produce short-term benefits unless high-quality services support children throughout their entire childhood. Leaving a gap in services between infant

Table 5

Ordered Sequence for High-Quality Infant and Toddler Care

Step 1: Increase availability of high-quality care

- Establish partnership between EHS and community-based centers
- Enforce Mississippi Child Care Quality Step System as mandatory
- Provide business investment tax credits for providers to improve services

Step 2: Provide incentives for usage

- Create consumer tax credits for parents who choose to use high-quality care

Step 3: Evaluate continued needs of vulnerable infants and toddlers

- Ensure vulnerable children are in high-quality infant and toddler care
-

and toddler care and elementary school could easily erase the progress made in the earliest of years and continue the disparity for vulnerable children. These options for Mississippi's infant and toddler care system could easily be replicated into preschool care.

The Future of Infant and Toddler Care

The field of early education has made significant gains in the last few decades. The field has experienced the introduction of high standards formulated by the NAEYC, research-based findings clarifying the development of young children's learning, and various policies fostering infant and toddler center-based care. One of the driving forces behind these advances has been widespread acknowledgement of the fact that low-quality child care can cause harm to young children's growth and development. The nation learned that the early years matter, and, especially for vulnerable children, high-quality care generates great outcomes.

Many vulnerable families, however, continue to struggle with access to and affordability of high-quality child care. To ensure all children have the opportunity of utilizing high-quality care, states must implement creative policies that increase access and

affordability. The passing of the American Recovery and Reinvestment Act serves as a launching pad for the early education field to invest money in its services. The selected policy alternatives promise to bring the future of infant and toddler center-based care to new heights.

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The Impact of Policy on the Economic Opportunities and Well-Being of the LGBT Community

Theadora Fisher

This paper examines the impact of public policy on the economic position of the lesbian, gay, bisexual, and transgender (lgbt) community when compared to the rest of the US population. The paper explores this issue by examining the impact of public policy on asset building opportunities. First, the assets approach is outlined. Second, a range of asset building barriers are explored that could be addressed through public policy, such as prejudice and discrimination in the workplace, and the exclusion of same-sex couples from the benefits of legal marriage. Policy implications suggest the development of non-discrimination policies and access to equal benefits through marriage and/or civil unions, which would help address the wage differential and higher parenting and living costs faced by lgbt families.

Within the gay rights movement, the rhetoric surrounding the push for civil rights is often couched in terms of social equality and citizenship, however the underlying arguments are often economic. One of the fundamental concerns is that the lesbian, gay, bisexual, and transgender (lgbt)¹ community faces barriers to economic opportunities that are available to other citizens due to their status as a sexual minority. Current anti-discrimination policies are often called for to prevent gay and lesbian individuals from losing their jobs or employment opportunities, and hence their income. Access to marriage is often portrayed as a civil or human right, with the rhetoric surrounding the debate about love in manners such as the Unitarian-Universalist slogan, “standing on the side of love” (Unitarian Universalist 2009) and individual freedom of choice. However, the issue of access to marriage is much larger. Marriage, sanctioned by the state, brings economic protection and asset-building opportunities (in the form of tax benefits, joint credit applications for mortgages and other debts, and access to benefits such as social security), secures inheritance, and reduces costs for family formation and child-rearing through legal recognition of parenting relationships (Bennett and Gates, 2004). This paper

explores how public policies may directly or indirectly limit the asset-building opportunities of the lgbt population to improve our understanding of the impact of policy on this population.

Assets, Policy and Opportunity

What Do We Know about the lgbt Population?

One major challenge that arises when looking at issues that impact the lgbt community is that of the availability of data. There are only a few national surveys that ask questions about sexual orientation, namely the General Social Survey (GSS) which is used generally as a pooled sample from 1988-1996, the National Health and Social Life Survey (NHSLs) conducted in 1992, and the U.S. Census beginning with 1990 (Black et al. 2000, 140). These data are very useful, and since information started being collected on this community, many researchers have taken advantage of these sources. However, according to Black et al (2000), there are some issues with information from these surveys. For one, the GSS and the NHSLs results are very small samples. Fewer than 2% of 3,432 respondents for the NHSLs identified as either gay or lesbian; the GSS produces a sample of about 150-450 gays and lesbians depending on how these categories are defined.

The U.S. Census is a much bigger dataset, with 13,700 identifiable gays and lesbians (Black et al. 2000). The problem with the census data, however, is that the method used to distinguish gays and lesbians is participation in a cohabiting, non-roommate household with a member of the same sex. Since the only lgbt people this dataset counts are same-sex partner-headed households, it is useful for comparisons between gay and straight couples, but does not tell the whole story of the lgbt experience. Many researchers run extra comparison tests between their gay and lesbian observations and their straight observations to try to make sure that their sample is as trustworthy as possible. Black et al. (2007) compare statistics on key areas like income and education across the census data and the GSS data (which tracks gays and lesbians at the individual level, not the couple level) and finds these statistics are similar for both individuals and couples across both dataset. This suggests that, though the census just deals with partnered gays and lesbians, they are representative of the general population of gays and lesbians. Additionally, all three datasets

have the issue of non-disclosure. There is a stigma attached to being recognized or perceived as gay; many people are not out to their communities, workplaces, and even to their families. There is no way to tell how many respondents choose to conceal or lie about their sexualities.

Assets and their Connection to Well-being

Poverty and financial well-being are often equated with earned and unearned income. However, the commonly accepted Sherraden (1991) argument suggests that in order to more accurately understand an individual's well-being and capacity for economic mobility, one must look at the resources held – the assets as well as the income. The assets approach understands income as the means for day-to-day survival and assets as the resources to get ahead. However, assets are not just financial – social capital, in the form of family networks, business contacts, and group affiliation, and human capital, in the form of education and job skills, are both very important to an individual's pursuit of financial stability and well-being. Assets are instrumental in achieving higher education, homeownership, class mobility, and financial security (Page-Adams and Scanlon 2001, 8), and provide an important buffer against unexpected financial crises such as a lost job or an extended illness. One out of four American households are 'asset-poor', meaning that their stock of assets is not big enough to sustain them for three months at the poverty level if they were to lose their income (Woo et al. 2004). In this theoretical framework, assets are key to financial stability and security.

There is a growing body of literature that shows a positive relationship between assets and well-being. Page-Adams and Scanlon (2001) survey the literature and find that homeownership, youth savings accounts, financial wealth and investment income are all correlated with positive benefits for parents as well as their children. They also point out that "homeownership plays a crucial role in wealth accumulation for U.S. households" (Page-Adams and Scanlon 2001, 7). Assets have more than a practical, financial impact on the lives of those who have them – they have a psychological impact as well. According to Sherraden (1991), assets increase the time horizon for a person's thinking about their future; if they are aware of a concrete opportunity, then there is a goal they can work towards accomplishing. Sen (1999) makes this point in a slightly different way – a person's circumstances may be so

restricted that it is not possible for them to imagine another way of life, but that simple fact should not be misconstrued to mean that they would not be happier with more and better opportunities.

The U.S. has many policies that directly or indirectly impact asset-building for individuals and families. Tax policies include the mortgage interest tax deduction, which allows homeowners to reduce their income tax if they are paying off a mortgage, tax benefits to saving money in special retirement accounts, and tax breaks on interest from higher education debt (Howard 1997). The many benefits that accrue to married couples also promote asset-building, including social security survivor benefits, joint credit assessments used for determining eligibility for mortgages and large purchases, and the tax bonus for married couples making unequal incomes. Therefore, focusing on asset-building policies and opportunities is potentially a fruitful way to look at the economic challenges faced by the lgbt community. We have seen that assets are important to individual well-being and development; through this lens, we will explore policies that influence asset accumulation within the lgbt population, whether through limitations related to discrimination and inadequate provision for anti-discrimination measures or through the lack of access to institutions like marriage.

Linking Policy to Economic Opportunity

Why do disparities exist between different communities, and what role does policy play in providing economic opportunities to some people and not others? Many legal barriers to equality have been lifted including 21 states with antidiscrimination laws, 13 of which include gender identity as well as sexual orientation, and four states, Massachusetts, Connecticut, Iowa, and Vermont allow same-sex couples to legally marry each other (National 2009). However research suggests that policy barriers that restrict opportunities and advancement for the lgbt community compared to the general population continue to exist. Three barriers stand out: 1) absence of specified protection from discrimination, such as in the workplace; 2) specific discriminatory policy, such as the ban on serving in the military; and 3) the lack of access to the institution of marriage and its attendant benefits. Existing studies primarily examine these barriers by looking at an individual's access to resources such as income and employment, which are important components of asset accumulation. This section first examines the

acquisition of income and education through the framework of specific and non-specific discrimination policies and then will turn to an examination of the impacts of the access barrier to marriage as it affects asset accumulation, child-rearing choices, and tax status.

Assets and Employment

The Wage Differential

When addressing the question of barriers to asset accumulation, one of the most basic facts to establish in assessing the economic position of the lgbt community is whether or not average earnings are the same between both lgbt and straight populations. There is a common stereotype about the lgbt community in which they are more highly educated and well-paid than the rest of the population (Badgett 2001, 1). According to Vaid (1996) this assumption stems from marketing studies, where surveys were sent out to magazine subscribers and given to people who attended gay pride events in urban metropolitan areas. These studies found that household income was well above average for both gay men and lesbians. This promoted an image of two gay white men living in an urban environment, both with good jobs and no children as the primary profile of the population. In fact, the opposite is true. More recent and systematic studies suggest that a negative wage differential does exist for the lgbt community. For example, Badgett's (1995) groundbreaking study of the wage effects of sexual orientation discrimination found that gay and bisexual men earn between 11% and 27% less than their straight male counterparts.

However, Badgett (1995) also found no statistically significant difference between lesbian and bisexual women's earnings and their straight female counterparts. Although her findings about gay men have not been challenged and are very robust, the observation about lesbians' wages have not been replicated in subsequent studies. Black et al. (2003) found that lesbians actually earn more than straight women, and hypothesize that this may be for a number of reasons. Lesbians have a different view of their life trajectory – they do not plan to marry men, which is a factor for straight women's decisions about investment in their market production skills. The authors discuss gender discrimination against women, which could lead to a perception effect – straight women often assume they will get married and so put less effort

into market production skills because they expect to partner with a higher-earning man and/or seek careers that will enable them to have flexible working hours during child-rearing years which often provide lower wages. Lesbians, on the other hand, believe that they will face discrimination on the basis of gender, and possibly also on the basis of sexual orientation, and so put extra effort into market production skills and career tracks that afford advancement believing that their potential partners will face the same constraints that they themselves face (Black et al. 2003, 468). Additionally, Black et al. (2003) stated that lesbians also know that they will not be able to share in the financial benefits of marriage, so that living costs will be higher overall.

Human capital and education also influence wage and employment levels and are important assets in leveraging and increasing income and financial wealth (Sherraden 1991). The research points toward lesbians and gay men having higher education levels than the average population, which would, at first glance, reinforce the stereotype of the lgbt community's higher income outlined earlier. However, some studies (Barrett et al. 2002; Black et al. 2003) show that in spite of higher average educational achievement, gays and lesbians are still earning less than their straight counterparts. In Black et al.'s (2003) study of the earnings effects of sexual orientation, they control for the effect of men's backgrounds on their educational achievement. They find that the gay men in the sample have higher educational achievement relative to straight men, but that there is no difference in the educational achievement of their fathers across the study. This suggests that gay men, all other things equal, are choosing to pursue more education than comparable straight men. Yet despite their higher levels of education, gay men are still unable to close the wage gap between themselves and straight men (Black et al 2003). Consistent with these findings, Barrett et al. (2002) study points out that "gay men overall earn less than heterosexual men, showing that they do not convert their education into income at the same rate as straight men" (178).

The discussed studies demonstrate how the lgbt community face wage-based barriers in accumulating financial assets. Gay men continue to earn less than, not only their straight male counterparts, but even those of lower education levels as well. Additionally, although lesbian women are able to earn equal to or more than their heterosexual counterparts, these differences may

be the result of employment decisions that are influenced by gender and sexual-orientation based discrimination.

Employment Antidiscrimination Policy

Currently, federal policies do not prohibit sexual orientation discrimination in private employment or explicitly in public employment (Kalawitter and Flatt 1998). However, the Employment Non-Discrimination Act, a federal legislation that would ban sexual orientation discrimination in private employment, is under consideration. At the state level, twenty-one states and the District of Colombia have passed laws banning sexual orientation discrimination in employment (Human Rights 2010).

One might think that in regions where there are antidiscrimination policies in place to protect lgbt people from being fired because of their sexual identity there would be a smaller wage penalty. However contrastingly, research indicates that these local legislative efforts either have no or a negative effect on the lgbt workers' wages. For example, Klawitter and Flatt (1998) did not find that "employment protections for sexual orientation directly increase earnings for members of same-sex households. Average earnings for both same-sex and different-sex couples are higher in areas with more employment protection, but these differences are explained by worker and area characteristics," such as urban/rural differences and skill level/occupational differences (Klawitter and Flatt 1998, 676). Although antidiscrimination policies do not adequately decrease the wage differential between gays and lesbians and their straight counterparts, Klawitter and Flatt (1998) did suggest that such policies could still contribute to the well-being of gays and lesbians, since they give an individual "recourse against discrimination."

However, another study indicates that not only do antidiscrimination policies not reduce the wage gap between gay men and married straight men, they could potentially increase this gap as well. Carpenter (2007) found that in localities where gays and lesbians have protection from employment discrimination, the straight male marriage premium is higher than in localities where gays and lesbians have no protection from discrimination. His argument is that "employers who are uncertain about a worker's sexual orientation might plausibly use marriage as a signal for heterosexuality (i.e. marriage could signal that the worker is not

gay)” (Carpenter 2007, 77). This would mean that there is an implicit bias against gay men, and the more ‘non-gay’ one appears, the more the wage will increase. This is a fairly weak finding, however, and Carpenter calls for further research on the connection between the heterosexual marriage premium and the homosexual wage penalty.

In looking beyond government policies, employment policy set by companies themselves can have the power to fill the gap left by the absence of government protections for lgbt workers. Such policies have shown to have a major impact on the well-being of lgbt employees. For example, Ragins and Cornwell (2007) points out that though gay and lesbian employees make up a significant part of the workforce, they “do not enjoy the basic ‘family-friendly’ privileges of their heterosexual counterparts; many lesbian and gay employees do not have health care benefits for their partners and cannot take time off work if their partner becomes ill or dies” (105). The authors find that gay family-friendly policies had a significantly positive effect on workers’ organizational commitment, organizational self-esteem, and a negative effect on employees’ intention to quit their jobs. Lesbian and gay workers were also more likely to come out at work when these policies were in place.

Military Service Discrimination

Military service is a special barrier that can be understood as both employment discrimination and a significant barrier to asset building opportunities. There are many ways that military service can create career trajectories and enhance educational qualifications (key features of economic mobility), which makes the exclusion of gays and lesbians a particularly significant barrier to opportunity. However the US military has an active government policy of excluding gays and lesbians.² Gays and lesbians are currently officially banned from serving in the military, but under the ‘don’t ask, don’t tell’ policy, they are allowed to serve as long as they do not disclose their sexuality or discuss it in any way (Gates 2004, 7). This policy has not stopped gays and lesbians from serving, however. According to a research brief by Gates (2004), partnered gay men are slightly less likely to serve in the armed forces than straight men, and partnered lesbians are almost twice as likely to serve as straight women. It is interesting to think about this high propensity for partnered lesbians to serve in the military, since one would assume that being partnered would increase the

chances of having one's sexuality revealed and subsequently being thrown out of the military. Perhaps there is an even higher proportion of un-partnered lesbians serving in the military who are not counted by the census. It is very difficult to get statistics on sexual minorities serving in the armed forces since the 'don't ask, don't tell' policy creates a significant barrier to inquiring about the topic.

Assets and Family Well-Being

As noted earlier, access to marriage and its state protected benefits is a major focus of the gay rights movement. In all but five states (Massachusetts, Connecticut, Iowa, New Hampshire, and Vermont), same-sex marriage is not legal, and no same-sex couples are accorded the federal benefits of marriage due to the Federal Defense of Marriage Act (DOMA),³ though this policy is currently the target of several lawsuits (Alliance 2008). Aside from the many social and cultural benefits that society accords to marriage, the officially recognized legal status confers many rights and privileges that are key to promoting family security and stability. Specific aspects of marriage that this paper examines are parenting and custody laws, the economic and tax implications of joint households, inheritance laws, and the possibility of being covered under their partner's health insurance policy.

Marriage is a main concern of same-sex couples when they decide to become parents. Couples may have children that are genetically related to one of them, from a previous heterosexual relationship or artificial insemination and surrogacy; others may adopt children either domestically or internationally. In the 1990 census sample, 21.7% of partnered lesbians and 5.2% of partnered gays had children present in the home, about 75% of whom were under 18 years of age. More recent numbers from the 2000 census show that 20% of same-sex couples are raising children under the age of 18 (Romero et al. 2007, 2). Marriage plays an important role in access to methods of starting families – many fertility clinics explicitly choose not to work with women who are in relationships with other women (Cahill and Tobias 2006). Once the child is conceived, lack of access to the institution of marriage introduces the cost of adoption into the relationship, as even if one parent is the biological parent, the other parent must always officially adopt

in order to be recognized as a second legal guardian (this process is known as ‘second-parent adoption’) (American Academy 2002, 1).

If a same-sex couple wants to start a family via adoption, they may also face additional costs, and in six states they are prohibited from adoption outright including Utah, Nevada, Michigan, Florida, Arkansas, and Mississippi (National 2008). As either adoption or second-parent adoption plays a role in almost all same-sex-parented family configurations, the cost of this process must be seen as a pernicious economic penalty that accrues to same-sex couples. For example, Black et al. (2007) found that “gay and lesbian couples who wish to adopt must face not just monetary costs but also time and effort to overcome implicit and explicit discriminatory obstacles” (57).

Once they have the child, the new family may be operating within significant resource constraints. According to the 2000 census, lesbian and gay parents have fewer financial resources than straight married parents. They have a lower median household income (\$46,200 versus \$59,600), and fewer of them own their own homes (51% versus 77% of straight married parents) (Romero et al. 2007, 3). Ash et al. (2004) found that the state of same-sex parenting in Massachusetts posits that same-sex couples face credit constraints when applying for mortgages because they cannot marry, making it more difficult to buy a home together.⁴ More generally, Black et al. (2000) found that “regardless of age category, the rate of homeownership is lower for partnered gay and lesbian households than for married-couple households” (153). This study also revealed that in the event that same-sex couples do own a house, it is either somewhat more expensive (lesbians) or much more expensive (gay men) than those owned by married-couple households; this is counterintuitive given the lower average income held by gays and lesbians, but may indicate that same-sex couples are choosing to parent in wealthier than average communities, where they may feel that there is a more tolerant attitude towards their family.

Another major benefit of marriage is inheritance. Inheritance is automatic for the spouse of a married person in the event of their death, and if an unmarried partner dies with a will, their wishes will be most likely be followed (Johnson et al. 1998). However, if an unmarried partner dies without a will, then state intestacy law will prevail. In most cases, the state will pass along the deceased’s

estate first to children, then to parents, then to siblings and other blood relatives if there are no surviving children or parents. According to Johnston et al. (1998), states developed these policies in light of public opinion that the deceased's estate should not be kept by the government but given back to the family. Same-sex couples who do not have access to marriage must create new legal documents to designate their partner as the person who inherits their estate as well as to address other important matters, such as who has the power to make medical decisions in case of incapacity; this is another way in which lack of relationship recognition adds to the cost burden of same-sex couples, since hiring a lawyer to draw up these documents is expensive and time-consuming (Johnson et al. 1998). Furthermore, these documents are not always respected when it comes time to disperse the deceased's estate. Unmarried partners are also infrequently covered under their partner's health insurance. Even in places where they are covered, the benefit is taxed, unlike that of a straight married spouse, which adds to the financial burden faced by the couple (Konrad 2009).

Marriage also has many tax implications for couples: married couples can file their taxes jointly, transfer ownership of property without paying a transfer tax, pay for a spouse's health insurance policy before taxes, and inherit property from a deceased spouse without paying estate tax. One practical problem brought into play by DOMA is that though a couple may be married in their home state, and thus may inherit without tax penalties, the IRS has no obligation to recognize that marriage for tax purposes. These highlighted issues in this section illustrate the importance of marriage as an asset-building opportunity as well as a social institution with many important benefits.

Policy Reflections

The issues and barriers to equal opportunities for the lgbt community outlined in this paper suggest a need for policy change in several areas related to employment, marriage, and family formation. As long as legal barriers exist to exclude the lgbt community from engaging fully in society and the economy, they as individuals and the families they form will be have fewer opportunities than the rest of the population for economic mobility and security. From employment to adoption to inheritance, these

barriers to opportunity lead lgbt families to face greater obstacles to security and incur greater costs than their straight counterparts. The most effective strategy for ensuring that these individuals and families experience the same security and stability as the straight population is to grant them the same rights and benefits and access to opportunities that straight people enjoy. This can be achieved through revising policies that single out and discriminate against gays and lesbians, or that simply fail to protect their rights; eliminating the ban on serving in the military and adoption restrictions; removing barriers to marriage, or creating a legal status that is identical to marriage which carries with it the legal benefits of marriage at both the federal and the state level.

This paper has started to identify the existing policy barriers that negatively impact the lgbt community and restrict its opportunities for wealth-building and advancement. Granting access to the legal institution of marriage would address issues of inheritance and family-building. Implementing protection from employment discrimination would give the lgbt community more job security and access to employment. Further, the census and other national surveys should be adapted to ensure that data on the lgbt community is being gathered to help inform our understanding of the challenges faced by this population.

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Notes

1. This is the acronym most commonly used in literature. Using lower-case font is a newer practice among members of this community, and reflects the fact that the words themselves are not capitalized in everyday usage.

2. This is codified in the Uniform Code of Military Justice (10 U.S.C. sec. 801-946)
3. Public Law 104-199, "An Act to Define and Protect the Institution of Marriage" signed into law on Sept. 21, 1996 (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=104_cong_public_laws&docid=f:publ199.104).
4. This report was published before same-sex marriage rights were recognized in Massachusetts. These constraints are no longer present for same-sex couples in MA, but this point is generalizable to the broader lgbt population.

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Faculty Interview: David Gil

Sara A. Wall

Professor Gil studies and teaches societal roots and dynamics of violence and oppression, links between social institutions and human development, the nature and dynamics of social policy, and strategies to transform social orders into development-conducive ways of life. He has taught at the Heller School since 1964. He was honored at this year's Heller 50th Anniversary celebration for his dedication and contribution to the school and the fields of theories of social justice and social work. This interview took place on December 11, 2009.

Sara Wall, for Inquiries in Social Policy: *As students of public policy, we are often pragmatic in thinking about small incremental changes to improve the lives of vulnerable populations today, even though we know it is far from what needs to be done. Others argue that working within the existing system reinforces unjust norms and that we should stop nothing short of revolution. For those of us planning for a career in public policy, what is the balance between these two perspectives?*

David Gil: Well, the dilemma between doing things immediately to reduce the intensity of deprivation and suffering makes sense as long as one doesn't confuse it with the real answer. We certainly need a revolution of our way of life, we need a very comprehensive transformation. But that is a matter for the long-term. I don't think we can have a successful revolution through violent processes. That is what history teaches us, if we look at the Russian revolution or French revolution. If we believe in justice we need a comprehensive answer. The war in Afghanistan has not brought justice. We have to learn through Mohandas Gandhi and Martin Luther King to obtain justice through non-violent strategies. We need a long-term strategy to address injustice through a non-violent means.

But in the meantime people need to eat and be housed and have a sense of usefulness. So, we need policies that assure food, assure health, and assure education. All of these things are attainable

within a system of injustice. In other countries, like Scandinavian countries, other European countries, they demonstrate that this is possible. There is no country in Europe that doesn't have universal health care, but here we have to accept conversations in Congress and media about whether we should establish health care. We need a two-level strategy: a short-range and long-range one and we have to try to integrate them. The problem is that many political people inside and outside of government promote an important minor step, but they act as if that's a real answer. And they don't say, 'we ought to do this right away, but in the long-term we have to overcome the dynamics of injustice.' That is why I call it a dual strategy. And as far as possible, (we need) to integrate them.

In the present, we have food kitchens and shelters. It is better to have food kitchens than starvation and it is better to have shelters than people homeless, but it is better if we don't have conditions that lead to the need for these and that is what we have to focus on for the long-term.

We have to be honest about what we do, when we do it, and know if it is an incremental change or not. Right now the big issue is health policy. This is an example of an incremental change, and we should pass it, but we shouldn't say that is a real answer or the only answer. This is an essential measure, but not an answer.

To me, the yardstick for the policy system is the extent to which it is conducive to meeting peoples' universal needs: biological-material needs, social-psychological needs, productive creative needs, and the need for security. The need for self-actualization and their spiritual needs. We all have these needs. To me, these are the criteria for evaluating any policy, both short-term and long-term. If we pass the health policy, that's a short-term positive step because thousands of the un-insured will now have health care. But many people will continue to be deprived of their social-psychological and productive needs and so forth. This dilemma is real and can only be dealt with constructively if both dimensions of the short-term and long-term are considered.

SW: *Part of policy making is assessing political feasibility. The idea of "long-term" can be hard to sell to politicians who are reluctant to admit they did not solve a problem.*

DG: All elections, at the present, do not deal with the long-term. Largely because what and who we elect focuses on the top and solutions come from the bottom. Governments don't provide solutions, they maintain the status quo. They are paid for by people who are interested in the status quo. The administrators, representatives and the president do the bidding for those who pay for the election. If you want real change, it comes from outside the government.

For example, the women's movement and the Civil Rights movement in this country, they did not come from the top. Look at the Civil Rights movement which was a struggle that came from the black churches. It was not driven from the top. So, the politicians, I am not questioning their decency, they are as decent and you and I, but they operate in a system that is geared at maintaining privilege and deprivation. And the long-term change requires social movements.

You are studying for the Masters in Public Policy, so that you can enter into current political processes and administrative arrangements, but that shouldn't stop you from linking-up with people who are interested in long-term fundamental change. And you can inject these ideas into your various political or administrative jobs. If you can teach politicians that what they're working for is not a real answer, that it's an emergency measure and is necessary, but it is not a real answer, this can start the integration process. And you have to be involved in organizing movements. Look at what they did in the women's movement. A small group of women got together in what they called 'consciousness raising groups.' They talked about their situation. Then in the Civil Rights movement women were exploited by men. They did the cooking and cleaning and the men created the ideas. It promoted critical consciousness; that is the key.

SW: *I often have debates with friends about whether mankind is innately good or evil. Is the goal of a just society a utopian goal? Is a just society attainable?*

DG: Human nature is far broader than the behavior of any particular culture. If you study anthropology, you learn about human groups who have lived cooperatively. Many of the native peoples of this country practiced cooperation, prior to the invasion

Wall

of the Europeans. They had justice for women. Women voiced their opinions and there was a division of labor. Women were not deprived relative to men in these cultures. There were also European cultures that were cooperative. This tells you human nature is not good or evil, it has the capacity for both. What humans actually do depends on their social system, their culture. We are competitive because we are rewarded for being competitive. That doesn't mean we couldn't be cooperative. So, this discussion is not an either or, it is both under different conditions.

SW: *In thinking about the careers that graduates of the Heller School will pursue, how can we begin to embody our motto of knowledge advancing social justice professionally?*

DG: The process of transformation starts with the self. I ask all of us here in the school, where we are more or less privileged, relatively speaking. But most people take their privilege for granted and do not acknowledge that they are privileged in an injustice system. So, the first steps are self-examination of one's family (and) one's relations to others. And that's not easy to do. Because the school, the university, is a reflection of the culture and it is a competitive culture....People don't examine their own position within this competitive culture.

Once one examines this, once you conclude that you ought to change your own way of life, then you can begin to change your relations to others. And you can look for like minded people and develop support groups, like egalitarian communities in this country. Now, these are people who have learned from history that change doesn't come overnight. It comes from a process of creating alternatives. If you study the history of capitalism, a system which we live within now, how did it start? It didn't start as a global system. People created islands in opposition to the lords and the feudal system. And that is what these people are trying to do, to create island of justice within the context of injustice. I used to live in such a community in Palestine a long time ago.

Part of the process towards real change, is to create the new within the old. These efforts don't eliminate capitalism, they function within it. But they create cooperation between people and demonstrate what is possible. That is how, eventually, we can create a new system.

SW: *I want to conclude by asking you about your 45 years here at the Heller School. At Heller's 50th anniversary, you were recognized for your contribution to the school. I remember Professor Jon Challengerian said he "always learns when you speak." Others on campus have called you the "moral compass" of the school. You have served for years as a mentor for both faculty and students. What is it that guides your own work on a day to day basis?*

DG: I have to tell you a little bit prior to Heller because what I did here makes only sense in terms of what I did a long time ago. I grew up in Vienna, Austria when it was occupied by Germany. I was 14 years old. My father was arrested and I had to leave my school. Then I was sent to a segregated school for Jewish kids. After a year, I left without my family to Sweden where I worked on a farm. And of course I kept thinking, what is the meaning of all this? And at that time I was fortunate to read the biography of Mohandas Gandhi and that really showed me that you cannot deal with Hitler by being like him or being a better Hitler. Since then, I have been committed to non-violence and to fundamental change through non-violent measures, cooperation, and through critical consciousness. Now that is the philosophy I brought to Heller. I have tried through my decades here is to educate for fundamental change through my classes, and writings and to do it consistently. To believe we can keep going the way we are. That is unreal. We are on a suicidal course if we don't change direction. We will destroy ourselves.

You ask about my 45 years at Heller School. I came here because this school from the beginning said "we are not training clinical social workers." All of the faculty were social workers at the beginning, but were frustrated from the futility of clinical practice that helps an individual and is necessary, but leaves the causes of peoples' problems untouched. The Heller School was established to study the causes and think about fundamental solutions. And is what I still think is attractive about the school.

